	Reimbursement Policy	
Subject: Early and Periodic Screening, Diagnosis and Treatment		
Effective Date: **05/01/20**	Committee Approval Obtained: **12/16/20**	Section: **Prevention**
*****The most current version of our reimbursement policies can be found on our provider website. If you are using a printed version of this policy, please verify the information by going to **https://providers.healthybluela.com**.*****		
These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement by Healthy Blue if the service is covered by a member's Healthy Louisiana benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with CPT® codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities. If appropriate coding/billing guidelines or current reimbursement policies are not followed, Healthy Blue may: • Reject or deny the claim. • Recover and/or recoup claim payment. Healthy Blue reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Healthy Blue strives to minimize these variations. Healthy Blue reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to this site.		
Policy	Healthy Blue allows reimbursement of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program services unless provider, state, federal or CMS contracts and/or requirements indicate otherwise. Reimbursement is based on the applicable fee schedule or contracted/negotiated rate. The following EPSDT component services are included in the reimbursement of the preventive medicine Evaluation and Management (E&M) visit unless they are appended with Modifier 25 to indicate a	

	significant, separately identifiable E&M service by the same physician on the same date of service:
	• Comprehensive health history
	• Comprehensive unclothed physical examination
	• Health education
	• Nutritional assessment
	• Dental screening
	
	The following component services are separately reimbursable from the preventive medicine E&M visit:
	• Developmental screening using a standardized screening tool
	• Immunization and administration
	• Vision screening
	• Hearing screening services
	• Laboratory tests:
	  o Newborn metabolic screening test
	  o Tuberculosis test
	  o Hematocrit and hemoglobin tests
	  o Lead toxicity screening
	  o Cholesterol test
	  o Pap smear for sexually active members (only in certain clinical scenarios when medically indicated in the members' medical record for members under the age of 21)
	  o Sexually transmitted disease (STD) screening for sexually active members
	  o Urinalysis
	
	Providers are required to follow a periodicity schedule equal to or greater than the schedule referenced in Appendix A of the Medicaid Professional Services Manual. If a provider performs EPSDT services in conjunction with a sick visit, all services are subject to Preventive Medicine and Sick Visits on Same Day policy of Healthy Blue.
	
	Claims Requirements
	Provider claims for EPSDT services should include all of the following items:
	• EPSDT Special Program Indicator
	• EPSDT Referral Indicator Codes (also known as Referral Condition Codes) — if applicable
	• Appropriate diagnosis code(s)
	• Appropriate HCPCS code identifying the completed EPSDT service (list in addition to code for appropriate E&M service)
	• Appropriate E&M code(s) for new or established members
	• Appropriate procedure code for the component services
	• Modifier EP (used with vision screening code)

History	• Biennial review approved **12/16/20**

	• Biennial review approved **12/21/18** effective **05/01/20**: Policy language updated to include vision and hearing screenings as separately reimbursable • Effective **01/01/17**: Policy language updated due to regulatory directive (committee approval not required in accordance with Reimbursement Policy Program Guidelines) • Effective **09/01/17**: Policy template updated • Biennial review approved **06/06/16**: Policy language updated • Biennial review approved and effective **11/18/13**: Policy language updated • Review approved and effective **10/08/12**: Policy language updated • Biennial review approved **12/05/11** and effective **03/16/12**: Policy language updated • Initial review approved and effective **08/09/06**
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State Medicaid • State contracts • American Academy of Pediatrics • CDC
Definitions	• **General Reimbursement Policy Definitions**
Related Policies	• Modifier 25: Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service • Modifier Usage • Preventive Medicine and Sick Visits on the Same Day • Vaccines for Children Program
Related Materials	• None