

EPSDT Periodicity Guidelines

UPMC *for You*

General guidelines

In order for providers to receive payments in full, they should follow the guidelines below:

- Providers are allowed to perform EPSDT services during a sick visit; however, providers cannot bill a sick visit and an EPSDT visit with the same date of service. Therefore, providers may only bill for the sick visit or EPSDT visit.
- The provider must bill within 90 days from the date of service for all original claims as well as resubmissions and corrected claims.
- Providers may use the CMS-1500 form or electronic 837 form to submit EPSDT claims. UPMC *for You* will deny UB claims and require a resubmission in a CMS-1500 or electronic 837 form.
- All EPSDT claims must be billed with one of the appropriate CPT codes (99460 or 99463 [inpatient setting], or 99381 – 99385, or 99391 – 99395) with an EP modifier and any other required modifiers. Refer to the UPMC *for You* periodicity table to identify the appropriate code for each EPSDT age group.
 - Assessment code 99460 and modifier EP are to be used for newborn EPSDT screens performed in the inpatient hospital setting, but not on the same day as hospital discharge.
 - Assessment code 99463 and modifier EP are to be used for newborn EPSDT screens performed in the inpatient hospital setting on the same day as the hospital discharge.
- The ICD diagnosis code must be Z76.1, Z76.2, Z00.121, or Z00.129.
 - For newborn EPSDT screenings performed in the inpatient setting, providers should bill the Place of Service 21 accordingly, with the diagnosis code Z38.00, Z38.01, or Z38.2 in the primary field, AND with diagnosis code Z76.1, Z76.2, Z00.121 or Z00.129 in the secondary field.

Billing for the Autism Screening

- The Autism Screening is required for the 18-month and 24-month visit.
 - This screening must be billed with CPT code 96110 with a U1 modifier. The U1 modifier distinguishes the autism Screening from the Developmental Screening.
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- The appropriate services associated with the EPSDT screening must be rendered and the codes for these services included in the claim with an EP modifier accompanying each code. Refer to the UPMC *for You* periodicity table to identify the appropriate services for each EPSDT age group. Modifiers must be used as appropriate.
 - The EP modifier must be included on the claim lines for all EPSDT services.
 - Children ages 4 and older must complete a hearing test; however, they only require one of the hearing tests on the periodicity schedule. The provider may perform the Audio Screen (92551 and EP modifier) or the Pure Tone-Air Only screen (92552 and EP modifier).
 - The age requirements for each age group must be followed for required services per the UPMC *for You* periodicity schedule. The following page shows examples of how a claim should be billed in order to receive payment in full.

Providers are responsible for the appropriate billing of services.

Example: For a 9-11 Month Periodicity Service:

- The claim must have a CPT code of 99381 or 99391 with an EP modifier.
- The claim must have a diagnosis code of Z76.1, Z76.2, Z00.121, or Z00.129.
- The child must be between 261 and 365 days old.
- The following services must be fully rendered and as a claim item:
 - Developmental Screening (CPT code 96110 and EP modifier)
 - The provider should use a standardized tool, such as the Denver Developmental Screening Test, when assessing and billing for developmental delays.
 - DHS requires children with developmental delays to be referred to CONNECT at 1-800-692-7288. The referral should be documented in the medical record and communicated to UPMC *for You*.
 - Anemia — Hematocrit (CPT code 85013 and EP modifier) or Hemoglobin (CPT code 85018 and EP modifier)
 - Lead Test (CPT code 83655 and EP modifier)
- The 52 and 90 modifiers must be used appropriately in order for the claim to be paid in full.

Example: For a 10-Year Periodicity Service:

- The claim must have a CPT code of 99383 or 99393 code with an EP modifier.
- The claim must have a diagnosis code of Z76.1, Z76.2, Z00.121, or Z00.129.
- The child must be between 3,469 and 3,833 days old (between 9 years 6 months old and 10 years 6 months old).
- The following services must be fully rendered and as a claim item:
 - Visual Acuity Screen (CPT code 99173 and EP modifier)
 - Audio Screen (CPT code 92551 and EP modifier) or the Pure Tone-Air Only (CPT code 92552 and EP modifier)
 - Dental Referral (referral code YD in box 10D)
- The 52 and 90 modifiers must be used appropriately in order for the claim to be paid in full.

Modifiers and referral codes

The YD referral code:

- The YD referral code is a referral to the dental home. Per the Pennsylvania MA Bulletin, the provider must notify the MCO about the dental referral via telephone or fax form. The EPSDT Department can be reached by phone at 1-800-286-4242. A fax form has been provided with the training packet.
- The YD referral code is to be placed in box 10D of HCFA or 837 file when needed, per the UPMC *for You* periodicity schedule.
- In order to fulfill the requirements necessary for billing a YD referral code, providers should assess the need for fluoride supplementation and determine whether the patient has a dental home. If the patient does not have a dental home, a referral should be made to one.

Any discussion, referrals, and risk assessments performed should be documented in the medical record. Absence of the YD referral code during any required screening period will indicate an incomplete EPSDT screen.

Please note: All EPSDT dental referrals must be communicated to UPMC *for You* via a telephone call or fax form. A fax form is provided for your convenience.

All referral codes (box 10D of the HCFA or 837 file)

- YM** – Medical Referral
- YD** – Dental Referral
- YV** – Vision Referral
- YH** – Hearing Referral
- YB** – Behavioral Health Referral
- YO** – Other Referral

The 52 modifier:

- The 52 modifier is a CPT modifier to be used if an EPSDT screening service or component of a service was not completed.
- For services that can be completed, but a 52 modifier was used, the provider must complete the service at the next screening opportunity.
- All services billed with a 52 modifier must be noted in the medical record.

The 90 modifier:

- CPT modifier 90 is used to identify when laboratory procedures are performed by a party other than the treating or reporting physician (for example, an outside lab).
- The 90 modifier is used in conjunction with a CPT code.

Payment structure

- To be paid in full for an EPSDT screening, each service with a code listed on the UPMC *for You* periodicity schedule must be completed for the age appropriate EPSDT age group. Please refer to the UPMC *for You* periodicity schedule. In addition, the EP modifier, ICD diagnosis code, and assessment code must be present. The 52 modifier must be used where appropriate.
- If all coding is correct per the appropriate EPSDT age group, refer to the UPMC *for You* periodicity schedule, then the EPSDT screening will be paid in full.
- If any of the required codes (for example, EP modifier, ICD diagnosis code, any additional services, etc.) are not included, the service will be paid at a reduced rate of an office visit.
- For any “incomplete” EPSDT claim that is submitted later with the same date of service as the original claim with correct billing, the payment received will be the difference between the EPSDT rate and amount paid on the original claim (the office visit).
- For any “incomplete” EPSDT claim that is submitted with a different date of service from the original claim with correct billing, the payment will be the difference between the EPSDT rate and amount paid on the original claim (the office visit).
 - This is only applicable if the second date of service falls within the same EPSDT age group per the UPMC *for You* periodicity schedule.
 - Example: If a child received a service for his or her 9-year EPSDT screen at age 3,200 days and a completed claim is resubmitted for a service at the child’s 3,400th day, then the claim is within the same EPSDT age group.
 - If the date of service falls in the next EPSDT age group per the UPMC *for You* periodicity schedule and age breakdown, the claim must meet the required services for the new age.
 - Using the same example as above: If a child received a service for his or her 9-year EPSDT screen at age 3,200 days and a completed claim is resubmitted for a service at the child’s 3,600th day, then the claim is not within the same EPSDT age group. Therefore, the appropriate services must be completed for the EPSDT screen of 10 years.
- If a claim is submitted with the wrong assessment code, per the UPMC *for You* periodicity schedule, the claim will deny and require a resubmission of the claim with the correct assessment code.

Complex case management

Arranging for medically necessary follow-up care for health care services is an integral part of the provider’s continuing care responsibility after a screening or any other health care contact. In cases involving a member under the age of 21 with complex medical needs or serious or multiple disabilities or illnesses, case management services must be offered, consistent with MA Bulletin #1239-94-01 regarding “Medical Assistance Case Management Services for Recipients Under the Age of 21.”

Medical record documentation

All services required as part of the EPSDT screen must be noted in the child’s medical record. The services submitted on the EPSDT claim must be reflected in the medical record for that child.

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