PART II

POLICIES AND PROCEDURES
for
EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES – Health Check Program (COS 600)

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION OF MEDICAID

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Policy Revisions Record

Part II Policies and Procedures Manual for EPSDT Services (Health Check)

2021

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INTRODUCTION

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit includes a comprehensive array of preventive, diagnostic, and treatment services for Medicaid eligible infants, children and adolescents under age 21, as specified in Section 1905(r) of the Social Security Act (the Act). The EPSDT benefit is also available to PeachCare for Kids® members up to 19 years of age. The EPSDT benefit is designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible. The goal of the EPSDT benefit is to assure that individual children get the health care they need when they need it. The EPSDT benefit also covers medically necessary diagnostic services. When a screening examination indicates the need for further evaluation of a child's health, the child should be appropriately referred for diagnosis without delay. States are required to arrange for and cover under the EPSDT benefit any Medicaid covered service listed in Section 1905(a) of the Act if that treatment or service is determined to be medically necessary to correct or ameliorate defects and physical and mental illnesses or conditions. This includes physician, nurse practitioner and hospital services; physical, speech/language, and occupational therapies; home health services, including medical equipment, supplies, and appliances; treatment for mental health and substance use disorders; treatment for vision, hearing and dental diseases and disorders, and much more. This broad coverage requirement results in a comprehensive, high-quality health benefit for children under age 21 enrolled in Medicaid.

Rev. 10/14

Reference: EPSDT – A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents available at
https://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf

The Health Check Program provides reimbursement for preventive health services, interperiodic visits, developmental screenings, brief emotional/behavioral assessments, hearing and vision screenings, and immunizations under the EPSDT benefit. This manual provides information pertaining to the required screening components of the EPSDT program which should be performed in accordance with the American Academy of Pediatrics (AAP) Bright Futures recommendations for preventive health/well-child check-ups. Diagnostic and Treatment (DT) services available under the EPSDT benefit are reimbursed under other program areas within the Georgia Medicaid and PeachCare for Kids® programs.

Rev. 07/11
Rev. 07/14
Rev. 10/14
Rev. 04/16

The Early and Periodic Screening Components of EPSDT

All screening components for the preventive exam should be provided as outlined in this manual. The required screening components include: a comprehensive unclothed physical examination (unclothed means to the extent necessary to conduct a full, age-appropriate examination); a comprehensive health and developmental history; developmental appraisal (including mental, emotional and behavioral health components); anticipatory guidance and health education; measurements; dental/oral health assessment; vision and hearing tests; certain laboratory procedures; lead risk assessments, and immunizations. Immunizations as needed should be given at the time of the preventive health visit as appropriate. All of the age appropriate components per the periodicity schedule and this manual must be completed and documented for each screening as appropriate. All preventive/well-child services must be provided under the EPSDT benefit following the policies and procedures as outlined in this manual.

Rev. 10/09
Rev. 07/14
Rev. 10/14

The Diagnostic and Treatment Components of EPSDT

Rev. 01/10
Rev. 07/14

The Diagnostic and Treatment policies, procedures, and billing for the EPSDT benefit are found under other Georgia Medicaid programs. However, the Health Check provider may address a medical condition at the time of the preventive health visit or during an interperiodic visit. Under these circumstances, the Health Check provider bills for the office visit associated with the medical condition.

Rev. 04/14
Rev. 10/14
Rev. 01/15

Provider Manuals relevant to the EPSDT benefit include, but may not be limited to:

- Advanced Nurse Practitioner Services
- Children's Intervention Services (CIS)
- Children's Intervention School Services (CISS)
- Dental Services
- Diagnostic Screening and Preventive Services (DSPS)
- Durable Medical Equipment (DME) Services
- Federally Qualified Health Center (FQHC) Services
- Georgia Pediatric Program (GAPP)
- Hospice Services
- Hospital Services
- Medicaid/PeachCare for Kids® Provider Billing Manuals
- Nurse Midwifery Services
- Orthotic and Prosthetic Services
- Pharmacy Services
- Physician Assistant Services
- Physician Services
- Rural Health Clinic (RHC) Services
- Vision Care Services

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Provider Manuals are available for downloading. Contact Gainwell Technologies at 1-800-766-4456 or visit the website at **www.mmis.georgia.gov** for more information.

The Medically Fragile Child

Rev. 07/14
Rev. 10/14

Many medically fragile children are under the care of medical specialists. The child's primary care provider may request Diagnostic and Treatment services for the child by documenting the medical necessity for the proposed medical service. The practitioner must state the medical reason for the requested service as it relates to the child's medical condition or diagnosis. These providers should refer to their applicable Medicaid programs' policies and procedures manual for policy guidelines. See Appendix M for resources available to children in Georgia and Appendix D for an explanation of services provided under the *Children's Intervention Services* program.

PART II - CHAPTER 600

Special Conditions of Participation

601. Enrollment

Rev. 07/11
Rev. 04/12
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Rev. 10/14

Physicians (pediatricians, family practitioners, general practitioners, internists, and OB/GYN specialists), Advanced Nurse Practitioners (pediatric, OB/GYN, family medicine or adult medicine), Certified Nurse Midwives, Local Education Agencies (LEAs) [*school districts*], hospitals, Local Boards of Health (county health departments), Rural Health Centers (RHCs) or Federally Qualified Health Centers (FQHCs) may enroll in the Health Check Program to provide EPSDT services. Physician sponsored advanced nurse practitioners (pediatric, OB/GYN, family medicine or adult medicine) and physician's assistants may also enroll in the Health Check program but must maintain current written protocols and physician sponsorship. These non-physician providers must submit an official letter from their physician sponsor as proof of physician sponsorship at the time of enrollment and at the time their physician sponsorship changes. Providers who wish to provide Diagnostic and Treatment services should enroll in their respective Medicaid program, such as Physician Services, Advanced Nurse Practitioner Services, etc. Physicians, nurse practitioners and nurse midwives may enroll in the Health Check Program to provide EPSDT services and their respective programs to provide diagnostic and treatment services by completing only one provider data form.

Local Education Agencies, hospitals, Local Boards of Health, RHCs or FQHCs must enroll as an entity, as opposed to each provider that will be providing services enrolling individually. The enrolling entity must ensure that only staff members who meet the qualifications listed in Section 602 of this manual are providing services.

Rev. 01/10
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Rev. 07/17

Application Process

Providers who wish to enroll in the Health Check program are required to:

- Meet the Conditions of Participation in Medicaid's Part I Policies and Procedures for Medicaid and PeachCare for Kids® Manual (Part I Manual) and the special conditions listed in Section 602;
- Read the EPSDT Benefit Policy Manual prior to signing enrollment forms and;
- Complete and sign the Health Check Required Equipment form in Appendix G

In addition, it is strongly encouraged that providers submit an application for enrollment into the Vaccines For Children (VFC) Program – see Section 905.3 for more information.

Rev. 01/21

The Department of Community Health contracts with Gainwell Technologies to provide an electronic health care administration system for its contracted providers. The Gainwell Technologies field representatives are responsible for assisting Medicaid and PeachCare for Kids® providers with claims adjudication, the web portal and technical support. Contact Gainwell Technologies at 1-800-766-4456 for more information.

602. Special Conditions of Participation

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Rev. 01/16

In addition to the general Conditions of Participation contained in Part I Policies and Procedures for Medicaid and PeachCare for Kids®, providers in the Health Check program must meet the following requirements:

A. Physicians, including those employed or contracted by an LEA, must be currently licensed to practice medicine. (Refer to the Physician Services Manual)

B. Nurse Practitioners, including those employed or contracted by an LEA, must maintain a current registered nurse license for the State of Georgia and current specialty certification by the appropriate certifying agent of the American Nurses Association. (Refer to the Advanced Nurse Practitioners Manual)

C. Nurse Midwives, including those employed or contracted by an LEA, must maintain a current registered nurse license and current certification as a nurse-midwife by the American College of Nurse-Midwives (ACNW). A copy of the national certification must be on file with the Division of Medicaid. (Refer to the Nurse Midwifery Manual)

D. Physician-sponsored providers, including those employed or contracted by an LEA, must be currently licensed to practice and must submit a copy of their license with the application. They must also maintain current written protocols, physician sponsorship and submit an official letter from their physician sponsor as proof of physician sponsorship. These providers include:

- Certified pediatric, OB/GYN, family, general or adult nurse practitioners. A recent graduate of a Nurse Practitioner Program may enroll as a Nurse Practitioner once he/she passes the Specialty Certification exam.
- Physician assistants must be licensed by the Georgia Board of Medical Examiners and be associated with one or more sponsoring physician(s) on file with the Composite State Board of Medical Examiners. (Refer to the Physician Assistant Services Manual)
- Public Health registered nurses, affiliated with a Georgia local board of health, who have successfully completed the required training for expanded role nurses.

602.1 Health Check providers **must** provide immunizations. It is recommended the provider enroll in the VFC program and submit a VFC Provider Enrollment Letter with their Health Check Provider Enrollment Application. This is encouraged because the vaccine administration fee is the only reimbursement a provider will receive for administering vaccines otherwise available through the VFC program. (The VFC vaccines may only be used by certain populations. See Section 905.3.) For members nineteen (19) years of age through twenty (20) years of age, VFC stock is not available. Providers must use their own stock of vaccines for these Medicaid eligible members and the Division will reimburse for the vaccine product and for vaccine administration.

Rev. 07/11
Rev. 10/14

602.2 Health Check providers must submit documentation verifying they possess the necessary equipment to perform all components of the periodic screening (See Chapter 900, Section 903 for the equipment list.)

602.3 Health Check providers must determine whether members requesting a preventive health visit have already received that periodic screening. Periodic screenings for foster children in state custody are an exception to this requirement.

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Rev. 10/14

602.4 Health Check providers must perform, at the time of the member's preventive health visit, all of the EPSDT required components for that visit as listed below, along with those identified in the Bright Futures Periodicity Schedule (see Section 902.1). The EPSDT required components include:

A. A comprehensive health and developmental history, developmental appraisal (including mental, emotional and behavioral)

B. A comprehensive unclothed physical examination (unclothed means to the extent necessary to conduct a full, age-appropriate examination) including measurements

C. Health education and anticipatory guidance for both the child and caregiver

D. Dental/oral health assessment

E. Vision and hearing assessments

F. Laboratory testing (including blood lead screening appropriate for age and risk factors)

G. Appropriate immunizations, in accordance with the pediatric and adult schedules for vaccines established by the Advisory Committee on Immunization Practices

602.5 The Health Check provider must:

Rev. 07/11
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Rev. 01/15

A. Use Place of Service (POS) code 99 for all preventive health services and interperiodic visits. Public Health providers – see Section 1003 for additional information;

B. Document, in the member's health record, all services provided during the preventive health visit;

C. Make available for on-site audits by the Division or its agents all records related to EPSDT services. Providers must submit plans for corrective action when requested;

D. Refer the member to other ancillary service providers for services that are not covered under the Medicaid or PeachCare for Kids® programs;

E. Provide services in a manner consistent with the policies, procedures and requirements outlined in this manual;

F. If performing the required laboratory testing, be in compliance with the Clinical Laboratory Improvement Amendment. Providers seeking information concerning laboratory services should contact:

Rev. 04/11

Office of Health Care Facilities Regulations at (404) 657-5700

G. Maintain an office, clinic, or other similar physical facility, which complies with local business and building license ordinances;

Rev. 07/14
Rev. 01/15

H. Provide immunizations as needed at the time of the preventive health visit. Providers not enrolled in the VFC program will not be reimbursed for the cost of the vaccine they administer to Medicaid members if those vaccines can be provided under the VFC program. They will only be reimbursed the vaccine administration fee. To enroll in the Vaccines For Children Program, please call 1-800-848-3868. For members nineteen (19) years of age through twenty (20) years of age, VFC stock is not available. Providers must use their own stock of vaccines for these Medicaid eligible members and the Division will reimburse for the vaccine product and for vaccine administration.

Rev. 01/10

I. Maintain legible, accurate, and complete medical records in order to support and justify the services provided. A *Medical record* is a summary of essential medical information on an individual patient including dated reports supporting claims submitted to the Division for services provided in an office, hospital, outpatient, or other place of service. Records of service shall be entered in chronological order by the practitioner who rendered the service.

602.6 All documentation in the medical record shall be legible and shall include but not be limited to:

1. Date(s) of service
2. Patient's name and date of birth
3. Name and title of person performing the service
4. Pertinent medical history; immunizations
5. Pertinent findings on examination
6. Medications, equipment or supplies prescribed/provided
7. Recommendations for additional treatment, procedures, or consultations
8. Tests and results
9. Plan of treatment/care and outcomes
10. Refusal of care documented with signed form by responsible person for member
11. The signature of the person performing the service. The original handwritten personal signature (electronic or fax signatures are acceptable only if these documents are legible) of the person performing the service must be on each document contained in the patient's medical record. When a fax document or signature is included in the medical record, the document with the original signature must be retrievable from the original source. This includes but is not limited to progress notes and lab reports for each date of service billed.

Rev. 10/14
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NOTE: *Electronic signature is defined as "an electronic or digital method executed or adopted by a party with the intent to be bound by or to authenticate a record, which is unique to the person using it, is capable of verification, is under the sole control of the person using it, and is linked to the data in such a manner that if the data are changed the signature is invalidated." O.C.G.A. 10-12-3. (1) (1997)*

12. All documents contained in the medical record must be written in Standard English Language. Records must be available to the Georgia Division of Medicaid or its agents and to the U.S. Department of Health and Human Services upon request. Documentation must be timely, complete, and consistent with the by-laws and medical policies of the office or facility where the services are provided.

Rev. 01/16

PART II - CHAPTER 700

Special Eligibility Conditions

Rev. 01/11
Rev. 07/14
Rev. 10/14

All persons eligible for Medicaid who are less than twenty-one (21) years of age are eligible for the EPSDT benefit with the exception of women aged eighteen to twenty-one (18 to 21) who are enrolled in the Planning for Healthy Babies Program (P4HB®). P4HB participants are not eligible for the EPSDT benefit. All persons eligible for the PeachCare for Kids® program are eligible for the EPSDT benefit.

PART II - CHAPTER 800

Prior Approval/Authorization

Rev. 01/10
Rev. 07/11
Rev. 10/11
Rev. 10/14

801. The Health Check provider must provide all of the required EPSDT preventive health services, as identified by the periodicity schedule and this manual, during the preventive visit in order to be reimbursed at the Health Check visit rate. If additional service needs are identified, through the screening process, that are outside the scope of practice of the EPSDT primary care provider (PCP), the member must be referred to a provider who can address those needs.

If the provider is not the member's EPSDT PCP, the provider must notify the member's PCP of the preventive health/interperiodic visit and any additional service needs identified during that visit. The member's PCP must make the appropriate referral(s).

Some EPSDT services provided to Medicaid and PeachCare for Kids® members may require prior authorization and/or a referral if the member has a PCP/medical home and the member's PCP/medical home does not perform those additional services.

Documentation of care rendered outside of the PCP or the medical home (such as medical records and immunization charting) must be sent to the PCP or the medical home as identified by the member within five (5) business days of the provision of those services.

802. Prior authorization may be required for services rendered by Diagnostic and Treatment providers. These providers should refer to their applicable Medicaid policy and procedure manuals for a listing of the services that require prior approval.

PART II - CHAPTER 900

Scope of Services

901. General

Rev. 01/11
Rev. 07/11
Rev. 10/14

The Health Check Program provides reimbursement for preventive health and interperiodic visits and other services provided during those visits.

The Diagnostic and Treatment components of the EPSDT benefit are covered under other Georgia Medicaid programs as described previously in this manual. Those programmatic policies and procedures should be followed as specified in the appropriate related manuals (i.e., Physician Services program, etc.). Diagnostic and Treatment services are provided for identified suspicious or abnormal conditions by either the Health Check provider, if qualified to perform those services, or upon referral to an appropriate service provider of the member's choice.

902. AAP Periodicity Schedule and Georgia Minimum Standards for Screening Components

Rev. 07/11
Rev. 10/14
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Rev. 04/16
Rev. 04/17
Rev. 07/17
Rev. 04/19
Rev. 07/19

Effective July 1, 2019, the Georgia Division of Medical Assistance Plans will adopt the AAP 2019 Bright Futures "Recommendations for Pediatric Health Care" Periodicity Schedule as the periodicity schedule for EPSDT visits and services. The schedule is available at https://www.aap.org/en-us/Documents/periodicity_schedule.pdf
The updated 2019 schedule consists of revisions to footnote 6 (blood pressure), footnote 24 (anemia) and footnote 25 (lead). A copy of the summary of changes is displayed in Appendix Q.

902.1 Periodicity Schedule and Screening Sequence

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Rev. 07/17
Rev. 07/19

The periodic intervals for screening for all Medicaid and PeachCare for Kids® Health Check providers, as shown on the following page, are based on the American Academy of Pediatrics' recommendations.

NOTE: *The updated 2019 Periodicity Schedule will be used for all EPSDT preventive health visits completed on or after July 1, 2019. Exception: the prenatal visit and over 21 years of age visit as listed on the schedule are not covered under the Health Check Category of Service (COS) 600.*

Effective July 1, 2019, the GA Division of Medicaid adopted the updated AAP Bright Futures "Recommendations for Pediatric Health Care" Periodicity Schedule as the periodicity schedule for EPSDT preventive health visits and services.

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

Bright Futures

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in a satisfactory fashion. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits. Additional visits also may become necessary if circumstances suggest variations from normal.

These recommendations represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

Refer to the specific guidance by age as listed in the *Bright Futures Guidelines* (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents.* 4th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2017).

The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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	INFANCY								EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE										
AGE[1]	Prenatal[2]	Newborn[3]	3-5 d[4]	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 y	4 y	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y	21 y
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																																
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●																				
Weight for Length		●	●	●	●	●	●	●	●	●	●																					
Body Mass Index[5]												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[6]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																																
Vision[7]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	★	●	★	●	★	●	★	★	●	★	★	★	★	★	★
Hearing		●[8]	●[9]	←——→	★	★	★	★	★	★	★	★	★	★	●	●	●	★	●	★	●	←——●——→			←——●——→			←——●——→				
DEVELOPMENTAL/BEHAVIORAL HEALTH																																
Developmental Screening[11]								●			●		●																			
Autism Spectrum Disorder Screening[12]											●	●																				
Developmental Surveillance		●	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Psychosocial/Behavioral Assessment[13]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Tobacco, Alcohol, or Drug Use Assessment[14]																						★	★	★	★	★	★	★	★	★	★	★
Depression Screening[15]																							●	●	●	●	●	●	●	●	●	●
Maternal Depression Screening[16]				●	●	●	●																									
PHYSICAL EXAMINATION[17]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[18]																																
Newborn Blood		●[19]	●[20]	←——→																												
Newborn Bilirubin[21]		●																														
Critical Congenital Heart Defect[22]		●																														
Immunization[23]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Anemia[24]						★			●	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead[25]							★	★	● or ★[26]		★	● or ★[26]		★	★	★	★															
Tuberculosis[27]				★			★		★			★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia[28]												★			★		★		★	←——●——→		★	★	★	★	★	★	←———			●——→	
Sexually Transmitted Infections[29]																						★	★	★	★	★	★	★	★	★	★	★
HIV[30]																						★	★	★	★	←———	●——→			★	★	★
Cervical Dysplasia[31]																																●
ORAL HEALTH[32]							●[33]	●[33]	★		★	★	★	★	★	★	★															
Fluoride Varnish[35]							←———				●——→					——→																
Fluoride Supplementation[36]							★	★	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★					
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up-to-date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per "The Prenatal Visit" (http://pediatrics.aappublications.org/content/124/4/1227.full).
3. Newborns should have an evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).
4. Newborns should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding newborns should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in "Breastfeeding and the Use of Human Milk" (http://pediatrics.aappublications.org/content/129/3/e827.full). Newborns discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per "Hospital Stay for Healthy Term Newborns" (http://pediatrics.aappublications.org/content/125/2/405.full).
5. Screen, per "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" (http://pediatrics.aappublications.org/content/120/Supplement_4/S164.full).
6. Screening should occur per "Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents" (http://pediatrics.aappublications.org/content/140/3/e20171904). Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
7. A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3-year-olds. Instrument-based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/e20153596) and "Procedures for the Evaluation of the Visual System by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/e20153597).
8. Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (http://pediatrics.aappublications.org/content/120/4/898.full).
9. Verify results as soon as possible, and follow up, as appropriate.
10. Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See "The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies" (http://www.jahonline.org/article/S1054-139X(16)00048-3/fulltext).
11. See "Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening" (http://pediatrics.aappublications.org/content/118/1/405.full).
12. Screening should occur per "Identification and Evaluation of Children With Autism Spectrum Disorders" (http://pediatrics.aappublications.org/content/120/5/1183.full).
13. This assessment should be family centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health. See "Promoting Optimal Development: Screening for Behavioral and Emotional Problems" (http://pediatrics.aappublications.org/content/135/2/384) and "Poverty and Child Health in the United States" (http://pediatrics.aappublications.org/content/137/4/e20160339).
14. A recommended assessment tool is available at http://www.ceasar-boston.org/CRAFFT/index.php.
15. Recommended screening using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit and at http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf.
16. Screening should occur per "Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice" (http://pediatrics.aappublications.org/content/126/5/1032).
17. At each visit, age-appropriate physical examination is essential, with infant totally unclothed and older children undressed and suitably draped. See "Use of Chaperones During the Physical Examination of the Pediatric Patient" (http://pediatrics.aappublications.org/content/127/5/991.full).
18. These may be modified, depending on entry point into schedule and individual need.

(continued)

KEY: ● – to be performed ★ – risk assessment to be performed with appropriate action to follow, if positive ←——●——→ – range during which a service may be provided

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(continued)

19. Confirm initial screen was accomplished, verify results, and follow up, as appropriate. The Recommended Uniform Screening Panel (https://www.hrsa.gov/advisory-committees/heritable-disorders/rusp/index.html), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (http://genes-r-us.uthscsa.edu/home) establish the criteria for and coverage of newborn screening procedures and programs.
20. Verify results as soon as possible, and follow up, as appropriate.
21. Confirm initial screening was accomplished, verify results, and follow up, as appropriate. See "Hyperbilirubinemia in the Newborn Infant ≥35 Weeks' Gestation: An Update With Clarifications" (http://pediatrics.aappublications.org/content/124/4/1193).
22. Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per "Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease" (http://pediatrics.aappublications.org/content/129/1/190.full).
23. Schedules, per the AAP Committee on Infectious Diseases, are available at http://redbook.solutions.aap.org/SS/Immunization_Schedules.aspx. Every visit should be an opportunity to update and complete a child's immunizations.
24. Perform risk assessment or screening, as appropriate, per recommendations in the current edition of the AAP *Pediatric Nutrition: Policy of the American Academy of Pediatrics* (Iron chapter).
25. For children at risk of lead exposure, see "Prevention of Childhood Lead Toxicity" (http://pediatrics.aappublications.org/content/138/1/e20161493) and "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention" (http://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf).
26. Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence areas.
27. Tuberculosis testing per recommendations of the AAP Committee on Infectious Diseases, published in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*. Testing should be performed on recognition of high-risk factors.
28. See "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.html).
29. Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*.
30. Adolescents should be screened for HIV according to the USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspshiv.htm) once between the ages of 15 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.
31. See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm). Indications for pelvic examinations prior to age 21 are noted in "Gynecologic Examination for Adolescents in the Pediatric Office Setting" (http://pediatrics.aappublications.org/content/126/3/583.full).
32. Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment (http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf) and refer to a dental home. Recommend brushing with fluoride toothpaste in the proper dosage for age. See "Maintaining and Improving the Oral Health of Young Children" (http://pediatrics.aappublications.org/content/134/6/1224).
33. Perform a risk assessment (http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf). See "Maintaining and Improving the Oral Health of Young Children" (http://pediatrics.aappublications.org/content/134/6/1224).
34. See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspsdvch.htm). Once teeth are present, fluoride varnish may be applied to all children every 3–6 months in the primary care or dental office. Indications for fluoride use are noted in "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626).
35. If primary water source is deficient in fluoride, consider oral fluoride supplementation. See "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626).

Summary of Changes Made to the Bright Futures/AAP Recommendations for Preventive Pediatric Health Care

(Periodicity Schedule)

This schedule reflects changes approved in December 2018 and published in March 2019.
For updates and a list of previous changes made, visit www.aap.org/periodicityschedule.

CHANGES MADE IN DECEMBER 2018

BLOOD PRESSURE

- Footnote 6 has been updated to read as follows: "Screening should occur per 'Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents' (http://pediatrics.aappublications.org/content/140/3/e20171904). Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years."

ANEMIA

- Footnote 24 has been updated to read as follows: "Perform risk assessment or screening, as appropriate, per recommendations in the current edition of the AAP *Pediatric Nutrition: Policy of the American Academy of Pediatrics* (Iron chapter)."

LEAD

- Footnote 25 has been updated to read as follows: "For children at risk of lead exposure, see 'Prevention of Childhood Lead Toxicity' (http://pediatrics.aappublications.org/content/138/1/e20161493) and 'Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention' (https://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf)."

KEY

• = to be performed

* = risk assessment to be performed, with appropriate action follow, if positive

← • → = range during which a service may be provided, with the symbol indicating the preferred age.

FOOTNOTES

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1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up-to-date at the earliest possible time.

2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per "The Prenatal Visit" (http://pediatrics.aappublications.org/content/124/4/1227.full).

3. Newborns should have an evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).

4. Newborns should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding newborns should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in "Breastfeeding and the Use of Human Milk" http://pediatrics.aappublications.org/content/129/3/e827.full).
   Newborns discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per "Hospital Stay for Healthy Term Newborns" (http://pediatrics.aappublications.org/content/125/2/405.full).

5. Screen, per "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" (http://pediatrics.aappublications.org/content/120/Supplement_4/S164.full).

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6. Screening should occur per "Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents" (http://pediatrics.aappublications.org/content/140/3/e20171904). Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.

7. A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3-year-olds. Instrument-based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/e20153596) and "Procedures for the Evaluation of the Visual System by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/e20153597).

8. Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (http://pediatrics.aappublications.org/content/120/4/898.full).

9. Verify results as soon as possible, and follow up, as appropriate.

10. Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See "The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies" http://www.jahonline.org/article/S1054-139X(16)00048-3/fulltext

11. See "Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening" (http://pediatrics.aappublications.org/content/118/1/405.full).

12. Screening should occur per "Identification and Evaluation of Children With Autism Spectrum Disorders" (http://pediatrics.aappublications.org/content/120/5/1183.full).

13. This assessment should be family centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health. See "Promoting Optimal Development: Screening for Behavioral and Emotional Problems" (http://pediatrics.aappublications.org/content/135/2/384) and "Poverty and Child Health in the United States" (http://pediatrics.aappublications.org/content/137/4/e20160339).

14. A recommended assessment tool is available at http://crafft.org.

15. Recommended screening using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit and at http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf.

16. Screening should occur per "Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice" (http://pediatrics.aappublications.org/content/126/5/1032).

17. At each visit, age-appropriate physical examination is essential, with infant totally unclothed and older children undressed and suitably draped. See "Use of Chaperones During the Physical Examination of the Pediatric Patient" (http://pediatrics.aappublications.org/content/127/5/991.full).

18. These may be modified, depending on entry point into schedule and individual need.

19. Confirm initial screen was accomplished, verify results, and follow up, as appropriate. The Recommended Uniform Newborn Screening Panel https://www.hrsa.gov/advisory-committees/heritable-disorders/rusp/index.html as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (http://genes-r-us.uthscsa.edu/home) establish the criteria for and coverage of newborn screening procedures and programs.

20. Verify results as soon as possible, and follow up, as appropriate.

21. Confirm initial screening was accomplished, verify results, and follow up, as appropriate. See "Hyperbilirubinemia in the Newborn Infant ≥35 Weeks' Gestation: An Update With Clarifications" http://pediatrics.aappublications.org/content/124/4/1193

22. Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per "Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease" http://pediatrics.aappublications.org/content/129/1/190.full

23. Schedules, per the AAP Committee on Infectious Diseases, are available at http://redbook.solutions.aap.org/SS/Immunization_Schedules.aspx Every visit should be an opportunity to update and complete a child's immunizations.

24. Perform risk assessment or screening, as appropriate, per recommendations in the current edition of the AAP *Pediatric Nutrition: Policy of the American Academy of* Pediatrics (Iron chapter).

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25. For children at risk of lead exposure, see "Prevention of Childhood Lead Toxicity" (http://pediatrics.aappublications.org/content/138/1/e20161493) and Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention" (http://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf)

26. Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence areas.

27. Tuberculosis testing per recommendations of the AAP Committee on Infectious Diseases, published in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases.* Testing should be performed on recognition of high-risk factors.

28. See "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).

29. Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases.*

30. Adolescents should be screened for HIV according to the USPSTF recommendations http://www.uspreventiveservicestaskforce.org/uspstf/uspshivi.htm once between the ages of 15 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.

31. See USPSTF recommendations http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/cervical-cancer-screening2 Indications for pelvic examinations prior to age 21 are noted in "Gynecologic Examination for Adolescents in the Pediatric Office Setting" (http://pediatrics.aappublications.org/content/126/3/583.full).

32. Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Oral-Health/Pages/Oral-Health-Practice-Tools.aspx and refer to a dental home. Recommend brushing with fluoride toothpaste in the proper dosage for age. See "Maintaining and Improving the Oral Health of Young Children" (http://pediatrics.aappublications.org/content/134/6/1224).

33. Perform a risk assessment https://www.aap.org/en-us/Documents/oralhealth_RiskAssessmentTool.pdf See "Maintaining and Improving the Oral Health of Young Children" (http://pediatrics.aappublications.org/content/134/6/1224).

34. See USPSTF recommendations https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/dental-caries-in-children-from-birth-through-age-5-years-screening Once teeth are present, fluoride varnish may be applied to all children every 3–6 months in the primary care or dental office. Indications for fluoride use are noted in "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626).

35. If primary water source is deficient in fluoride, consider oral fluoride supplementation. See "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626).

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Rev. 10/14

902.2 Minimum Standards for Screening Components during the Preventive Health Visits

Required Components are specified here and in the chart and footnotes of the American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care (AAP Periodicity Schedule).

Visit Components:
Every periodic health supervision (well-child) visit must include:

1. A comprehensive health, psycho-social and developmental history;
2. Documentation of vital signs;
3. An unclothed comprehensive physical examination (unclothed means to the extent necessary to conduct a full, age-appropriate examination);
4. Assessment of growth and nutritional status;
5. Assessment of immunization status and provision of appropriate immunizations. **(**Use the Advisory Committee on Immunization Practices (ACIP) schedules**);**
6. Screening for vision, hearing, and development, as per AAP guidance;
7. Laboratory testing where appropriate to age and exam findings, and in line with AAP guidance. **(**Some testing, if not bundled, may be covered under other programs i.e. Physician Services, DSPS, etc. Please follow those programs' guidelines for reimbursement.**);**
8. Oral health screening, preventive counseling, and referral to a dentist for ongoing dental care;
9. Screening for and if suspected, reporting of child abuse and neglect;
10. Anticipatory guidance (Health Education); and
11. Referrals /follow-ups where appropriate based on history and exam findings.

Helpful materials:
https://brightfutures.aap.org

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CDC Positive Parenting Tips (handouts English and Spanish to download for families) at:
http://www.cdc.gov/ncbddd/child/infants.htm

Immunization schedule (Recommended Immunization Schedule, 0-18 years)
http://aapredbook.aappublications.org/site/resources/izschedules.xhtml

A. Age

Calculate the child's age. If a child comes under care for the first time at any point on the schedule, or if any items were not accomplished at the suggested age, the member's visit should be brought up to date.

B. History

Initial history: All ages: The history may be obtained at the time of the visit from the parent/guardian or it may be obtained through a form or checklist sent to the parent/guardian prior to the visit for completion.

History must contain, but is not limited to:

1. Present health status and past health history of member;
2. Developmental information;
3. Allergies and immunization history - allergies must be clearly and easily found in records;
4. Family history;
5. Dietary (nutrition) history;
6. Risk assessment of lead exposure; and
7. Refusal of Care documentation form (as necessary).

***Documentation**:* Initial health history is recorded in the medical record.

Interval history: All ages: For known patients, the age-specific history may be confined to the interval since the previous evaluation. The provider must review and supplement these histories at the time of the patient's examination. Include nutrition history.

***Documentation**:* Evidence of review.

C. Measurements

1. Assessment of Growth:

All ages: Growth must be measured, plotted on a graph, and recorded as outlined below.

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Rev. 07/14
Rev. 10/14

Children younger than 2 years: Age, weight, length, and head circumference are required. Measurements should be plotted on the appropriate World Health Organization (WHO) growth chart(s).

Children 2 years of age and older: Age, weight, height, and BMI are required. Measurements must be plotted on the appropriate Centers for Disease Control and Prevention (CDC) growth chart(s). The BMI number must be plotted on the BMI-for-age growth chart to obtain a BMI percentile ranking.

The CDC and WHO growth charts are available at the following website: http://www.cdc.gov/growthcharts/

Documentation: All measurements in numerical values must be recorded and plotted as indicated. All measurements outside of normal range must have an intervention. Interventions following assessments, as suggested by the CDC, are also acceptable. Please refer to Appendix F for the correct BMI diagnosis codes to be recorded on the claim. The diagnosis code must align with the BMI percentile plotted on the growth chart.

Fee For Service (FFS) EPSDT providers should not link the preventive health visit code to the BMI percentile diagnosis code on the claim.

2. **Blood Pressure Assessment:**

Children younger than 3 years: Infants and children with specific risk conditions need a blood pressure assessment. See the Bright Futures Guidance (BFG).

Children 3 years and older: Blood pressure assessment is performed at every visit.

Documentation: All measurements in numerical values must be recorded. All measurements outside of the normal range must have an intervention.

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Rev. 04/15

NOTE: Definitions for High Blood Pressure must follow the range published by the National High Blood Pressure Education Program in "The Fourth Report on the Diagnosis, Evaluation, and Treatment of High Blood Pressure in Children and Adolescents."
http://www.nhlbi.nih.gov/files/docs/resources/heart/hbp_ped.pdf

The article, "Simple Table to Identify Children and Adolescents Needing Further Evaluation of Blood Pressure," can be found in Pediatrics 2009; 123; e972-e974; David C. Kaelber and Frieda Pickett
http://pediatrics.aappublications.org/cgi/reprint/123/6/e972

D. Sensory Screening

1. **Vision Procedure*:***

Rev. 10/14

Children from birth to 3 years of age: A Vision Risk Assessment is needed at every visit. This risk assessment includes: ocular history, vision assessment, external inspection of the eyes and lids, ocular motility assessment, pupil and red reflex examination.

If the risk assessment is positive, refer to an ophthalmologist.

Rev. 04/16

Children 3 years and older: A Vision Screening is required at the 3, 4, 5, 6, 8, 10, 12, and 15 year old visits. (The routine screening at age 18 has been changed to a risk assessment). A Vision Risk Assessment should be performed at all other visits. Patients uncooperative with screening and with no history, nor signs/symptoms of problems, should be re-screened within 6 months. To test visual acuity, use age appropriate tests. BFG suggests the Snellen letter or Symbol E charts. The use of alternative tests (HOTV or Matching Symbol, Faye Symbol, Allen Pictures) should be considered for preschoolers.

If the risk assessment is positive, conduct a vision screening. If the vision screening is positive, refer to an ophthalmologist.

Reminder: If a child wears eyeglasses, assessment regarding the need for referral for optometric re-evaluation must be made based on screening with eyeglasses and the length of time since the last evaluation.

***Documentation**:* Sensory Screening documentation consists of an age appropriate assessment, assessment results (normal or abnormal) and examinations performed and results (pass/fail) data. Appropriate follow up or referral is needed for results outside of the normal range.

2. Hearing Procedure:

Rev. 10/14
Rev. 07/16

Newborns: All newborns should receive a newborn hearing screening per the AAP "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (http://pediatrics.aappublications.org/content/120/4/898.full)
If the newborn does not pass the hearing screening, refer for a follow-up outpatient rescreening within one month. For newborns who do not pass the rescreening, refer to an audiologist.

Georgia's Early Hearing Detection and Intervention (EHDI) Program is housed in the Georgia Department of Public Health along with the Newborn Metabolic Screening Program and the Children 1st Program. These three programs maintain and support a comprehensive, coordinated, statewide public health screening and referral system. EHDI includes:

- Screening for hearing loss in the birthing hospital;
- Referral of newborns who do not pass the hospital screening for rescreening;
- Referral of newborns who do not pass the rescreening for diagnostic audiological evaluation; and
- Linkage to appropriate intervention for those babies diagnosed with hearing loss.

Refer to the Georgia EHDI Program (http://dph.georgia.gov/EHDI) for further guidance.

Infants and toddlers under age 2 years: These children should be monitored for auditory skills, middle ear status, and developmental milestones (surveillance).

Infancy and Early Childhood visits: Conduct a risk assessment at each preventive visit during the Infancy and Early Childhood years (from the three to five days visit through the 3 year old visit). If the risk assessment is positive, refer to an audiologist.

Rev. 07/17

Middle Childhood and Adolescent visits: Conduct a risk assessment during the preventive visit at ages 7 years and 9 years. If the risk assessment is positive, refer to an audiologist.

At the 4, 5, 6, 8 and 10 year visits: Appropriate universal hearing screening (objective) is required.

At the 11 years through 20 years visits: Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 20 years. See *"The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies"* https://www.jahonline.org/article/S1054-139X(16)00048-3/fulltext

Additional Guidance for Hearing Assessment Visits
Concerns identified during surveillance for children less than 2 years of age should be followed by performance of screening using a validated global screening tool (ASQ, PEDS, etc.). Those who do not pass the speech-language portion of the global screen or who have a caregiver concern should be referred immediately for further evaluation. Children with persistent middle ear effusions should be referred for otologic evaluation.

Older children who fail the risk assessment tool or screening should have appropriate intervention. Older children with persistent middle ear effusions should be referred for otologic evaluation.

***Documentation**:* Sensory Screening documentation consists of an age appropriate assessment, assessment results (normal or abnormal) and examinations performed and results (pass/fail) data. Appropriate follow up or referral is needed for results outside of the normal range.

Patients uncooperative with screening and with no history, nor signs/symptoms of problems, should be re-screened within 6 months. This time frame is not appropriate for newborns.

E. Psychosocial/Behavioral Assessment and Developmental Surveillance

1. Surveillance:

Required for all ages: This assessment should occur with each clinical encounter with the child or adolescent. Comprehensive childhood surveillance of development includes activities that will document *social, emotional, communication*, *cognitive*, and *physical development* concerns (this content is listed at each health supervision visit in BFG under *Surveillance of Development*). Psychosocial/ behavioral surveillance will encourage activities and interventions to promote mental health and emotional well-being. See BFG Chapter 3.

***Documentation**:* Evidence of surveillance.

2. Developmental Screening:

Rev. 04/12
Rev. 07/14
Rev. 01/15

Required at ages 9 months, 18 months, and 30 months: This screening **must** be accomplished using one or more of the following recommended standardized developmental screening tools:

- Ages and Stages Questionnaire (ASQ) - 2 months to 5 years
- Ages and Stages Questionnaire - 3rd Edition (ASQ-3)
- Battelle Developmental Inventory Screening Tool (BDI-ST) – Birth to 95 months
- Bayley Infant Neuro-developmental Screen (BINS) - 3 months to 2 yrs
- Brigance Screens-II – Birth to 90 months
- Child Development Inventory (CDI) - 18 months to 6 years
- Infant Development Inventory – Birth to 18 months
- Parents' Evaluation of Developmental Status (PEDS) – Birth to 8 years
- Parents' Evaluation of Developmental Status - Developmental Milestones (PEDS-DM)

NOTE: Screening tools not included in the list are not acceptable. *It is important to note that standardized tools specifically focused on one domain of development [e.g. child's socio-emotional development (ASQ-SE) or autism (M-CHAT)] are not included in the list. The screening is anchored to recommendations related to global developmental screening using tools that identify risk for developmental, behavioral and social delays.*

Rev. 01/15

Documentation: Evidence of the screening. Documentation in the medical record must include all of the following: a note indicating the date on which the screening was performed; a copy of the completed standardized tool used; and documented evidence of a screening result or screening score. If indicated, document the follow-up assessment, therapeutic interventions used, referrals made, and treatments received.

3. Autism Screening:

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Rev. 07/17

Required at ages 18 months and 24 months or any time parents raise a concern: The screening should be performed with an autism-specific screening tool. The Modified Checklist For Autism in Toddlers (MCHAT) is the recommended tool and downloadable at https://m-chat.org. The M-CHAT is a validated developmental screening tool for toddlers between 16 and 30 months of age, and should not be used for children younger than 16 months of age. The M-CHAT is designed to identify children who may benefit from a more thorough developmental and autism evaluation The M-CHAT can be administered and scored as part of the preventive health visit, and also can be used by specialists or other professionals to screen for developmental delay and autism. The M-CHAT on-line version features the latest scoring system, Modified Checklist for Autism in Toddlers, Revised with Follow-Up (M-CHAT-R/F), making the results more sensitive in detecting developmental concerns.

Documentation: Evidence of the screening. Documentation in the medical record must include a note indicating the date on which the screening was performed; a copy of the screening tool used; and documented evidence of a screening result or screening score. If Iindicated, document the follow-up assessment, therapeutic interventions used, referrals made, and treatments received.

4. <u>Tobacco, Alcohol, or Drug Use Assessment</u>:

Required at 11 years through 20 years of age: At all adolescent (11-20 years) visits, pre-teens and teens should be asked about substance use.
The screening should be performed and documented or the child referred for care at any encounter when a parent raises a concern. AAP recommends using the CRAFFT screening tool (available at http://www.crafft.org) for this assessment. A copy of the CRAFFT Screening Interview is available in Appendix P.

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Documentation: Evidence of assessment. Screening tool must be standardized and scorable. Document the screening tool used and the screening results (i.e., CRAFFT score). If indicated, document the follow-up assessment, therapeutic intervention used, referrals made, and treatments received.

5. <u>Depression Screening:</u>

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Required at 12 years through 20 years of age: At all adolescent (12-20 years) visits, pre-teens and teens should be asked about depression.

AAP recommends using the Patient Health Questionnaire (PHQ)-2 (see Appendix P) http://www.cqaimh.org/pdf/tool_phq2.pdf or other tools available in the GLAD-PC toolkit.
The Bright Futures instructions for use of the PHQ 2 Questionnaire are available at https://brightfutures.aap.org.

Documentation: Evidence of assessment. Document the screening tool used and the screening results in the medical record. If indicated, document the follow-up assessment, therapeutic intervention used, referrals made, and treatments received.

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Rev. 10/15
Rev. 04/16

Fee For Service EPSDT providers should link the depression screening procedure code (96127) to the applicable preventive health visit ICD-10 diagnosis code. The providers should not link a depression screening diagnosis code to the preventive health visit procedure code.

Rev. 07/17
Rev. 01/18

6. **Maternal Depression Screening:**

Required at the 1, 2, 4 and 6 month visits: At all visits (1, 2, 4, and 6 months), the mothers of newborn children should be asked about depression.

The relevant AAP guidance, in concert with Bright Futures recommendations (http://brightfutures.aap.org), references screening mothers with one of the two methods endorsed by the US Preventive Task Force: (1) the Edinburgh Postnatal Depression Scale (EPDS) or (2) the Patient Health Questionnaire-2 (PHQ-2), the two-question screening, administered at 1, 2, 4 and 6 months postpartum, with follow up referral for resources and treatment.

A copy of the EPDS and instructions can be found at the following link: https://psychology-tools.com/epds/)

A copy of the PHQ2 is available at http://www.cqaimh.org/pdf/tool_phq2.pdf

NOTE: Per the BF guidance, "Screening should occur per "Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice"
http://pediatrics.aappublications.org/content/early/2010/10/25/peds.2010-2348

Rev. 10/18

***Documentation**:* Evidence of assessment. Screening tool must be standardized and scorable. Document the screening tool used and the screening results in the medical record. If indicated, document the follow-up assessment, therapeutic intervention used, referrals made, and treatments received.

If evidence of depression is documented, EPSDT providers may refer the mother to the Georgia Crisis and Access Line (GCAL). GCAL, a statewide toll free crisis hotline, provides access to resources and services to individuals in need of crisis management for mental health, addictive disease, and crisis services. GCAL can be reached 24 hours a day, 7 days per week at 1-800-715-4225 (GCAL) or accessed on the web at www.mygcal.com.

F. Physical Exam

1. **Physical Exam**:

Rev. 10/14

All children: A comprehensive physical exam is required for periodic and catch-up visits. The physical examination is the cornerstone of pediatric evaluation. Per the Federal EPSDT policy guidelines, the physical examination must be an unclothed physical inspection (unclothed means to the extent necessary to conduct a full, age-appropriate examination) that checks the general appearance of the child to determine overall health status. This process can pick up obvious physical defects, including orthopedic disorders, hernias, skin diseases, genital abnormalities and oral health needs. Physical inspection includes an examination of all organ systems such as pulmonary, cardiac, and gastrointestinal.

***Documentation**:* Findings on all organ systems must be documented in the medical record. A checklist type form allowing documentation of normal/ abnormal findings may be utilized for recording the different organ systems. Abnormal findings require further evaluation, follow-up or parental counseling.

2. Nutrition:

Rev. 10/14
Rev. 01/15

The Federal EPSDT policy guidelines mandate assessment of nutritional status but state it can be accomplished during many different parts of the exam. "Accurate measurements of height and weight...are among the most important indices of nutritional status." "If information suggests dietary inadequacy, obesity or other nutritional problems, further assessment is indicated."

Documentation: Evidence of the assessment.

G. Procedures

1. Newborn Screenings

a. Newborn Blood Screening

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Rev. 10/14
Rev. 07/16

All infants under 4 months: Georgia law requires that every live born infant receive a metabolic screening for selective inherited disorders. The Georgia Newborn Screening (NBS) Program ensures that every newborn in Georgia is screened for 31 heritable disorders for prompt identification and treatment.

If the infant is discharged before twenty-four (24) hours after birth, a blood specimen shall be collected prior to discharge. In this case a second specimen shall be collected prior to 7 days of age.

Refer to the Georgia NBS Program for further guidance.

Documentation: All infants whose test results are unavailable at the time of the 3-5 day preventive visit must have a specimen collected immediately during this visit unless the results are pending due to processing.

The Newborn Blood Screening process may not be complete with results available before the first scheduled preventive health visit; however, these results should be actively tracked to completion and documented as soon as possible. If the results are outside the normal limits for a newborn screening disorder, the provider should ensure that the child receives prompt appropriate retesting and/or make a referral to an appropriate sub specialist.

Providers may access newborn screening results online through the State Electronic Notification Surveillance System (SendSS). Results are also available through the Georgia Public Health Laboratory's Newborn Screening eReports web portal.

Rev. 10/12
Rev. 10/14

Information regarding the SendSS registration process is available at:

https://sendss.state.ga.us/sendss/login.screen

Providers may register as a user of the Georgia Department of Public Health Laboratory's Newborn Screening eReports electronic portal by completing the Newborn Screening eReports Web Portal Registration Form. The form is available at http://dph.georgia.gov/sites/dph.georgia.gov/files/NBS%20eReports%20Web%20Portal%20Registration%20form.pdf

NOTE

Rev. 07/17

Newborn Bilirubin: The screening for bilirubin concentration at the newborn visit has been added. See "Hyperbilirubinemia in the Newborn Infant > 35 Weeks' Gestation: An Update With Clarifications" http://pediatrics.aappublications.org/content/124/4/1193

b. **Critical Congenital Heart Defect (CCHD) Screening**

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Rev. 07/17

Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per the 2011 AAP statement, "Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease" http://pediatrics.aappublications.org/content/129/1/190.full

CCHD was added to the Georgia newborn screening panel in 2014. In accordance with the Georgia Newborn Screening Program's Policy and Procedure Manual, hospitals and birthing centers shall be equipped to conduct a critical congenital heart defect (CCHD) screening test on newborns using pulse oximetry. This screening can detect 14 common congenital heart defects in newborns which could result in disability and death. The CCHD screening should be performed in newborns before discharge from the hospital.

Documentation: Refer to the Georgia Newborn Screening Program for further guidance and documentation requirements.

2. Immunizations

All children: An immunization assessment is required for all children. This is a key element of preventive health services. Immunizations, if needed and appropriate, shall be given at the time of the preventive health visit. The Federal EPSDT policy guidelines mandate the use of the current ACIP schedule at http://www.cdc.gov/vaccines

Documentation: All immunizations (historic and current) must be documented in the medical record and recorded in the Georgia Registry of Immunization Transactions and Services (GRITS). Refusals must be documented with a signed document.

Rev. 07/17

3. Anemia Screening (Hematocrit and Hemoglobin)

Anemia Screening Procedure:

At 12 months*:* Screening must be performed on all members with documentation of a hemoglobin or hematocrit measurement.

At 4 months: Selective screening may be performed on all preterm, low birth weight infants and those not on iron fortified formula.

Rev. 10/14

Anemia Risk Assessment: An anemia risk assessment is required at the 4, 15, 18, 24, and 30 months visits, and annually starting at 3 years.

Documentation*:* Evidence of screening, if required, and/or test results as well as any further evaluation, treatment or counseling for results outside of the normal limits. Evidence of a risk assessment performed at the 4, 15, 18, 24, and 30 months visits, and annually thereafter starting at 3 years. This can be part of the nutrition assessment.

4. Lead Screening

Rev. 10/14

Blood Lead Risk Assessment:

The Blood Lead Risk Assessment is required at 6, 9 and 18 months and 3 to 6 years per the BFG periodicity schedule. A questionnaire, based on currently accepted public health guidelines, should be administered to determine if the child is at risk for lead poisoning. A recommended tool is the Georgia Healthy Homes and Lead Poisoning Prevention Program (GHHLPPP) Blood Lead Risk Assessment Questionnaire which can be found at https://dph.georgia.gov/lead-screening-guidelines-children

When using the questionnaire, a blood lead test should be done immediately if the child is at high risk (one or more "yes" or "I don't know" answers on the lead risk assessment questionnaire) for lead exposure. Completing this questionnaire does not count as a blood lead screening.

Note: Assessment questions are not needed if a Blood Lead Level (BLL) screening (test) will be done at the visit.

Documentation: Risk assessment findings per the Bright Futures periodicity schedule with selective BLL screening (test) if there is a positive response or a change in risk.

Blood Lead Level (BLL) Screen:
A BLL screening (test) is required at 12 and 24 months.

Children between the ages of 36 months and 72 months*:* All children in this age range must receive one BLL screening IF they have not previously been tested for lead exposure.

Rev. 07/17

ALL **venous** sample lead screening tests conducted using any Magellan Diagnostic lead testing system should be laboratory analyzed by a properly accredited laboratory.

Documentation: Test results as well as any further evaluation, treatment or counseling for results outside of the normal limits must be documented in the medical record.

Note: Completing a lead risk assessment questionnaire **DOES NOT** count as a blood lead level screening and does not meet Medicaid requirements.

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Rev. 07/15

NOTE: The Georgia Healthy Homes and Lead Poisoning Prevention Program (GHHLPPP) at 404-657-6534 has a Lead Risk Assessment Questionnaire that the provider may choose to use at https://dph.georgia.gov/lead-screening-guidelines-children

Resource: See Appendix A: Guidelines for Elevated BLL. These must be used if a child has results outside normal limits.

5. Tuberculin Risk Assessment and Test:

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Rev. 01/15
Rev. 10/15

Tuberculin Risk Assessment: Required at the 1, 6, 12, and 24 month visits then annually beginning at age 3 years. An assessment is given using a risk assessment questionnaire. The questionnaire should assess at least four (4) major risk factors:

- Contact with TB disease
- Foreign birth
- Foreign travel to TB endemic countries; and
- Household contact with TB

The AAP Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents (3rd edition) recommends asking the following questions:

1) Was your child born in a country at high risk for tuberculosis?
2) Has your child traveled (had contact with resident populations) for longer than 1 week to a country a high risk for tuberculosis?
3) Has a family member or contact had tuberculosis or a positive tuberculin skin test?

Documentation: Validated risk assessment and responses. If positive on initial risk assessment questions, there should be a TB test recorded.

Resources: https://brightfutures.aap.org/materials-and-tools/Pages/default.aspx

Tuberculin Test

TB testing is not required at any age. The TB test is only administered to a child when questions are positive on the TB risk assessment or as the practitioner designates.

Rev. 01/15

Documentation*:* If administered, a recorded Tuberculin skin test. If the practitioner needs to defer testing for reasons that cannot be validated with professionally written guidelines, consult with state TB experts. If a child cannot be given the screening test on this day, a follow-up visit is necessary. Document risk appropriate attempts to contact and re-schedule the appointment if the parent fails to keep the follow up appointment.

If the TB skin test result for a high-risk child less than six (6) months is negative, please retest the child at six (6) months of age.

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For more information visit the Georgia Department of Public Health Tuberculosis (TB) Prevention and Control Program. TB Public Health Clinic Forms (reporting & notification forms, legal forms, case management/clinic forms, TB assessments), including the Pediatric Tuberculosis (TB) Risk Assessment, are available.

6. Dyslipidemia

Risk Assessment and selective screening when indicated: At the 2, 4, 6, 8 year and adolescence (12 through 16 year) visits.

Rev. 10/14
Rev. 07/17

Screening: Once between 9 and 11 years and once between 17 and 20 years: Universal screening is needed if not done previously in late adolescence (see periodicity schedule).

***Documentation*:** Results of risk assessment and screening. Abnormal findings during assessment or screening require further evaluation, follow-up or parental counseling.
Resource: See AAP-endorsed 2011 guidelines from the National Heart Blood and Lung Institute, "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).

7. **Sexually Transmitted Infections (STIs):**

Risk Assessment: At the 11 through 20 year visits.

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Rev. 10/15
Rev. 07/17

Screening: Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*."

Documentation: Results of risk assessment and screening. Abnormal findings during assessment or screening require further evaluation, treatment, follow-up, referral or parental counseling.

8. **Human Immunodeficiency Virus (HIV):**

Rev. 07/17

Risk Assessment: At the 11 through 14 year and 19 through 20 year visits.

Screening: Adolescents should be screened for HIV once between the ages of 15 and 18 years, according to the USPSTF recommendations (https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/human-immunodeficiency-virus-hiv-infection-screening1), making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.

Documentation: Results of risk assessment and screening. Abnormal findings during assessment or screening require further evaluation, treatment, follow-up, referral or parental counseling.

The following in-office procedure codes are available for reimbursement for the routine HIV screening:

Rev. 10/15

86701 – Analysis for antibody to HIV-1 virus
86702 – Analysis for antibody to HIV-2 virus
86703 – Analysis for antibody to HIV-1 and HIV-2 virus (Oraquick test)
87389 – Detection test for HIV-1 and HIV-2
87390 – Detection test for HIV-1
87391 – Detection test for HIV-2

Refer to the Part II Policies and Procedures For Independent Lab Services Program Manual.

9. **Cervical Dysplasia (Pap Test)**

Rev. 10/12
Rev. 10/14

Adolescents should not be routinely screened for cervical dysplasia prior to age 21 years.

Indications for pelvic exams prior to age 21 are noted in the "Gynecologic Examination for Adolescents in the Pediatric Office Setting" (http://pediatrics.aappublications.org/content/126/3/583.full)

H. Oral Health

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Rev. 10/14
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Rev. 07/17

Every child should begin to receive oral health risk assessments by 6 months of age.

The AAP recommends both the establishment of a dental home and the first dental exam no later than 12 months of age.

Assessing for a dental home should occur at the 12-month and 18-month through 6-year visits.

Risk Assessment: At the 6 and 9 month visits, conduct an oral health risk assessment.
https://www.aap.org/en-us/Documents/oralhealth_RiskAssessmentTool.pdf
Encourage the parent to select a dental home.

For the 12, 18, 24, and 30 month visits, assess whether the child has a dental home. If no dental home is identified, perform a risk assessment and refer to a dental home. Recommend brushing with fluoride toothpaste in the proper dosage for age. See Maintaining and Improving the Oral Health of Young Children" (http://pediatrics.aappublications.org/content/134/6/1224). For those at high risk, consider application of fluoride varnish for caries prevention.

At 3 and 6 years: Determine if the patient has a dental home. If not, a refer

al must be made. If a dental home has not been established, perform a risk assessment. For those at high risk, consider application of fluoride varnish for caries prevention.

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Rev. 07/17

Documentation: Document a referral or inability to refer to a dental home if one has not been established. Document the risk assessment if less than 6 years and dental home not established. Document dental appointment for older children and care per AAPD periodicity schedule. Any abnormal findings must have an appropriate intervention for all children.
An oral health risk assessment tool has been developed by the AAP/Bright Futures. This tool can be accessed at
https://www.aap.org/en-us/Documents/oralhealth_RiskAssessmentTool.pdf
(www.aap.org/oralhealth)

1. Fluoride Varnish

Rev. 04/16
Rev. 10/16

Once teeth are present, the application of fluoride varnish is required and may be applied every 3-6 months in the primary care or dental office for children between the ages of 6 months and 5 years. Indications for fluoride use are noted in the 2014 AAP clinical report "Fluoride Use in Caries Prevention in the Primary Care Setting"
(http://pediatrics.aappublications.org/cgi/doi/10.1542/peds.2014-1699)

***Documentation**:* Evidence that fluoride varnish was applied once between the ages of 6 months and 5 years OR evidence that the provider addressed the fluoride varnish requirement and/or its importance with the parent.

2. Fluoride Supplementation

Rev. 07/17

Starting at tooth eruption, fluoridated toothpaste is recommended. (https://www.aap.org/en-us/about-the-aap/aap-press-room/pages/aap-recommends-fluoride-to-prevent-dental-caries.aspx) (http://www.aapd.org/media/policies_guidelines/g_fluoridetherapy.pdf)

If primary water source is deficient in fluoride, consider oral fluoride supplementation. See "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626)

Risk Assessment: Required at the 6 through 12 month visits, 18 month through 30 month visits, and then annually beginning at 3 years through 16 years.

***Documentation**:* Evidence that the provider addressed the fluoride supplementation requirement and/or its importance with the parent.

I. Anticipatory Guidance Procedure:

Rev. 04/11
Rev. 10/14

For all ages: Anticipatory guidance and health education must be offered. It is a federally required component of the EPSDT preventive health visit. Age appropriate topics/information must be presented during each visit. Providers may use oral and written information. Providers may refer to the specific guidance by age as listed in the Bright Futures Guidelines.

Note: Providers must document discussion or provision of guidance for all children on Injury and Violence Prevention. Bright Futures Guidelines recommend and DCH requires sleep positioning counseling and documentation of such at every visit for members aged birth to six (6) months. DCH encourages sleep positioning counseling through the nine (9) month visit.

Documentation: Topics or name of handout given.

J. Referral/Treatment noted between the PCP and Specialist *or* Follow-Up for Abnormal Values

Rev. 10/14

All suspicious or abnormal findings identified during an EPSDT visit must be treated or be further evaluated. The provider must either treat (if qualified) or refer all members with abnormal findings.

***Documentation**:* Evidence of appropriate plan of care, treatment or referral for all components, results, and overriding concerns.

903. Required Equipment and Required Location Where Services Are To Be Provided

Rev. 01/11
Rev. 04/11
Rev. 10/14
Rev. 07/15
Rev. 07/17

In addition to an examination table and routine supplies, providers **must** have the following equipment in their office or clinic in order to complete the EPSDT preventive health exam:

1. Scale for weighing infants and other children;
2. Measuring board or appropriate device for measuring length or height in the recumbent position for infants and children up to the age of two (2) years;
3. Measuring board or accurate device for measuring height in the vertical position for children who are over two (2) years old;
4. Blood pressure apparatus with infant, child and adult cuffs;
5. Screening audiometer;
6. Eye charts appropriate for age of the child;
7. Ophthalmoscope and otoscope;
8. Developmental/Behavioral Health screening tools and supplies for the following:
   Developmental Screening - *The required developmental screenings at ages 9 months, 18 months, and 30 months* ***must*** *be accomplished using one or more of the recommended standardized developmental screening tools specified in Section 902.2.*
   - Autism Screening
   - Depression Screening
   - Maternal Depression Screening
   - Tobacco, Alcohol, or Drug Use Assessment
9. Vaccines and immunization administration supplies; and
10. Lab supplies for appropriate lab tests/screenings.
    The provider may also have a Centrifuge or other device for measuring hematocrit or hemoglobin.

904. Periodic, Catch-up and Interperiodic Visits

Rev. 10/10
Rev. 10/12
Rev. 04/14
Rev. 07/14
Rev. 10/14
Rev. 01/16
Rev. 07/17

The Georgia Department of Community Health, Division of Medicaid adopted the updated 2017 Bright Futures Periodicity Schedule and the schedule's components as the guidelines for each EPSDT preventive health visit. Please use these guidelines, the following tables and the EPSDT HIPAA referral codes (See Section 911) when billing for the EPSDT visit.

Table A: Use this table when billing for the EPSDT periodic visits of children who are on time for their visits according to the updated 2017 Bright Futures Periodicity schedule. One visit from each sequence may be billed.

Table B: Use this table when billing for the EPSDT periodic visits of children who have missed one or more of their EPSDT periodic visits according to the updated 2017 Bright Futures Periodicity schedule and need to get caught up with the Periodicity schedule.

Table C: Use this table when billing for the EPSDT interperiodic visits of children who are up to date on their periodic visits but have a medical necessity for another visit: i.e. referred to the EPSDT provider because of a suspected problem by a health, developmental, or educational professional who comes into contact with the child outside of the formal health care system or a need identified by the provider or parent.

Note: *Children in state custody (foster care) may require more frequent EPSDT services. Effective March 3, 2014, all children in state custody were transitioned to Medicaid managed care.*

Table A

On Time EPSDT Periodic Visit Procedure Codes

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Rev. 03/13
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Rev. 04/14
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Rev. 10/14
Rev. 01/15
Rev. 07/15
Rev. 10/15
Rev. 01/16
Rev. 04/16
Rev. 07/16

Use the preventive visit codes (99381-99385, 99391-99395) for Medicaid-eligible and PeachCare for Kids® (PCK)-eligible children. All preventive visits must be coded with the EP modifier (Refer to Table A) and appropriate diagnosis code (Refer to Table A-2). The 25 modifier must be included when a vaccine is administered during the preventive visit. A preventive visit that is not performed as specified in the periodicity schedule should be coded as a catch-up visit (Refer to Table B.) Catch-up visits are only available for children younger than three (3) years of age.

If an abnormality/ies is encountered or a preexisting problem is addressed during the EPSDT Periodic visit, and if the problem/abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M (evaluation and management) service, then the appropriate Office/Outpatient code 99211 or 99212 should also be reported. If the member is a new patient, *defined as one who has not received any EPSDT services (face-to-face services reported with a CPT code) from a practitioner or any practitioner within the same group practice of the exact same specialty or subspecialty within the past 3 years*, code the EPSDT preventive visit using the 9938x codes. If the member is an established patient, *defined as one who has received an EPSDT service from a practitioner or any practitioner within the same group practice of the same specialty or subspecialty within the past 3 years*, code the EPSDT preventive visit using the 9939x codes. Use the 99211 or 99212 code for the office visit component. (There is a reimbursement rate differential for PCK's members as identified in Table C.)

Modifier EP and 25 should be added to the Office/Outpatient code to indicate that a significant, separately identifiable Evaluation and Management service was provided by the same EPSDT provider on the same day as the EPSDT Periodic visit. The appropriate EPSDT Periodic visit code is additionally reported. If an abnormality/ies is encountered use the appropriate HIPAA diagnosis code which relates to the medical service(s) provided.

Other helpful information

The blood lead level screening is due at the 12 and 24 month preventive visits and the preventive visit will not be reimbursed without documentation that the blood lead level screening occurred. Providers must bill CPT code 36415 or 36416 with ICD-10 diagnosis code Z13.88 to signify blood lead level screening.

Reimbursement for immunization administration will be provided when vaccines are administered and properly coded on the claim by the provider.

Rev. 10/14
Rev. 10/15

The appropriate EPSDT Referral Code should be documented on the EPSDT claim when an EPSDT preventive visit has occurred. (See Section 911 – EPSDT HIPAA Referral Codes and Appendix K – EPSDT HIPAA Referral Code Examples.)

Table A

Sequence Numbers	HIPAA Procedure Code	HIPAA Modifier	Fee For Service Reimbursement	Periodic Exam to take place at stated age. Otherwise, code as Catch-Up Visit
1				*Newborn Visit* *(performed in the hospital)*
2	99381 or 99391	EP	$67.38	3-5 days
3				by 1 month
4				2 months
5				4 months
6				6 months
7				9 months
8	99382 or 99392	EP	$67.38	12 months
9				15 months
10				18 months
11				24 months
12				30 months
13				3 years
14				4 years
15	99383 or 99393	EP	$67.38	5 years
16				6 years
17				7 years
18	99383 or 99393	EP	$75.38 – Private $55.38 – Public Health	8 years
19				9 years
20				10 years
21				11 years
22	99384 or 99394	EP	$75.38 – Private $55.38 – Public Health	12 years
23				13 years
24				14 years
25				15 years
26				16 years
27				17 years
28	99385 or 99395	EP	$75.38 – Private $55.38 – Public Health	18 years
29				19 years
30				20 years

Rev. 07/16

Effective July 1, 2015, physicians and physician extenders who are eligible for the HB 76 FY 2016 Primary Care Providers (PCP) rate increase will be reimbursed at the following rates, as indicated below in **Table A-1**, when the specified codes are billed for established Medicaid-eligible and PCK-eligible members.

Rev. 10/16

Effective July 1, 2016, physicians and physician extenders who are eligible for the HB 751 FY 2017 Primary Care Providers (PCP) rate increase will be reimbursed at the following rates, as indicated below in **Table A-1**, when the specified codes are billed for established Medicaid-eligible and PCK-eligible members.

Rev. 4/18

Effective July 1, 2017, physicians and physician extenders who are eligible for the HB 44 FY 2018 Primary Care Providers (PCP) rate increase will be reimbursed at the following rates, as indicated below in **Table A-1**, when the specified codes are billed for established Medicaid-eligible and PCK-eligible members.

Table A-1

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Primary Care Providers (PCP) Rate Increases					
Age	**Preventive Visit Code**	**HIPAA Modifier**	**HB 76 FY2016 Increased Reimbursement Rate**	**HB 751 FY2017 Increased Reimbursement Rate**	**HB 44 FY2018 Increased Reimbursement Rate**
Birth – 11 months	99381	EP		$106.68	
	99391		$86.47	$96.08	
12 months – 4 years	99382	EP			$111.27
	99392		$92.46	$102.74	
5 years – 11 years	99383	EP			$116.19
	99393		$92.17	$102.41	
12 years – 17 years	99384	EP			$131.62
	99394		$101.03	$112.25	
18 years – 20 years	99385	EP			$127.75
	99395		$103.24	$114.71	

Table A-2

Table A-2 displays the correct ICD-10 diagnosis codes to be used when billing preventive health visits.

Rev. 07/16

ICD-10 Code	At this Age
Z00.110	0 – 7 days
Z00.111	8 – 28 days
Z00.121 or Z00.129	29 days through 14 years
Z00.121 or Z00.129 Z00.00 or Z00.01	15 years through 17 years
Z00.00 or Z00.01	18 years through 20 years
Z02 – Z02.89	0 through 20 years

TABLE B

Catch-Up EPSDT Visit Procedure Codes

Use Table B-1 for Medicaid-eligible and PeachCare for Kids®-eligible children who have missed their EPSDT periodic visit(s). Catch-up preventive visits are only available for children younger than three (3) years of age. All catch-up preventive visits must be coded with the EP and HA modifiers (see Table B-1) and appropriate diagnosis code (see Table B-1). The 25 modifier must be included when a vaccine is administered during the catch-up preventive visit.

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The Health Check provider must complete all missed components during this catch-up visit but may only bill for one catch-up visit (Example - Child presents to the Health Check provider at eight (8) months of age and has missed the four and six month periodic visits. All components of the four and six month periodic visits must be included during the present catch-up visit and documentation must be provided for all periodic visit components included during this catch-up visit.) The appropriate EPSDT Catch-Up visit procedure code (see Table B-1 above) along with the EP and HA modifiers and appropriate diagnosis code (see Table B-1) must be included on the claim.

If abnormalities are encountered or a preexisting problem is addressed during the EPSDT Catch-Up visit, and if the problem/abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then the appropriate Office/Outpatient code 99211 or 99212 should also be reported. The provider should use the appropriate HIPAA diagnosis code that relates to the medical service(s) provided and include modifiers EP and 25.

Rev. 10/12
Rev. 10/14

If the member is a new patient, *one who has not received any EPSDT services (defined as face-to-face services reported with a CPT code) from a practitioner or any practitioner within the same group practice of the exact same specialty or subspecialty within the past 3 years,* code the EPSDT preventive visit using the 9938x codes. If the member is an established patient, *defined as one who has received an EPSDT service from a practitioner or any practitioner within the same group practice of the same specialty or subspecialty within the past 3 years,* code the EPSDT preventive visit using the 9939x codes. Use the 99211 or 99212 codes for the office visit component. (There is a reimbursement rate differential for PCK's members as identified in Table C.)

Other helpful information

Rev. 10/14
Rev. 10/15

The blood lead level screening is due at the 12 and 24 month preventive visits and the preventive visit will not be reimbursed without documentation that the blood lead level screening occurred. Providers must bill CPT code 36415 or 36416 with ICD-10 diagnosis code Z13.88 to signify blood lead level screening.

Reimbursement for immunization administration will be provided when vaccines are administered and properly coded on the claim by the provider.

The appropriate EPSDT Referral Code should be documented on the EPSDT claim when an EPSDT periodic visit has occurred. (See Section 911 – EPSDT HIPAA Referral Codes and Appendix K – EPSDT HIPAA Referral Code Examples.)

Tables B-1 and B-2 display the correct modifiers to be used when billing catch-up preventive health visits.

Rev. 10/16

Effective July 1, 2016, physicians and physician extenders who are eligible for the HB 751 FY 2017 Primary Care Providers (PCP) rate increase will be reimbursed at the following rates, as indicated below in **Table B-2**, when the specified codes are billed for established Medicaid-eligible and PCK-eligible members.

Rev. 04/18

Effective July 1, 2017, physicians and physician extenders who are eligible for the HB 44 FY 2018 Primary Care Providers (PCP) rate increase will be reimbursed at the following rates, as indicated below in **Table B-2**, when the specified codes are billed for established Medicaid-eligible and PCK-eligible members.

Table B-1

HIPAA Proc Code	Age of Child	HIPAA Modifier	2nd modifier	Fee For Service Reimbursement
99381 or 99391	0 days through 11 months	EP	HA	$67.38
99382 or 99392	12 months up to 3 years	EP	HA	$67.38

Table B-2

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Rev. 04/18

Primary Care Providers Rate Increases						
HIPAA Proc Code	Age of Child	HIPAA Modifier	2nd modifier	HB 76 FY2016 Increased Reimbursement Rate	HB 751 FY2017 Increased Reimbursement Rate	HB 44 FY2018 Increased Reimbursement Rate
99381	0 days through 11 months	EP	HA		$106.68	
99391				$86.47	$96.08	
99382	12 months up to 3 years	EP	HA			$111.27
99392				$92.46	$102.74	

Table B-3 displays the correct ICD-10 diagnosis codes to be used when billing catch-up preventive health visits.

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Table B-3

ICD-10 Diagnosis Code	At this Age
Z00.110	0 – 7 days
Z00.111	8 – 28 days
Z00.121 or Z00.129	29 days to 3 years
Z02 – Z02.89	0 to 3 years

TABLE C

Interperiodic EPSDT Visit Procedure Codes

Per the Federal EPSDT policy guidelines, interperiodic screening, vision, hearing, and dental services which are medically necessary to determine the existence of suspected physical or mental illnesses or conditions are to be provided.

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Rev. 07/16

Use Table C-1 for Medicaid-eligible and PeachCare for Kids®-eligible children who are up to date on their periodic exams but have been referred because of a suspected problem to a qualified health provider by a health, developmental, or educational professional who comes into contact with the child outside of the formal health care system or a need identified by the provider or parent. The complete set of EPSDT preventive health visit components does not have to be performed. EPSDT providers must document the correct level of care when using office visit codes. The rate differential for PCK's members are shown in Table C-1.

Rev. 01/21

Code the EPSDT interperiodic visit (99202-99203, 99211-99214) with the EP modifier. When vaccines are administered during the interperiodic visit, code the EPSDT interperiodic visit (99202-99203, 99212-99214) with the EP and 25 modifiers. The National Correct Coding Initiative (NCCI) does not allow reimbursement of the 99211 code when it is billed together with any of the vaccine administration codes (90460, 90471-90474).

Table C-1

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HIPAA Procedure Code	HIPAA Modifier	HIPAA Diagnosis Code	Medicaid Fee For Service (FFS) Reimbursement	PeachCare for Kids® (PCK) Fee for Service (FFS) Reimbursement
99202 (new patient)	EP	*	$54.57	$71.16
99203 (new patient)	EP	*	$76.33	$103.01
99211 (established patient)	EP	*	$17.46	$17.46
99212 (established patient)	EP	*	$29.67	$41.54
99213 (established patient)	EP	*	$40.70	$69.11
99214 (established patient)	EP	*	$62.71	$102.49

*Use the appropriate HIPAA diagnosis code that relates to the medical service(s) provided.
NOTE: 99201 deleted effective 1-1-2021

TABLE C

Primary Care Providers Rate Increases

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Rev. 10/16

Effective July 1, 2015, physicians and physician extenders who are eligible for the HB 76 FY 2016 Primary Care Providers (PCP) Rate Increase will be reimbursed $63.14, as indicated below in Table C-2 when procedure code 99213 is billed. This rate increase does not apply to PeachCare for Kids® members.

Effective July 1, 2016, physicians and physician extenders who are eligible for the HB 751 FY 2017 Primary Care Providers (PCP) rate increase will be reimbursed at the following rates, as indicated below in Table C-2, when the specified codes are billed for established Medicaid-eligible and PeachCare for Kids®-eligible members.

Rev. 04/18

Effective July 1, 2017, physicians and physician extenders who are eligible for the HB 44 FY 2018 Primary Care Providers (PCP) rate increase will be reimbursed at the following rates, as indicated below in **Table C-2**, when the specified codes are billed for established Medicaid-eligible and PCK-eligible members.

Table C-2

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Primary Care Providers Rate Increases					
HIPAA Procedure Code	**HIPAA Modifier**	**HIPAA Diagnosis Code**	**HB 76 FY2016 Increased Reimbursement Rate**	**HB 751 FY2017 Increased Reimbursement Rate**	**HB 44 FY2018 Increased Reimbursement Rate**
99201 (new patient) **deleted eff. 1-1-2021	EP	*			$41.30
99202 (new patient)	EP	*		$71.33	
99203 (new patient)	EP	*		$103.80	
99211 (established patient)	EP	*			$18.97[1] (FFS) $19.79[2] (PCK)
99212 (established patient)	EP	*		$41.63	
99213 (established patient)	EP	*	$63.14 [1] (FFS)	$70.15	
99214 (established patient)	EP	*		$103.72	

*Use the appropriate HIPAA diagnosis code that relates to the medical service(s) provided.
** 99201 deleted effective 1-1-2021
[1]This rate increase does not apply to PeachCare for Kids® members.
[2]This rate increase does not apply to Medicaid FFS members.

Table C

Interperiodic Vision and Hearing Screening

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Rev. 04/14

An enrolled provider may use the codes as indicated below in Table C-3 when billing for vision and/or hearing screening only. For example, a recheck of a failed hearing screening or a child who needs Form 3300 (Certificate of Vision, Hearing, Dental and Nutrition Screening) completed. Separate reimbursement is not allowed when these screenings are performed during the periodic preventive visit. Please see Table C-3 below.

Table C-3

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HIPAA Procedure Code	HIPAA Modifier	Interperiodic Screening	ICD-10 Diagnosis Code	PCK and FFS Rate
99173	EP	Interperiodic Vision	Z01.00 or Z01.01 Or appropriate abnormal results code	$5.62
V5008, 92551–92553, 92555-92556	EP	Interperiodic Hearing	Z01.10 or Z01.110 Or Z01.118 Or appropriate abnormal results code	$5.62

Rev. 01/18

Note: The Georgia Department of Public Health's Form 3300 has been revised to document a nutrition screening. More information and a copy of the form can be found at: http://www.gachd.org/DPH_Form_3300.pdf

Rev. 04/11

The determination of whether an interperiodic screen is medically necessary may be made by a health, developmental, or educational professional who comes into contact with the child outside of the formal health care system [e.g., State early intervention or special education programs, Head Start and day care programs, the Special Supplemental Food Program for Women, Infants and Children (WIC), and other nutritional assistance programs]. Providers may not bill interperiodic and periodic visits on the same day.

905. Immunizations

905.1 Recommended Immunization Schedule:

The Recommended Childhood Immunization Schedule should be used as the guideline for administering immunizations.

905.2 Delayed Immunizations:

Practitioners who begin the immunization process on children who are late or at times other than the recommended optimal immunization schedule may use recommendations from the Advisory Committee on Immunization Practices (ACIP) - see schedule for Children and Adolescents Who Start Late.

905.3 Vaccines for Children (VFC) Program:

Rev. 04/09
Rev. 10/14

It is recommended that all Health Check providers enroll in the Vaccines For Children program to provide immunizations to Medicaid eligible children whose ages are birth through eighteen (18) years of age. If the Health Check provider giving the EPSDT preventive health exam does not wish to participate in VFC, it is expected that they administer vaccines at the time of service and understand that only the administration fee will be reimbursed. The Vaccines For Children (VFC) program is a federally funded and state operated vaccine supply program that began October 1, 1994. The program supplies, at no cost to all public health and private health care providers, federally purchased vaccines to be administered to children in certain groups. Children eligible to receive VFC-provided vaccines include the following:

A. children enrolled in Medicaid;

B. children who do not have health insurance;

C. children who are American Indian or Alaskan native; and

D. children who have health insurance but for whom vaccines are not a covered benefit.

Note: PeachCare for Kids® members may receive state purchased vaccines.

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Questions regarding enrollment and vaccine orders should be directed to the appropriate VFC program (1-800-848-3868).

Since vaccines are provided at no cost to the Health Check provider for children eighteen (18) years and younger, only administration costs are allowed to be submitted for reimbursement for vaccines administered to this age group.

905.4 Tdap and Meningococcal Requirements

7th Grade Immunization Requirements

Rev. 07/14
Rev. 04/20

Beginning in the 2014-2015 academic school year (effective July 1, 2014), the Georgia Department of Public Health (DPH) Rule (511-2-2) requires all students born on or after January 1, 2002 entering or transferring into seventh (7th) grade and any "new entrant" entering into 8th-12th grades in Georgia must provide proof that the student has received one dose of Tdap (tetanus, diphtheria, pertussis) vaccine and one dose of memingococcal conjugate (MCV4) vaccine. DPH guidelines state that the student must have received the meningococcal vaccine on or after their 10th birthday for entry into the 7th grade. A student that received the meningococcal vaccine before their 10th birthday will need to be revaccinated on or after his/her 10th birthday. There is a minimum time interval of 8 weeks between the previous dose of the MCV4 vaccine and the newly required dose.

This law affects all public and private schools including, but not limited to, charter schools, community schools, juvenile court schools and other alternative school settings (excluding homeschool). "New Entrant" means any child entering any school in Georgia for the first time or entering after having been absent from a Georgia school for more than twelve months or one school year.

11th Grade Immunization Requirements

Rev. 04/20

Georgia's immunization requirements for students entering or transferring into the eleventh grade have been revised to align with the current recommendations of the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).

Beginning in the 2020-2021 academic school year (effective July 1, 2020), all students who are new entrants or transfers into a Georgia school in the eleventh grade, will require proof of a booster dose of the meningococcal conjugate vaccine, unless their first dose was received on or after their sixteenth birthday. Georgia law requires students be vaccinated against this disease, unless the child has an exemption.

https://dph.georgia.gov/immunization-section

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Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger, United States, 2020

(For those who fall behind or start late, see the catch-up schedule)

Table 1 Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2020

These recommendations must be read with the notes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars. To determine minimum intervals between doses, see the catch-up schedule (Table 2). School entry and adolescent vaccine age groups are shaded in gray.

Vaccine	Birth	1 mo	2 mos	4 mos	6 mos	9 mos	12 mos	15 mos	18 mos	19–23 mos	2–3 yrs	4–6 yrs	7–10 yrs	11–12 yrs	13–15 yrs	16 yrs	17–18 yrs
Hepatitis B (HepB)	1st dose	2nd dose			3rd dose												
Rotavirus (RV): RV1 (2-dose series), RV5 (3-dose series)			1st dose	2nd dose	See Notes												
Diphtheria, tetanus, acellular pertussis (DTaP <7 yrs)			1st dose	2nd dose	3rd dose			4th dose				5th dose					
Haemophilus influenzae type b (Hib)			1st dose	2nd dose	See Notes		3rd or 4th dose, See Notes										
Pneumococcal conjugate (PCV13)			1st dose	2nd dose	3rd dose		4th dose										
Inactivated poliovirus (IPV <18 yrs)			1st dose	2nd dose	3rd dose							4th dose					
Influenza (IIV)					Annual vaccination 1 or 2 doses								Annual vaccination 1 dose only				
or													or				
Influenza (LAIV)											Annual vaccination 1 or 2 doses		Annual vaccination 1 dose only				
Measles, mumps, rubella (MMR)					See Notes		1st dose					2nd dose					
Varicella (VAR)							1st dose					2nd dose					
Hepatitis A (HepA)					See Notes		2-dose series, See Notes										
Tetanus, diphtheria, acellular pertussis (Tdap ≥7 yrs)														Tdap			
Human papillomavirus (HPV)													*	See Notes			
Meningococcal (MenACWY-D ≥9 mos, MenACWY-CRM ≥2 mos)			See Notes											1st dose		2nd dose	
Meningococcal B														See Notes			
Pneumococcal polysaccharide (PPSV23)											See Notes						

Range of recommended ages for all children
Range of recommended ages for catch-up immunization
Range of recommended ages for certain high-risk groups
Recommended based on shared clinical decision-making or *can be used in this age group
No recommendation/ not applicable

NOTE: The above recommendations must be read along with the footnotes of this schedule
Refer to footnotes at https://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf

Catch-up Immunization Schedule for Children and Adolescents who start late or who are more than 1 month behind, United States, 2020

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Table 2 Recommended Catch-up Immunization Schedule for Children and Adolescents Who Start Late or Who are More than 1 month Behind, United States, 2020

The table below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age. **Always use this table in conjunction with Table 1 and the notes that follow.**

Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
Children age 4 months through 6 years					
Hepatitis B	Birth	**4 weeks**	**8 weeks *and* at least 16 weeks after first dose.** Minimum age for the final dose is 24 weeks.		
Rotavirus	6 weeks Maximum age for first dose is 14 weeks, 6 days	**4 weeks**	**4 weeks** Maximum age for final dose is 8 months, 0 days.		
Diphtheria, tetanus, and acellular pertussis	6 weeks	**4 weeks**	**4 weeks**	**6 months**	**6 months**
Haemophilus influenzae type b	6 weeks	**No further doses needed** if first dose was administered at age 15 months or older. **4 weeks** if first dose was administered before the 1st birthday. **8 weeks (as final dose)** if first dose was administered at age 12 through 14 months.	**No further doses needed** if previous dose was administered at age 15 months or older. **4 weeks** if current age is younger than 12 months ***and*** first dose was administered at younger than age 7 months ***and*** at least 1 previous dose was PRP-T (ActHib, Pentacel, Hiberix) or unknown. **8 weeks *and* age 12 through 59 months (as final dose)** if current age is younger than 12 months ***and*** first dose was administered at age 7 through 11 months; OR if current age is 12 through 59 months ***and*** first dose was administered before the 1st birthday ***and*** second dose administered at younger than 15 months; OR if both doses were PRP-OMP (PedvaxHIB, Comvax) ***and*** were administered before the 1st birthday.	**8 weeks (as final dose)** This dose only necessary for children age 12 through 59 months who received 3 doses before the 1st birthday.	
Pneumococcal conjugate	6 weeks	**No further doses needed** for healthy children if first dose was administered at age 24 months or older. **4 weeks** if first dose was administered before the 1st birthday. **8 weeks (as final dose for healthy children)** if first dose was administered at the 1st birthday or after.	**No further doses needed** for healthy children if previous dose administered at age 24 months or older. **4 weeks** if current age is younger than 12 months and previous dose was administered at <7 months old. **8 weeks (as final dose for healthy children)** if previous dose was administered between 7–11 months (wait until at least 12 months old); OR if current age is 12 months or older and at least 1 dose was given before age 12 months.	**8 weeks (as final dose)** This dose only necessary for children age 12 through 59 months who received 3 doses before age 12 months or for children at high risk who received 3 doses at any age.	
Inactivated poliovirus	6 weeks	**4 weeks**	**4 weeks** if current age is < 4 years. **6 months (as final dose)** if current age is 4 years or older.	**6 months** (minimum age 4 years for final dose).	
Measles, mumps, rubella	12 months	**4 weeks**			
Varicella	12 months	**3 months**			
Hepatitis A	12 months	**6 months**			
Meningococcal ACWY	2 months MenACWY-CRM 9 months MenACWY-D	**8 weeks**	See Notes	See Notes	
Children and adolescents age 7 through 18 years					
Meningococcal ACWY	Not applicable (N/A)	**8 weeks**			
Tetanus, diphtheria; tetanus, diphtheria, and acellular pertussis	7 years	**4 weeks**	**4 weeks** if first dose of DTaP/DT was administered before the 1st birthday. **6 months (as final dose)** if first dose of DTaP/DT or Tdap/Td was administered at or after the 1st birthday.	**6 months** if first dose of DTaP/DT was administered before the 1st birthday.	
Human papillomavirus	9 years	**Routine dosing intervals are recommended.**			
Hepatitis A	N/A	**6 months**			
Hepatitis B	N/A	**4 weeks**	**8 weeks *and* at least 16 weeks after first dose.**		
Inactivated poliovirus	N/A	**4 weeks**	**6 months** A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose.	A fourth dose of IPV is indicated if all previous doses were administered at <4 years or if the third dose was administered <6 months after the second dose.	
Measles, mumps, rubella	N/A	**4 weeks**			
Varicella	N/A	**3 months** if younger than age 13 years. **4 weeks** if age 13 years or older.			

NOTE: The above recommendations must be read along with the footnotes of this schedule
Refer to footnotes at https://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf

Recommended Child and Adolescent Immunization Schedule by Medical Indication, United States, 2020

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Table 3 Recommended Child and Adolescent Immunization Schedule by Medical Indication, United States, 2020

Always use this table in conjunction with Table 1 and the notes that follow.

VACCINE	INDICATION									
	Pregnancy	Immunocompromised status (excluding HIV infection)	HIV infection CD4+ count[1] <15% and total CD4 cell count of <200/mm3	HIV infection CD4+ count[1] ≥15% and total CD4 cell count of ≥200/mm3	Kidney failure, end-stage renal disease, or on hemodialysis	Heart disease or chronic lung disease	CSF leaks or cochlear implants	Asplenia or persistent complement component deficiencies	Chronic liver disease	Diabetes
Hepatitis B										
Rotavirus		SCID[2]								
Diphtheria, tetanus, & acellular pertussis (DTaP)										
Haemophilus influenzae type b										
Pneumococcal conjugate										
Inactivated poliovirus										
Influenza (IIV) or Influenza (LAIV)						Asthma, wheezing: 2–4yrs[3]				
Measles, mumps, rubella										
Varicella										
Hepatitis A										
Tetanus, diphtheria, & acellular pertussis (Tdap)										
Human papillomavirus										
Meningococcal ACWY										
Meningococcal B										
Pneumococcal polysaccharide										

Vaccination according to the routine schedule recommended

Recommended for persons with an additional risk factor for which the vaccine would be indicated

Vaccination is recommended, and additional doses may be necessary based on medical condition. See Notes.

Not recommended/ contraindicated—vaccine should not be administered

Precaution—vaccine might be indicated if benefit of protection outweighs risk of adverse reaction

Delay vaccination until after pregnancy if vaccine indicated

No recommendation/ not applicable

1 For additional information regarding HIV laboratory parameters and use of live vaccines, see the General Best Practice Guidelines for Immunization, "Altered Immunocompetence," at www.cdc.gov/vaccines/hcp/acip-recs/immunocompetence.html and Table 4-1 (footnote D) at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html.

2 Severe Combined Immunodeficiency

3 LAIV contraindicated for children 2-4 years of age with asthma or wheezing during the preceding 12 months.

Recommended Adult Immunization Schedule by Age Group, United States, 2020

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Table 1 Recommended Adult Immunization Schedule by Age Group, United States, 2020

Vaccine	19–26 years	27–49 years	50–64 years	≥65 years
Influenza inactivated (IIV) or **Influenza recombinant** (RIV)	1 dose annually			
or	or			
Influenza live, attenuated (LAIV)	1 dose annually			
Tetanus, diphtheria, pertussis (Tdap or Td)	1 dose Tdap, then Td or Tdap booster every 10 years			
Measles, mumps, rubella (MMR)	1 or 2 doses depending on indication (if born in 1957 or later)			
Varicella (VAR)	2 doses (if born in 1980 or later)		2 doses	
Zoster recombinant (RZV) *(preferred)*			2 doses	
or			or	
Zoster live (ZVL)			1 dose	
Human papillomavirus (HPV)	2 or 3 doses depending on age at initial vaccination or condition	27 through 45 years		
Pneumococcal conjugate (PCV13)	1 dose			65 years and older
Pneumococcal polysaccharide (PPSV23)	1 or 2 doses depending on indication			1 dose
Hepatitis A (HepA)	2 or 3 doses depending on vaccine			
Hepatitis B (HepB)	2 or 3 doses depending on vaccine			
Meningococcal A, C, W, Y (MenACWY)	1 or 2 doses depending on indication, see notes for booster recommendations			
Meningococcal B (MenB)	2 or 3 doses depending on vaccine and indication, see notes for booster recommendations			
	19 through 23 years			
***Haemophilus influenzae* type b** (Hib)	1 or 3 doses depending on indication			

Recommended vaccination for adults who meet age requirement, lack documentation of vaccination, or lack evidence of past infection

Recommended vaccination for adults with an additional risk factor or another indication

Recommended vaccination based on shared clinical decision-making

No recommendation/ Not applicable

The above recommendations are located at https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf

Recommended Adult Immunization Schedule by Medical Condition and Other Indications

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Table 2 Recommended Adult Immunization Schedule by Medical Condition and Other Indications, United States, 2020

Vaccine	Pregnancy	Immuno-compromised (excluding HIV infection)	HIV infection CD4 count <200	HIV infection CD4 count ≥200	Asplenia, complement deficiencies	End-stage renal disease; or on hemodialysis	Heart or lung disease, alcoholism[1]	Chronic liver disease	Diabetes	Health care personnel[2]	Men who have sex with men
IIV or RIV	1 dose annually										
or										or	
LAIV	NOT RECOMMENDED					PRECAUTION				1 dose annually	
Tdap or Td	1 dose Tdap each pregnancy	1 dose Tdap, then Td or Tdap booster every 10 years									
MMR	NOT RECOMMENDED			1 or 2 doses depending on indication							
VAR	NOT RECOMMENDED			2 doses							
RZV *(preferred)*	DELAY				2 doses at age ≥50 years						
or					or						
ZVL	NOT RECOMMENDED				1 dose at age ≥60 years						
HPV	DELAY	3 doses through age 26 years			2 or 3 doses through age 26 years						
PCV13		1 dose									
PPSV23		1, 2, or 3 doses depending on age and indication									
HepA					2 or 3 doses depending on vaccine						
HepB							2 or 3 doses depending on vaccine				
MenACWY	1 or 2 doses depending on indication, see notes for booster recommendations										
MenB	PRECAUTION	2 or 3 doses depending on vaccine and indication, see notes for booster recommendations									
Hib		3 doses HSCT[3] recipients only			1 dose						

- Recommended vaccination for adults who meet age requirement, lack documentation of vaccination, or lack evidence of past infection
- Recommended vaccination for adults with an additional risk factor or another indication
- Precaution—vaccination might be indicated if benefit of protection outweighs risk of adverse reaction
- Delay vaccination until after pregnancy if vaccine is indicated
- Not recommended/ contraindicated—vaccine should not be administered
- No recommendation/ Not applicable

The above recommendations are located at https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf

906. Diagnostic, Treatment and Referral Services

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Rev. 10/14

All suspicious or abnormal findings identified during an EPSDT preventive health visit must be treated or be further evaluated.

When an EPSDT service is needed but not performed during the EPSDT preventive health visit, the child provider should be appropriately referred for diagnosis.

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For non-CMO (care management organization) Medicaid and PeachCare for Kids® Fee-For Service (FFS) members, the screening provider must either treat (if qualified) or refer all members with abnormal findings. Members needing referrals must be appropriately referred to Medicaid or PeachCare for Kids® enrolled providers. For information on billing levels allowed for treatment during the EPSDT periodic and interperiodic visits, see section 1003. Billing Tips.

If the provider is not the member's EPSDT PCP, the provider must notify the member's PCP of the preventive health/interperiodic visit to discuss any clinical findings which require prompt medical attention.
Referral and prior authorization may be required for children who are assigned a PCP.

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Rev. 10/14

The level of treatment required should determine whether additional services are billed or provided during the EPSDT scheduled visit.

Rev. 07/10

907. Lead Risk Assessment and Screening

907.1 Purpose:

The purpose of screening for lead absorption is to identify children who have either symptomatic or asymptomatic lead poisoning and to intervene as quickly as possible to reduce their blood lead levels.

907.2 Lead Screening:

A. Since 1989, Federal law has required that children enrolled in Medicaid must have their blood lead level measured at 12 and 24 months of age.

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Rev. 07/10
Rev. 10/14

B. A blood lead test, *capillary* or *venous*, must be used when screening Medicaid-eligible children. A capillary Blood Lead Test that is elevated (≥ 10ug/dL reported by a certified lab or ≥ 6ug/dL with the Lead Care II analyzer) must be confirmed with a repeat Blood Lead Test (confirmatory venous specimen is preferred) at a certified laboratory.

Rev. 07/17

C. ALL **venous** sample lead screening tests conducted using any Magellan Diagnostic lead testing system should be laboratory analyzed by a properly accredited laboratory.

907.3 Lead Health Education and Anticipatory Guidance

Health education is a required component of screening services **(**EPSDT benefit in accordance with section 1905(r) of the Act) and includes anticipatory guidance.

Anticipatory Guidance regarding Lead Exposure

Anticipatory guidance should be provided to families when children are:

A. 3-6 months of age and again at 12 months.

B. Between the ages of 24 and 72 months at well-child visits and when a lead risk assessment questionnaire is administered.

The following topics should be covered with anticipatory guidance:

A. Effects of lead poisoning on children

B. Sources of lead poisoning

C. Pathways of exposure (including placental exposure)

D. How to prevent a child's exposure to lead hazards

E. Appropriate schedule for testing children for lead poisoning

907.4 Lead Case Management

Rev. 10/12
Rev. 04/14

All children whose initial screening test shows an elevated blood lead level should follow the Georgia Healthy Homes and Lead Poisoning Prevention Program's (GHHLPPP) Case Management Guidelines. Georgia Department of Public Health (DPH) Lead Hazard Risk Assessors, under the guidance of the GHHLPPP, will perform an environmental lead risk assessment for all children with a confirmed blood lead level of $\geq$10 ug/dL, as well as provide education about low cost methods to reduce identified lead hazards. As a primary care provider, you will be notified by a DPH Lead Hazard Risk Assessor of the results of the environmental lead risk assessment and remediation recommendations.

Refer to the GHHLPPP Case Management Guidelines located in Appendix A, Guidelines in Screening and Reporting Elevated Blood Lead Levels.

908. Oral Health and Dental Services

Rev. 10/14

Per the Federal EPSDT policy guidelines, dental services must be provided to eligible members under twenty-one years of age. Dental services required under the EPSDT benefit include:

- Dental care needed for relief of pain, infection, restoration of teeth, and maintenance of dental health (provided at as early an age as necessary); and
- Emergency, preventive, and therapeutic services for dental disease that, if left untreated, may become acute dental problems or cause irreversible damage to the teeth or supporting structures.

In addition, medically necessary oral health and dental services, including those identified during an oral screening or a dental exam, are covered under the EPSDT benefit.

Refer to the Dental Services Program Policy and Procedures Manual.

Rev. 07/12
Rev. 10/19

In accordance with the American Academy of Pediatric Dentistry (AAPD) Periodicity of Examination, Preventive Dental Services, Anticiptory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents, dental providers should refer to the "Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling" Schedule. The AAPD intends these recommendations to help practitioners make clinical decisions concerning preventive oral health interventions, including anticipatory guidance and preventive counseling, for infants, children, and adolescents. The schedule may be assessed at http://www.aapd.org/assets/1/7/periodicity-aapdschedule.pdf

Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/ Counseling

Since each child is unique, these recommendations are designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations will need to be modified for children with special health care needs or if disease or trauma manifests variations from normal. The American Academy of Pediatric Dentistry (AAPD) emphasizes the importance of very early professional intervention and the continuity of care based on the individualized needs of the child. Refer to the text of this guideline for supporting information and references.

American Academy of Pediatric Dentistry	AGE				
	6 TO 12 MONTHS	12 TO 24 MONTHS	2 TO 6 YEARS	6 TO 12 YEARS	12 YEARS AND OLDER
Clinical oral examination [1]	•	•	•	•	•
Assess oral growth and development [2]	•	•	•	•	•
Caries-risk assessment [3]	•	•	•	•	•
Radiographic assessment [4]	•	•	•	•	•
Prophylaxis and topical fluoride [3,4]	•	•	•	•	•
Fluoride supplementation [5]	•	•	•	•	•
Anticipatory guidance/counseling [6]	•	•	•	•	•
Oral hygiene counseling [7]	Parent	Parent	Patient/parent	Patient/parent	Patient
Dietary counseling [8]	•	•	•	•	•
Injury prevention counseling [9]	•	•	•	•	•
Counseling for nonnutritive habits [10]	•	•	•	•	•
Counseling for speech/language development	•	•	•		
Substance abuse counseling				•	•
Counseling for intraoral/perioral piercing				•	•
Assessment and treatment of developing malocclusion			•	•	•
Assessment for pit and fissure sealants [11]			•	•	•
Assessment and/or removal of third molars					•
Transition to adult dental care					•

1 First examination at the eruption of the first tooth and no later than 12 months. Repeat every 6 months or as indicated by child's risk status/susceptibility to disease. Includes assessment of pathology and injuries.

2 By clinical examination.

3 Must be repeated regularly and frequently to maximize effectiveness.

4 Timing, selection, and frequency determined by child's history, clinical findings, and susceptibility to oral disease.

5 Consider when systemic fluoride exposure is suboptimal. Up to at least 16 years.

6 Appropriate discussion and counseling should be an integral part of each visit for care.

7 Initially, responsibility of parent; as child matures, jointly with parent; then, when indicated, only child.

8 At every appointment; initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity.

9 Initially play objects, pacifiers, car seats; when learning to walk; then with sports and routine playing, including the importance of mouthguards.

10 At first, discuss the need for additional sucking: digits vs pacifiers; then the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.

11 For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption.

American Academy of Pediatric Dentistry (AAPD) 2009 "Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/ Counseling"

FOOTNOTES

1. First examination at the eruption of the first tooth and no later than 12 months. Repeat every 6 months or as indicated by child's risk status/susceptibility to disease. Includes assessment of pathology and injuries.
2. By clinical examination.
3. Must be repeated regularly and frequently to maximize effectiveness.
4. Timing, selection, and frequency determined by child's history, clinical findings, and susceptibility to oral disease.
5. Consider when systemic fluoride exposure is suboptimal. Up to at least 16 years.
6. Appropriate discussion and counseling should be an integral part of each visit for care.
7. Initially, responsibility of parent; as child matures, jointly with parent; then, when indicated, only child.
8. At every appointment; initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity.
9. Initially play objects, pacifiers, car seats; when learning to walk; then with sports and routine playing, including the importance of mouth guards.
10. At first, discuss the need for additional sucking: digits vs pacifiers; then the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.
11. For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption.

909. Other Related Medicaid Programs (This is not an inclusive list)

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See the policies and procedures manual of the related programs for complete information. Provider Manuals relevant to EPSDT providers include, but may not be limited to:

- Advanced Nurse Practitioner Services
- Children's Intervention Services (CIS)
- Children's Intervention School Services (CISS)
- Dental Services
- Diagnostic Screening and Preventive Services (DSPS)
- Durable Medical Equipment (DME) Services
- Federally Qualified Health Center (FQHC) Services
- Georgia Pediatric Program (GAPP)
- Hospice Services
- Hospital Services
- Medicaid Medicaid/PeachCare for Kids® Provider Billing Manuals
- Nurse Midwifery Services
- Orthotic and Prosthetic Services
- Pharmacy Services
- Physician Assistant Services
- Physician Services
- Rural Health Clinic (RHC) Services
- Vision Care Services

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Provider Manuals are available for downloading. Contact Gainwell Technologies at 1-800-766-4456 or visit the website at **www.mmis.georgia.gov** for more information.

910. Summary of Non-covered Services

Rev. 10/11

Non-Covered Services include:

Screenings performed outside the provider's office or clinic.
Services provided in a manner inconsistent with the provisions of this manual.

911. EPSDT Profile (Appointment Tracking System)

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The purpose of the EPSDT Appointment Tracking System is to track enrolled Fee-For-Service children eligible for services and to assist providers in conducting and documenting outreach and follow-up activities to EPSDT families and children.

The EPSDT Appointment Tracking System fully supports the State's goals of providing appropriate and continuing screening and treatment services to Georgia's children and of preventing more costly health problems by encouraging regular health care.

This system provides immediate access to medical and dental information on EPSDT members through online inquiry and provides a reminder call system at no cost to the EPSDT provider. These capabilities enhance the control and operation of the EPSDT program and allow information gathering to support research and program development.

In collaboration with the monthly EPSDT roster (Periodic Screenings Due Report), the EPSDT Profile (Appointment Tracking System) provides:

1. Member's demographic information in addition to the last dates for Hearing (Interperiodic Hearing), Vision (Interperiodic Vision), EPSDT Medical and Dental screenings.
2. Detailed information on the member's entire EPSDT history. This allows the provider to view the member's entire EPSDT history and document outreach attempts as a result of letters/rosters distributed. Based on the notice type distributed by Gainwell Technologies, all the provider has to do is document the member's response and a response date. For example, if the provider arranges a future appointment with the member, he/she will select scheduled appointment under the drop down box for response type and enter the date of the appointment under response date.

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3. The Response Type options on the drop down box are:
    a. Set Appointment (EPSDT preventive health screening visit)
    b. Set Appointment (Dental)
    c. Set Appointment (Blood Lead).
    d. Screen Completed
4. The last section of the EPSDT Profile is the critical health information. EPSDT medical and dental providers are encouraged to enter information determined to be useful to another Health Care professional in the delivery of care to the member (For example, allergic to Penicillin).
5. If you need further instructions, feel free to click on the help link.

912. EPSDT HIPAA Referral Codes

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Rev. 04/15
Rev. 07/15

The Centers for Medicare and Medicaid Services (CMS) defines an EPSDT referral as a member scheduled for another appointment with the EPSDT Provider or a referral to another provider for further needed diagnostic and treatment services as a result of at least one health problem identified during the EPSDT preventive health visit. Effective with HIPAA implementation, CMS and DCH require documentation of EPSDT Referral Codes when submitting EPSDT Screening Code Claims (See Appendix K for examples). When completing the Health Insurance Claim Form [*CMS-1500*], the EPSDT Referral Codes must be entered in the shaded area of box 24H. (See Appendix L)

Example 1: If the EPSDT screening is normal, the referral code is NU (No follow up visit needed)

Example 2: If the EPSDT screening indicates the need for further diagnostic and treatment services and a follow-up visit is necessary, use the applicable referral code(s):

- AV Available, Not Used: Patient refused referral
- S2 Under Treatment: Patient is currently under treatment for health problem and has a return appointment.
- ST New Services Requested: Referral to another provider for diagnostic or corrective treatment/scheduled.

913. Access to Mental Health Services

Rev. 10/14

Behavioral Health Link operates the Georgia Crisis and Access Line (GCAL) through a contract with the Department of of Behavioral Health and Developmental Disabilities (DBHDD). To access mental health, addictive disease, and crisis services 24 hours a day, 7 days per week call 1-800-715-4225 (GCAL) or go to www.mygcal.com

914. Services for Foster Care Children

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Rev. 07/14
Rev. 10/14
Rev. 10/15

As of March 3, 2014, children, youth, and young adults in state custody, children receiving adoption assistance and a select group of children under the Juvenile Justice system, were transitioned to Medicaid managed care under the Georgia Families 360º Program. Amerigroup Community Care is the single Care Management Organization (CMO) managing this population (see Appendix I). Children in state custody under the Kenny A. Consent Decree are required to have an EPSDT preventive health visit and a dental visit within 10 days of official transition to state custody. Unless otherwise noted, EPSDT services for all other children enrolled in the Georgia Families 360º Program should follow the Bright Futures Periodicity Schedule.

PART II - CHAPTER 1000

Basis for Reimbursement

1001. Fee for Service Reimbursement Methodology

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Rev. 07/14

The Division will pay the lower of the lowest price regularly and routinely offered to any segment of the general public for the same service or items on the same date(s) of service, the lowest price charged to other third party payers, or effective with dates of service July 1, 2003, the statewide maximum allowable reimbursement which is 84.645% of Medicare's Resource Based Relative Value Scale (RBRVS) for 2000 for Region IV (Atlanta). All procedure codes recognized and adopted after the 2000 RBRVS are subject to the statewide maximum allowable reimbursement – 84.645% of the Region IV Medicare RBRVS in effect at the time the procedure code was adopted.

1002. Vaccines for Children

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Rev. 10/14

Since the Vaccines For Children (VFC) program supplies vaccines to providers at no cost to the provider for children birth through eighteen (18) years who have Medicaid, the Division will reimburse an administration fee only for immunizations given to Medicaid enrolled children of this age group. These fees cover the cost of administering the immunizations as well as any paper work involved (including an immunization or health certificate). Refer to Appendix C-2 for the reimbursement rates for the administration of vaccines provided by the VFC program for the Medicaid-eligible children birth through eighteen (18) years. Appendix C-2 also includes the reimbursement rate for the administration of state-purchased vaccines for the PeachCare for Kids® Fee for Service population, for children birth through age eighteen (18) years.

For members nineteen (19) years of age through twenty (20) years of age, VFC stock is not available. Providers must use their own stock of vaccines for these Medicaid eligible members. Health Check providers may include a vaccine administration code on their EPSDT claims when vaccines are administered to members nineteen (19) years of age through twenty (20) years of age. The Division will reimburse for the vaccine product <u>and</u> for vaccine administration. Billing tips for vaccine administration and the effective date for this change are located in Appendix C-1 of this manual and providers are strongly encouraged to follow those tips.

1003. Billing Tips

The following are tips to assist with billing for EPSDT screening services and interperiodic visits.

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Rev. 07/18

1. The EPSDT preventive health visit is reimbursed as a package of services. All of the age appropriate EPSDT preventive health visit components (as identified in the updated 2017 Bright Futures periodicity schedule) must be completed for each screening visit and billed under one procedure code except where indicated. All preventive or well-child services, except normal newborn care in the hospital, must be billed under the EPSDT Program following the policies and procedures as outlined in this manual.

2. EPSDT preventive health visits must be referred by or performed by the child's primary care practitioner in order for those services to be reimbursed. Only one (1) periodic preventive or well-child visit will be reimbursed per member at each age appropriate interval, as specified in the periodicity schedule (excluding foster care members).

3. Providers must perform the age appropriate hearing and vision screening in order to be reimbursed for the complete EPSDT preventive health exam. Providers may not refer the child to another provider for hearing and vision screening which is required at the time of the EPSDT preventive health visit.

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Rev. 07/15

4. When a visit is found to be medically necessary between periodic visit sequences, the EPSDT provider may be reimbursed by billing the appropriate interperiodic visit procedure code. An interperiodic visit cannot be billed on the same date of service as a complete EPSDT preventive health visit.

5. The Georgia Medicaid program reimburses for many of the Diagnostic and Treatment services under other Medicaid programs.

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6. **Developmental Screenings**

   A developmental screening should be performed at the following periodic visits: 9, 18, and 30 months. Providers must bill code 96110 with the EP modifier and the appropriate preventive ICD-10 diagnosis code in order to receive reimbursement for this screening.

   Only one (1) developmental screening will be reimbursed at each of these intervals. If the child is not seen at the 9, 18, or 30 month visit, a developmental screening should be performed during the catch-up visit for the missed periodic visit. This catch-up developmental screening should be billed, using the EP <u>and</u> HA modifiers with code 96110 and the appropriate preventive ICD-10 code. The provider can only bill one (1) catch-up developmental screening during any one (1) catch-up interval.

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ICD-10 Diagnosis Codes (preventive)
Z00.121 or Z00.129
Z02 – Z02.89

7. **Autism Screenings**

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Rev. 10/17
Rev. 10/18
Rev. 04/19

Autism screenings should be performed at the 18 and 24 month periodic visits (or catch-up visits). Providers must bill code 96110 with the EP,UA or EP,UA,HA modifiers and the appropriate ICD-10 diagnosis code in order to receive reimbursement for this screening.

Autism screenings when performed outside of the Bright Futures requirements can also be reported. Providers must bill code 96110 with the EP,UA modifiers and Z13.41 or the applicable ICD-10 diagnosis code to receive reimbursement for the screening.

8. **Brief Emotional/Behavioral Assessments**

Periodic Screening Visits

An annual depression screening should be performed for members ages 12 years through 20 years during the EPSDT periodic screening visit. When completed during the periodic visit, the depression screening can be reported as a brief emotional/behavioral assessment. Providers should bill code 96127 with the EP modifier, POS 99 and the appropriate ICD-10 diagnosis code in order to receive reimbursement.

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Rev. 04/19

Non-Periodic Screening Visits (Sick Visits)

Brief emotional /behavioral assessments, when performed during non-periodic screening visits, can also be reported for the following:

- depression screenings (outside of the BF requirements); AND
- emotional/behavioral assessments conducted for other conditions, such as ADHD, suicidal risk, anxiety, eating disorders, etc.

Brief emotional /behavioral assessments performed during non-periodic visits should be billed with the E/M office visit code (992xx) and reported with procedure code 96127, the appropriate ICD-10 diagnosis code, along with the EP modifier and POS 99.

Procedure code 96127:

- is reimbursed at the current default rate
- should be listed only once per claim for multiple units
  - units submitted should not exceed acceptable medically unlikely edit (MUE) maximum established by CMS

9. **Patient-Focused Health Risk Assessments**

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Rev. 10/18
Rev. 04/19

Patient Focused health risk assessments performed during the EPSDT periodic screening visit in accordance with the Bright Futures requirements may be reported (i.e., tobacco, alcohol, or drug use assessment; anemia risk assessment; lead risk assessment).

Providers should bill procedure code 96160 with the EP modifier, POS 99 and the appropriate ICD-10 diagnosis code in order to receive reimbursement. Code the health risk assessment (96160) with the EP, 59 modifiers when reporting the health risk assessment(s) and vaccine administration codes for the same visit.

Health risk assessments when performed outside of the Bright Futures requirements can also be reported. Health risk assessments performed during non-periodic visits should be reported with procedure code 96160, the appropriate ICD-10 diagnosis code, along with the EP modifier and POS 99. Code the health risk assessment (96160) with the EP, 59 modifiers when reporting the health risk assessment(s) and vaccine administration codes for the same visit.

Procedure Code 96160:

- is reimbursed at the current default rate.
- should be listed only once per claim for multiple units.
- units submitted should not exceed acceptable medically unlikely edit (MUE) maximum established by CMS.

10. **Caregiver-Focused Health Risk Assessments**

Rev. 07/18
Rev. 10/18
Rev. 04/19

Caregiver focused health risk assessments performed during the EPSDT periodic screening visit in accordance with the Bright Futures requirements may be reported, (i.e., maternal depression screening).

A maternal depression screening should be performed during the following EPSDT periodic screening visits:

- By 1 month
- 2 month
- 4 month
- 6 month

Providers should bill procedure code 96161 with the EP modifier, POS 99 and the appropriate ICD-10 diagnosis code in order to receive reimbursement. Code the caregiver focused health risk assessment (96161) with the EP, 59 modifiers when reporting the health risk assessment(s) and vaccine administration codes for the same visit.

Caregiver focused health risk assessments when performed outside of the Bright Futures requirements can also be reported. Health risk assessments performed during non-periodic visits should be reported with procedure code 96161, the appropriate ICD-10 diagnosis code, along with the EP modifier and POS 99. Code the health risk assessment (96161) with the EP, 59 modifiers when reporting the health risk assessment(s) and vaccine administration codes (90460, 90471-74) for the same visit.

Procedure Code 96161:

- is reimbursed at the current default rate.
- should be listed only once per claim for multiple units.
- units submitted should not exceed acceptable medically unlikely edit (MUE) maximum established by CMS.

11. **Hematocrit and Hemoglobin Level**

The laboratory tests due at the twelve (12) month visit for hematocrit and hemoglobin levels may be performed as in office tests at the time of the EPSDT preventive health visit by the PCP; or the blood sample may be obtained by the PCP and submitted to a Medicaid contracted lab; or the member may be sent to a Medicaid contracted lab for the blood draw and laboratory analysis. The PCP must document in the medical record which option was selected. These tests cannot be sent to a non-participating laboratory for analysis.

12. **Federally required Blood Lead Level (BLL) screening**

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Rev. 10/15

If FFS EPSDT providers use private laboratories for BLL screening or perform BLL screening using an in office Lead Analyzer, the EPSDT provider cannot file a claim for reimbursement of the BLL test.

The Georgia Public Health Laboratory provides analysis of blood lead specimen and charges a laboratory fee. Fee for Service providers may submit claims to DCH for this fee if the blood sample is obtained by them during the visit and sent to the GPHL for analysis. To ensure accurate reimbursement, FFS providers must submit the CPT code 83655 with modifier EP and 90 or 91 on the CMS 1500 claim form along with the CPT codes 36415 or 36416 – modifier EP and ICD-10 diagnosis code Z13.88. Additional details regarding this process are contained in Appendix C-4.

13. **Vaccine Administration**

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Rev. 10/14

In order to receive the administration fee from the Division for administering federally or state purchased vaccines for children 0 – 18 years of age, the child must be a Medicaid or PeachCare for Kids® member. Since the federally or state purchased vaccines are provided at no cost to the provider, the Division will only reimburse an administration fee based upon the Division's maximum allowable rate. (See Chapter 1000, Section 1002). The vaccine's National Drug Code (NDC) is not required to be included on the EPSDT claim for reimbursement for the administration of federally or state purchased vaccines for children 0-18 years of age.

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Rev. 07/14
Rev. 10/14

Beginning April 1, 2013, providers should bill any and all of the following appropriate vaccine administration codes, when administering VFC vaccines, as they apply: 90460, 90471, 90472, 90473, 90474. Additional details regarding the use of the vaccine administration codes are contained in Appendix C-1.

EPSDT providers may bill the EPSDT Program for vaccines administered to members nineteen (19) years of age through twenty (20) years of age. Include the vaccine CPT code, diagnosis code, and NDC, along with the appropriate vaccine administration code**(s)** [90471, 90472, 90473, 90474] on the EPSDT claim. The Division will reimburse for the vaccine product (providers must use their own stock of vaccines) and for vaccine administration. Additional details regarding the use of the vaccine administration codes and the effective date for this change are contained in Appendix C-1.

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Rev. 07/17

14. **Office Visit Codes**

Providers must use place of service (POS) code 99 when billing office visits for EPSDT preventive health screening services. All diagnostic x-ray, laboratory testing (except hematocrit, hemoglobin) and/or treatment services provided to the EPSDT member at the time of the preventive health visit, can be billed on the same CMS 1500 claim form as the EPSDT preventive health visit if the EPSDT provider uses a CMS 1500 form to bill Diagnostic and Treatment Services (i.e., Physician Services, Nurse Practitioner Services, etc.).

Rev. 01/21

Effective May 1, 2015, paper claims are no longer accepted by Gainwell Technologies. As part of the Georgia Paperless Initiative, providers are required to submit CMS 1500 claims electronically over the GAMMIS web portal. For more information regarding the Paperless Initiative, please access the web portal and review all related Banner Messages.

If an EPSDT provider uses a UB 04 to bill Diagnostic and Treatment services (i.e., Hospitals, Rural Health Clinics, etc.), they may also bill the EPSDT preventive health visit services on the UB 04.

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Rev. 04/12

15. **School-Based Influenza Vaccine Clinics**

Public Health providers must use place of service (POS) code 03 when billing the vaccine administration fee for Influenza vaccines administered during school-based Influenza vaccine clinics held within their county of jurisdiction. Only the Influenza vaccine administration will be reimbursed during these school-based Influenza vaccine clinics.

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Rev. 04/16

16. **School-Based Telemedicine Services**

LEAs enrolled as Health Check providers to serve as telemedicine originating sites only will be allowed to bill the telemedicine originating site facility fee (procedure code Q3014). The LEA provider should report procedure code Q3014 along with the EP and GT modifiers, POS 03, and the appropriate ICD-10 diagnosis code(s). The diagnosis code(s) should be the same diagnosis code(s) listed on the distant site (rendering) provider's claim.

The rendering provider serving as the telemedicine distant site should report the E/M office visit code (992xx) along with the GT modifier (including any other applicable modifiers), the appropriate POS, and the ICD-10 diagnosis code(s).

In order for the originating site (LEA) provider to receive reimbursement for procedure code Q3014, a corresponding paid history claim from the distant site provider must be found in GAMMIS. The distant site provider's claim billed for the same member, same date of service, with an E/M office visit code (992xx), the same ICD-10 diagnosis code(s) and the GT modifier, will confirm that a telemedicine service was rendered. If no record of the E/M claim is found that aligns with the LEA provider's originating site claim, the originating site claim will suspend up to 30 days after submission in search of the E/M claim. If no record of an E/M claim is found within 30 days after submission of the LEA provider's originating site claim, reimbursement to the LEA provider will be denied. It is the responsibility of the LEA provider to contact the provider who rendered the distant site service to determine if the E/M visit was billed.

The telemedicine originating facility fee is reimbursed at the current DEFAULT rate.

17. **Consultation Services**

Rev. 07/14
Rev. 10/14

Effective July 1, 2014, providers enrolled in the EPSDT Program, may bill for reimbursement of the following office/outpatient consultation codes: 99241, 99242, 99243, 99244, 99245. The EP modifier must be added to the applicable code along any other applicable modifiers. A consultation service can be rendered once every three years.

18. **Tobacco Cessation Counseling Services**

Rev. 10/14
Rev. 04/15

Effective January 1, 2014, the Division began coverage of tobacco cessation counseling services to all Medicaid members. Providers enrolled in the EPSDT Program may bill 99406 and 99407 for the reimbursement of tobacco cessation counseling. The EP modifier must be added to the applicable code.

The tobacco cessation counseling must be rendered in a face-to-face setting with the member. Only two 12-week tobacco cessation treatment periods will be allowed per member per year. The provider must document the services in the member's medical record every 30 days during the 12-week treatment period.

19. **Incontinence Supplies**

Rev. 01/16
Rev. 01/20

Incontinence supplies are covered for children ages 2 through 20 years who have an underlying medical condition that prevents control of the bowels or bladder. Incontinence supplies are not covered for convenience. Children under the age of 2 years will be considered for coverge on a case-by-case basis. Since incontinence supplies are not covered for members over 20 years of age, or on a general basis for members under 21 years, providers must ensure the following for services to be considered for coverage:

- the item is considered durable medical equipment (DME);
- there is a current order prescribed by a physician; and

- a prior authorization (PA) must be submitted which includes documentation of medical necessity.

The following procedure codes are covered under DME services with unique HCPCS codes, but are without Medicare-based or nationally accepted rates (T4521-T4535, T4541, T4544). These HCPCS codes require a PA. Refer to the DME Manual for further guidance.

20. **Fluoride Varnish**

Rev. 04/16
Rev. 10/16

Once teeth are present, the application of fluoride varnish is required and may be applied every 3-6 months in the primary care or dental office for children between the ages of 6 months and 5 years.

21. **Other Procedure Codes**

Rev. 04/15

When billing for EPSDT screening services and interperiodic visits, only the procedure codes for those services found in this manual may be reimbursed under the EPSDT Program. Reimbursement for other services billable to Medicaid is covered under the program areas overseeing the delivery of those services.

22. **National Correct Coding Initiative (NCCI) Medically Unlikely Edits (MUEs) Limits**

Rev. 04/16

Providers are reminded to bill in compliance with the NCCI MUE limit for procedure codes and to check the MUE file, at minimum, on a quarterly basis for updates. Procedure codes submitted with frequencies greater than the allowed MUE will be denied according to the NCCI MUE regulations set by CMS.

23. N**CCI Procedure-To-Procedure (PTP) Edits**

Rev. 10/18

Providers are reminded to bill in compliance with the NCCI PTP edits. The NCCI PTP edits define pairs of Healthcare Common Procedure Coding System (HCPCS)/ Current Procedural Terminology (CPT) codes that should not be reported together. The purpose of the PTP edits is to prevent improper payments when incorrect code combinations are reported. Procedure codes that should not be reported together will be denied according to the NCCI PTP edits defined by CMS.

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Rev. 07/18

24. **Other Reimbursement Rates**

OTHER REIMBURSEMENT RATES		
Procedure Code & Description	**Modifier(s)**	**Current Default Rate**
96110 – Developmental Screening	EP or EP HA	$11.77
96110 – Autism Screening	EP UA or EP UA HA	$11.77
96127 – Brief Emotional/ Behavioral Assessment (depression screening)	EP	$4.55
96160 – Patient-Focused Health Risk Assessment (i.e., tobacco, alcohol, drug use risk assessment)	EP	$3.95
96161 – Caregiver-Focused Health Risk Assessment (i.e., maternal depression screening)	EP	$3.95
Q3014 – Telehealth Originating Site Facility Fee	EP	$20.52
99241 – Patient Office Consultation, typically 15 minutes	EP	$48.05
99242 – Patient Office Consultation, typically 30 minutes	EP	$78.78
99243 – Patient Office Consultation, typically 40 minutes	EP	$100.50
99244 – Patient Office Consultation, typically 60 minutes	EP	$139.12
99245 – Patient Office Consultation, typically 80 minutes	EP	$180.61
99406 – Smoking and Tobacco Use Intermediate Counseling, Greater than 3 minutes up to 10 minutes	EP	$10.51
99407 – Smoking and Tobacco Use Intensive Counseling, Greater than 10 minutes	EP	$20.71

Reviewed 12/7/2020

Rev. 10/16

Effective July 1, 2016, physicians and physician extenders who are eligible for the HB 751 FY 2017 Primary Care Providers (PCP) rate increase will be reimbursed $180.26 when procedure code 99244 is billed for established Medicaid-eligible and PeachCare for Kids®-eligible members.

Rev. 04/18

Effective July 1, 2017, physicians and physician extenders who are eligible for the HB 44 FY 2018 Primary Care Providers (PCP) rate increase will be reimbursed at the following rates, as indicated in the table below when the specified codes are billed for established Medicaid-eligible and PCK-eligible members.

Primary Care Providers (PCP) Rate Increases

Procedure Code	Description	Modifier(s)	HB 751 FY2017 Increased Reimbursement Rate	HB 44 FY2018 Increased Reimbursement Rate
99241	Patient Office Consultation, typically 15 minutes	EP	n/a	$48.05
99242	Patient Office Consultation, typically 30 minutes	EP	n/a	$88.77
99243	Patient Office Consultation, typically 40 minutes	EP	n/a	$121.39
99244	Patient Office Consultation, typically 60 minutes	EP	$180.26	n/a
99245	Patient Office Consultation, typically 80 minutes	EP	n/a	$220.80
99406	– Smoking and Tobacco Use Intermediate Counseling, greater than 3 min up to 10 min	EP	n/a	$13.59
99407	– Smoking and Tobacco Use Intensive Counseling, greater than 10 minutes	EP	n/a	$26.91

Questions regarding Medicaid billing should be directed to Georgia Health Partnership (GHP) at 1-800-766-4456 or 'contact us' at www.mmis.georgia.gov

APPENDIX A

Guidelines in Screening and Reporting Elevated Blood Lead Levels

Rev. 04/12
Rev. 04/14

The mission of the Georgia Healthy Homes and Lead Poisoning Prevention Program (GHHLPPP) is to eliminate childhood lead poisoning in Georgia.

Screening Guidelines: Children

Rev. 04/12
Rev. 07/15
Rev. 07/16
Rev. 01/20

Screening for lead poisoning helps identify children who need interventions to reduce their blood lead levels. Many children who may have been exposed to lead or who are at risk for lead poisoning go without being screened. This makes their chances of being harmed by lead greater. Parents and providers should know when a child should be tested for lead poisoning.

Guidelines in Screening and Reporting Elevated Blood Lead Levels:

Lead Screening Requirements & Medical Management Recommendations

(For Children ages 6 to 72 months)

GHHLPPP
RISK FACTORS ASSESSMENT QUESTIONNAIRE

---ask these questions at the 6, 9, and 18 months and 3, 4, 5, 6 years of age preventive visits---

Rev. 04/20

1. Does your child live in or often visit a house that may have been built before 1978?

2. Does your child live in or often visit a house, built before 1978, that is being remodeled or is having paint removed?

3. Does your child live with or often visit another child that had or has an elevated blood lead level?

4. Does your child live with anyone who works at a job where lead may be found or has a hobby that uses lead?

5. Does your child chew on or eat non-food items like paint chips or dirt?

6. Does your child live near an active lead smelter, battery recycle plant, or other industry likely to release lead?

7. Does your child receive medicines such as greta, azarcon, kohl, or pay-loo-ah?

When using the questionnaire, blood lead tesst should be done immediately if the child is at high risk (one or more "yes" or "I don't know" answers on the risk assessment questionnaire) for lead exposure.

https://dph.georgia.gov/environmental-health/healthy-homes-and-lead-poisoning-prevention

Test the blood of ALL Medicaid children for lead poisoning at 12 and 24 months of age AND children 3 to 6 years of age if never tested *regardless* of their risk factors.

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Lead Screening Requirements and Medical Management Recommendations for Children

Test ALL Medicaid children at 12 and 24 months of age AND children 3 to 6 years of age if never tested *regardless of their risk factors*

IT IS A FEDERAL REQUIREMENT

Recommended Medical and Case Management Actions

Blood Lead Level (BLL)	*Confirmatory Blood Lead Test*	*Hospitalization*	*Chelation Therapy (A)*	*Blood Lead Level Re-Test*	*Referrals (B)*	*History & Physical (C)*	*Lead Poisoning Education (D)*	*Reducing Exposure & Absorption (E)*
5 - 9 µg/dL	*No*	*No*	*No*	*Within 1 year*	*No*	*No*	*Yes*	*Yes*
10 - 14 µg/dL[1]	*Within 1 day to 3 months – venous or capillary*	*No*	*No*	*See Retest Chart below*	*Yes*	*Yes*	*Yes*	*Yes*
15 - 19 µg/dL	*Within 1 day to 3 months – venous or capillary*	*No*	*No*	*See Retest Chart below*	*Yes*	*Yes*	*Yes*	*Yes*
20 - 44 µg/dL	*Within 1 day to 3 months – venous or capillary*	*No*	*No*	*See Retest Chart below*	*Yes*	*Yes*	*Yes*	*Yes*
45 - 69 µg/dL	*Within 1 day to 1 month – venous or capillary*	*No if home is lead-safe*	*Yes*	*See Retest Chart below*	*Yes*	*Yes*	*Yes*	*Yes*
70 ug/dL or Higher	*within 24-48 hours, venous only*	*YES MEDICAL EMERGENCY*	*Yes*	*See Retest Chart below*	*Yes*	*Yes*	*Yes*	*Yes*
THERE IS NO SAFE LEVEL OF LEAD IN THE BODY – DAMAGE CAUSED BY LEAD POISONING IS *PERMANENT* AND *IRREVERSIBLE*!								

[1] If the child's blood lead level persists between 10-14 ug/dL (2 blood lead tests 3 months apart) proceed according to the level of care for 15-19 µg/dL.

Explanation of Recommended Medical and Case Management Actions

(A) Chelation Therapy: if chelation therapy is indicated, the child should be immediately removed from the hazardous environment until the child's environment is made lead-safe; however, if the home is already lead-safe, the child may remain in the home unless hospitalization is indicated.

(B) Referrals: contact local health department and/or **GHHLPPP** to assist in case management and environmental investigations.

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(C) History and Physical: take medical, environmental, and nutritional history, test for anemia and iron deficiency, assess neurological, psychosocial, and language development, screen all siblings under age 6, and evaluate risk of other family members, especially pregnant women.

(D) Lead Poisoning Education: discuss sources of lead, effects of lead, lead-based paint hazards associated with living in a pre-1978 and/or renovating a pre-1978 home. Discuss how lead affects prenatal care and well child care at ages 3, 6, and 12 months and explain what blood lead levels mean and their significance. Lastly, contact **GHHLPPP** for information.

(E) Reducing Exposure and Absorption: discuss damp cleaning to remove lead dust on surfaces, eliminating access to deteriorating lead paint surfaces, and ensuring regular meals which are low in fat and rich in calcium and iron; contact **GHHLPPP** for materials.

ELEVATED BLOOD LEAD RE-TEST CHART

Use this chart to determine when to retest children who are *confirmed as lead-poisoned.* Venous testing is **strongly preferred**, but capillary testing is acceptable.

If the child's last confirmed BLL was…	**and…**	
	if the child's blood lead level HAS NOT DROPPED at least 3 µg/dl over a span of at least 3 months…	if the child's blood lead level HAS DROPPED at least 3 µg/dl over a span of at least 3 months…
	then test the child again in…	
10-14 µg/dL	3 months	6 months
15-19 µg/dL	3 months	3 months
20-24 µg/dL	1 month	2 months
25-44 µg/dL	1 month	1 month
45-69 µg/dL	1 month after chelation	1 month after chelation
≥70 µg/dL	1 month after chelation	1 month after chelation
Retesting should occur until the blood lead level is less than 10 µg/dL for six months, all lead hazards have been removed, housing is made lead-safe, and no new exposure exists.		

Department of Public Health, 2 Peachtree Street NW, 13th Floor, Atlanta, Ga, 30303,
Phone (404) 657-6534 | For more info: Toll Free 1-888-247-9054 | Fax (404) 463-4039
https://dph.georgia.gov/healthy-homes-and-lead-poisoning-prevention
https://dph.georgia.gov/lead-screening-case-management-lab-submissions-reporting-guidelines

Lead Screening Guidelines for Children
Screening for lead poisoning helps identify children who need interventions to reduce their blood lead levels. Many children who may have been exposed to lead or who are at risk for lead poisoning go without being screened. This makes their chances of being harmed by lead greater. Parents and providers should know when a child should be tested for lead poisoning.

Medicaid and PeachCare for Kids
All children enrolled in Medicaid and PeachCare for Kids® should be tested for lead poisoning and offered certain services based on the following schedule:

Age	Lead Blood Test	Lead Risk Assessment Questionnaire	Anticipatory Guidance
6 months		X	X
9 months		X	X
12 months	X (risk assessment if not enrolled in Medicaid)		X
24 months	X (risk assessment if not enrolled in Medicaid)		X
36-72 months	X - If there's no record of previous test at 12 and 24 months	X - Complete annually unless blood lead test performed	X

Source: https://dph.georgia.gov/lead-screening-guidelines-children

Lead Risk Assessment Questionnaire

Rev. 04/14
Rev. 10/14

The GHHLPPP Childhood Lead Risk Questionnaire can be found at: https://dph.georgia.gov/lead-screening-guidelines-children in English, Spanish and Vietnamese.

Rev. 04/12

When using the questionnaire, blood lead tests should be done right away if the child is at high risk (one or more "yes" or "I don't know" answers on the lead risk assessment questionnaire) for lead exposure. Completing this questionnaire does not count as a lead screening.

Blood Lead Test

Rev. 04/12
Rev. 07/15
Rev. 10/19

A blood test is the preferred method for lead screening. There are two tests used to obtain blood lead specimens: capillary blood test or venous blood test. Finger stick capillary blood tests (the Lead Care II Analyzer uses capillary blood) can be done as the initial screening. However, a lab analyzed sample is necessary for confirmation. Safety measures should be taken to reduce the risk of contamination of the capillary blood sample. These measures include:

- Rinsing powder from the examination gloves
- Thoroughly washing patient's hands with soap and water, then drying them before taking a sample.

A venous blood test can be done as the initial screening as well. This method should always be used to confirm elevated blood lead test results when a capillary test was used as the initial screening. Alternatively, a second lab analyzed capillary test can be used to confirm an initial capillary test when the test is conducted according to the schedule in Table 1 - Lead Screening Requirements and Medical Management Recommendations for Children ages 6 to 72 months.

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Rev. 07/17

All venous sample lead screening tests conducted using any Magellan Diagnostic lead testing system should be laboratory analyzed by a properly accredited laboratory.

If a child's capillary Blood Lead Test comes back elevated (≥ 10ug/dL reported by a certified lab or ≥ 6ug/dL using the Lead Care II analyzer), then a confirmatory test must be performed. The confirmatory diagnostic test should be lab analyzed and done according to the schedule in Table 1 - Lead Screening Requirements and Medical Management Recommendations for Children ages 6 to 72 months.

If the schedule in Table 1 is not followed and 6 months has gone by since the initial screening test, the next test is considered a new screening test. Decisions on follow-up testing should be made based on the results of the new screening test, not on the basis of the original screening test.

Lab Submission

Rev. 10/19

The Waycross Regional Laboratory provides an analysis of blood lead specimens to Georgia children less than 72 months of age. The provider's office should contact the laboratory to use this service. GHHLPPP does not recommend or endorse the use of another lab.

Waycross Public Health Laboratory
1751 Gus Karle Parkway
Waycross, Georgia 31503
912-338-7050

Reporting Guidelines

Laboratories attempt to test each lead specimen on the day it arrives. The reports are mailed back to providers on the same day. All laboratory data is sent monthly in electronic format to GHHLPPP.

Rev. 10/19

Providers should report the results of all screening and follow-up blood lead level (BLL) tests to GHLPPP. Because data from laboratories often do not include demographic information, complete reports from providers' office are very important. If reports are not complete, GHHLPPP may contact providers' offices for missing information.

Results must be reported by:

- State Electronic Notification Disease Surveillance System (SendSS)
- SendSS is a web-based reporting system designed to collect information about notifiable diseases in Georgia. Click here for reporting instructions. Click here for Blood Lead Test Reporting Log spreadsheet template.

Rev. 04/12
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Providers who utilize the Lead Care II Analyzer to perform blood lead tests should report the Lead Care II Analyzer generated results to the GHHLPPP. On a weekly basis, providers should upload their test results to the State Electronic Notification Disease Surveillance System (SendSS). SendSS recommends providers keep track of their Lead Care II Analyzer test results by documenting those results in a Blood Lead Test Reporting Log provided by GHHLPPP (link above). If reports are not complete, GHHLPPP may contact providers' offices for missing information. Complete a new Blood Lead Reporting each week. Upload the Blood Lead Test Reporting Log and submit weekly to the GHHLPPP via SendSS. For uploading instructions, refer to the *SendSS Registration and Login Manual for Uploading Lead Report Files*.

Blood Lead Test Reporting Log: Click here

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Registration and Login Manual for Uploading Lead Report Files

Version 4.0

Table of Contents

Registration Procedure

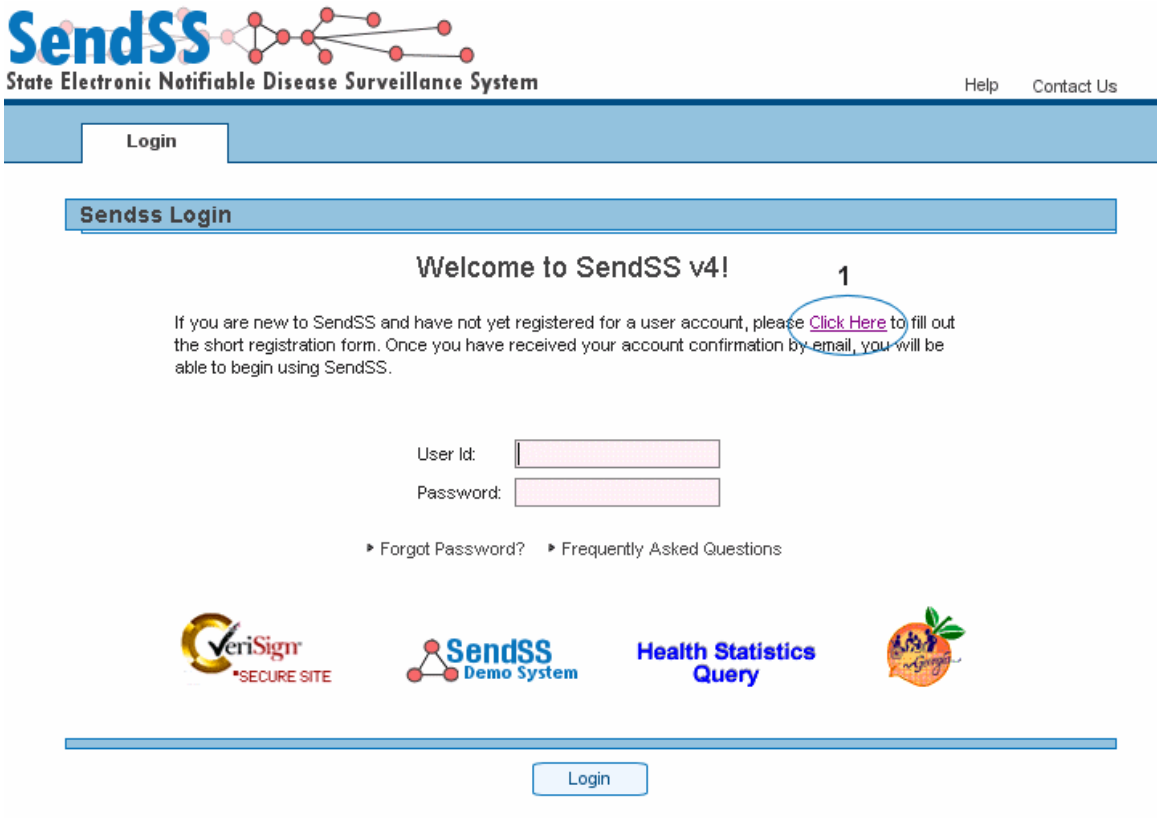
Signing In

File Upload Process

Registration and Login Manual for Uploading Lead Report Files may be accessed at:

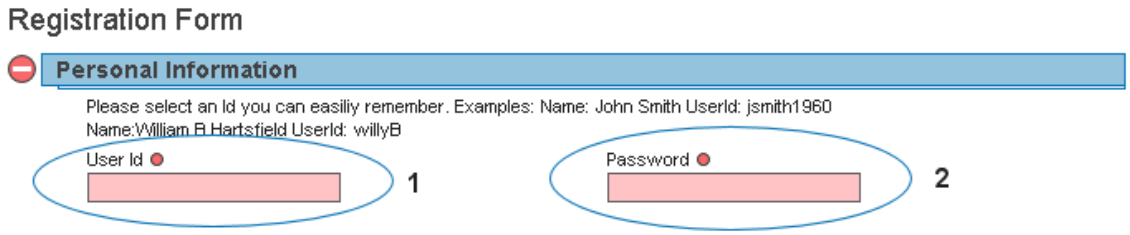
https://dph.georgia.gov/sites/dph.georgia.gov/files/related_files/site_page/EnvHealthLeadReportingInstructions.pdf

Registration procedure



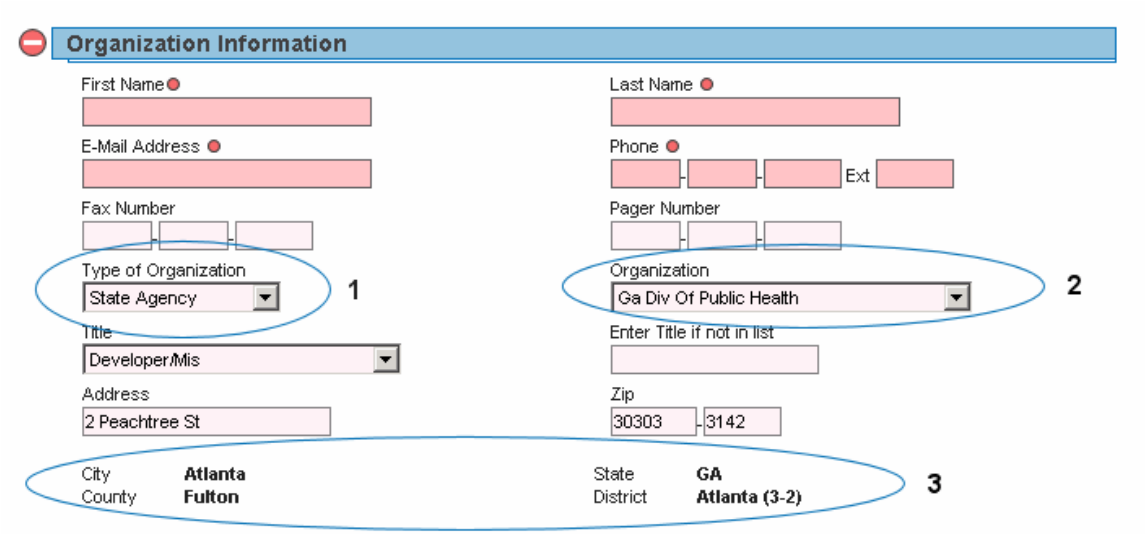
The home page can be accessed with the following URL and is best viewed using Microsoft Internet Explorer Version 6.x.x. https://sendss.state.ga.us

In order to gain access to SENDSS, you will first need to fill in a registration form and create a login. This can be done by pressing “Click Here” as shown above [1].

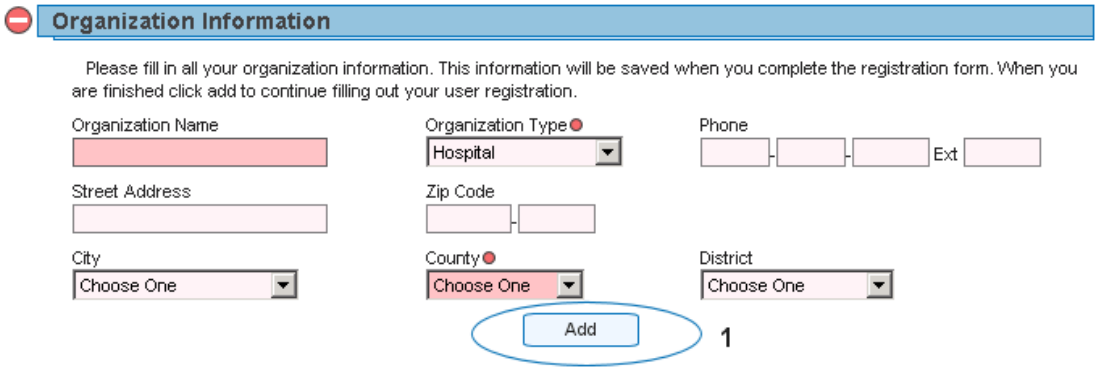


- **Remember to use a userid that is easily remembered**
- **Fill out Password Information**

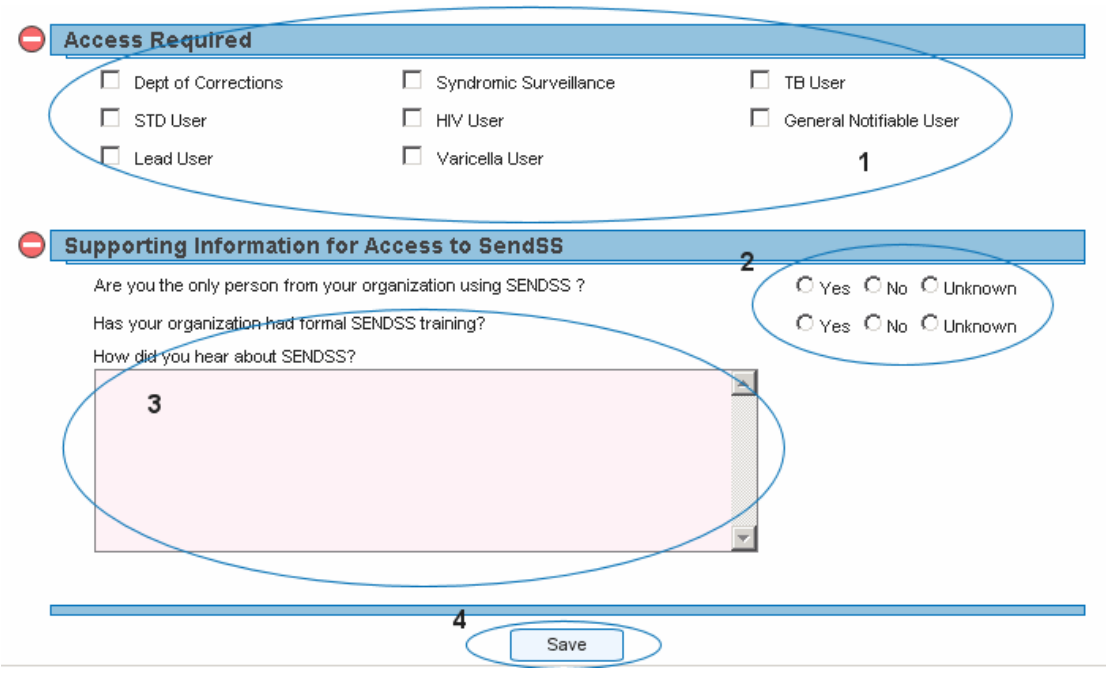
Registration Form (continued)



1. Select the type of organization you will be entering cases for.
2. Select the name of your organization. If you cannot find your organization select "Enter a New Organization" from the select box and the section will change and appear as below.
3. City, County, State, and District are not editable once an organization is entered into SendSS. If all the information for this section does not appear when you select an organization, you will be asked to provide it the first time you log in to SendSS.

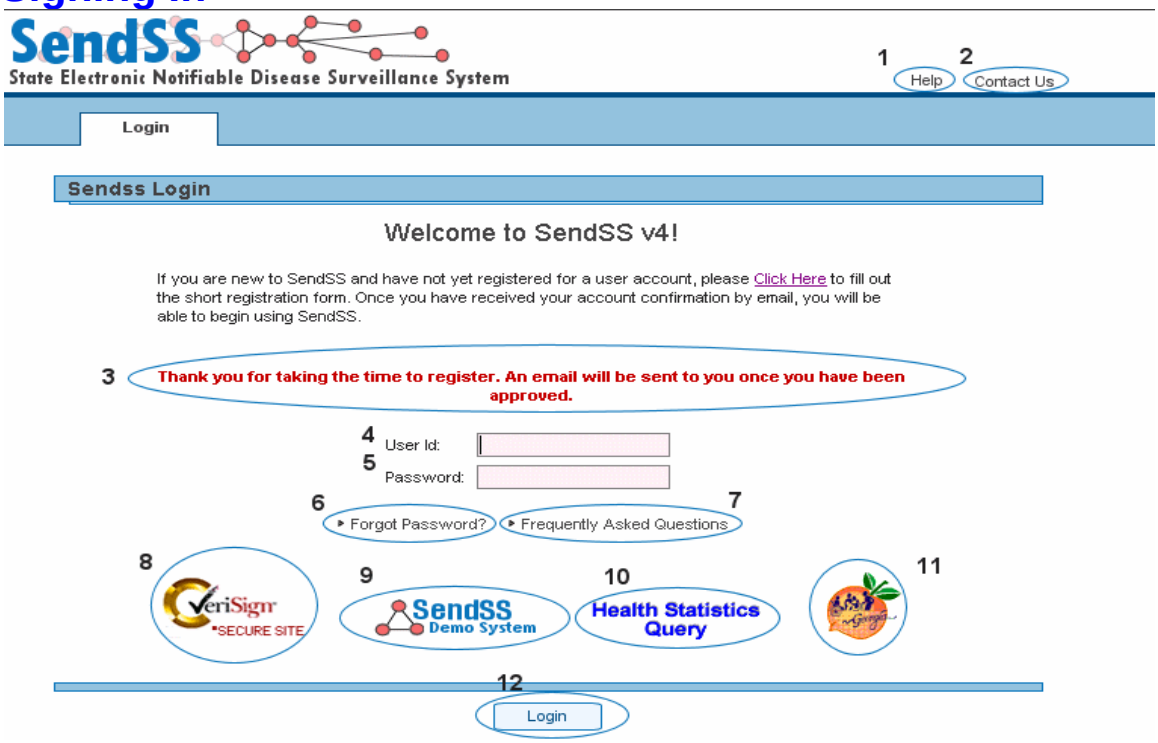


1. This section appears if a new user needs to enter an organization for which SendSS does not have a current user. Please fill in all information and press "Add". Then continue filling out the registration form.



1. Select the type of access you will require from SendSS from section 1. At a minimum, please check "**Lead User**"
2. Please answer the questions in section 2.
3. Enter any comments is this section
4. Press "Save" to complete your registration.

Signing In



Key to features

1. Help – A link to documentation and manual for SendSS version 4.0.
2. Contact Us – Send an internal message.
3. Warnings and Messages – Text will appear in red to alert users of failed logins or other relevant messages such as successful registration.
4. User Id – Enter the user id you chose when registering.
5. Password – Enter the password you chose when registering. This password must be reset every 3 months. After 3 months SendSS will allow 3 grace logins before locking your account. You will be prompted to change your password at this time.
6. Forgot Password – Click here to request your password.
7. Frequently Asked Questions –
8. VeriSign -- The certificate authority utilized by SENDSS is Verisign. Clicking on the graphic will display the validity of the SSL certificate.
9. SendSS Demo System -- Clicking on this image will take you to the Demonstration site. A separate registration is required to access this site.
10. Health Statistics Query -- This link will take you to the Notifiable Disease Query
11. Georgia Peach – Click this image to access the Georgia State Epidemiology Web site.

SendSS - Disclaimer

Sendss Privacy Statement

This system will allow persons authorized by DHR to access protected health information about individuals for reporting and treatment purposes. This information is entitled to significant privacy protections under federal and state law. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) permits a covered entity to use and disclose protected health information without written authorization if the use or disclosure is for treatment, payment, or health care operations. However, HIPAA requires covered entities to have in place appropriate administrative, technical, and physical safeguards to protect the privacy of protected health information. The disclosure of this information to unauthorized persons or for unauthorized purposes is prohibited without the written consent of the person who is the subject of the information, unless specifically permitted by federal or state law. Unauthorized disclosures of this information may result in significant criminal or civil penalties, as well as punishment up to and including the termination of employment. Failure to properly logout of SENDSS can result in an unauthorized disclosure. Any unauthorized disclosures will be investigated promptly and thoroughly prosecuted.

Agreeing with the Privacy Statement confirms your status as an authorized SENDSS user who is accessing the database only for reporting and treatment purposes. Agreeing with the Privacy Statement also confirms that as an authorized SENDSS user you will reasonably safeguard protected health information from any use or disclosure that is in violation of the Privacy Statement or state and federal law.

Source: HIPAA, 45 CFR §§ 164.502, 164.506, 164.530.

1

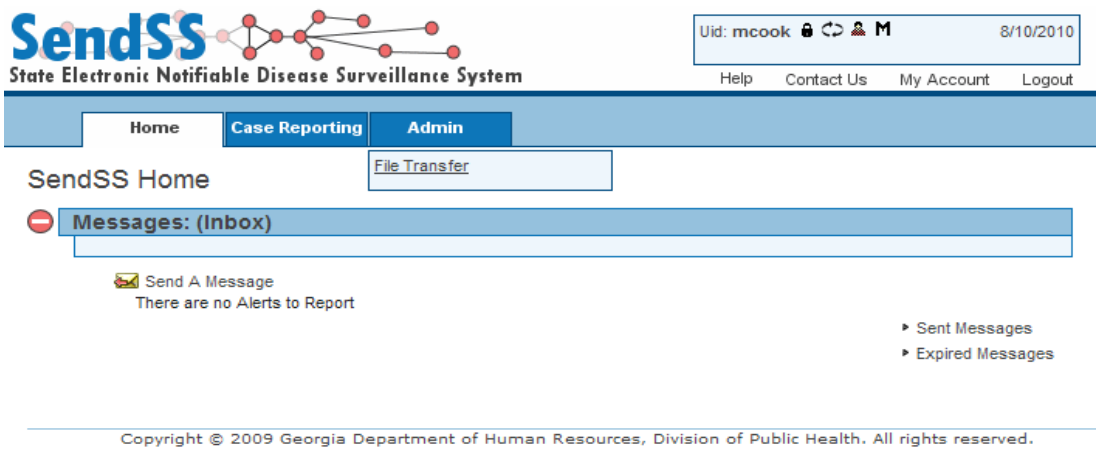
I agree with this statement

I disagree with this statement

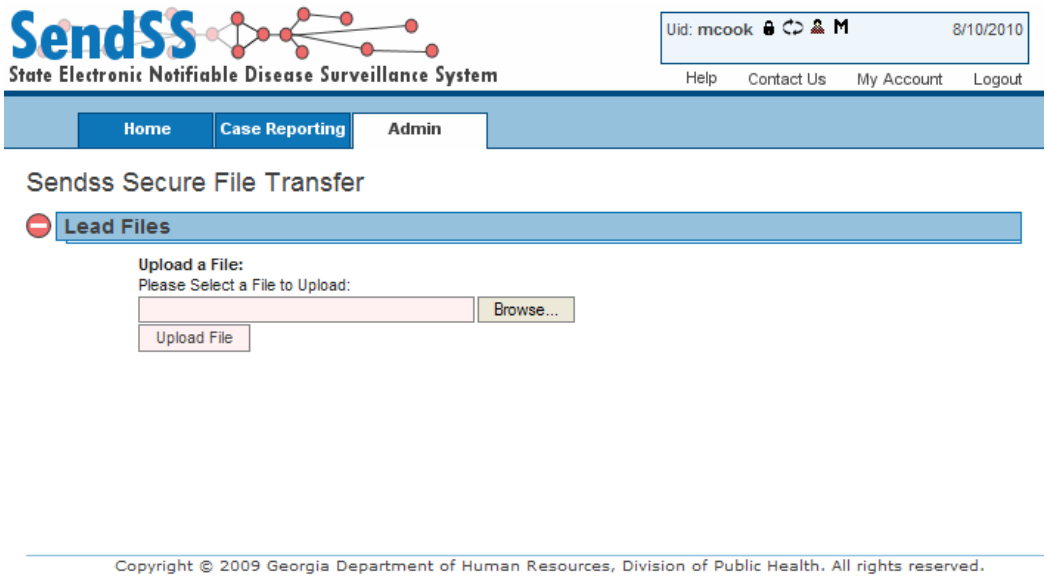
Before you can enter the system, you must accept the Privacy Statement [1]. Selecting "I disagree with this statement" will terminate your login and return you to the login page.

File Upload Process

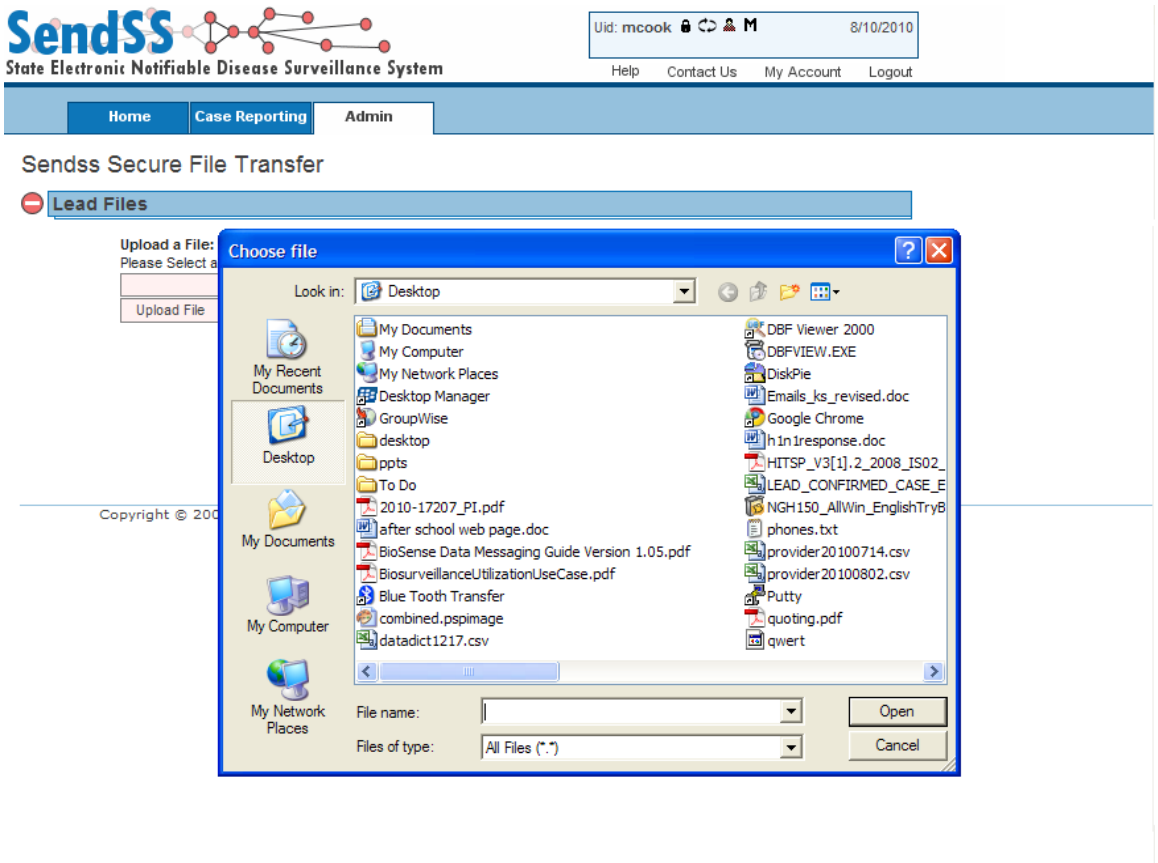
To upload a lead report file, begin by moving your mouse over the "Admin Tab" and clicking on the "File Transfer" menu item:



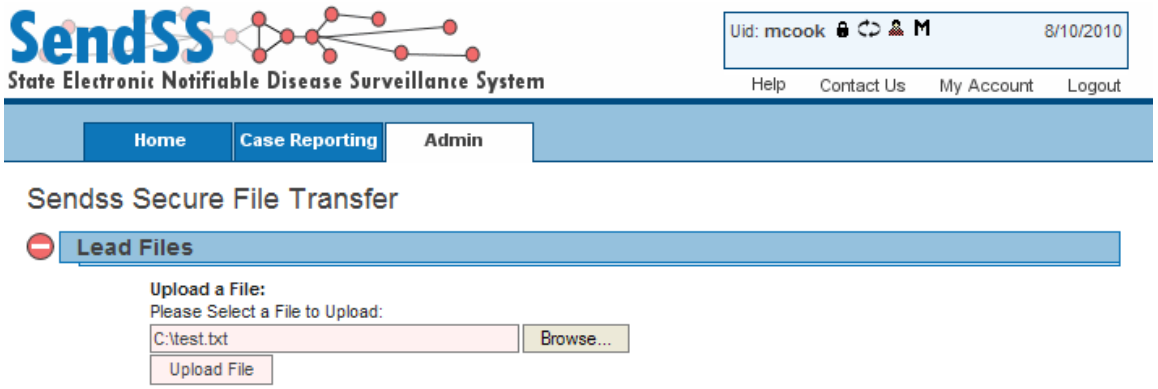
You will see a screen that asks you to select a file for uploading. To do this, click the browse button:



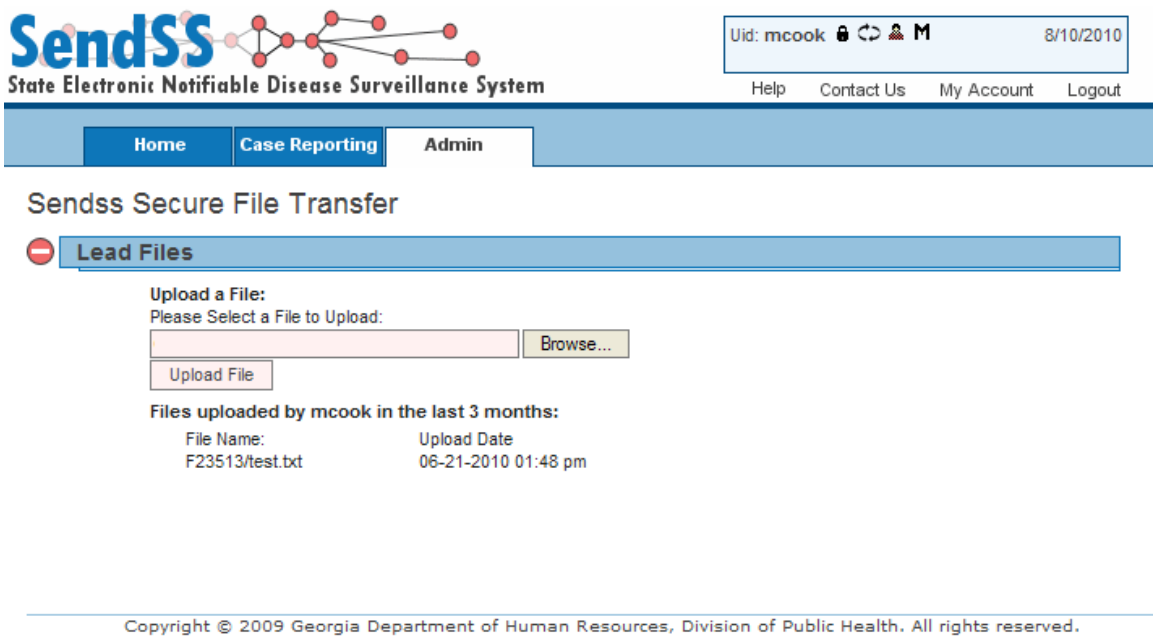
Locate the folder where you have saved the lead report files and then click the file name. After clicking on the file, click the open button:



You should see the file name that you selected appear in the box next to the browse button:



Click the "Upload File" button. Once the file is uploaded the screen will refresh and the file will appear in the list of recently uploaded files, as below:



You are finished!

Rev. 02/12
Rev. 10/19

Georgia Childhood Lead Poisoning Prevention Program
Case Management Guidelines

Blood Lead Level	Recommendations
< 5 µg/dL	• No safe threshold above "0" has been identified. Medical provider should provide anticipatory guidance for any blood lead level (BLL) above "0".
5 – 9µg/dL	• Perform additional blood lead tests within 1 year according to the Georgia Childhood Lead Screening Guidelines.* • GHHLPPP will provide educational material to parents • GHHLPPP will contact parents for consultation on confirmed cases
10 – 19µg/dL	Per GHHLPPP recommendations, the **medical provider** will: • Conduct diagnostic (confirmatory) test (venous preferred) within 3 months. If child is < 12 months old or it is believed the BLL may be increasing rapidly, the test should be done earlier. • Test other children in the home <72 months of age who have not been tested in the last 6 months. • Conduct nutritional assessment • Continue testing at 3 month intervals until all the following conditions are met: o BLL has remained <10µg/dL for at least 6 months (two tests at least 3 months apart) o Lead hazards have been controlled. o There are no new sources of lead exposure GHHLPPP or the Case Management Provider will send, by mail, or deliver the following information to the caregiver: • Child should receive a diagnostic (confirmatory) test (venous preferred) within 3 months. • Recommendation to have other children in the home <72 months of age who have not been tested in the last 6 months, tested. GHHLPPP will refer the case to one of the Regional Healthy Homes Coordinators (RHHC) **Regional Healthy Homes Coordinator** or Case Management Provider will give in-person (or in some cases by phone or mail) to caregiver: • Information on lead poisoning cause and effect, environmental lead hazard reduction, and nutrition. • Information on WIC services available. • Information on Children 1st Program information (newborns to 5 years old) • Information on Children's Medical Services (CMS) if child =>5 years old **Regional Healthy Homes Coordinator** will also: • Conduct or arrange an environmental risk assessment by a certified risk assessor. Risk assessment should occur within 2 weeks of receiving referral from GHHLPPP.

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Blood Lead Level	Recommendations
20 – 44µg/dL	Per GHHLPPP recommendations, the **medical provider** will: • Conduct diagnostic (confirmatory) test (venous preferred) within 1 week-1 month • Test other children in the home <72 months of age who have not been tested in the last 6 months. • Conduct comprehensive medical evaluation including nutritional assessment • Continue testing at 3 month intervals until all the following conditions are met: o BLL has remained <10µg/dL for at least 6 months (two tests at least 3 months apart) o Lead hazards have been controlled, o There are no new sources of lead exposure GHHLPPP or the Case Management Provider will send, by mail, the following information to the caregiver: • Child should receive a diagnostic (confirmatory) test (venous preferred) within 1 week to 1 month, • Recommendation to have other children in the home <72 months of age who have not been tested in the last 6 months, tested. GHHLPPP will refer the case to one of the Regional Healthy Homes Coordinators (RHHC) **Regional Healthy Homes Coordinator** or the Case Management Provider will give in-person (or in some cases by phone or mail) to caregiver: • Information on lead poisoning cause and effect, environmental lead hazard reduction, and nutrition. • Information on WIC services available. • Information on Children 1st Program information (newborns to 5 years old) • Information on Children's Medical Services (CMS) if child =>5 years old **Regional Healthy Homes Coordinator** will also: • Conduct or arrange an environmental risk assessment by a certified risk assessor. Risk assessment should occur within 1-2 weeks of receiving referral from GHHLPPP. • Send by mail (or in some cases call) a summary of risk assessment and recommendations to the caregiver, property owner and medical provider. • Provide a copy of the risk assessment in approved format to GHHLPPP.
45 – 69µg/dL	***URGENT*** Per GHHLPPP recommendations, the **medical provider** will: • Conduct diagnostic (confirmatory) test (venous preferred) within 24-48 hours. • Test other children in the home <72 months of age who have not been tested in the last 6 months. • Conduct comprehensive medical evaluation, including nutrition assessment and consider pharmacologic treatment. Contact the Georgia Poison Center for consultation.

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Blood Lead Level	Recommendations
45 – 69µg/dL	• Continue testing at 1-2 month intervals until all the following conditions are met: ○ BLL has remained <45µg/dL for at least 4 months (two tests at least 2 months apart) then start follow up blood lead testing at 3 month intervals until BLL has remained <10µg/dL for at least 6 months (two tests at least 3 months apart) ○ All identified lead hazards have been controlled Note: A child receiving chelation therapy MAY NOT return to the home until all lead hazards have been controlled. ○ There are no new sources of lead exposure. GHHLPPP or the Case Management Provider will give, by phone, the following recommendation to the caregiver: • Child should receive a diagnostic (confirmatory) test (venous preferred) within 24-48 hours, • Recommendation to have other children in the home <72 months of age who have not been tested in the last 6 months, tested. GHHLPPP will refer the case to one of the Regional Healthy Homes Coordinators (RHHC) **Regional Healthy Homes Coordinator** or the Case Management Provider will give in-person (or in some cases by phone) to caregiver: • Information on lead poisoning cause and effect, environmental lead hazard reduction, and nutrition. • Information on WIC services available. • Information on Children 1st Program information (newborns to 5 years old) • Information on Children's Medical Services (CMS) if child =>5 years old **Regional Healthy Homes Coordinator** will also: • Conduct or arrange an environmental risk assessment by a certified risk assessor. Risk assessment should occur within 48 hours of receiving referral from GHHLPPP. • Call-in a summary of risk assessment and recommendations to the caregiver, property owner and medical provider. • Provide a copy of the risk assessment in approved format to GHHLPPP.
≥ 70µg/dL	**MEDICAL EMERGENCY.** **DO NOT DELAY MEDICAL TREATMENT.** Per GHHLPPP recommendations, the **medical provider** will: • Conduct diagnostic (confirmatory) test (venous preferred) as emergency lab test. • Conduct immediate medical evaluation and pharmacologic treatment. Contact the Georgia Poison Center for consultation. • Test other children in the home <72 months of age who have not been tested in the last 6 months.

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Case Management Guidelines

Blood Lead Level	Recommendations
≥ 70µg/dL	• Continue testing at 1-2 month intervals until all the following conditions are met: ○ BLL remains <45µg/dL for at least 4 months (two tests at least 2 months apart) then start follow up blood lead testing at 3 month intervals until BLL has remained <10µg/dL for at least 6 months (two tests at least 3 months apart) ○ All identified lead hazards have been controlled Note: A child receiving chelation therapy MAY NOT return to the home until all lead hazards have been controlled. ○ There are no new sources of lead exposure. GHHLPPP or the Case Management Provider will give, by phone, the following recommendation to the caregiver: • Child should receive a diagnostic (confirmatory) test (venous preferred) immediately. • Recommendation to have other children in the home <72 months of age who have not been tested in the last 6 months, tested. GHHLPPP will refer the case to one of the Regional Healthy Homes Coordinators (RHHC) **Regional Healthy Homes Coordinator** or the Case Management Provider will give in-person (or in some cases by phone) to caregiver: • Information on lead poisoning cause and effect, environmental lead hazard reduction, and nutrition. • Information on WIC services available. • Information on Children 1st Program information (newborns to 5 years old) • Information on Children's Medical Services (CMS) if child =>5 years old **Regional Healthy Homes Coordinator** will also: • Conduct or arrange an environmental risk assessment by a certified risk assessor. Risk assessment should occur within 24 hours of receiving referral from GHHLPPP. • Call-in a summary of risk assessment and recommendations to the caregiver, property owner and medical provider • Provide a copy of the risk assessment in approved format to GCLPPP. • If child must go to different housing unit post chelation, RHHC will inspect the new unit for lead hazards and inform medical provider that home is lead safe prior to child's release from hospital.

Access guidelines at:
https://dph.georgia.gov/sites/dph.georgia.gov/files/EnvHealth/Lead/EnvHealthLeadCaseManagementGuidelines2018.pdf

*GA-AAP recommends a follow-up blood test within 3 months if the initial test is 5-9 µg/dL

For questions on the GHHLPPP guidelines, please contact:
Georgia Healthy Homes and Lead Poisoning Prevention Program
2 Peachtree Street, NW | 13th Floor | Atlanta, GA 30303
Phone: 404-657-6534 Fax: 404-463-4039
https://dph.georgia.gov/lead

ENVIRONMENTAL LEAD RISK ASSESSMENTS

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Certified Lead Risk Assessors who conduct the initial environmental lead risk assessment should bill Medicaid using code T1028 and the appropriate diagnosis code. For follow up clearance inspections following removal of the lead hazards, the certified lead risk assessor should bill Medicaid using code T1028 with the U-1 modifier. For additional information, please consult the Diagnostic Screening and Preventive Services (DSPS) Manual.

	Procedure Code
Initial lead investigation	T1028
Post hazard abatement	T1028 - (Modifier U-1)

Georgia and other Lead Resources

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Lead Information for Professionals and Parents

For information on lead poisoning and prevention, professionals and parents can call GHHLPPP (Georgia Healthy Homes and Lead Poisoning Prevention Program) at 404-657-6534 or the National Lead Information Center at
1-800-424-lead (5323).

Georgia Public Health Laboratory (GPHL)

The Georgia Public Health Laboratory, which has locations in Decatur and Waycross performs blood lead testing on children for the Georgia Healthy Homes and Lead Poisoning Prevention Program (GHHLPPP). Contact information:

GPHL
1749 Clairmont Road
Decatur, GA 30033
Phone 1-800-GEORGIA.

Emergency Information on Lead:

Call the Georgia Poison Center at 1-800-222-1222.

Sources of Lead

Common Sources of Lead

- Lead-based paint
- Lead dust, which is produced by aging lead-based paint
- Soil, which is contaminated by lead emissions from gasoline (prior to 1978), lead-based paint chips, storage of old batteries, etc.
- Water which flows through lead pipes or copper pipes soldered with lead (prior to 1986)
- Improperly glazed ceramic pottery and cooking utensils
- Construction workers, particularly those doing:
  - Department of Transportation (DOT) Sign Makers
  - Painting
  - Remodeling
  - Renovation
  - Road work (specifically painters)

Industries

- Battery manufacturers or reclamation
- Window replacement
- Bronze manufacture
- Firing range instructors
- Gas station attendants
- Glass manufacturers
- Lead pigment manufacture
- Lead smelters and refiners
- Plumbers, pipe fitters
- Policemen who work in automobile tunnels
- Printers
- Radiator manufacture or repair
- Shipbuilders
- Welders or Cutters – Steel burning or cutting (dismantling bridges, ships, etc.)
- Bridge or ship workers (including airports and boats)

Hobbies, Sports, Other

- Moonshine whiskey
- Car or boat repair
- Fishing
- Glazed pottery making
- Home remodeling
- Lead soldering
- Making lead shot or bullet
- Shooting at firing range
- Stained glass manufacture
- Additives to some “health foods” and imported candies
- Substance Use
- Toy soldiers (leaded)
- Folk Remedies – Most commonly found in Mexican, Asian Indian, and Middle Eastern groups. Names include: *Alarcon, Alkohl, Azarcon, Bali Goli, Coral, Ghasard, Greta, Liga, Pay-loo-ah, Rueda*. Cosmetics, used commonly by those from the Middle East and India.

APPENDIX B

Guidelines in Screening and Reporting for TB Disease and Infection

Tuberculin Skin Testing

Mantoux tuberculin skin testing is the standard method of identifying persons infected with M. tuberculosis. Multiple puncture tests should NOT be used to determine whether a person is infected.

The Mantoux test is performed by giving an intradermal injection of 0.1 ml of purified protein derivative (PPD) tuberculin containing 5 tuberculin units (TU) into either the volar or dorsal surface of the forearm. The injection should be made with a disposable tuberculin syringe, just beneath the surface of the skin, with the needle bevel facing upward. This should produce a discrete, pale elevation of the skin (a wheal) 6 mm to 10 mm in diameter.

The reaction to the Mantoux test should be read by a trained health care worker 48 to 72 hours after the injection. If a patient fails to show up for the scheduled reading, a positive reaction may still be measurable up to 1 week after testing.

However, if a patient who fails to return within 72 hours has a negative reaction, tuberculin testing should be repeated.

The area of induration (palpable swelling) around the site of injection is the reaction to tuberculin. The diameter of the indurated area should be measured across the forearm (perpendicular to the long axis). Erythema (redness) should not be measured. All reactions should be recorded in millimeters of induration, even those classified as negative. If no induration is found, “0 mm” should be recorded.

Reporting requirements

In Georgia, all tuberculosis must be reported immediately to the local county health department. Physicians, hospitals, laboratories and other health care providers are required to report any of the following:

- Any child less than 5 years discovered with Latent TB Infection
- Any confirmed case of TB
- Any suspected case of TB
- Any person being treated with two (2) or more anti-tuberculosis drugs
- Any positive culture for Mycobacterium tuberculosis
- Any positive smear for AFB (Acid Fast Bacilli)

How to report

- Report cases electronically through the State Electronic Notifiable Disease Surveillance System (SENDSS)
- Complete a Notifiable Disease Report Form and mail in an envelope marked CONFIDENTIAL, or
- Call your District Health Office
- If your District Health Office cannot be reached, call the Georgia Department of Public Health, TB Section at 404-657-2634.

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Childhood TB Risk Assessment Questionnaires

The AAP Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents (3rd edition) recommends asking the following questions:

1) Was your child born in a country at high risk for tuberculosis?

2) Has your child traveled (had contact with resident populations) for longer than 1 week to a country a high risk for tuberculosis?

3) Has a family member or contact had tuberculosis or a positive tuberculin skin test?

Resource: https://brightfutures.aap.org/materials-and-tools/Pages/default.aspx

For more information about tuberculosis in Georgia: contact
Georgia Tuberculosis (TB) Section
2 Peachtree St. NW
12th Floor
Atlanta, GA 30303
(Phone) 404-657-2634
(Fax) 404-463-3460
The TB Program has the legal responsibility for all TB clients in Georgia regardless of who provides the direct services. TB services are available to all who fall within the service criteria without regard to the client's ability to pay.

Information also available at https://dph.georgia.gov/tuberculosis-tb-prevention-and-control

APPENDIX C-1

Vaccine Administration Codes

Vaccine Administration Codes		
HIPAA Procedure Code	**HIPAA Modifier**	**Procedure Code Description**
90460	EP	**Pediatric Immunization Administration Code**. Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional.
90471	EP	**Non-Age Specific Immunization Administration Code.** Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid)
90472	EP	**Non-Age Specific Immunization Administration Code.** Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/ toxoid)
90473	EP	**Non-Age Specific Immunization Administration Code.** Immunization administration (includes intranasal or oral administration); one vaccine (single or combination vaccine/toxoid)
90474	EP	**Non-Age Specific Immunization Administration Code.** Immunization administration (includes intranasal or oral administration); each additional vaccine (single or combination vaccine/toxoid)

Vaccine Administration Code for Face-to-Face Counseling

90460 - Vaccine administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional.

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90460 is reported when both of the following requirements are met: (1) The patient must be 18 years of age or younger. (2) The physician or other qualified health care professional must perform face-to-face vaccine counseling associated with the administration. *(Any clinical staff can do the actual administration of the vaccine per the physician's or the qualified health care professional's orders.)*
If both of these requirements are not met, report a non-age specific vaccine administration code(s) (90471-90474) instead.

90460 may be reported for more than one (1) unit of vaccine administered during a single office visit.

Note*:* Local Public Health Departments May use vaccine administration code 90460 only if a physician or other qualified health care professional performs face-to-face vaccine counseling associated with administration of the vaccine

A 'qualified health care professional' is an individual who by education, training, licensure/ regulation, facility credentialing (when applicable), and payer policy is able to perform a professional service within their scope of practice and independently report a professional service. These professionals are distinct from 'clinical staff.' A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation, facility, and payer policy to perform or assist in the performance of specified professional services, but who does not individually report any professional services. (CPT 2012)

Non-Age Specific Vaccine Administration Codes

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These codes must be used when there is no face-to-face physician counseling associated with vaccine administration. The add-on codes (90472, 90474) may also be used in conjunction with the 90460 code.

Codes 90471 and 90473 are used to code for the first vaccine given during a single office visit. Codes 90472 and 90474 are considered add-on codes *(hence the + symbol next to them)* to 90471 and 90473, respectively. This means that the provider will use 90472 and 90474 in addition to 90471 or 90473 if more than one vaccine is administered during a visit. Providers may use 90460 for the first (i.e., counseled) vaccine and 90472 or 90474 for the second (i.e., non-counseled) vaccine. Note that there can only be one first administration during a given visit.

90471 - Vaccine administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid)

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Do not report 90471 in conjunction with 90473 or 90460

+90472 - Vaccine administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure.)

May use 90472 in conjunction with 90471 or 90473 or 90460

90473 - Vaccine administration (includes intranasal or oral administration); one vaccine (single or combination vaccine/toxoid)

Do not report 90473 in conjunction with 90471 or 90460

+90474 - Vaccine administration (includes intranasal or oral administration); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure.)

May use 90474 in conjunction with 90471 or 90473 or 90460

Vaccine Administration Codes for 19 – 20 year olds

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EPSDT providers may bill the EPSDT benefit for vaccines administered to members nineteen (19) years of age through twenty (20) years of age. Providers must include the vaccine's CPT, NDC, and diagnosis code, along with the appropriate vaccine administration code(s) [90471, 90472, 90473, 90474] on the EPSDT claim. The Division will reimburse for the vaccine product (providers must use their own stock of vaccines) and for vaccine administration.

Billing Tips

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- Code the vaccine administration with the appropriate vaccine administration code and the EP modifier.

- For the vaccine, code the vaccine product code, the associated diagnosis code and the EP modifier.

- The primary vaccine administration code (90460, 90471, or 90473) must precede the add-on vaccine administration code(s) (90472 or 90474), if applicable.

- The vaccine product code must immediately follow the corresponding vaccine administration code.

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- Code the vaccine administration code(s), the vaccine product code(s), and the preventive or interperiodic visit on the same claim when vaccines are administered during a preventive or interperiodic visit. Each vaccine administration code should be listed only once per claim. If multiple vaccine product codes correspond to the same vaccine administration code, the vaccine administration code is listed once with the appropriate number of units indicated.

- 90460 may be reported for more than one (1) unit of vaccine administered during a single office visit.

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- May report diagnosis code Z00.121 or Z00.129 or Z23 with each of the vaccine administration codes ONLY when vaccines are administered during EPSDT preventive health visits for members through age 17 years.

- May report diagnosis code Z00.00 or Z00.01 or Z23 with the applicable vaccine administration code ONLY when vaccines are administered during EPSDT preventive health visits for members age 15 years through 20 years.

- Use the appropriate vaccine diagnosis code with the vaccine administration code when the vaccine is administered outside of the EPSDT preventive health visit.

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- Code the EPSDT preventive visit (9938x or 9939x) with the EP and the 25 modifiers when vaccines are administered during the preventive health visit.

- Code the EPSDT interperiodic visits (99202-99203 or 99212-99214) with the EP and the 25 modifiers when vaccines are administered during the interperiodic health visit.

Rev. 04/14

- The National Correct Coding Initiative (NCCI) does not allow reimbursement of the 99211 code when it is billed together with any of the vaccine administration codes regardless of whether the 25 modifier is appended to the 99211 code.

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Rev. 01/11
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Rev. 07/12
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Rev. 10/14
Rev. 01/15
Rev. 10/16

Effective January 1, 2013, the vaccine administration reimbursement rates for administering immunizations under the EPSDT Program were adjusted. The Medicaid maximum allowable reimbursement for vaccine administration is $10.00 for Medicaid Fee for Service Providers and $18.50 for PeachCare for Kids® Fee for Service Providers, as indicated in Table C-1a.

Table C-1a

Vaccine Administration Reimbursement Rates		
HIPAA Procedure Code	**Medicaid Fee For Service (FFS) Reimbursement**	**PeachCare for Kids® (PCK) Fee For Service (FFS) Reimbursement**
90460	$10.00	$18.50
90471	$10.00	$18.50
90472	$10.00	$18.50
90473	$10.00	$18.50
90474	$10.00	$18.50

Rev. 10/16

Effective July 1, 2016, physicians and physician extenders who are eligible for the HB 751 FY 2017 Primary Care Providers (PCP) rate increase will be reimbursed the following rates, as indicated below in Table C-1b, when the specified codes are billed for established Medicaid-eligible and PeachCare for Kids®-eligible members.

Table C-1b

Primary Care Providers Rate HB 751 FY2017 Increased Reimbursement Rates Vaccine Administration		
HIPAA Procedure Code	**Medicaid Fee For Service (FFS) Reimbursement**	**PeachCare for Kids® (PCK) Fee For Service (FFS) Reimbursement**
90460	$21.93	$21.93
90471	$23.54	$23.54
90472	$11.98	$18.50

Rev. 04/18

Effective July 1, 2017, physicians and physician extenders who are eligible for the HB 44 FY 2018 Primary Care Providers (PCP) rate increase will be reimbursed at the following rates, as indicated below in Table C-1c, when the specified codes are billed for established Medicaid-eligible and PCK-eligible members.

Table C-1c

Primary Care Providers Rate HB 44 FY2018 Increased Reimbursement Rates Vaccine Administration		
HIPAA Procedure Code	**Medicaid Fee For Service (FFS) Reimbursement**	**PeachCare for Kids® (PCK) Fee For Service (FFS) Reimbursement**
90473	$23.54	$23.54
90474	$11.98	$18.50

APPENDIX C-2

Vaccine Procedure and Diagnosis Codes

(Ages Birth through 18 years)

The following vaccine procedure and diagnosis codes must be included on the claim, following the vaccine administration code, when billing for vaccine administration.

	HIPAA Procedure Code	HIPAA Modifier	Procedure Code Description
	90620 90621	EP	Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B (MenB-4C), 2 dose schedule, for intramuscular use (10-18 years) [Bexsero] Meningococcal recombinant lipoprotein vaccine, serogroup B (MenB-FHbp), 2 or 3 dose schedule, for intramuscular use (10-18 years) [Trumenba]
Rev. 01/08 Rev. 07/08 Rev. 07/10 Rev. 07/11 Rev. 07/12 Rev. 01/13 Rev. 03/13 Rev. 01/14 Rev. 04/14 Rev. 07/14 Rev. 10/14 Rev. 01/15 Rev. 04/15 Rev. 10/15 Rev. 01/16 Rev. 04/16 Rev. 10/16 Rev. 01/17 Rev. 01/18 Rev. 04/18 Rev. 10/18 Rev. 01/19	90633	EP	Hepatitis A vaccine (HepA), pediatric/adolescent dosage-2 dose schedule, for intramuscular use
	90636	EP	Combination Hepatitis A/Hepatitis B vaccine, adult dosage, 3 dose, for intramuscular use (18 years)
	90647 90648	EP	Haemophilus influenzae type B vaccine (Hib), PRP-OMP conjugate, 3 dose schedule, for intramuscular use Haemophilus influenzae type b vaccine (Hib), PRP-T conjugate, 4 dose schedule, for intramuscular use
	90651	EP	Human Papillomavirus (HPV) vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58 nonavalent (9vHPV), 2 or 3-dose schedule, for intramuscular use (females and males 9 years and older) [Gardasil 9]
	90674 90685 90686 90687 90688 90672 90756	EP	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit preservative and antibiotic free, 0.5mL dosage, for intramuscular use Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.25 mL dosage, for intramuscular use Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.5 mL dosage, for intramuscular use Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.25 mL dosage, for intramuscular use Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.5 mL dosage, for intramuscular use Influenza virus vaccine (FluMist), quadrivalent, live (LAIV4), for intranasal use (2 years and older) Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use

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Rev. 04/14
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Rev. 10/14
Rev. 01/15
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HIPAA Procedure Code	HIPAA Modifier	Procedure Code Description
90670	EP	Pneumococcal conjugate vaccine, 13 valent (PCV13), for intramuscular use
90680	EP	Rotavirus vaccine, pentavalent (RV5), 3 dose schedule, live, for oral use (RotaTeq)
90681	EP	Rotavirus vaccine, human, attenuated (RV1), 2 dose schedule, live, for oral use (Rotarix)
90696	EP	Diphtheria, tetanus toxoids, and acellular pertussis vaccine and inactivated poliovirus vaccine, (DTaP-IPV), for intramuscular use (ages 4-6 years)
90698	EP	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Haemophilus influenza type B, and inactivated poliovirus vaccine (DTaP-IPV/Hib), for intramuscular use
90700	EP	Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), for intramuscular use (ages younger than 7 years)
90707	EP	Measles, mumps, and rubella virus vaccine (MMR), live, for subcutaneous use
90710	EP	Measles, mumps, rubella, and varicella vaccine (MMRV), live, for subcutaneous use
90713	EP	Poliovirus vaccine (IPV), inactivated, for subcutaneous or intramuscular use
90714	EP	Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, for intramuscular use (7 years to 18 years, 11 months)
90715	EP	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), for intramuscular use (7 years to 18 years, 11months)
90716	EP	Varicella virus vaccine (VAR), live, for subcutaneous use
90723	EP	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B and inactivated poliovirus vaccine (DTaP-Hep B-IPV), for intramuscular use
90732	EP	Pneumococcal polysaccharide vaccine, 23-valent (PPSV23), adult or immunosuppressed patient dosage, when administered to 2 years or older, for subcutaneous or intramuscular use
90734	EP	Meningococcal conjugate vaccine, serogroups A, C, W, Y, quadrivalent, diptheria toxoid carrier, (MenACWY-D) or CRM197 carrier (MenACWY-CRM), for intramuscular use
90744	EP	Hepatitis B vaccine (HepB), pediatric/adolescent dosage, 3 dose schedule, for intramuscular use
90747		Hepatitis B vaccine (HepB), dialysis or immunosuppressed patient dosage, 4 dose schedule, for intramuscular use

Vaccine Procedure and Diagnosis Codes

(Ages 19 through 20 years)

The Division will reimburse for the vaccine product (providers must use their own stock of vaccines) and for vaccine administration for vaccines administered to Medicaid-eligible members nineteen (19) years of age through twenty (20) years of age. Providers who administer any one of the vaccines listed below will receive reimbursement for administering each vaccine PLUS reimbursement for the vaccine product. The reimbursement rates for the vaccine products may be found in the Physicians' Injectable Drug List Manual. Providers must include the vaccine's procedure and diagnosis codes on the claim.

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Vaccine Procedure and Diagnosis Codes

(Ages 19 through 20 years)

HIPAA Procedure Code	HIPAA Modifier	Procedure Code Description
90620	EP	Meningococcal recombinant protein and outer member vesicle vaccine, serogroup B (MenB-4C), 2 dose schedule, for intramuscular use (Bexsero)
90621		Meningococcal recombinant lipoprotein vaccine, serogroup B (MenB-FHbp), 2 or 3 dose schedule, for intramuscular use (Trumenba)
90632	EP	Hepatitis A vaccine (HepA), adult dosage, for intramuscular use
90636		Combination Hepatitis A/Hepatitis B vaccine, adult dosage, 3 dose, for intramuscular use
90746	EP	Hepatitis B vaccine (HepB), adult dosage 3 dose schedule, for intramuscular use
90747		Hepatitis B vaccine (HepB), dialysis or immunosuppressed patient dosage 4 dose, for intramuscular use
90651	EP	Human Papillomavirus HP vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (9vHPV), 2 or 3-dose schedule, for intramuscular use (females & males) [Gardasil 9]
90674	EP	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5mL dosage, for intramuscular use
90682		Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use
90686		Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.5 mL dosage, for intramuscular use
90688		Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.5 mL dosage, for intramuscular use
90672		Influenza virus vaccine (FluMist), quadrivalent, live (LAIV4), for intranasal use (2 years and older)
90756		Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use
90707	EP	Measles, mumps, and rubella virus vaccine (MMR), live, for subcutaneous use

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Vaccine Procedure and Diagnosis Codes

(Ages 19 through 20 years)

HIPAA Procedure Code	HIPAA Modifier	Procedure Code Description
90713	EP	Poliovirus vaccine (IPV), inactivated, for adults at high risk, for subcutaneous or intramuscular use
90714	EP	Tetanus and diphtheria toxoids (Td) absorbed, preservative free, for intramuscular use
90715	EP	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), for intramuscular use
90716	EP	Varicella virus vaccine (VAR), live, for subcutaneous use
90670 90732	EP	Pneumococcal conjugate vaccine, 13 valent (PCV13), for intramuscular use Pneumococcal polysaccharide vaccine, 23-valent (PPSV23), adult or immunosuppressed patient dosage, for subcutaneous or intramuscular use
90734	EP	Meningococcal conjugate vaccine, serogroups A, C, W, Y, quadrivalent, diptheria toxoid carrier, (MenACWY-D) or CRM197 carrier (MenACWY-CRM), for intramuscular use

APPENDIX C-3

Tuberculin (TB) Skin Test Procedure Codes

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The maximum reimbursement rate for the TB skin test provided by private providers is $8.13 and $3.00 for public health providers.

Use the following procedure and diagnosis codes to document the Tuberculin Skin Test.

HIPAA Procedure Code	ICD-10 Diagnosis Code	HIPAA Modifier	Procedure Code Description	Fee For Service Reimbursement
86580	Z11.1	EP	TB Skin Test	$3.00 (public) $8.13 (private)

APPENDIX C-4

Blood Lead Level Testing Procedure Codes

Blood Lead Level (BLL):

Blood Lead Screenings should be performed at the 12 and 24 month periodic visits (or catch-up visits). There are two tests used to obtain blood lead level (BLL) specimens: capillary blood test or venous blood test. Finger stick capillary blood tests can be done as the initial screening; however, a lab analyzed sample is necessary for confirmation. The specimen may be sent to a private laboratory for analysis, the analysis may be performed using an in-office blood lead level analyzer (the Lead Care II Analyzer uses capillary blood), or sent to the Georgia Public Health Laboratory (GPHL).

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Providers should bill code 83655 with the EP modifier, diagnosis code Z13.88 *(or other applicable diagnosis code that indicates the child is receiving a screening blood lead test)*, on the same claim with the appropriate blood test code 36415 (blood lead venous) or 36416 (blood lead capillary).

HIPAA Procedure Code	HIPAA Modifier	Procedure Code Description	ICD-10 Diagnosis Code
83655	EP	Blood Lead Level Test	Z13.88*
36415	EP	Blood Lead Level Venous	Z13.88
36416	EP	Blood Lead Level Capillary	Z13.88

**Z13.88 (or other applicable diagnosis code that indicates the child is receiving a screening blood lead test)*

Providers who send BLL specimen to the Georgia Public Health Laboratory (GPHL) will be billed $10.00 lab handling fee assessed by the GPHL. Therefore, Fee For Service (FFS) providers should bill code 83655 with modifiers EP, 90 or EP, 91 and diagnosis code Z13.88 on the same claim with the appropriate codes (36415 or 36416) as seen below. This billing will result in a FFS reimbursement of $10.00 for the lab handling fee assessed by the GPHL. This reimbursement is only available when documentation supports that the BLL specimen was sent to the GPHL.

HIPAA Procedure Code	HIPAA Modifier	ICD-10 Diagnosis Code	Fee For Service Reimbursement
83655	EP, 90 or EP, 91	Z13.88*	$10.00 (only available when documentation supports that the BLL specimen was sent to the GPHL)
36415	EP	Z13.88	
36416	EP	Z13.88	

**Z13.88 (or other applicable diagnosis code that indicates the child is receiving a screening blood lead test)*

Diagnosis Code/ Modifier	Description
Z13.88	Encounter for screening for disorder due to exposure to contaminants.
Modifier 90	Reference (Outside) Laboratory: When laboratory procedures are performed by a party other than the treating or reporting practitioner, the procedure may be identified by adding modifier 90 to the usual procedure number.
Modifier 91	Repeat Clinical Diagnostic Laboratory Test: In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results.

APPENDIX D

Children's Intervention Services

The Children's Intervention Services (CIS) program offers coverage for restorative and/or rehabilitative services to eligible members in non-institutional settings. Services must be determined medically necessary and be recommended and documented as appropriate interventions by a physician or other licensed practitioner of the healing arts, within their scope of practice under state law, for the maximum reduction of physical disability or developmental delay and restoration of the member to the best possible functional level.

The CIS program is comprised of seven intervention services that must be provided by licensed practitioners of the healing arts. The seven services are:

- Audiology
- Nursing
- Nutrition provided by licensed dieticians
- Occupational Therapy
- Physical Therapy
- Counseling provided by licensed clinical Social Workers
- Speech-language Pathology

Qualified providers must be currently licensed as audiologists, registered nurses, dietitians, occupational therapists, physical therapists, clinical social workers, or speech-language pathologists.

APPENDIX E

Medicaid Non-Emergency Transportation

People enrolled in the Medicaid program need to get to and from health care services, but many do not have any means of transportation. The Non-Emergency Transportation Program (NET) provides a way for Medicaid recipients to get that transportation so they can receive necessary medical services covered by Medicaid.

How do I get non-emergency transportation services?
If you are a Medicaid recipient and have no other way to get to medical care or services covered by Medicaid, you can contact a transportation broker to take you. In most cases, you must call three days in advance to schedule transportation. Urgent care situations and a few other exceptions can be arranged more quickly. Each broker has a toll-free telephone number to schedule transportation services, and is available weekdays (Monday-Friday) from 7 a.m. to 6 p.m. All counties in Georgia are grouped into five regions for NET services. A NET Broker covers each region. If you need NET services, you must contact the NET Broker serving the county you live in to ask for non-emergency transportation. See the chart below to determine which broker serves your county, and call the broker's telephone number for that region.

What if I have problems with a NET broker?
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The Division of Medical Assistance (DMA) monitors the quality of the services brokers provide, handling consumer complaints and requiring periodic reports from the brokers. The state Department of Audits also performs on-site evaluations of the services provided by each broker. If you have a question, comment or complaint about a broker, call the Member CIC at 866-211-0950.

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Region	Broker/Phone Number	Counties Served
North	Southeastrans Toll free 1-866-388-9844 Local 678-510-4555	Banks, Barrow, Bartow, Catoosa, Chattooga, Cherokee, Cobb, Dade, Dawson, Douglas, Fannin, Floyd, Forsyth, Franklin, Gilmer, Gordon, Habersham, Hall, Haralson, Jackson, Lumpkin, Morgan, Murray, Paulding, Pickens, Polk, Rabun, Stephens, Towns, Union, Walker, Walton, White, and Whitfield
Atlanta	Southeastrans 404-209-4000	Fulton, DeKalb, and Gwinnett
Central	LogistiCare Toll free 1-888-224-7981	Baldwin, Bibb, Bleckley, Butts, Carroll, Clayton, Coweta, Dodge, Fayette, Heard, Henry, Jasper, Jones, Lamar, Laurens, Meriwether, Monroe, Newton, Pike, Putnam, Rockdale, Spalding, Telfair, Troup, Twiggs, and Wilkinson

Region	Broker/Phone Number	Counties Served
East	LogistiCare Toll free 1-888-224-7988	Appling, Bacon, Brantley, Bryan, Bulloch, Burke, Camden, Candler, Charlton, Chatham, Clarke, Columbia, Effingham, Elbert, Emanuel, Evans, Glascock, Glynn, Greene, Hancock, Hart, Jeff Davis, Jefferson, Jenkins, Johnson, Liberty, Lincoln, Long, Madison, McDuffie, McIntosh, Montgomery, Oconee, Oglethorpe, Pierce, Richmond, Screven, Taliaferro, Tattnall, Toombs, Truetlen, Ware, Warren, Washington, Wayne, Wheeler, and Wilkes
Southwest	LogistiCare Toll free 1-888-224-7985	Atkinson, Baker, Ben Hill, Berrien, Brooks, Calhoun, Chattahoochee, Clay, Clinch, Coffee, Colquitt, Cook, Crawford, Crisp, Decatur, Dooly, Dougherty, Early, Echols, Grady, Harris, Houston, Irwin, Lanier, Lee, Lowndes, Macon, Marion, Miller, Mitchell, Muscogee, Peach, Pulaski, Quitman, Randolph, Schley, Seminole, Stewart, Sumter, Talbot, Taylor, Terrell, Thomas, Tift, Turner, Upson, Webster, Wilcox, and Worth

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APPENDIX F

Childhood Obesity – Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

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Body Mass Index (BMI)

What is BMI?

Body Mass Index (BMI) is used as a screening tool to identify possible weight problems for children and adolescents. The Centers for Disease Control and Prevention (CDC) and the American Academy of Pediatrics (AAP) recommend the use of BMI to screen for overweight and obesity in children and adolescents aged 2 through 19 years.

BMI is a number calculated from a child's weight and height. BMI does not measure body fat directly, but it is a reliable indicator of body fatness for most children and adolescents.

For children and adolescents, BMI is age- and sex-specific and is often referred to as BMI-for-age. A child's weight status is determined using an age- and sex-specific percentile for BMI rather than the BMI categories used for adults because children's body composition varies as they age and varies between boys and girls.

What is a BMI percentile?

After the BMI is calculated for children and adolescents, the BMI number is plotted on the BMI-for-age growth charts (for either girls or boys) to obtain a percentile ranking. Percentiles are the most commonly used indicator to assess the size and growth patterns of individual children in the United States. The percentile indicates the relative position of the child's BMI number among children of the same sex and age. The CDC's growth charts show the weight status categories used with children and adolescents.

WEIGHT STATUS CATEGORY	PERCENTILE RANGE
Underweight	Less than the 5th percentile
Healthy Weight	5th percentile to less than the 85th percentile
Overweight	85th to less than the 95th percentile
Obese	Equal to or greater than the 95th percentile

These percentiles are based on the CDC's growth charts which **are available at http://www.cdc.gov/growthcharts/**

How to calculate BMI using a handheld calculator?

Rev. 10/13 The BMI can be calculated using either English or metric units.

With the metric system, the formula for BMI is weight in kilograms divided by height in meters squared. Since height is commonly measured in centimeters, an alternate calculation formula, dividing the weight in kilograms by the height in centimeters squared, and then multiplying the result by 10,000, can be used.

Formula: weight (kg) / [height (m)]^2

When using English measurements, ounces (oz.) and fractions must be changed to decimal values. Then, calculate BMI by dividing weight in pounds (lbs.) by height in inches (in) squared and multiplying by a conversion factor of 703. Plot the calculated BMI to obtain the BMI percentile.

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Formula: weight (lb.) / [height (in)]^2 x 703

How to interpret BMI?

Calculating the BMI-for-age for children of different ages and sexes may yield the same numeric result, but the result may fall at a different percentile for each child for one or both of the following reasons:

- The normal BMI-related changes that take place as children age and as growth occurs (ex. The amount of body fat changes with age).

- The normal BMI-related differences between sexes (ex. The amount of body fat differs between girls and boys).

Documentation for HEDIS Compliance – Weight Assessment

Documentation in the medical record for BMI must include the following:

- Height
- Weight
- BMI percentile

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Documentation must include height, weight and BMI percentile during the measurement year. The height, weight and BMI percentile must be from the same data source. Either of the following meets criteria for BMI percentile: BMI percentile documented as a value (e.g., 85th percentile) OR BMI percentile plotted on an age-growth chart. Only evidence of the BMI percentile or BMI percentile plotted on an age-growth chart meets HEDIS criteria.

ICD-10 Codes to Identify BMI

Body Mass Index (BMI) – Pediatrics		
BMI Code	**BMI Percentile**	**Range**
Z68.51	< 5th percentile for age	Underweight
Z68.52	5th to < 85th percentile for age	Normal/ Healthy Weight Range
Z68.53	85th to < 95th percentile for age	Overweight
Z68.54	≥ 95th percentile for age	Obese

FFS EPSDT providers are encouraged to report BMI diagnosis codes with the EPSDT preventive health codes. Do not point the preventive health visit code to the BMI diagnosis code because this will cause the FFS claim to deny payment.

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Counseling for Nutrition

Guidelines

The *Dietary Guidelines for Americans* (*http://health.gov/dietaryguidelines/2015/guidelines/*) comprise core principles to help people, ages 2 years and older, develop healthy lifestyles based on individual needs, likes, and dislikes related to both eating and physical activity. The Dietary Guidelines recommend that children and adolescents consume a healthy eating pattern that accounts for all foods and beverages within an appropriate calorie level. A healthy eating pattern includes a variety of vegetables from all of the subgroups, fruits, grains, fat-free or low-fat dairy, a variety of protein foods and oils. A healthy eating pattern limits saturated fats and *trans* fats, added sugars, and sodium.

Documentation for HEDIS compliance – Counseling for Nutrition

Documentation (in the medical record) of counseling for nutrition must include a statement indicating the date and at least one of the following:

- Discussion of current nutrition behaviors (e.g., eating habits, dieting behaviors).
- Checklist indicating nutrition was addressed.
- Counseling or referral for nutrition education.
- Member received educational materials on nutrition during a face-to-face visit.
- Anticipatory guidance for nutrition.
- Weight or obesity counseling.

ICD-10 Code to Identify Counseling for Nutrition

- Z71.3 – nutritional counseling

FFS EPSDT providers are encouraged to report the nutrition diagnosis code with the EPSDT preventive health codes. Do not point the preventive health visit code to the nutrition and physical activity counseling diagnosis code because this will cause the FFS claim to deny payment.

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Counseling for Physical Activity

Guidelines

The *Physical Activity Guidelines for Americans* (*http://health.gov/paguidelines/guidelines/children.aspx*) describe the types and amounts of physical activity that offer substantial health benefits for children and adolescents (ages 6 to 17) and adults. The *Physical Activity Guidelines for Americans* complement the *Dietary Guidelines for Americans*, and together the documents provide guidance on the importance of being physically active and eating healthy foods to promote health and reduce the risk of chronic diseases. The Physical Activity Guidelines recommend that children and adolescents have 60 minutes (1 hour) or more of physical activity each day. Physical activity includes aerobic/endurance activities (to increase cardiorespiratory fitness), muscle-strengthening (resistance training which builds strong muscles), and bone-strengthening (weight-bearing or weight-loading activities which promote bone growth and strength).

Documentation for HEDIS Compliance – Counseling for Physical Activity

Documentation (in the medical record) of counseling for physical activity must include a statement indicating the date and at least one of the following:

- Discussion of current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation).
- Checklist indicating physical activity was addressed.
- Counseling or referral for physical activity.
- Member received educational materials on physical activity during a face-to-face visit.
- Anticipatory guidance specific to the child's physical activity.
- Weight or obesity counseling.

The following notations or examples of documentation are not compliant with HEDIS requirements:

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- **BMI**
  - No BMI percentile documented in medical record or plotted on age-growth chart.
  - Notation of BMI value only.
  - Notation of height and weight only.

- **Nutrition**
  - No counseling/education on nutrition and diet.
  - Counseling/education before or after the HEDIS measurement year
  - Notation of "health education" or "anticipatory guidance" without specific mention of nutrition.
  - A physical exam finding or observation alone (e.g., well-nourished) is not compliant because it does not indicate counseling for nutrition.
  - Documentation related to a member's "appetite" does not meet criteria

- **Physical Activity**
  - No counseling/education on physical activity.
  - Notation of "cleared for gym class" along without documentation of a discussion.
  - Counseling/education before or after the HEDIS measurement year.
  - Notation of "health education" or "anticipatory guidance" without specific mention of physical activity.
  - Notation of anticipatory guidance related solely to safety (e.g., wears helmet or water safety) without specific mention of physical activity recommendations.
  - Notation solely related to screen time (computer or television) without specific mention of physical activity.

Services may be rendered during a visit other than a well-child visit. These services count if the specified documentation is present, regardless of the primary intent of the visit. **Services specific to the assessment or treatment of an acute or chronic condition do not count toward the "Counseling for Nutrition" and "Counseling for Physical Activity" measures.**

APPENDIX G

EPSDT Program Required Equipment Form

- ☐ Scale for Weighing Infants **present**
- ☐ Scale for Weighing Children and Adolescents **present**
- ☐ Measuring Board or Device for measuring Length or Height in the recumbent position for Infants and Children up to the age of two (2) **present**
- ☐ Measuring Board or Device for measuring Height in the vertical position for children who are over two (2) years old **present**
- ☐ Blood Pressure apparatus with infant, child, and adult cuffs **present**
- ☐ Screening audiometer **present**
- ☐ Centrifuge or other device for measuring hematocrit or hemoglobin may be **present**
- ☐ Eye charts appropriate for age of the child **present**
- ☐ Developmental/Behavioral, Alcohol/Substance Abuse and Depression screening tools and supplies **present** (*The required developmental screenings at ages 9 months, 18 months, and 30 months **must** be accomplished using one or more of the recommended standardized developmental screening tools specified in Section 902.2)*

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- ☐ Vaccines and immunization administration supplies **present**
- ☐ Lab supplies for appropriate lab tests/screenings **present**
- ☐ Ophthalmoscope and Otoscope **present**

The information supplied in this document is true, accurate and complete and is hereby released to the Georgia Department of Community Health, Division of Medicaid, for purpose of enrolling in the EPSDT Program. I understand that falsification, omission or misrepresentation of any information in this enrollment document will result in a denial of enrollment, the closure of current enrollment, and the denial of future enrollment request, and may be punishable by criminal, civil or other administrative actions. I understand that my completion of this form certifies that I have the necessary equipment as listed in Part II-Policies and Procedures Manual for the EPSDT Program.

_____ _____

Provider Name *Date*

_____

Provider Title

_____

Provider/Confirmation Number

APPENDIX H

Georgia Families

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Georgia Families® (GF) is a statewide program designed to deliver health care services to members of Medicaid, PeachCare for Kids®, and Planning for Healthy Babies® (P4HB) recipients. The program is a partnership between the Department of Community Health (DCH) and private care management organizations (CMOs). By providing a choice of health plans, Georgia Families allows members to select a health care plan that fits their needs.

It is important to note that GF is a full-risk program; this means that the four CMOs licensed in Georgia to participate in GF are responsible and accept full financial risk for providing and authorizing covered services. This also means a greater focus on case and disease management with an emphasis on preventative care to improve individual health outcomes.

The four licensed CMOs:

Amerigroup Community Care 1-800-454-3730 www.amerigroup.com	CareSource 1-855-202-1058 www.caresource.com
Peach State Health Plan 866-874-0633 www.pshpgeorgia.com	WellCare of Georgia 866-231-1821 www.wellcare.com

Children, parent/caretaker with children, pregnant women and women with breast or cervical cancer on Medicaid, as well as children enrolled in PeachCare for Kids® are eligible to participate in Georgia Families. Additionally, Planning for Healthy Babies® (P4HB) recipients receive services through Georgia Families® (GF). Children in foster care or receiving adoption assistance and certain youths committed to juvenile justice are enrolled in Georgia Families 360°.

Eligibility Categories for Georgia Families:	
Included Populations	**Excluded Populations**
Parent/Caretaker with Children	Aged, Blind and Disabled
Transitional Medicaid	Nursing home
Pregnant Women (Right from the Start Medicaid – RSM)	Long-term care (Waivers, SOURCE)
Children (Right from the Start Medicaid – RSM)	Federally Recognized Indian Tribe
Children (newborn)	Georgia Pediatric Program (GAPP)
Women Eligible Due to Breast and Cervical Cancer	Hospice
PeachCare for Kids®	Children's Medical Services program
Parent/Caretaker with Children	Medicare Eligible
Children under 19	Supplemental Security Income (SSI) Medicaid
Women's Health Medicaid (WHM)	Medically Needy
Refugees	Recipients enrolled under group health plans
Planning for Healthy Babies®	Individuals enrolled in a Community Based Alternatives for Youths (CBAY)
Resource Mothers Outreach	

Medicaid and PeachCare for Kids® members will continue to be eligible for the same services they receive through traditional Medicaid and state Value Added Benefits. Members will not have to pay more than they paid for Medicaid co-payments or PeachCare for Kids® premiums. With a focus on health and wellness, the CMOs will provide members with health education and prevention programs giving them the tools needed to live healthier lives. Providers participating in Georgia Families will have the added assistance of the CMOs to educate members about accessing care, referrals to specialists, member benefits, and health and wellness education. **All four CMOs are State-wide.**

The Department of Community Health has contracted with four CMOs to provide these services:

- Amerigroup Community Care
- CareSource
- Peach State Health Plan
- WellCare of Georgia

Members can contact Georgia Families for assistance to determine which program best fits their family's needs. If members do not select a plan, Georgia Families will select a health plan for them.

Members can visit the Georgia Families Web site at www.georgia-families.com or call 1-800-GA-ENROLL (1-888-423-6765) to speak to a representative who can give them information about the CMOs and the health care providers.

The following categories of eligibility are included and excluded under Georgia Families:

Included Categories of Eligibility (COE):	
COE	**DESCRIPTION**
104	LIM – Adult
105	LIM – Child
118	LIM – 1st Yr Trans Med Ast Adult
119	LIM – 1st Yr Trans Med Ast Child
122	CS Adult 4 Month Extended
123	CS Child 4 Month Extended
135	Newborn Child
170	RSM Pregnant Women
171	RSM Child
180	P4HB Inter Pregnancy Care
181	P4HB Family Planning Only
182	P4HB ROMC - LIM
183	P4HB ROMC - ABD
194	RSM Expansion Pregnant Women
195	RSM Expansion Child < 1 Yr
196	RSM Expn Child w/DOB < = 10/1/83
197	RSM Preg Women Income < 185 FPL
245	Women's Health Medicaid
471	RSM Child
506	Refugee (DMP) – Adult
507	Refugee (DMP) – Child
508	Post Ref Extended Med – Adult
509	Post Ref Extended Med – Child
510	Refugee MAO – Adult
511	Refugee MAO – Child
571	Refugee RSM - Child
595	Refugee RSM Exp. Child < 1
596	Refugee RSM Exp Child DOB </= 10/01/83
790	Peachcare < 150% FPL
791	Peachcare 150 – 200% FPL
792	Peachcare 201 – 235% FPL
793	Peachcare > 235% FPL
835	Newborn
836	Newborn (DFACS)
871	RSM (DHACS)
876	RSM Pregnant Women (DHACS)
894	RSM Exp Pregnant Women (DHACS)
895	RSM Exp Child < 1 (DHACS)
897	RSM Pregnant Women Income > 185% FPL (DHACS)
898	RSM Child < 1 Mother has Aid = 897 (DHACS)

Included Categories of Eligibility (COE):	
COE	**DESCRIPTION**
918	LIM Adult
919	LIM Child
920	Refugee Adult
921	Refugee Child

Excluded Categories of Eligibility (COE):	
COE	**DESCRIPTION**
124	Standard Filing Unit – Adult
125	Standard Filing Unit – Child
131	Child Welfare Foster Care
132	State Funded Adoption Assistance
147	Family Medically Needy Spend down
148	Pregnant Women Medical Needy Spend down
172	RSM 150% Expansion
180	Interconceptional Waiver
210	Nursing Home – Aged
211	Nursing Home – Blind
212	Nursing Home – Disabled
215	30 Day Hospital – Aged
216	30 Day Hospital – Blind
217	30 Day Hospital – Disabled
218	Protected Med/1972 Cola - Aged
219	Protected Med/1972 Cola – Blind
220	Protected Med/1972 Cola - Disabled
221	Disabled Widower 1984 Cola - Aged

Excluded Categories of Eligibility (COE):	
COE	**DESCRIPTION**
222	Disabled Widower 1984 Cola – Blind
223	Disabled Widower 1984 Cola – Disabled
224	Pickle - Aged
225	Pickle – Blind
226	Pickle – Disabled
227	Disabled Adult Child - Aged
227	Disabled Adult Child - Aged
229	Disabled Adult Child – Disabled
230	Disabled Widower Age 50-59 – Aged
231	Disabled Widower Age 50-59 – Blind
232	Disabled Widower Age 50-59 – Disabled
233	Widower Age 60-64 – Aged
234	Widower Age 60-64 – Blind
235	Widower Age 60-64 – Disabled
236	3 Mo. Prior Medicaid – Aged
237	3 Mo. Prior Medicaid – Blind
238	3 Mo. Prior Medicaid – Disabled
239	Abd Med. Needy Defacto – Aged
240	Abd Med. Needy Defacto – Blind
241	Abd Med. Needy Defacto – Disabled
242	Abd Med Spend down – Aged
243	Abd Med Spend down – Blind
244	Abd Med Spend down – Disabled

Excluded Categories of Eligibility (COE):	
COE	**DESCRIPTION**
246	Ticket to Work
247	Disabled Child – 1996
250	Deeming Waiver
251	Independent Waiver
252	Mental Retardation Waiver
253	Laurens Co. Waiver
254	HIV Waiver
255	Cystic Fibrosis Waiver
259	Community Care Waiver
280	Hospice – Aged
281	Hospice – Blind
282	Hospice – Disabled
283	LTC Med. Needy Defacto – Aged
284	LTC Med. Needy Defacto –Blind
285	LTC Med. Needy Defacto – Disabled
286	LTC Med. Needy Spend down – Aged
287	LTC Med. Needy Spend down – Blind
288	LTC Med. Needy Spend down – Disabled
289	Institutional Hospice – Aged
290	Institutional Hospice – Blind
291	Institutional Hospice – Disabled
301	SSI – Aged
302	SSI – Blind

Excluded Categories of Eligibility (COE):	
COE	**DESCRIPTION**
303	SSI – Disabled
304	SSI Appeal – Aged
305	SSI Appeal – Blind
306	SSI Appeal – Disabled
307	SSI Work Continuance – Aged
309	SSI Work Continuance – Disabled
308	SSI Work Continuance – Blind
315	SSI Zebley Child
321	SSI E02 Month – Aged
322	SSI E02 Month – Blind
323	SSI E02 Month – Disabled
387	SSI Trans. Medicaid – Aged
388	SSI Trans. Medicaid – Blind
389	SSI Trans. Medicaid – Disabled
410	Nursing Home – Aged
411	Nursing Home – Blind
412	Nursing Home – Disabled
424	Pickle – Aged
425	Pickle – Blind
426	Pickle – Disabled
427	Disabled Adult Child – Aged
428	Disabled Adult Child – Blind
429	Disabled Adult Child – Disabled

Excluded Categories of Eligibility (COE):	
COE	**DESCRIPTION**
445	N07 Child
446	Widower – Aged
447	Widower – Blind
448	Widower – Disabled
460	Qualified Medicare Beneficiary
466	Spec. Low Inc. Medicare Beneficiary
575	Refugee Med. Needy Spend down
660	Qualified Medicare Beneficiary
661	Spec. Low Income Medicare Beneficiary
662	Q11 Beneficiary
663	Q12 Beneficiary
664	Qua. Working Disabled Individual
815	Aged Inmate
817	Disabled Inmate
870	Emergency Alien – Adult
873	Emergency Alien – Child
874	Pregnant Adult Inmate
915	Aged MAO
916	Blind MAO
917	Disabled MAO
983	Aged Medically Needy
984	Blind Medically Needy
985	Disabled Medically Needy

HEALTH CARE PROVIDERS

For information regarding the participating health plans (enrollment, rates, and procedures), please call the numbers listed below.

Prior to providing services, you should contact the member's health plan to verify eligibility, PCP assignment and covered benefits. You should also contact the health plan to check prior authorizations and submit claims.

Amerigroup Community Care	**CareSource**	**Peach State Health Plan**	**WellCare of Georgia**
800-454-3730 (general information) www.amerigroup.com	1-855-202-1058 www.careSource.com / GeorgiaMedicaid	866-874-0633 (general information) 866-874-0633 (claims) 800-704-1483 (medical management) www.pshpgeorgia.com	866-231-1821 www.wellcare.com

Registering immunizations with GRITS:
If you are a Vaccine for Children (VFC) provider, please continue to use the GRITS (Georgia Immunization Registry) system for all children, including those in Medicaid and PeachCare for Kids®, fee-for-service, and managed care.

Important tips for the provider to know/do when a member comes in:

Understanding the process for verifying eligibility is now more important than ever. You will need to determine if the patient is eligible for Medicaid/PeachCare for Kids® benefits and if they are enrolled in a Georgia Families health plan. Each plan sets its own medical management and referral processes. Members will have a new identification card and primary care provider assignment.

Rev. 01/21

You may also contact Gainwell Technologies at 1-800-766-4456 (statewide) or www.mmis.georgia.gov for information on a member's health plan.

Use of the Medicaid Management Information System (MMIS) web portal:

Rev. 01/21

The call center and web portal will be able to provide you information about a member's Medicaid eligibility and health plan enrollment. Gainwell Technologies will **not** be able to assist you with benefits, claims processing or prior approvals for members assigned to a Georgia Families health plan. You will need to contact the member's plan directly for this information.

Participating in a Georgia Families' health plan:

Each health plan will assign provider numbers, which will be different from the provider's Medicaid provider number and the numbers assigned by other health plans.

Billing the health plans for services provided:

For members who are in Georgia Families, you should file claims with the member's health plan.

If a claim is submitted to Gainwell Technologies in error:

Rev. 01/21

Gainwell Technologies will deny the claim with a specific denial code. Prior to receiving this denial, you may go ahead and submit the claim to the member's health plan.

Credentialing

Effective August 1, 2015, Georgia's Department of Community Health (DCH) implemented a NCQA certified Centralized Credentialing Verification Process utilizing a Credentialing Verification Organization (CVO). This functionality has been added to the Georgia Medicaid Management Information System (GAMMIS) website (www.MMIS.georgia.gov) and has streamlined the time frame that it takes for a provider to be fully credentialed.

Credentialing and recredentialing services is provided for Medicaid providers enrolled in Georgia Families and/or the Georgia Families 360° program.

This streamlined process results in administrative simplification thereby preventing inconsistencies, as well as the need for a provider to be credentialed or recredentialed multiple times.

The CVO's one-source application process:

- Saves time
- Increases efficiency
- Eliminates duplication of data needed for multiple CMOs
- Shortens the time period for providers to receive credentialing and recredentialing decisions

The CVO will perform primary source verification, check federal and state databases, obtain information from Medicare's Provider Enrollment Chain Ownership System (PECOS), check required medical malpractice insurance, confirm Drug Enforcement Agency (DEA) numbers, etc. A Credentialing Committee will render a decision regarding the provider's credentialing status. Applications that contain all required credentialing and recredentialing materials at the time of submission will receive a decision within 45 calendar days. Incomplete applications that do not contain all required credentialing documents will be returned to the provider with a request to supplement all missing materials. Incomplete applications may result in a delayed credentialing or recredentialing decision. The credentialing decision is provided to the CMOs.

HP provider reps will provide training and assistance as needed. Providers may contact HP for assistance with credentialing and recredentialing by dialing 1-800-766-4456.

Assignment of separate provider numbers by all of the health plans:

Each health plan will assign provider numbers, which will be different from the provider's Medicaid provider number and the numbers assigned by other health plans.

Billing the health plans for services provided:

For members who are in Georgia Families, you should file claims with the member's health plan.

If a claim is submitted to Gainwell Technologies in error:

Rev. 01/21

Gainwell Technologies will deny the claim with a specific denial code. Prior to receiving this denial, you may go ahead and submit the claim to the member's health plan.

Receiving payment:

Claims should be submitted to the member's health plan. Each health plan has its own claims processing and you should consult the health plan about their payment procedures.

Health plans payment of clean claims:

Each health plan (and subcontractors) has its own claims processing and payment cycles. The claims processing and payment timeframes are as follows:

Amerigroup Community Care	**CareSource**	**Peach State Health Plan**	**WellCare of Georgia**
Amerigroup runs claims cycles twice each week (on Monday and Thursday) for **clean** claims that have been adjudicated. Monday Claims run: Checks mailed on Tuesday. Providers enrolled in ERA/EFT receive the ACH on Thursday. Thursday Claims run: Checks mailed on Wednesday. Providers enrolled in ERA/EFT receive the ACH on Tuesday. **Dental:** Checks are mailed weekly on Thursday for **clean** claims. **Vision**: Checks are mailed weekly on Wednesday for **clean** claims (beginning June 7th) **Pharmacy**: Checks are mailed to pharmacies weekly on Friday (except when a holiday falls	CareSource runs claims cycles twice each week on Saturdays and Tuesdays for clean claims that have been adjudicated. Pharmacy: Payment cycles for pharmacies is weekly on Wednesdays.	Peach State has two weekly claims payment cycles per week that produces payments for **clean** claims to providers on Monday and Wednesday. For further information, please refer to the Peach State website, or the Peach State provider manual.	WellCare runs claims payment cycles up to six (6) times each week for **clean** claims. For further information, please refer to the WellCare website, the WellCare provider manual, or contact Customer Service at 866-231-1821

Amerigroup Community Care	CareSource	Peach State Health Plan	WellCare of Georgia
on Friday, then mailed the next business day)			

How often can a patient change his/her PCP?

Amerigroup Community Care	CareSource	Peach State Health Plan	WellCare of Georgia
Anytime	Members can change their PCP one (1) time per month. However, members can change their PCP at any time under extenuating circumstances such as: • Member requests to be assigned to a family member's PCP • PCP does not provide the covered services a member seeks due to moral or religious objections • PCP moves, retires, etc.	Within the first 90 days of a member's enrollment, he/she can change PCP monthly. If the member has been with the plan for 90 days or longer, the member can change PCPs once every six months. There are a few exclusions that apply and would warrant an immediate PCP change.	Members can change PCPs for any reason within the first 90 days of their enrollment. After the first 90 days, members may change PCPs once every six months.

Once the patient requests a PCP change, how long it takes for the new PCP to be assigned:

Amerigroup Community Care	CareSource	Peach State Health Plan	WellCare of Georgia
Next business day	PCP selections are updated in CareSource's systems daily.	PCP changes made before the 24th day of the month and are effective for the current month. PCP changes made after the 24th day of the month are effective for the first of the following month.	PCP changes made between the 1st and 10th of the month will go into effect right away. Changes made after the 10th of the month will take effect at the beginning of the next month

PHARMACY

Georgia Families does provide pharmacy benefits to members. Check with the member's health plan about who to call to find out more about enrolling to provide pharmacy benefits, including information about their plans reimbursement rates, specific benefits that are available, including prior approval requirements.

To request information about contracting with the health plans, you can call the CMOs provider enrollment services.

Amerigroup Community Care	CareSource	Peach State Health Plan	WellCare of Georgia
800-454-3730 https://providers.amerigroup.com/pages/ga-2012.aspx	844-441-8024 https://cvs.az1.qualtrics.com/jfe/form/SV_cvyY0ohqT2VXYod	866-874-0633 www.pshpgeorgia.com	866-300-1141 ProspectiveProviderGA@WellCare.com or https://www.wellcare.com/en/Georgia/Become-a-Provider

All providers must be enrolled as a Medicaid provider to be eligible to contract with a health plan to provide services to Georgia Families members.

Rev. 01/11
Rev. 10/12
Rev. 04/14
Rev. 07/17
Rev. 10/18
Rev. 04/19

The CMO Pharmacy Benefit Managers (PBM) and the Bin Numbers, Processor Control Numbers and Group Numbers are:

Health Plan	PBM	BIN #	PCN
Amerigroup Community Care	ESI	003858	MA
CareSource	CVS Caremark	004336	MCAIDADV Group: RX0835
Peach State Health Plan	Envolve Pharmacy Solutions (PBM) Caremark (Claims Processor)	004336	MCAIDADV
WellCare of Georgia	Caremark	004336	MCAIDADV

If a patient does not have an identification card:

Rev. 01/21

Providers can check the enrollment status of Medicaid and PeachCare for Kids® members through Gainwell Technologies by calling 1-800-766-4456 or going to the web portal at www.mmis.georgia.gov. Gainwell Technologies will let you know if the member is eligible for services and the health plan they are enrolled in. You can contact the member's health plan to get the member's identification number.

Use of the member's Medicaid or PeachCare for Kids® identification number to file a pharmacy claim:

Amerigroup Community Care	CareSource	Peach State Health Plan	WellCare of Georgia
No, you will need the member's health plan ID number	Yes, you may also use the health plan ID number.	Yes	Yes, you may also use the WellCare subscriber ID

Health plans preferred drug list, prior authorization criteria, benefit design, and reimbursement rates:

Each health plan sets their own procedures, including preferred drug list, prior authorization criteria, benefit design, and reimbursement rates.

Will Medicaid cover prescriptions for members that the health plans do not?

No, Medicaid will not provide a "wrap-around" benefit for medications not covered or approved by the health plan. Each health plan will set its own processes for determining medical necessity and appeals.

Who to call to request a PA:

Amerigroup Community Care	**CareSource**	**Peach State Health Plan**	**WellCare of Georgia**
1 (800) 454-3730	1 (855) 202-1058 1(866) 930-0019 (fax)	1 (866) 399-0929	1 (866) 231-1821 1 (866) 455-6558 (fax)

APPENDIX I

Information for Providers Serving Medicaid Members in the Georgia Families 360°SM Program

Rev. 04/14
Rev. 07/18

Georgia Families 360°SM, the state's managed care program for children, youth, and young adults in Foster Care, children and youth receiving Adoption Assistance, as well as select youth in the juvenile justice system, launched Monday, March 3, 2014. Amerigroup Community Care is the single Care Management Organization (CMO) that will be managing this population.

Amerigroup is responsible, through its provider network, for coordinating all DFCS, DJJ required assessments and medically necessary services for children, youth and young adults who are eligible to participate in the Georgia Families 360°SM Program. Amerigroup will coordinate all medical/dental/trauma assessments for youth upon entry into foster care or juvenile justice (and as required periodically).

Georgia Families 360°SM Every member in Georgia Families 360° is assigned a Care Coordinator who works closely with them to ensure access to care and ensure that appropriate, timely, and trauma informed care is provided for acute conditions as well as ongoing preventive care. This ensures that all medical, dental, and behavioral health issues are addressed. Members also have a medical and dental home to promote consistency and continuity of care. The medical and dental homes coordinate care and serve as a place where the child is known over time by providers who can provide holistic care. DFCS, DJJ, foster parents, adoptive parents and other caregivers are involved in the ongoing health care plans to ensure that the physical and behavioral health needs of these populations are met.

Electronic Health Records (EHRs) are being used to enhance effective delivery of care. The EHRs can be accessed by Amerigroup, physicians in the Amerigroup provider network, and DCH sister agencies, including the DFCS, regardless of where the child lives, even if the child experiences multiple placements. Ombudsman and advocacy staff are in place at both DCH and Amerigroup to support caregivers and members, assisting them in navigating the health care system. Additionally, medication management programs are in place to focus on appropriate monitoring of the use of psychotropic medications, to include ADD/ADHD as well as other behavioral health prescribed medications.

Providers can obtain additional information by contacting the Provider Service Line at 1-800-454-3730 or by contacting their Provider Relations representative.

To learn more about DCH and its dedication to A Healthy Georgia, visit www.dch.georgia.gov

APPENDIX J

Preventive Oral Health: Fluoride Varnish

Rev. 07/10
Rev. 07/11
Rev. 04/15
Rev. 10/15
Rev. 01/16
Rev. 04/16
Rev. 10/16
Rev. 10/19

Fluoride varnish acts to retard, arrest, and reverse the caries process. The teeth absorb the fluoride varnish, strengthening the enamel and helping prevent cavities. It is not a substitute for fluoridated water or toothpaste.

Once teeth are present, the application of fluoride varnish is required and may be applied every 3-6 months in the primary care or dental office for children between the ages of 6 months and 5 years.
https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/dental-caries-in-children-from-birth-through-age-5-years-screening
Indications for fluoride use are noted in the 2014 AAP clinical report "Fluoride Use in Caries Prevention in the Primary Care Setting"
http://pediatrics.aappublications.org/cgi/doi/10.1542/peds.2014-1699

Documentation: Evidence that fluoride varnish was applied once between the ages of 6 months and 5 years OR evidence that the provider addressed the fluoride varnish requirement and/or its importance with the parent.

D1206 - Current Dental Terminology (CDT) Code
99188 - Current Procedural Terminology (CPT) Code

Effective January 1, 2015, the application of topical fluoride varnish by a physician or other qualified health care professional may be billed with the new CPT code 99188. This applies to providers enrolled in and filing claims under GA Medicaid programs 430, 431, and 740. Only providers enrolled in and filing claims under GA Medicaid programs 430, 431, 450, and 740 may bill Code D1206 Fluoride Varnish (eff. 1/1/2010).

Note:

- Dentists: under category of service 450
- Physicians: under category of service 430
- Physician Assistants (PA): under category of service 431
- Nurse Practitioners: under category of service 740

Providers may not bill for an Evaluation and Management (E/M) visit in addition to billing for the application of fluoride varnish, if the sole purpose of the visit was to apply the fluoride varnish. In this instance, the provider may bill for the fluoride varnish code only.

For more information including the payment rate for this service, please see the Part II Policies and Procedures Manual for Dental Services.

RESOURCES (not mandatory to use):

Rev. 07/10
Rev. 07/11
Rev. 04/15
Rev. 10/15
Rev. 01/16
Rev. 04/16
Rev. 10/16
Rev. 10/19

Smiles for Life Oral Health Risk Assessment Tool:

Caries risk assessments:
ADA Caries Risk Assessment Form (Age 0-6)
ADA Caries Risk Assessment Form (Age >6)

Smiles for Life Online trainings:
Child Oral Health (Course 2)
Caries Risk Assessment, Fluoride Varnish and Counseling (Course 6) (Course 6)

Oral Health Professional Websites: American Dental Association (ADA): http://www.ada.org
American Academy of Pediatric Dentistry (AAPD): http://www.aapd.org
Parent Handouts: 'For The Dental Patient' by the ADA freely available for download and photocopy at http://www.ada.org/993.aspx

*Patients at risk for caries include those with: insufficient sources of dietary fluoride; high carbohydrate diets; caretakers who transmit decay-causing bacteria to children via their saliva; areas of tooth decalcification; reduced salivary flow; and poor oral hygiene. AAP training course also includes "children from low socioeconomic and ethnocultural groups."

APPENDIX K

EPSDT HIPAA Referral Code Examples

Rev. 10/14

1. Child has come in for an EPSDT Interperiodic Hearing Screen and the provider finds that the child has an ear infection. The provider treats the child for the ear infection at the time of the interperiodic visit and requests a follow up appointment with him in two weeks. What EPSDT referral code should be documented?

   A. EPSDT Referral Code: **S2**

2. Child has come in for an EPSDT Screen and has experienced complications with diabetes since birth. The provider treats the child for the diabetes complications at the time of the preventive health visit and does not request a follow up appointment. What EPSDT referral code should be documented?

   A. EPSDT Referral Code: **NU**

3. Child has come in for an EPSDT Screen and during the screen, the mother informs the provider that the child has behavior problems. The provider refers the child for further diagnostic testing within two weeks with a Diagnostic and Behavioral Center. What EPSDT referral code should be documented?

   A. EPSDT Referral Code: **ST**

4. Child has come in for EPSDT Screen and the provider finds that the child has some developmental problems. The provider refers the child for further diagnostic testing with a Developmental and Behavioral Center. Mom refuses the Developmental and Behavioral appointment. What EPSDT referral code should be documented?

   A. EPSDT Referral Code: **AV**

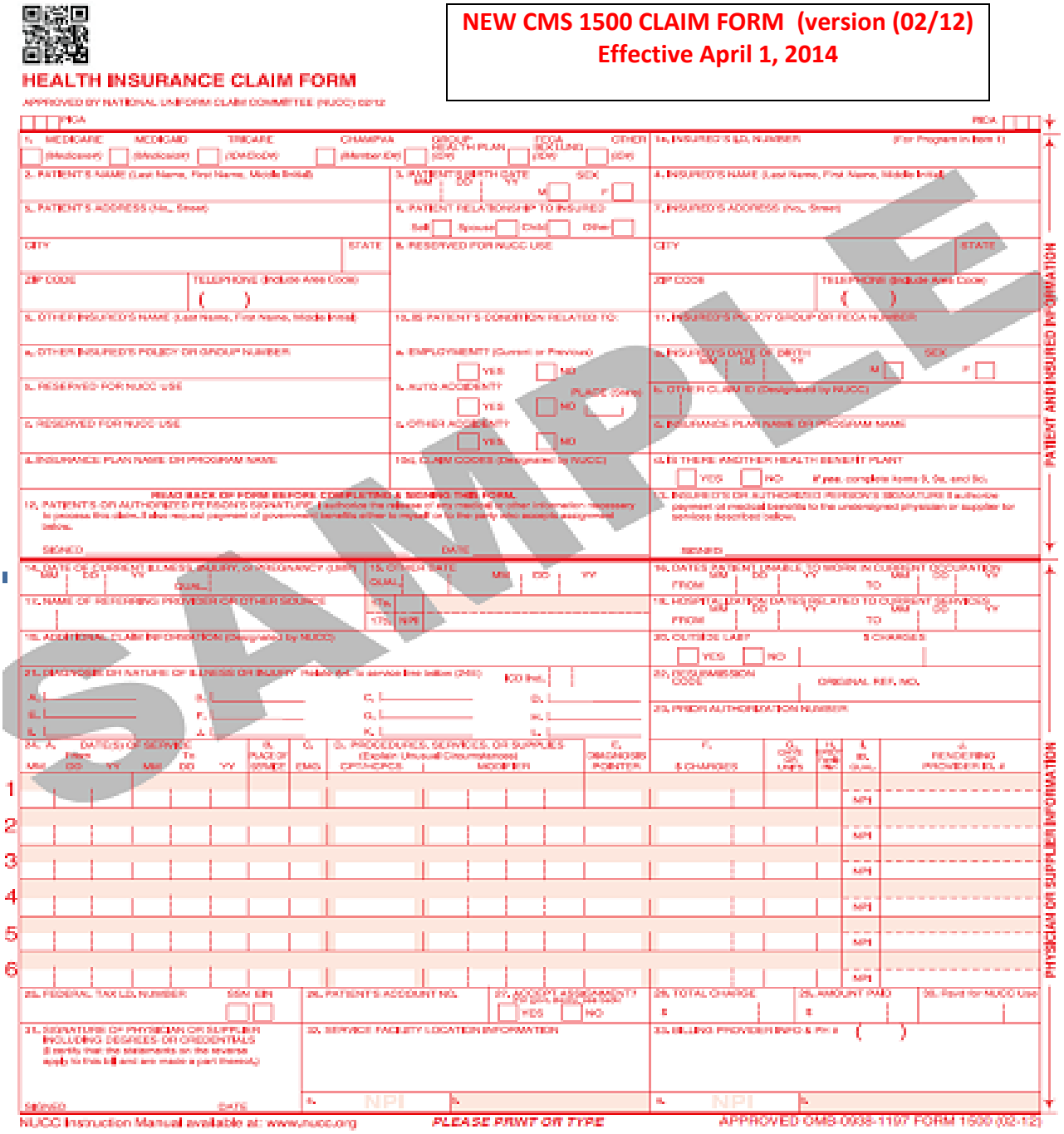
Rev. 04/14
Rev. 07/15
Rev. 07/17
Rev. 01/21

APPENDIX L

NEW CMS 1500 CLAIM FORM (version 02/12) - SAMPLE

Effective May 1, 2015, paper claims are no longer accepted by Gainwell Technologies. As part of the Georgia Paperless Initiative, providers are required to submit CMS 1500 claims electronically over the GAMMIS web portal. For more information regarding the Paperless Initiative, please access the web portal and review all related Banner Messages.

NEW CMS 1500 CLAIM FORM (version (02/12)
Effective April 1, 2014


HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)
1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
3. PATIENT'S BIRTH DATE MM DD YY SEX M F
4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)
6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other
7. INSURED'S ADDRESS (No., Street)
CITY STATE
8. RESERVED FOR NUCC USE
CITY STATE
ZIP CODE TELEPHONE (Include Area Code) ( )
ZIP CODE TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER
a. EMPLOYMENT? (Current or Previous) YES NO
b. INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. RESERVED FOR NUCC USE
b. AUTO ACCIDENT? YES NO PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE
c. OTHER ACCIDENT? YES NO
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED DATE
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY QUAL.
15. OTHER DATE MM DD YY QUAL.
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a.
17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) ICD Ind.
A. B. C. D. E. F. G. H. I. J. K. L.
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER
24. A. DATES OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. $ CHARGES G. DAYS OR UNITS H. EPSDT Fam. Plan I. ID. Qual. J. RENDERING PROVIDER ID. #
1 NPI
2 NPI
3 NPI
4 NPI
5 NPI
6 NPI
25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO
28. TOTAL CHARGE $
29. AMOUNT PAID $
30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SIGNED DATE
32. SERVICE FACILITY LOCATION INFORMATION
a. NPI b.
33. BILLING PROVIDER INFO & PH # ( )
a. NPI b.
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION
NUCC Instruction Manual available at: www.nucc.org
PLEASE PRINT OR TYPE
APPROVED OMB-0938-1197 FORM 1500 (02-12)
SAMPLE

New CMS 1500 Field Locator Instructions

The following table outlines the **revised changes** on the above CMS 1500 claim form version 02/12:

FLD Location	NEW Change
Header	Replaced 1500 rectangular symbol with black and white two-dimensional QR Code (Quick Response Code)
Header	Added "(NUCC)" after "APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE."
Header	Replaced "08/05" with "02/12"
Item Number 1	Changed "TRICARE CHAMPUS" to "TRICARE" and changed" (Sponsor's SSN)" to "(ID#/DoD#)."
Item Number 1	Changed "(SSN or ID)" to "(ID#)" under "GROUP HEALTH PLAN"
Item Number 1	Changed "(SSN)" to "(ID#)" under "FECA BLK LUNG."
Item Number 1	Changed "(ID)" to "(ID#)" under "OTHER.'
Item Number 8	Deleted "PATIENT STATUS" and content of field. Changed title to "**RESERVED FOR NUCC USE**."
Item Number 9b	Deleted "OTHER INSURED's DATE OF BIRTH, SEX." Changed title to "**RESERVED FOR NUCC USE**."
Item Number 9c	Deleted "EMPLOYER'S NAME OR SCHOOL." Changed title to "**RESERVED FOR NUCC USE**."
Item Number 10d	Changed title from "RESERVED FOR LOCAL USE" to "CLAIM CODES (Designated by NUCC)." **Field 10d is being changed to receive Worker's Compensation codes or Condition codes approved by NUCC.** **FOR DCH/Gainwell Technologies:** FLD 10d on the OLD Form CMS 1500 Claim (08/05) will no longer support receiving the Medicare provider ID.
Item Number 11b	Deleted "EMPLOYER'S NAME OR SCHOOL." **Changed title to "OTHER CLAIM ID** (Designated by NUCC)". Added dotted line in the left-hand side of the field to accommodate a 2-byte qualifier
Item Number 11d	Changed "If yes, return to and complete Item 9 a-d" to "If yes, complete items 9, 9a, and 9d." (Is there another Health Benefit Plan?)
Item Number 14	Changed title to "DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)." Removed the arrow and text in the right-hand side of the field. Added "QUAL." with a dotted line to accommodate a 3-byte qualifier." **FOR DCH/Gainwell Technologies: Use Qualifiers: 431 (onset of current illness); 484 (LMP); or 453 (Estimated Delivery Date)**.
Item Number 15	Changed title from 'IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE" to "OTHER DATE." Added "QUALIFIER." with two dotted lines to accommodate a 3-byte qualifier: 454 (Initial Treatment); 304 (Latest Visit or Consultation); 453 (Acute Manifestation of a

FLD Location	NEW Change
	Chronic Condition); 439 (Accident); 455 (Last X-ray); 471 (Prescription); 090 (Report Start [Assumed Care Date); 091 (Report End [Relinquished Care Date); 444 (First Visit or Consultation).
Item Number 17	Added a dotted line in the left-hand side of the field to accommodate a 2-byte qualifier – **Used by Medicare** for identifiers for provider roles: Ordering, Referring and Supervising. **FOR DCH/Gainwell Technologies:** Use the following Ordering Provider, Referring, Supervising Qualifiers (**effective 4/01/2014**): **Ordering = DK; Referring = DN or Supervising = DQ.**
Item Number 19	Changed title from "RESERVED FOR LOCAL USE" to "ADDITIONAL CLAIM INFORMATION (Designated by NUCC)." **FOR DCH/Gainwell Technologies:** Remove the Health Check logic from field 19 and add it in **field 24H.**
Item Number 21	Changed instruction after title (Diagnosis or Nature of Illness or Injury) from "(Relate Items 1, 2, 3 or 4 to Item 24E by Line)" to "Relate A-L to service line below (24E)."
Item Number 21	Removed arrow pointing to 24E (Diagnosis Pointer).
Item Number 21	Added "ICD Indicator." and two dotted lines in the upper right-hand corner of the field to accommodate a 1-byte indicator. Use the highest level of code specificity in FLD Locator 21. **Diagnosis Code ICD Indicator** - new logic to validate acceptable values (0, 9). ICD-9 diagnoses (CM) codes = value 9; or ICD -10 diagnoses (CM) codes = value 0. **(Do not bill ICD 10 code sets before October 1, 2015.)**
Item Number 21	Added 8 additional lines for diagnosis codes. Evenly space the diagnosis code lines within the field.
Item Number 21	Changed labels of the diagnosis code lines to alpha characters (A-L).
Item Number 21	Removed the period within the diagnosis code lines
Item Number 22	Changed title from "MEDICAID RESUBMISSION" to "RESUBMISSION." The submission codes are: 7 (Replacement of prior claim) 8 (Void/cancel of prior claim)
Item Numbers 24A – 24 G (Supplemental Information)	The supplemental information is to be placed in the shaded section of 24A through 24G as defined in each Item Number. **FOR DCH/Gainwell Technologies**: Item numbers **24A** & **24G** are used to capture Hemophilia drug units. **24H** (EPSDT/Family Planning).
Item Number 30	Deleted "BALANCED DUE." Changed title to "**RESERVED FOR NUCC USE**."

FLD Location	NEW Change
Footer	Changed "APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)" to "APPROVED OMB-0938-1197 FORM 1500 (02/12)."

Completion of the Health Insurance Claim Form for EPSDT Services Billed by Fee-for-Service Providers

Review these helpful tips for completing the Health Insurance Claim Form (CMS-1500) for EPSDT Services. See Appendix K for EPSDT HIPAA Referral Code Examples.

Item 9 Other Insured's Name
Leave blank. EPSDT preventive health screenings are exempt from third party liability. Even if the member has other insurance, you may file Medicaid first for preventive health services.

Item 21 Diagnosis
Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field.

Enter the codes to identify the patient's diagnosis and /or condition. List no more than **twelve (12)** diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line.

Item 24A Dates of Service (DOS)
The "From" and "To" DOS will always be the same. Since there is only one DOS, enter the date under "From." Leave "To" blank or re-enter "From" date.

Item 24B Place of Service (POS)
Enter POS code 99 for all preventive health services and interperiodic visits.

Item 24C EMG (emergency)
Leave blank for "No".

Item 24D HCPCS Code and Modifier
Enter procedure code and the EP modifier, plus any additional modifiers as applicable.

Item 24E Diagnosis Pointer
Enter the diagnosis code reference letter (pointer) to relate to the DOS and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. Do not use commas between letters.

Item 24H HIPAA EPSDT Referral Codes

- If EPSDT screening resulted in an EPSDT referral, enter the appropriate referral code:
  - ✓ Document AV, S2, or ST in the shaded area of box 24H

- If EPSDT screening did not result in an EPSDT referral:
  - ✓ Document NU in the shaded area of box 24H
- A "Y" for Yes or "N" for No is **not** entered with the referral code in the shaded area or in the unshaded area of box 24H.

Rev. 01/13
Rev. 07/13
Rev. 01/14
Rev. 10/14
Rev. 10/15

CMS-1500 Health Claim Form – SAMPLE

SAMPLE EPSDT CLAIM
9-month preventive visit

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) | MEDICAID X (Medicaid#) | TRICARE (ID/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): MEDICAID NUMBER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, Mary J.

3. PATIENT'S BIRTH DATE: 12 25 2014 SEX: F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 123 Any Street

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown | STATE: GA

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE: 00000-0000 | TELEPHONE (Include Area Code): (404) 123-4567

ZIP CODE | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): Leave blank

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

9a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous): YES | NO

b. AUTO ACCIDENT? YES | NO | PLACE (State)

c. OTHER ACCIDENT? YES | NO

a. INSURED'S DATE OF BIRTH: MM DD YY | SEX: M | F

9b. RESERVED FOR NUCC USE

b. OTHER CLAIM ID (Designated by NUCC)

9c. RESERVED FOR NUCC USE

c. INSURANCE PLAN NAME OR PROGRAM NAME

9d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED:

14. DATE OF CURRENT: ILLNESS, INJURY, or PREGNANCY (LMP): MM DD YY 10 01 2015 QUAL.

15. OTHER DATE: QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: 17a. | 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)): A. Z00.121 or Z00.129 B. Z23 C. D. E. F. G. H. I. J. K. L. ICD Ind.

22. RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10 01 15	10 01 15	99	N	99391	EP 25	A			ST	NPI	
2	10 01 15	10 01 15	99	N	96110	EP	A				NPI	
3	10 01 15	10 01 15	99	N	90460	EP	A		2		NPI	
4	10 01 15	10 01 15	99	N	90744	EP	B				NPI	
5	10 01 15	10 01 15	99	N	90713	EP	B				NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER: SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For Govt. Claims, See back): YES | NO

28. TOTAL CHARGE: $

29. AMOUNT PAID: $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS: I certify that the statements on the reverse apply to this bill and are made a part thereof.

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-1197 FORM 1500 (02-12)

SAMPLE

CMS-1500 Health Claim Form – SAMPLE

Rev. 01/13
Rev. 07/13
Rev. 01/14
Rev. 10/14
Rev. 10/15

SAMPLE EPSDT CLAIM
Age: 10 months
9-month Catch-Up preventive visit

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) X | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): MEDICAID NUMBER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, Mary J.

3. PATIENT'S BIRTH DATE SEX: 11 25 2014 M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 123 Any Street

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown | STATE: GA

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE: 00000-0000 | TELEPHONE (Include Area Code): (404) 123-4567

ZIP CODE | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): Leave blank

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: ILLNESS, INJURY, or PREGNANCY (LMP): 10 01 2015 QUAL.

15. OTHER DATE MM DD YY QUAL.

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)): Z00.121 or Z00.129 Z23 ICD Ind.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 10 01 15	10 01 15	99	N	99391	EP 25 HA	A				NPI	
2 10 01 15	10 01 15	99	N	96110	EP HA	A				NPI	
3 10 01 15	10 01 15	99	N	90460	EP	A		2		NPI	
4 10 01 15	10 01 15	99	N	90744	EP	B				NPI	
5 10 01 15	10 01 15	99	N	90713	EP	B				NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

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PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

Rev. 01/13
Rev. 07/13
Rev. 01/14
Rev. 10/14
Rev. 10/15

CMS-1500 Health Claim Form – SAMPLE

SAMPLE EPSDT CLAIM
12-month preventive visit

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) | MEDICAID X (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): MEDICAID NUMBER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DOE, John C.

3. PATIENT'S BIRTH DATE: 09 30 2014 SEX: X M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 123 Any Street

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown STATE: GA

8. RESERVED FOR NUCC USE

CITY: STATE:

ZIP CODE: 00000-0000 TELEPHONE (Include Area Code): (404) 123-4567

ZIP CODE: TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): Leave blank

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous): YES NO

b. AUTO ACCIDENT? YES NO PLACE (State):

c. OTHER ACCIDENT? YES NO

b. RESERVED FOR NUCC USE:

c. RESERVED FOR NUCC USE:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. CLAIM CODES (Designated by NUCC):

a. INSURED'S DATE OF BIRTH: MM DD YY SEX: M F

b. OTHER CLAIM ID (Designated by NUCC):

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED:

14. DATE OF CURRENT: ILLNESS, INJURY, or PREGNANCY (LMP): 10 01 2015 QUAL.

15. OTHER DATE: QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC):

20. OUTSIDE LAB? YES NO $ CHARGES:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)): ICD Ind.
A. Z00.121 or Z00.129 B. K59.0 C. Z23 D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 10 01 15	10 01 15	99	N	99392	EP 25	A			S2	NPI	
2 10 01 15	10 01 15	99	N	99212	EP 25	B				NPI	
3 10 01 15	10 01 15	99	N	90460	EP	A		2		NPI	
4 10 01 15	10 01 15	99	N	90744	EP	C				NPI	
5 10 01 15	10 01 15	99	N	90710	EP	C				NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: SSN EIN

26. PATIENT'S ACCOUNT NO.:

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE: $

29. AMOUNT PAID: $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION: a. b.

33. BILLING PROVIDER INFO & PH # ( ): a. b.

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CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

Rev. 01/13
Rev. 07/13
Rev. 01/14
Rev. 07/14
Rev. 10/14
Rev. 10/15

CMS-1500 Health Claim Form – SAMPLE

SAMPLE EPSDT CLAIM
Preventive visit with
Immunization Administration Codes
and EPSDT Referral Code

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

1. MEDICARE [ ] (Medicare#) X MEDICAID (Medicaid#) [ ] TRICARE (ID#/DoD#) [ ] CHAMPVA (Member ID#) [ ] GROUP HEALTH PLAN (ID#) [ ] FECA BLK LUNG (ID#) [ ] OTHER (ID#)
1a. INSURED'S I.D. NUMBER (For Program in Item 1): MEDICAID NUMBER
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DOE, Jane
3. PATIENT'S BIRTH DATE MM 09 DD 29 YY 2004 SEX M [ ] F X
4. INSURED'S NAME (Last Name, First Name, Middle Initial):
5. PATIENT'S ADDRESS (No., Street): 123 Any Street
6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street):
CITY: Anytown STATE: GA
8. RESERVED FOR NUCC USE
CITY STATE
ZIP CODE: 00000-0000 TELEPHONE (Include Area Code): (404) 123-4567
ZIP CODE TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): Leave blank
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER
a. EMPLOYMENT? (Current or Previous) [ ] YES [ ] NO
a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]
b. RESERVED FOR NUCC USE
b. AUTO ACCIDENT? [ ] YES [ ] NO PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE
c. OTHER ACCIDENT? [ ] YES [ ] NO
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED DATE
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED

14. DATE OF CURRENT: ILLNESS, INJURY, or PREGNANCY (LMP) MM 10 DD 01 YY 2015 QUAL.
15. OTHER DATE MM DD YY QUAL.
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a. QUAL.
17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind.
A. Z00.121 or Z00.129 B. Z23 C. D. E. F. G. H. I. J. K. L.
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

	24A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Fam. Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10 01 15	10 01 15	99	N	99393	EP 25	A			NU	NPI	
2	10 01 15	10 01 15	99	N	90460	EP	A		2		NPI	
3	10 01 15	10 01 15	99	N	90715	EP	B				NPI	
4	10 01 15	10 01 15	99	N	90650	EP	B				NPI	
5	10 01 15	10 01 15	99	N	90472	EP	A		1		NPI	
6	10 01 15	10 01 15	99	N	90649	EP	B				NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] YES [ ] NO
28. TOTAL CHARGE $
29. AMOUNT PAID $
30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SIGNED DATE
32. SERVICE FACILITY LOCATION INFORMATION
a. b.
33. BILLING PROVIDER INFO & PH # ( )
a. b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARR — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

CMS-1500 Health Claim Form – SAMPLE

Rev. 01/14
Rev. 10/14
Rev. 10/15

SAMPLE EPSDT CLAIM
19 year old – Preventive
with Immunization Administration Codes
and EPSDT Referral Code

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) | MEDICAID X (Medicaid#) | TRICARE (ID# DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): MEDICAID NUMBER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DOE, James

3. PATIENT'S BIRTH DATE MM DD YY: 09 30 1996 SEX M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 123 Any Street

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY: Anytown STATE: GA

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE: 00000-0000 TELEPHONE (Include Area Code): (404) 123-4567

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): Leave blank

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 10 01 2015 QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E.) ICD Ind.

A. Z00.00 or Z00.01 B. Z23 C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10 01 15	10 01 15	99	N	99395	EP 25	A			AV	NPI	
2	10 01 15	10 01 15	99	N	90473	EP	A		1		NPI	
3	10 01 15	10 01 15	99	N	90672	EP	B				NPI	
4	10 01 15	10 01 15	99	N	90472	EP	A		1		NPI	
5	10 01 15	10 01 15	99	N	90649	EP	B				NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION a. b.

33. BILLING PROVIDER INFO & PH # ( ) a. b.

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

APPENDIX M

Resources for Children in Georgia

Georgia Public Health Programs

Rev. 01/09
Rev. 07/11
Rev. 07/14
Rev. 07/16

Programs for Children with Disabilities or Special Health Care Needs:

Babies Can't Wait Program (Birth – 3 years)
2 Peachtree Street, NW
11th floor
Atlanta, GA 30303
http://dph.georgia.gov/Babies-Cant-Wait
404-657-2850
888-651-8224

Children's Medical Services (Birth – 21 years)
2 Peachtree Street, NW
11th floor
Atlanta, GA 30303
http://dph.georgia.gov/CMS
404-657-2850

Children 1st Program
2 Peachtree Street, NW
11th floor
Atlanta, GA 30303
http://dph.georgia.gov/children1st
404-657-2850

Women, Infants, and Children (WIC)
2 Peachtree Street, NW
10th floor
Atlanta, GA 30303
https://dph.georgia.gov/WIC
1-800-228-9173

Rev. 01/08
Rev. 07/11
Rev. 04/12
Rev. 07/14
Rev. 07/16

Georgia Families

For members in Medicaid or PeachCare for Kids®

Most Medicaid and PeachCare for Kids members must enroll in the Georgia Families managed care program and choose a health plan and a provider.

https://www.georgia-families.com/GASelfService/en_US/home.htm
1-888-GA-ENROLL (1-888-423-6765)

PeachCare for Kids®

CHIP Program

(PeachCare for Kids offers free to low cost health insurance, inclusive of the EPSDT benefit, to uninsured, eligible children living in Georgia)

P.O. Box 2583
Atlanta, GA 30301-2583
www.PeachCare.org
1-877-GA-PEACH (1-877-427-3224)

Vaccines for Children (VFC) Program

GA Department of Public Health Immunization Program
2 Peachtree St NW, 13-276
Atlanta, GA 30303
https://dph.georgia.gov/vaccines-children-program
(800) 848-3868
(404) 657-5013/ 5015
DPH-gavfc@dph.ga.gov

Georgia Department of Education (GaDOE)

Ask DOE Manager
2054 Twin Towers East
205 Jesse Hill Jr. Drive SE
Atlanta, GA 30334
(404) 656-2800
(800) 311-3627 (GA)
(404) 651-8737 (fax)
askdoe@doe.k12.ga.us

Special Education

Division for Special Education Services and Supports
Georgia Department of Education
1870 Twin Towers East
Atlanta, GA 30334-9048
(404) 656-3963
Web: www.doe.k12.ga.us/

Programs for Children with Disabilities: Ages 3 through 7

Young Children/619 Coordinator
Division for Special Education Services and Supports
Georgia Department of Education
1870 Twin Towers East
Atlanta, GA 30334-5060
(404) 657-9965
Web: www.doe.k12.ga.us

Division of Family & Children Services (DFCS)

Rev. 07/10
Rev. 07/14
Rev. 07/16

http://dfcs.dhs.georgia.gov
1.800.georgia (1.800.436.7442)
678.georgia (678.436.7442) – Atlanta area

DFCS Office of Constituent Services
(404) 657-3433
- Child Welfare Online Contact Form
  complete online contact form for issues related to Adoptions, Child Protective Services, Foster Care or any other Child Welfare issue.

Child Protective Services / Child Abuse & Neglect
1-855-GACHILD / 1-855-422-4453
(404) 657-3400

Medicaid
(877) 423-4746

Food Stamps
(877) 423-4746

Energy Assistance
(877) 423-4746

Temporary Assistance for Needy Families
(877) 423-4746

Department of Behavioral Health and Developmental Disabilities (DBHDD)

Two Peachtree Street, NW
24th Floor
Atlanta, GA 30303
404-657-2252
http://dbhdd.georgia.gov

Rev. 07/14
Rev. 10/14

Other Resources:

Parent-To-Parent of Georgia
Parent to Parent of Georgia offers a variety of services to Georgia residents ages birth to 26 years and their families impacted by disabilities or special healthcare needs.

3070 Presidential Parkway, Suite 130
Atlanta, GA 30340
(770) 451-5484
(800) 229-2038
Web: http://p2pga.org

Healthy Mothers, Healthy Babies Powerline
Source for healthcare referrals and information
2300 Henderson Mill Road
Suite 410
Atlanta, GA 30345
(770) 451-0020
(770) 451-2466
(800) 300-9003
(800) 822-2539
thecoalition@hmhbga.org
www.hmhbga.org

APPENDIX N

Rev. 07/13
Rev. 04/14

General Claims Submission Policy for Ordering, Prescribing, or Referring (OPR) Providers

The Affordable Care Act (ACA) requires physicians and other eligible practitioners who order, prescribe and refer items or services for Medicaid beneficiaries to be enrolled in the GA Medicaid Program. As a result, CMS expanded the claim editing requirements in Section 1833(q) of the Social Security Act and the providers' definitions in sections 1861-r and 1842(b)(18)C. Therefore, claims for services that are ordered, prescribed or referred must indicate who the ordering, prescribing or referring (OPR) practitioner is. The Department will utilize an enrolled OPR provider identification number for this purpose. Any OPR physicians or other eligible practitioners who are NOT already enrolled in Medicaid as participating (i.e. billing) must enroll separately as OPR. The National Provider Identifier (NPI) of the OPR provider must be included on the claim submitted by the participating, i.e. rendering provider. If the NPI of the OPR provider noted on the Georgia Medicaid claim is associated with a provider who is not enrolled in the Georgia Medicaid program, the claim will not be paid.

Effective 4/1/2014, DCH will begin editing claims submitted through the web, EDI, and on CMS 1500 forms for the presence of an ordering, prescribing or referring provider as required by program policy. The edit will be informational until 6/1/2014. Effective 6/1/2014, the ordering, prescribing or referring provider will become a mandatory field and claims that do not contain the information as required by policy will begin to deny.

For the New CMS-1500 claim form:
Enter qualifiers to indicate if the claim has an ordering, prescribing or referring to the left of the dotted line in box 17 (Ordering = DK; Referring = DN or Supervising = DQ.

For claims entered via the web:
Claims headers were updated to accept ordering or referring Provider ID and name for Dental and Institutional claims and the referring provider's name for Professional claims. The claim detail was updated to accept an ordering or referring provider ID and name. Utilize the "ordering" provider field for claims that require a prescribing physician.

For claims transmitted via EDI:
The 837 D, I and P companion guides were updated to specifically point out the provider loops that capture the rendering, ordering, prescribing, referring and service facility provider information that is now used to transmit OPR information.

APPENDIX O

Screening Tools

The CRAFFT Screening Interview

Begin: "I'm going to ask you a few questions that I ask all my patients. Please be honest. I will keep your answers confidential."

Part A

During the PAST 12 MONTHS, did you:	No	Yes
1. Drink any alcohol (more than a few sips)? (Do not count sips of alcohol taken during family or religious events.)	☐	☐
2. Smoke any marijuana or hashish?	☐	☐
3. Use anything else to get high? ("anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff")	☐	☐

For clinic use only: Did the patient answer "yes" to any questions in Part A?

No ☐ → **Ask CAR question only, then stop**

Yes ☐ → **Ask all 6 CRAFFT questions**

Part B	No	Yes
1. Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐	☐
2. Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?	☐	☐
3. Do you ever use alcohol or drugs while you are by yourself, or ALONE?	☐	☐
4. Do you ever FORGET things you did while using alcohol or drugs?	☐	☐
5. Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?	☐	☐
6. Have you ever gotten into TROUBLE while you were using alcohol or drugs?	☐	☐

CONFIDENTIALITY NOTICE:
The information recorded on this page may be protected by special federal confidentiality rules (42 CFR Part 2), which prohibit disclosure of this information unless authorized by specific written consent. A general authorization for release of medical information is NOT sufficient for this purpose.

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APPENDIX O

Rev. 10/15

Screening Tools

Patient Health Questionnaire-2 (PHQ-2)

PHQ-2

Over the past two weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things.
0 = Not at all
1 = Several days
2 = More than half the days
3 = Nearly every day

Feeling down, depressed, or hopeless.
0 = Not at all
1 = Several days
2 = More than half the days
3 = Nearly every day

Total point score: _____

Score interpretation:

PHQ-2 score	*Probability of major depressive disorder (%)*	*Probability of any depressive disorder (%)*
1	15.4	36.9
2	21.1	48.3
3	38.4	75.0
4	45.5	81.2
5	56.4	84.6
6	78.6	92.9

Figure 1. Patient Health Questionnaire-2 (PHQ-2). This questionnaire is used as the initial screening test for major depressive episode.

Information from Kroenke K, Spitzer RL, Williams JB. The Patient Health Questionnaire-2: validity of a two-item depression screener. Med Care 2003; 41:1284-92.

Thibault JM, Prasaad Steiner, RW. Efficient identification of adults with depression and dementia. American Family Physician, Vol. 70/No. 6 (September 15, 2004)

APPENDIX P

2016 Policy Revisions Record

Rev. 01/17

Part II Policies and Procedures Manual for EPSDT (Health Check) Services

REVISION DATE	SECTION & PAGE	REVISION DESCRIPTION	REVISION TYPE A = Added D = Deleted M = Modified	CITATION (Revision required by Regulation, Legislation, etc.)
01/01/16	902	Revised AAP BF Periodicity Schedule	M	AAP Bright Futures (BF)
01/01/16	1003.3	Depression Screenings and Alcohol/SA Risk Assessments (96127) – added	A	N/A
01/01/16	1003.16	Incontinence Products - added	A	N/A
01/01/16	Appendix C-2	Vaccine product codes: 90634 - Hepatitis A – removed 90655 – Influenza - added	D A	N/A
01/01/16	Appendix R	• Deleted BF Periodicity Schedule • Added upcoming 4/16 EPSDT Updates	D A	N/A
04/01/16	Introduction iii	Added brief emotional/behavioral assessments to services reimbursed under Health Check	M	N/A
04/01/16	902 p. IX-1-3	Revised AAP BF Periodicity Schedule (copyright 2016, updated 10/15)	A	AAP BF
04/01/16	902.1 #7, #25, #26 p. IX-4-7	Updated BF Footnotes: • Visual Acuity, Oral Health • Fluoride Varnish	M A	AAP BF
04/01/16	902.2 D.1., p. IX-9 E.4 & 5, p. IX-12-13 G.1.b., p. IX-14-15 G.8., p. IX-18 I., p. IX-19	Updated Screening Components • Vision- routine screening at age 18 changed to risk assessment. • Clarifications to Alcohol/Substance Abuse Risk Assessment & Depression Screening • Critical Congenital Heart Disease (CCHD) Screening – updated • Cervical Dysplasia / Pap Test – updated • Fluoride Varnish –added	M M M M A	AAP BF N/A AAP BF AAP BF N/A
04/01/16	904 Table A p. IX-23 & 23	99384 & 99394 – ICD-10 Z00.00 & Z00.01 for ages 15-17 years	M	ICD-10 coding guidelines
04/01/16	Immunization Schedules IX-30 - 32	2016 Immunizations Schedules posted	M	CDC
04/01/16	1003.3 p. X-2 & 3	Brief Emotional / Behavioral Assessment (96127) – updated	M	N/A

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Part II Policies and Procedures Manual for EPSDT (Health Check) Services

REVISION DATE	SECTION & PAGE	REVISION DESCRIPTION	REVISION TYPE A = Added D = Deleted M = Modified	CITATION (Revision required by Regulation, Legislation, etc.)
04/01/16	1003. p. 5-7 #13 #17 #19 #20	• School-based Telemedicine Services for LEAs (Q3014) – updated • Fluoride Varnish – added • NCCI-MUE limits – added • Other Reimbursement Rates - added	M A A A	N/A
04/01/16	Appendix C-2	Minor updates to vaccine procedure code descriptions: 90620, 90621, 90632, 90633, 90644, 90647, 90648, 90649, 90650, 90651, 90655, 90656, 90657, 90658, 90670, 90672, 90680, 90681, 90685, 90686, 90687, 90688, 90696, 90698, 90714, 90716, 90732, 90734, 90744, 90746, 90474 90670 – clarified age restriction (6 weeks to 17 years) 90733 - added for ages 19-20 years	M M A	2016 HCPCS N/A N/A
04/01/16	Appendix H	updates to CMO PBM, BIN# and PCN for AMG & WC	M	N/A
04/01/16	Appendix J	Fluoride varnish - revised	M	N/A
04/01/16	Appendix R	Removed upcoming 4/2016 EPSDT Updates	D	N/A
07/01/16	902.2 p. IX-7	Bright Futures helpful materials – updated hyperlink	M	N/A
07/01/16	902.2, D.2. p. IX-10	EHDI Program - updated hyperlink and info	M	N/A
07/01/16	902.2, E.3. 902.2, E.4. 902.2, E.5. p. IX-12 & 13	MCHAT tool - updated hyperlink CRAFFT tool - added hyperlink PHQ-2 tool - updated hyperlink	M A M	N/A

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2016 Policy Revisions Record

Part II Policies and Procedures Manual for EPSDT (Health Check) Services

REVISION DATE	SECTION & PAGE	REVISION DESCRIPTION	REVISION TYPE A = Added D = Deleted M = Modified	CITATION (Revision required by Regulation, Legislation, etc.)
07/01/16	902.2, G.1.a. & b. 902.2, G.2 p. IX-14 & 15	Georgia NBS Program - added hyperlink and minor info GRITS - added hyperlink	A	N/A
07/01/16	Tables A, C p. IX-22, 27	Minor revision for clarification related to modifiers	M	N/A
07/01/16	Appendix A p. A-1- 4	Minor revisions Posted the HB76 FY2016 PCP Increased Rates *(Implementation of rates is pending. Refer to Banner Message dated 6-17-2016)*	M A	N/A Legislation - HB76
07/01/16	Appendix F p. F-2 - 4	Counseling for Nutrition and Physical Activity – added info related to HEDIS requirements	A	HEDIS
07/01/16	Appendix M	Updated Resources	M	N/A
10/01/16	902.2 H., p. IX-19 902.2 I., p. IX-19 1003. #17. p. X-6 Appendix J p. J-1	Added clarifications to Oral Health section. Revised the statement to read: "The AAP recommends the establishment of a dental home six months after the first tooth erupts or by 12 months of age (whichever comes first). For clarification, deleted the statement *"One application of fluoride varnish is required for children between the ages of 6 months and 5 years."* Revised to read, "Once teeth are present, the application of fluoride varnish is required and may be applied every 3-6 months in the primary care or dental office for children between the ages of 6 months and 5 years."	M	AAP Bright Futures (BF)

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2016 Policy Revisions Record

Part II Policies and Procedures Manual for EPSDT (Health Check) Services

REVISION DATE	SECTION & PAGE	REVISION DESCRIPTION	REVISION TYPE A = Added D = Deleted M = Modified	CITATION (Revision required by Regulation, Legislation, etc.)
10/01/16	Table A-1 p. IX-24 Table B-2 p. IX-26 Table C-2 p. IX-28 1003. #20. p. X-7 Appendix C-1 Table C-1b p. C-1	Posted the HB 751 FY 2017 PCP rate increases for the preventive visits 99381, 99391-99395 Posted the HB 751 FY 2017 PCP rate increases for the catch-up preventive visits 99381, 99391, 99392 Posted the HB 751 FY 2017 PCP rate increases for the interperiodic visits 99202-99203, 99212-99214 Posted the HB 751 FY 2017 PCP rate increase for the office consultation code 99244 Posted the HB 751 FY 2017 PCP rate increase for the vaccine administration codes 90460, 90471, 90472	A	Legislation – HB 751
10/01/16	Appendix C-2 p. C-7	90630 *(influenza virus vaccine, quadrivalent, intradermal)* - added for ages 19-20 years	A	ACIP
10/01/16	Appendix F p. F-4	Under ICD-10 Codes to Identify Counseling for Physical Activity, ICD-10 diagnosis code Z71.89 (other specified counseling) was deleted.	M	HEDIS
10/01/16	Appendix H p. H-2	Updated the Georgia Families Regions – "Counties" Column revised	M	Policy
10/01/16	Appendix H p. H-11	Updated with the new PBM information for Peach State Health Plan	M	Policy

APPENDIX P

2017 Policy Revisions Record

Part II Policies and Procedures Manual for EPSDT (Health Check) Services

Rev. 01/18

REVISION DATE	SECTION & PAGE	REVISION DESCRIPTION	REVISION TYPE A = Added D = Deleted M = Modified	CITATION (Revision required by Regulation, Legislation, etc.)
01/01/17	902.2 H. p. IX-19	Clarifications to Oral Health: • The AAP recommends both the establishment of a dental home and the first dental exam no later than 12 months of age. • An oral health risk assessment tool has been developed by the AAP/Bright Futures.	M	AAP Bright Futures (BF)
01/01/17	Appendix C-2	The 2017 HCPCS influenza vaccine code description changes will not go into effect until the updates are completed in GAMMIS.	M	HCPCS
01/01/17		The "Mapping of EPSDT Preventive Health ICD-9 Codes to ICD-10 Codes" table was removed from Appendices. Accordingly, all references to the table were removed throughout the manual.	D	N/A
01/01/17	Appendix Q	The "2016 Policy Revisions Record" was added as Appendix Q.	A	N/A
04/01/17	902 p. IX-1	Notification – updated AAP 2017 BF Periodicity Schedule (effective date July 1, 2017)	M	AAP Bright Futures (BF)
04/01/17	p. IX-30-32	2017 Immunization Schedules posted	M	ACIP
04/01/17	Appendix C-2	90670 – age restriction removed. Refer to the ACIP Immunization Schedule for recommended age	M	N/A
04/01/17	Appendix H	Georgia Families – updated appendix	M	N/A
04/01/17	Appendix O	Performance Measures - minor updates	M	N/A
04/01/17	Appendix R	2017 BF Periodicity Schedule – displays updated schedule and summary of changes	A	AAP Bright Futures (BF)

APPENDIX P

2017 Policy Revisions Record

Part II Policies and Procedures Manual for EPSDT (Health Check) Services

REVISION DATE	SECTION & PAGE	REVISION DESCRIPTION	REVISION TYPE A = Added D = Deleted M = Modified	CITATION (Revision required by Regulation, Legislation, etc.)
07/01/17	Entire Manual	Vendor name change - HPE updated to reflect new name –DXC Technology (DXC)	M	N/A
07/01/17	902-902.1 p. IX-1 – IX-7 902.2 p. IX-11 – IX-22 903 IX-23	Updated 2017 BF Periodicity Schedule – adoption of new schedule effective July 1, 2017 with revised footnotes. Added new screening BF requirements, and deleted/ revised current screening requirements. Revised the minimum standards for screening components in accordance with the updated 2017 BF Periodicity Schedule. Changes to: • Hearing • Tobacco, Alcohol, or Drug Use Assessment • Depression Screening • Maternal Depression Screening • Newborn Blood • Newborn Bilirubin • Dyslipidemia Screening • STIs • HIV • Oral Health Screening tools requirements revised to reflect updated 2017 BF Periodicity Schedule.	M	AAP Bright Futures (BF)
07/01/17	902.2, G.4. p. IX-18, 907.2, C. p. IX-40, Appendix A, p. A-5	Blood Lead Test – provided clarification that "All **venous** sample lead screening tests conducted using any Magellan Diagnostic lead testing system should be laboratory analyzed by a properly accredited laboratory."	M	FDA, CDC, GA. Dept. of Public Health (DPH)
07/01/17	1003, #3, p. X-2	Effective July 1, 2017, DCH will allow separate reimbursement for the Autism screening (96110 EP, UA)	A	DCH

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2017 Policy Revisions Record

Part II Policies and Procedures Manual for EPSDT (Health Check) Services

REVISION DATE	SECTION & PAGE	REVISION DESCRIPTION	REVISION TYPE A = Added D = Deleted M = Modified	CITATION (Revision required by Regulation, Legislation, etc.)
07/01/17	1003, p. X-2 – X-3, p. X-7	Billing Requirements revisions: • added Autism screening code, modifiers and rate, • revised age ranges for brief emotional/behavioral assessments	M	DCH/ AAP Bright Futures (BF)
10/01/17	1003, #2 & #3, p. X-2	2) Developmental Screenings – included ICD-10 diagnosis codes 3) Autism Screenings – included ICD-10 diagnosis codes	M	DCH
10/01/17	Appendix C-2	Updates to influenza vaccines 1) 90672 - removed 2) 90674 – added 3) 90682 – added (19-20 years)	A, D	DCH

APPENDIX P

2018 Policy Revisions Record

Part II Policies and Procedures Manual for EPSDT (Health Check) Services

Rev. 01/19

REVISION DATE	SECTION & PAGE	REVISION DESCRIPTION	REVISION TYPE A = Added D = Deleted M = Modified	CITATION (Revision required by Regulation, Legislation, etc.)
10/1/2018	902.2.E.4. p. IX-14	➢ Tobacco, Alcohol, or Drug Use Assessment: Added clarification to Documentation - Screening tool must be standardized and scorable.	A	DCH
10/1/2018	902.2.E.6. p. IX-15	➢ Maternal Depression Screening: Added clarification to Documentation - Screening tool must be standardized and scorable.	A	DCH
10/1/2018	1003.7 p. X-3	➢ Autism Screenings: Updated ICD-10 diagnosis code Z13.4 to Z13.41	M	DCH
10/1/2018	1003.9. p. X-4	➢ Patient-Focused Health Risk Assessment - (96160) updated the guidance in order to allow the 59 modifier to bypass the NCCI PTP edit.	M	DCH
10/1/2018	1003.10. p. X-4-5	➢ Caregiver-Focused Health Risk Assessment - (96161) updated the guidance in order to allow the 59 modifier to bypass the NCCI PTP edit.	M	DCH
10/1/2018	1003.23. p. X-9	➢ NCCI PTP Edits –added guidance on NCCI PTP edits	A	DCH
10/1/2018	1003.23. p. X-9	➢ Q3014 – revised to include EP GT modifiers	M	DCH
10/1/2018	Appendix C-2 p. C-5	Updated vaccine codes (ages birth through 18 years) in accordance with current VFC supply ➢ Removed 90644, 90649, 90650 ➢ Removed trivalent influenza vaccines 90655, 90656, 90657, 90658	D	DCH
10/1/2018	Appendix C-2 p. C-7	Updated vaccine codes (ages 19 years through 20 years) in accordance with current VFC supply ➢ Removed HP bivalent vaccine 90650 ➢ Removed trivalent influenza vaccines 90658 ➢ Removed 90733	D	DCH
10/1/2018	Appendix H	Updated Georgia Families Appendix	M	DCH

APPENDIX P

2018 Policy Revisions Record

Part II Policies and Procedures Manual for EPSDT (Health Check) Services

REVISION DATE	SECTION & PAGE	REVISION DESCRIPTION	REVISION TYPE A = Added D = Deleted M = Modified	CITATION (Revision required by Regulation, Legislation, etc.)
07/01/18	1003, p. X-3-4	➢ Revised billing guidance for brief emotional/behavioral assessments (96127) ➢ New billing guidance for patient focused health risk assessments (96160) ➢ New billing guidance for maternal depression screenings (96161)	M A A	DCH
07/01/18	Appendix I p. I-1	➢ **Georgia Families 360^{0} SM** Appendix- Revisions to info for providers serving Medicaid members in the **Georgia Families 360^{0} SM** Program	M	DCH
04/01/18	905, p. IX-37-41	2018 Immunization Schedules posted	A	ACIP
04/01/18	 Appendix C-1, Table C-2, p. C-5 904, Table C-1, p. IX-32 904, Table C-2, p. IX-33 1003, #21, p. X-8 904, Table A-1 p. IX-27 904, Table B-2, p. IX-30	Posted the HB 44 FY 2018 PCP rate increase for the following codes: vaccine administration codes ➢ 90473 – FFS ➢ 90474 – FFS, PCK interperiodic visit codes ➢ 99201 – FFS ➢ 99211 – FFS, PCK office consultation codes ➢ 99241, 99242, 99243, 99245 behavior change smoking codes ➢ 99406, 99407 preventive visit codes 99382, 99383, 99384, 99385	A	Legislation – HB 44

APPENDIX P

2018 Policy Revisions Record

Part II Policies and Procedures Manual for EPSDT (Health Check) Services

REVISION DATE	SECTION & PAGE	REVISION DESCRIPTION	REVISION TYPE A = Added D = Deleted M = Modified	CITATION (Revision required by Regulation, Legislation, etc.)
04/01/18	Appendix C-2 p. C-7 p. C-9	Added new 2018 HCPCS code 90756 – Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use	A	HCPCS
04/01/18	Appendix F	Clarifications to Weight Assessment - BMI	M	N/A
01/01/18	#6 p. IX-14 & 15	Maternal Depression – added clarification to recommended tools	M	AAP USPSTF
01/01/18	Table C p. IX-32	Updated the hyperlink for the DPH Form 3300 - Certificate of Vision, Hearing, Dental and Nutrition Screening	M	DPH
01/01/18	Appendix C p. C-5 p. C-7	Revised descriptions for CPT codes 90620 90621 90651	M	HCPCS 2018
01/01/18	Appendix F p. F-2 p. F-4	1) Documentation for BMI – added the following clarification: "Only evidence of the BMI percentile or BMI percentile plotted on an age-growth chart meet HEDIS criteria." 2) Under the section containing the notations or examples of documentation that are not compliant with HEDIS requirements for **Nutrition**, added the following: o Documentation related to a member's "appetite" does not meet criteria.	M	HEDIS 2018

APPENDIX P

2019 Policy Revisions Record

Part II Policies and Procedures Manual for EPSDT (Health Check) Services

Rev. 01/20

REVISION DATE	SECTION & PAGE	REVISION DESCRIPTION	REVISION TYPE A = Added D = Deleted M = Modified	CITATION (Revision required by Regulation, Legislation, etc.)
10/2019	902.2, E.4., p. IX-14	4. Tobacco, Alcohol, or Drug Use Assessment – updated hyperlink to access CRAFFT screening tool	M	DCH
10/2019	902.2, G.5., p. IX-20	5. Tuberculin Risk Assessment and Test – updated hyperlinks to access info o DPH TB and forms	M	DCH/DPH
10/2019	908, p. IX-44	Oral Health and Dental Services - Added guidance - Periodicity of Examination, Preventive Dental Services, Anticiptory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents	A	DCH
10/2019	908, p. IX-45	Oral Health and Dental Services - Replaced the Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling	M	DCH
10/2019	Appendix A, p. A-2	"Lead Screening Requirements and Medical Management Recommendations for Children" – Updated table to reflect blood lead level of 5 µg/dL or greater requires further testing and monitoring.	M	DPH
10/2019	Appendix A, p. A-3	D) Lead Poisoning Education – minor rewording revision	M	DPH
10/2019	Appendix A, p. A-4	Blood Lead Test – minor rewording revision	M	DPH
10/2019	Appendix A, p. A-5	Lab Submission – lab submission guidance section added	A	DPH

APPENDIX P

2019 Policy Revisions Record

Part II Policies and Procedures Manual for EPSDT (Health Check) Services

REVISION DATE	SECTION & PAGE	REVISION DESCRIPTION	REVISION TYPE A = Added D = Deleted M = Modified	CITATION (Revision required by Regulation, Legislation, etc.)
10/2019	Appendix A, p. A-5, A-6	Reporting Guidelines - added clarification to the guidance - provided hyperlink for current Blood Lead Test Reporting Log provided by GHHLPPP - deleted previous copy of Blood Lead Test Reporting Log SendSS 'Registration and Login Manual for Uploading Lead Report Files' - - Updated hyperlink to access SendSS	M	DPH
10/2019	Appendix A, p. A-15 - A-18 Appendix A, p. A-19	Georgia Childhood Lead Poisoning Prevention Program Case Management Guidelines - updated guidelines to reflect blood lead level of 5 µg/dL or greater requires further testing and monitoring. - updated Regional Lead Coordinator (RLC) title to Regional Healthy Homes Coordinator (RHHC) - removed the specific number of coordinators. Georgia Public Health Laboratory (GPHL) - updated locations, removed Albany location	M	DPH
10/2019	Appendix C-4 p. C-10, C-11	Blood Lead Level Testing Procedure Codes - Clarifications to billing guidance	M	DCH
10/2019	Appendix J, p. J-1, J-2	Preventive Oral Health: Fluoride Varnish - - revised hyperlinks	M	ADA

APPENDIX P

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Part II Policies and Procedures Manual for EPSDT (Health Check) Services

REVISION DATE	SECTION & PAGE	REVISION DESCRIPTION	REVISION TYPE A = Added D = Deleted M = Modified	CITATION (Revision required by Regulation, Legislation, etc.)
07/2019	902, p. IX-1 – IX-7	AAP Bright Futures Periodicity Schedule, updated – Effective July 1, 2019, DCH will adopt the updated 2019 AAP Bright Futures Periodicity Schedule. Copyright © 2019 by the American Academy of Pediatrics, updated March 2019	M	AAP/ BF
07/2019	Appendix C-1 p. C-3	ICD 10 diagnosis code Z23.0 was added as a reportable diagnosis with the applicable vaccine administration code. • May report diagnosis code Z00.121 or Z00.129 or Z23.0 with each of the vaccine administration codes ONLY when vaccines are administered during EPSDT preventive health visits for members through age 17 years. • May report diagnosis code Z00.00 or Z00.01 or Z23.0 with the applicable vaccine administration code ONLY when vaccines are administered during EPSDT preventive health visits for members age 15 years through 20 years	A	DCH
07/2019	Appendix C-2 p. C-6 p. C-8	90734 – revised long description. <u>Revised description:</u> Meningococcal conjugate vaccine, serogroups A, C, W, Y, quadrivalent, diptheria toxoid carrier, (MenACWY-D) or CRM197 carrier (MenACWY-CRM), for intramuscular use	M	American Medical Association (AMA) – Jan. 1, 2019 released to AMA website Eff. July 1, 2019 Updated 12/19/18 CPT – Publication CPT® 2020

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2019 Policy Revisions Record

Part II Policies and Procedures Manual for EPSDT (Health Check) Services

REVISION DATE	SECTION & PAGE	REVISION DESCRIPTION	REVISION TYPE A = Added D = Deleted M = Modified	CITATION (Revision required by Regulation, Legislation, etc.)
04/2019	902, p. IX-1	Notification – effective July 1, 2019 DCH will adopt the updated 2019 AAP Bright Futures Periodicity Schedule	M	AAP/ BF
04/2019	905, p. IX-37-41	2019 CDC Immunization Schedules posted	A	CDC/ACIP
04/2019	1003, p. X-3-6 #6-10	Clarifications – (1) the appropriate ICD-10 diagnosis code may be either preventive or non-preventive; (2) the examples of the ICD-10 diagnosis codes listed are preventive	M	DCH
04/2019	Appendix H p. H-15	Pharmacy – updated Peach State Health Plan PBM US Script to PBM Envolve Pharmacy Solutions	M	DCH
04/2019	Appendix Q	2019 AAP Bright Futures Periodicity Schedule - summary of changes	A	AAP/ BF
04/2019	Appendix T	2019 CDC Immunization Schedules – summary of changes	A	CDC/ACIP
01/2019	Appendix C-2	90713 – added Poliovirus (IPV) added for high risk members, ages 19-20 yrs	A	DCH
01/2019	Appendix C-2	90630 – removed Influenza virus vaccine, quadrivalent (IIV4), no preservative, for intradermal use	D	CDC/DCH
01/2019	Appendix C-2	90672 - added Influenza virus vaccine (FluMist), quadrivalent, live (LAIV4), for intranasal use (≥2 years)	A	CDC
01/2019	Appendix	Performance Measures Appendix– removed	D	DCH

APPENDIX P

2020 Policy Revisions Record

Part II Policies and Procedures Manual for EPSDT (Health Check) Services

Rev. 01/21

REVISION DATE	SECTION & PAGE	REVISION DESCRIPTION	REVISION TYPE A = Added D = Deleted M = Modified	CITATION (Revision required by Regulation, Legislation, etc.)
10/2020	Appendix C-2, p. C-7	CPT 90656 influenza virus vaccine, trivalent (IIV3) – deleted from vaccines for ages 19-20 years	D	DCH/ CDC/ CMS
07/2020	Appendix S	Clarifications that rates are for Medicaid-eligible and PeachCare for Kids-eligible members.	M	DCH
04/2020	905.4. p. IX-36	New 11th Grade Immunization Requirement – booster dose of meningococcal conjugate vaccine required for new entrants or transfers into a GA school in the eleventh grade for 2020-21 academic school year	A	DPH
04/2020	905, p. IX-37-41	2020 CDC Immunization Schedules posted	A	CDC/ACIP
04/2020	Appendix A	Risk Factors Assessment Questionnaire revised	M	DPH
04/2020	Appendix R	2020 Immunization Schedules Changes & Guidance	A	CDC/ACIP
04/2020	Appendix S	EPSDT Health Check Reimbursement Rates	A	DCH
01/2020	1003, p. X-7 & 8 # 19	Incontinence Supplies: *Minimim age revised to 2 years.* Incontinence supplies are covered for children ages 2 through 21 years of age who have an underlying medical condition that prevents control of the bowels or bladder.	M	CMS
01/2020	Appendix A, p. A-1	Clarification made to requirements for Blood Lead Risk Assessment – Current Language: the questionnaire should be administered at 6, 9, and 18 months, and 3, 4, 5, 6 years of age.	M	DCH
01/2020	Appendix C-1 p. C-3	Correction: ICD 10 diagnosis code Z23 was inadvertently listed as Z23.0	M	DCH

2019 Recommendations for Preventive Pediatric Health Care

(Copyright © 2019 by the AAP, updated March 2019)

The Division will adopt the AAP 2019 Bright Futures "Recommendations for Pediatric Health Care" Periodicity Schedule effective date July1, 2019.

The schedule is available at https://www.aap.org/en-us/Documents/periodicity_schedule.pdf

The changes implemented in the 2019 schedule include the following footnote revisions. The following is a summary of changes:

BLOOD PRESSURE

- Footnote 6 has been updated to read as follows: "Screening should occur per 'Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents.' Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years."

ANEMIA

- Footnote 24 has been updated to read as follows: "Perform risk assessment or screening, as appropriate, per recommendations in the current edition of the AAP *Pediatric Nutrition: Policy of the American Academy of Pediatrics* (Iron chapter)."

LEAD

- Footnote 25 has been updated to read as follows: "For children at risk of lead exposure, see 'Prevention of Childhood Lead Toxicity' and 'Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention'."

2017 Recommendations for Preventive Pediatric Health Care

(Copyright © 2017 by the AAP, updated February 2017)

The Division adopted the AAP 2017 Bright Futures "Recommendations for Pediatric Health Care" Periodicity Schedule effective date July1, 2017.

The schedule is available at https://www.aap.org/en-us/documents/periodicity_schedule.pdf

The changes implemented in the 2017 schedule include numerous footnote revisions. The following is a summary of changes:

HEARING

- Timing and follow-up of the screening recommendations for hearing during the infancy visits have been delineated. Adolescent risk assessment has changed to screening once during each time period.
- Footnote 8 has been updated to read as follows: "Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per 'Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs' http://pediatrics.aappublications.org/content/120/4/898.full
- Footnote 9 has been added to read as follows: "Verify results as soon as possible, and follow up, as appropriate."
- Footnote 10 has been added to read as follows: "Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See 'The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies' http://www.jahonline.org/article/S1054-139X(16)00048-3/fulltext

PSYCHOSOCIAL/BEHAVIORAL ASSESSMENT

- Footnote 13 has been added to read as follows: "This assessment should be family centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health. See 'Promoting Optimal Development: Screening for Behavioral and Emotional Problems' (http://pediatrics.aappublications.org/content/135/2/384) and 'Poverty and Child Health in the United States' (http://pediatrics.aappublications.org/content/137/4/e20160339)."

TOBACCO, ALCOHOL, OR DRUG USE ASSESSMENT

- The header was updated to be consistent with recommendations

DEPRESSION SCREENING

- Adolescent depression screening begins routinely at 12 years of age (to be consistent with recommendations of the US Preventive Services Task Force [USPSTF].

MATERNAL DEPRESSION SCREENING

- Screening for maternal depression at 1-, 2-, 4-, and 6-month visits has been added.
- Footnote 16 was added to read as follows: "Screening should occur per 'Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice' (http://pediatrics.aappublications.org/content/126/5/1032)."

NEWBORN BLOOD

- Timing and follow-up of the newborn blood screening recommendations have been delineated.
- Footnote 19 has been updated to read as follows: "Confirm initial screen was accomplished, verify results, and follow up, as appropriate. The Recommended Uniform Newborn Screening Panel https://www.hrsa.gov/advisory-committees/heritable-disorders/rusp/index.html, as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (http://genes-r-us.uthscsa.edu/sites/genes-r-us/files/nbsdisorders.pdf) establish the criteria for and coverage of newborn screening procedures and programs."
- Footnote 20 has been added to read as follows: "Verify results as soon as possible, and follow up, as appropriate."

NEWBORN BILIRUBIN

- Screening for bilirubin concentration at the newborn visit has been added.
- Footnote 21 has been added to read as follows: "Confirm initial screening was accomplished, verify results, and follow up, as appropriate. See 'Hyperbilirubinemia in the Newborn Infant ≥35 Weeks' Gestation: An Update with Clarifications' (http://pediatrics.aappublications.org/content/124/4/1193)."

DYSLIPIDEMIA

- Screening for dyslipidemia has been updated to occur once between 9 and 11 years of age, and once between 17 and 21 years of age (to be consistent with guidelines of the National Heart, Lung, and Blood Institute).

SEXUALLY TRANSMITTED INFECTIONS

- Footnote 29 has been updated to read as follows: "Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the AAP Red Book: Report of the Committee on Infectious Diseases."

HIV

- A subheading has been added for the HIV universal recommendation to avoid confusion with STIs selective screening recommendation.
- Screening for HIV has been updated to occur once between 15 and 18 years of age (to be consistent with recommendations of the USPSTF).
- Footnote 30 has been added to read as follows: "Adolescents should be screened for HIV according to the USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspshivi.htm) once between the ages of 15 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually."

ORAL HEALTH

- Assessing for a dental home has been updated to occur at the 12-month and 18-month through 6-year visits. A subheading has been added for fluoride supplementation, with a recommendation from the 6-month through 12-month and 18-month through 16-year visits.
- Footnote 32 has been updated to read as follows: "Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment https://www.aap.org/en-us/Documents/oralhealth_RiskAssessmentTool.pdf and refer to a dental home. Recommend brushing with fluoride toothpaste in the proper dosage for age. See 'Maintaining and Improving the Oral Health of Young Children' (http://pediatrics.aappublications.org/content/134/6/1224
- Footnote 33 has been updated to read as follows: "Perform a risk assessment (http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf). See 'Maintaining and Improving the Oral Health of Young Children' (http://pediatrics.aappublications.org/content/134/6/1224)."
- Footnote 35 has been added to read as follows: "If primary water source is deficient in fluoride, consider oral fluoride supplementation. See 'Fluoride Use in Caries Prevention in the Primary Care Setting' (http://pediatrics.aappublications.org/content/134/3/626)."

2020 Immunization Schedules Changes & Guidance

Child Immunization Schedule Changes for 2020

https://www.cdc.gov/vaccines/schedules/hcp/schedule-changes.html

Haemophilus influenza type b vaccination

The **Hib** note was revised to indicate that catch-up vaccination is not recommended for previously unvaccinated children 5 years (60 months) or older who are not at high risk.

Hepatitis A vaccination

The **HepA** note was revised to include the recommendation that all children and adolescents 2 through 18 years of age who have not previously received hepatitis A vaccine should receive catch-up vaccination and complete a 2-dose series.

Hepatitis B vaccination

The "special situations" section of the **HepB** note contains information regarding populations for whom revaccination may be recommended.

Meningococal ACWY vaccination

Guidance regarding adolescent vaccination for children who received **MenACWY** prior to age 10 years has been added to the MenACWY note.

Meningococcal B vaccination

MenB booster doses are now recommended for persons aged ≥10 years with complement deficiency, those who use complement inhibitors, persons with asplenia, persons who are microbiologists, and persons determined by public health officials to be at increased risk during an outbreak. The MenB note has been updated to include a link to the detailed recommendations.

Poliovirus vaccination

Within the **poliovirus vaccination** note, detailed information has been added regarding which OPV doses may be counted toward the U.S. vaccination requirements.

Tdap vaccination

The **Tdap** note has been updated to allow either Td or Tdap, as an option for decennial tetanus booster doses and catch-up series doses in persons who have previously received Tdap. Additionally, the note has been edited to reflect recent updates to the clinical guidance for children 7 through 18 years of age who received doses of Tdap or DTaP at age 7 through 10 years. A dose of Tdap or DTaP administered at 10 years of age may now be counted as the adolescent Tdap booster. A dose of Tdap or DTaP administered at 7 through 9 years of age should not be counted as the adolescent dose, and Tdap should be administered at 11–12 years of age. The DTaP note has been updated to note that dose 5 is not necessary if dose 4 was administered at age 4 years or older AND at least 6 months after dose 3.

2020 Immunization Schedules Changes & Guidance

Adult Immunization Schedule Changes for 2020

https://www.cdc.gov/vaccines/schedules/hcp/schedule-changes.html

- In Table 1 the number of columns for age ranges has been reduced from five to four as the columns for ages 19-21 years and 22-26 years have been combined. This is due to the change made to recommended catch-up HPV vaccination for all adults through age 26 years.
- A blue color box has been added to the schedule, including a blue footnote key. These indicate that shared clinical decision-making is recommended regarding vaccination. This impacts HPV, pneumococcal conjugate vaccine (PCV13), and meningococcal rows.

Hepatitis A vaccination

The **HepA** note was revised to include minor changes to the chronic liver disease definition, minor changes for the pregnancy indication, addition of the recommendation for vaccination in settings of exposure, and removal of clotting factor disorders as an indication for HepA vaccination.

Hepatitis B vaccination

The **HepB** note was revised to include minor changes to the chronic liver disease definition and minor changes for the pregnancy indication.

Human papillomavirus vaccination

The **HPV** note was revised to indicate that HPV vaccination is recommended for all persons through age 26 years. A shared clinical decision-making subsection was added for persons 27-45 years.

Influenza vaccination

The **influenza** note has been updated to include a bulleted list indicating when LAIV should not be used and minor edits to the guidance for persons with a history of Guillain-Barré syndrome.

Measles, mumps, and rubella vaccination

The MMR note was revised to clarify recommendations for health care personnel, with a separate bullet for personnel born in 1957 or later with no evidence of immunity and for health care personnel born before 1957 with no evidence of immunity.

Meningococcal vaccination

The MenB note was revised to include the use of the complement inhibitor ravulizumab as a special situation for MenB administration. A shared clinical decision-making subsection was added that includes a bullet for adolescents and young adults age 16-23 years not at increased risk for meningococcal disease. Under the "Special situations" subsection, the recommendation was added to administer a booster dose of MenB 1 year after the primary series and revaccinate every 2-3 years if the risk remains.

Pneumococcal vaccination

The pneumococcal note has been updated to indicate the updated recommendations for vaccination of immunocompetent (defined in discussion as adults without an immunocompromising condition, CSF leak, or cochlear implants) adults 65 years and older. One dose of PPSV23 is still recommended. Shared clinical decision-making is recommended regarding administration of PCV13 to immunocompetent persons 65 years and older.

Tdap vaccination

The tetanus, diphtheria, and pertussis note has been updated to indicate that Td or Tdap may be used in situations where only Td vaccine is indicated for the decennial tetanus, diphtheria, and pertussis booster vaccination, tetanus prophylaxis for wound management, and catch-up vaccination.

Varicella vaccination

The **varicella** note has been updated to indicate that vaccination may be considered for persons with HIV without evidence of varicella immunity who have CD4 counts ≥200 cells/µL.

EPSDT Health Check Program (COS 600) Reimbursement Rates for Medicaid-Eligible Members & PeachCare for Kids® (PCK)-Eligible Members

Physicians and physician extenders (physician assistants, nurse practitioners) are reimbursed at 100% of the established rates when billing the specified codes and modifiers for Health Check services rendered to Medicaid-eligible members and PCK-eligible members.

Physicians and physician extenders who are eligible for the House Bill (HB) Primary Care Providers (PCP) rate increases are reimbursed 100% of the established rates, when billing the specified codes and modifiers for Health Check services rendered to Medicaid-eligible and PCK-eligible members.

Rev. 04/20
Rev. 07/20

PCP Rate Increase	Fiscal Year	Effective Date
HB 76	FY 2016	eff. July 1, 2015
HB 751	FY 2017	eff. July 1, 2016
HB 44	FY 2018	eff. July 1, 2017

Preventive Visit Codes	HIPAA Modifiers	Rates for Non-Attested Providers	HB 76 (eff. July 1, 2015)	HB 751 (eff. July 1, 2016)	HB 44 (eff. July 1, 2017)
99381	EP EP HA EP 25 EP HA 25	$67.38[1]		$106.68	
99391			$86.47	$96.08	
99382					$111.27
99392			$92.46	$102.74	
99383 (age 5-7 years)	EP EP 25	$67.38[1]			$116.19
99393 (age 5-7 years)			$92.17	$102.41	
99383 (age 8-11 years)	EP EP 25	$75.38 - private $55.38 – public health			$116.19
99393 (age 8-11 years)			$92.17	$102.41	
99384	EP EP 25	$75.38 - private $55.38 – public health			$131.62
99394			$101.03	$112.25	
99385	EP EP 25	$75.38 - private $55.38 – public health			$127.75
99395			$103.24	$114.71	
[1]This applies to non-attested private and public health providers.					
When reporting the preventive visit codes with EP, EP 25, EP HA, EP HA 25 modifier(s), reimbursement is at 100% for physicians and mid-level providers (physician assistants, nurse practitioners).					

EPSDT Health Check Program (COS 600) Reimbursement Rates for Medicaid-Eligible Members & PeachCare for Kids® (PCK)-Eligible Members

Interperiodic Visit Codes & Modifiers (EP, EP 25)	Rates for Non-Attested Providers		HB 76 (eff. July 1, 2015)	HB 751 (eff. July 1, 2016)	HB 44 (eff. July 1, 2017)
	Medicaid-eligible members	PCK-eligible members			
99201[4] deleted eff. 1-1-2021	$35.13	$41.20			$41.30[1]
99202	$54.57	$71.16		$71.33 [1]	
99203	$76.33	$103.01		$103.80 [1]	
99211	$17.46	$17.46			$18.97 [2] $19.79 [3]
99212	$29.67	$41.54		$41.63 [1]	
99213	$40.70	$69.11	$63.14 [2]	$70.15 [1]	
99214	$62.71	$102.49		$103.72 [1]	

[1]This rate increase applies to Medicaid-eligible members and PeachCare for Kids®-eligible members.
[2]This rate increase does not apply to PeachCare for Kids®-eligible members.
[3]This rate increase does not apply to Medicaid-eligible members.
[4]CPT code 99201 deleted effective 1-1-2021

When reporting the interperiodic visit codes with EP, EP 25 modifier(s), reimbursement is at 100% for physicians and mid-level providers (physician assistants, nurse practitioners)

Rev. 04/20
Rev. 07/20
Rev. 01/21

Immunization Codes & Modifier (EP)	Rates for Non-Attested Providers		HB 751 (eff. July 1, 2016)		HB 44 (eff. July 1, 2017)	
	Medicaid-eligible members	PCK-eligible members	Medicaid-eligible members	PCK-eligible members	Medicaid-eligible members	PCK-eligible members
90460	$10.00	$18.50	$21.93	$21.93		
90471	$10.00	$18.50	$23.54	$23.54		
90472	$10.00	$18.50	$11.98	$18.50		
90473	$10.00	$18.50			$23.54	$23.54
90474	$10.00	$18.50			$11.98	$18.50

When reporting the immunization codes with EP modifier, reimbursement is at 100% for physicians and mid-level providers (physician assistants, nurse practitioners)