INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

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

Note: For updates to the information in this module, see the following Indiana Health Coverage Programs (IHCP) bulletin, accessible from the IHCP Bulletins webpage at in.gov/medicaid/providers:

- *BT2025157 – MDwise to end participation as a managed care health plan for HIP and Hoosier Healthwise*

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Revision History

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7.0	Policies and procedures as of Oct. 1, 2024 Published: March 17, 2025	Scheduled update: • Edited text as needed for clarity • Updated the fluoride supplementation information for oral health in the *Required Components of EPSDT* section • Updated the *Diagnostic Services and Follow-Up Treatment* section • Updated the *Periodicity Schedule* section • Added a note regarding NPI requirement in the *EPSDT Billing Procedures* section • Added how to contact local First Steps offices in the *Children Younger Than 5 Years Old* section	FSSA and Gainwell

Version	Date	Reason for Revisions	Completed By
		• Updated the AAP journal article reference in the *Body Mass Index* section • Added information about screening for anxiety in the *Behavioral/Social/Emotional Assessment* section • Updated the *Newborn Screening* section • Updated the *Stand-Alone Vaccine Counseling* section • Updated the *Lead* section and *Required Blood Lead Tests* subsection • Updated the *HIV* section • Updated the *Preventive Fluoride Care* section • Updated the *Education Regarding Lead Poisoning for Pregnant Women and Children 6 Years Old or Younger* section • Added the *U.S. Preventive Services Task Force* section	
7.1	Policies and procedures as of Oct. 1, 2024 Published: Nov. 12, 2025	Interim update: • Added note on title page pointing to *IHCP Bulletin BT2025157*	FSSA and Gainwell

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Section 1: Program Overview

Note:	*For updates to information in this module, see IHCP Bulletins at in.gov/medicaid/providers.*

The federally mandated Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program is a preventive healthcare program designed to improve the overall health of Medicaid and Children's Health Insurance Program (CHIP) eligible individuals from birth through the month of their 21st birthday. Special emphasis is given to early detection and treatment of health issues, as these efforts can reduce the risk of more costly treatment or hospitalizations that can result when detection is delayed.

The objectives of the EPSDT program are:

- To increase the number of members who are up to date with their childhood immunizations
- To increase the number of members receiving an initial health examination
- To increase the number of members receiving a preventive care/well-visit examination
- To promote interaction between the member and provider by developing and coordinating preventive services
- To encourage members to take a more active role in managing their health

The EPSDT program consists of two mutually supportive operational components:

- Ensuring the availability and accessibility of required healthcare resources
- Helping Medicaid members and their parents or guardians effectively use these resources

The Indiana Family and Social Services Administration (FSSA) is collaborating with the Indiana Chapter of the American Academy of Pediatrics (INAAP) to develop policies and programs aimed at improving the quality of children's healthcare and children's health outcomes. See the INAAP website at inaap.org. The FSSA has elected to make Bright Futures the standard for infant, child and adolescent health supervision. See the *Bright Futures* page at aap.org.

EPSDT is a required component of Indiana Health Coverage Programs (IHCP) managed care and fee-for-service (FFS) program for members who fall within the age range for EPSDT. Specific rules about EPSDT services can be found in *Indiana Administrative Code 405 IAC 5-15*.

EPSDT Eligibility

EPSDT services are available to all IHCP members from birth through the month of the member's 21st birthday. Each eligible member will be informed about the program by the IHCP in accordance with federal regulations. Participation in EPSDT by IHCP members is voluntary.

It is important to understand the program in which the member is enrolled and follow that program's procedures for billing. Additional information about IHCP programs can be found in the *Member Eligibility and Benefit Coverage* module and on the *IHCP Programs and Services* page at in.gov/medicaid/providers.

The state of Indiana ensures that required services will be provided to qualified individuals recognized as part of a Tribal Nation. The methods and standards for payment are consistent with the current program – not less than one of the following:

- The federal Medicare reimbursement rate for the services provided
- A rate of 130% of the Medicaid reimbursement rate for a service that does not have a Medicare reimbursement rate

Providers may choose to offer EPSDT screenings to only those IHCP patients assigned to their practice or currently being seen in their office. There is no requirement that an IHCP provider accept new patients.

Managed Care Members

Members enrolled in Healthy Indiana Plan (HIP), Hoosier Care Connect or Hoosier Healthwise have a designated health plan and primary medical provider (PMP). The PMP is expected to personally provide or authorize most primary and preventive care services, including EPSDT services.

The FSSA has contracted with the following managed care entities (MCEs) to manage the care of eligible members and ultimately improve their quality of care and health outcomes:

- Anthem: anthem.com
- CareSource Indiana: caresource.com
- Managed Health Services (MHS): mhsindiana.com
- MDwise: mdwise.org
- UnitedHealthcare: UHCprovider.com/INcommunityplan

> *Note: Effective Jan. 1, 2026, MDwise is no longer participating as an IHCP MCE.*

Providers rendering services to members enrolled in a managed care program must refer to the member's MCE for any additional policies specific to that network. For a complete list of contact information, see the *IHCP Quick Reference Guide* available at in.gov/medicaid/providers.

Fee-for-Service Members

IHCP members not enrolled in a managed care program are covered under an FFS program, such as Traditional Medicaid. EPSDT services are covered for FFS members under age 21.

EPSDT-eligible members covered under the FFS delivery system may receive EPSDT screenings from any provider that is enrolled in the IHCP, licensed to perform an unclothed physical exam and providing the components listed in the *Required Components of EPSDT* section of this document.

Required Components of EPSDT

Ensuring that all children in the IHCP receive age-appropriate, comprehensive preventive services is the primary goal of the EPSDT program. Components of the screenings and the recommended frequency of the screenings are listed in the Bright Futures/American Academy of Pediatrics (AAP) *Recommendations for Preventive Pediatric Health Care* (periodicity schedule) at aap.org.

The coverage of EPSDT services and benefits is mandatory for all individuals under age 21 who are eligible for Medicaid. Physicians are accountable for making these services available to all Medicaid-eligible patients; however, members may choose not to participate.

> *Note: According to 405 IAC 5-15-2, a screening, or any portion of a screening, is not required when medical contraindications are documented.*

To provide quality assurance for members who participate in the EPSDT program, and to claim a higher level of reimbursement for EPSDT services, the following components must be provided and documented:

- Comprehensive health and developmental history, including assessment of physical and mental health development
- Physical examination

A comprehensive unclothed physical exam is required at each EPSDT visit. Guidelines for evaluating the general physical and mental health status for infants, children and youth up to 21 years of age are described in *Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents*. For more information, check out the *Bright Futures Guidelines and Pocket Guide* page at aap.org.

- Measurements

  Measurements of length/height and weight are made at each EPSDT visit. Head circumference is measured at each visit through 24 months, while weight for length is measured at each visit through 18 months. Blood pressure is measured, beginning at age 3 years, or earlier if risk assessment determines it needed. Providers should calculate and plot body mass index (BMI) beginning at age 2.

- Developmental/social/behavioral/mental health:

  The following assessments and screenings are required at EPDST visits:
  - *Developmental screening* (the use of standardized tools to identify and refine the risk of developmental delays) should be administered regularly during the 9-month, 18-month and 30-month visits. The detection of developmental delays is an integral component of well-child care.
  - *Developmental surveillance* (the process of recognizing children who may be at risk of developmental delays) should be incorporated into every EPSDT visit, except for the 9-month, 18-month and 30-month visits.
  - *Autism spectrum disorder screening* (using standardized screening tools) can be administered at the 18-month and 24-month visits or anytime that surveillance (medical history of developmental risk factors, parental/caregiver concern) identifies a need.
  - *Behavioral/social/emotional screening* is required at each EPDST visit. This screening should be family centered and may include an assessment of child's social-emotional health, caregiver depression and social determinants of health.
  - *Tobacco, alcohol or drug use assessment* (verbal assessment) should be completed at each annual EPSDT visit beginning at the 11-year visit.
  - *Depression and suicide risk screening* (using standard questionnaire or other tool) should be administered at each annual EPSDT visit, beginning at the 12-year visit.
  - *Maternal depression screening* of the mother should be done at the child's 1-, 2-, 4- and 6-month EPSDT visit.

- Sensory screening
  - Vision assessment or screening is required at each EPSDT visit. Assessment or screening is dependent on the age of child at the visit. Any screening that was not done due to a previous missed appointment should be done in lieu of an assessment. (The objective screening is not separately billable.) Direct referral to an optometrist or ophthalmologist is required when objective screening methods indicate a referral is warranted.
  - Hearing assessment or screening is required at each EPSDT visit. Any screening that was not done due to a previous missed appointment should be done in lieu of an assessment.

- Administration of or referral to any laboratory tests, procedures or immunizations appropriate for age and risk factors at corresponding EPSDT visit

- Oral Health
  - An oral health risk assessment, including oral observation and examination, is required at the 6-month and 9-month EPSDT visit. If the patient does not have an established dental home at the 12-month visit, continue performing an oral health risk assessment and referral to a dental provider at the 12-month and subsequent visits, when indicated.
  - Recommend brushing with fluoride toothpaste in the proper dosage for the individual's age.

- It is recommended that fluoride varnish be applied to the primary teeth of all infants and children, starting at the age of primary tooth eruption, with subsequent applications every three to six months based on risk assessment. Additionally, risk assessments for oral fluoride supplementation should begin at the 6-month visit.

- Anticipatory guidance/health education

  Patient health education is a required component of EPSDT services and should include documented and appropriate anticipatory guidance. Education and guidance should be conveyed to parents or guardians and children, and designed to assist in understanding what to expect in terms of the child's development, healthy lifestyle choices, and accident and disease prevention. At the outset, the physical and dental screenings provide the initial context for providing health education.

Diagnostic Services and Follow-Up Treatment

Providers must assist in setting appointments on behalf of EPSDT participants who need diagnostic services or follow-up treatment when indicated as a result of a screening. These additional services may require PMP authorization when performed by a provider other than the member's PMP.

Any enrolled IHCP provider may provide EPSDT diagnostic and/or treatment services, within their scope of practice, upon referral from the screening provider. If assistance is needed to locate a specialist enrolled in the IHCP for referral purposes, contact the member's MCE. For members who do not have an MCE, providers can use the IHCP Provider Locator search tool, accessible from the homepage at in.gov/medicaid/providers.

Any treatment found necessary as a result of a diagnosis pursuant to an initial or periodic screening may be provided, subject to any prior authorization requirements for the service. If a service is not covered under the Indiana Medicaid State Plan, it is still available to EPSDT members, subject to prior authorization requirements of *405 IAC 5-4*, if it is necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.

Providers performing screening or treatment services as a result of an EPSDT screening referral shall be subject to the same limitations for such services.

Periodicity Schedule

Every child and family is unique; therefore, the Bright Futures/AAP periodicity schedule at aap.org has been designed as a preventive healthcare plan for children with the absence of any significant health problems and who are growing and developing in satisfactory fashion. This schedule can be adjusted to meet the healthcare needs of specific patients.

The periodicity schedule is meant to be a guide for providers participating in the EPSDT program. This program emphasizes the importance of early and periodic screening for specific conditions and the need for continued diagnosis and treatment of conditions and symptoms identified by practicing professionals through the use of this schedule.

The periodicity schedule provides recommendations of EPSDT services to be provided during infancy, early childhood, middle childhood and adolescence. 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.

Section 2: Billing and Reimbursement for EPSDT Services

Providers must furnish all components of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) examination in accordance with the Bright Futures/American Academy of Pediatrics (AAP) periodicity schedule at aap.org, document services performed or referred, and include all applicable diagnosis codes for each EPSDT screening exam on the appropriate medical claim form or electronic transaction.

To ensure adherence to EPSDT requirements, the Indiana Health Coverage Programs (IHCP) monitors the following:

- Timely screening as recommended by the Bright Futures/AAP periodicity schedule includes:
  - Timely administration of immunizations
  - Hematocrit/hemoglobin testing
  - Blood lead testing
  - Urinalysis
  - Audiometric testing
- Follow-up treatment for diagnosed conditions

EPSDT Billing Procedures

EPSDT services are billed on the professional claim – 837P transaction or IHCP Provider Healthcare Portal (IHCP Portal) professional claim if submitted electronically, or the *CMS-1500* claim form if submitted on paper. Indiana does not require providers to bill EPSDT screenings on a separate EPSDT medical claim form. See the *Claim Submission and Processing* module for directions for fee-for-service claim submission. For managed care claims, follow the claim-submission procedures of the managed care entity (MCE) to which the member is assigned.

The following billing procedures must be followed for every EPSDT claim, to permit correct and prompt reimbursement:

- Providers must use the ICD-10 diagnosis codes **Z00.121** – Encounter for routine child health examination with abnormal findings or **Z00.129** – Encounter for routine child health examination without abnormal findings as the primary diagnosis for EPSDT claims.

  The appropriate preventive health diagnosis code must be used as the **primary** diagnosis (the first diagnosis code entered in the diagnosis code field). Any other applicable diagnosis codes must be entered in the other positions in the diagnosis code field and cross-referenced accordingly in the diagnosis pointer field for each service detail.
- The appropriate Current Procedural Terminology (CPT®[1]) code for initial or established patient exams (see Table 1) must be included on the first detail line of the claim. For the procedure code billed, the primary diagnosis code – Z00.121 or Z00.129 – must be indicated with the diagnosis pointer.
- When patient exams are billed in conjunction with Z00.121 or Z00.129 as the primary diagnosis code, the screening components must have been provided.
- Providers are strongly encouraged to include all applicable diagnosis codes and procedure codes on the claim for each EPSDT visit.
- Providers must report a service as EPSDT by selecting the EPSDT checkbox in the *Service Details* panel of the IHCP Portal professional claim or by entering the appropriate National Uniform Claim

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Committee (NUCC) two-character referral status code in the top portion of field 24H – EPSDT/Family Plan for each applicable service detail line on the *CMS-1500* claim form.

Claims submitted using any patient exam procedure codes listed in Table 1 are billed in conjunction with Z00.121 or Z00.129 as the primary diagnosis code to identify that all EPSDT screening components have been provided. Appropriate documentation of the services provided or referred must be included in the patient's medical records.

Note: Code of Federal Regulations 42 CFR 455.440 states that a state Medicaid agency must require all claims for payment for items and services that were ordered or referred to contain the National Provider Identifier (NPI) of the physician or other professional who ordered or referred such items or services. Effective Nov. 1, 2024, the IHCP will be enforcing this requirement for claims submitted by school corporations (provider specialty 120) and by the First Steps program.

Table 1 – CPT Codes for EPSDT Visits

Age	Initial Patient Exam	Established Patient Exam
Less than 1 year	99381	99391
1–4 years	99382	99392
5–11 years	99383	99393
12–17 years	99384	99394
18–20 years	99385	99395

Note: The patient exam codes in Table 1 should not be used for visits where the full EPSDT screening is not performed. Instead, such visits should be billed with the appropriate E/M office visit code and the applicable diagnosis code.

Billing for an EPSDT Visit and Sick Visit (Within the Same Appointment)

When a member presents to a provider for a sick visit, and the member's records indicate the need for an updated EPSDT visit, physicians can include services for both visits and bill **two** visit codes for reimbursement of both services on the same day. Providers must maintain a complete problem-focused visit exam for the presenting problem *and* a complete preventive visit documenting the EPSDT components of the screening exam within the member's health records.

Providers are allowed to bill an E/M code ***in conjunction*** with an EPSDT visit; however, there are specific billing instructions for billing both procedures.

If a patient is evaluated and treated for a problem during the same visit as an EPSDT annual exam, the problem-oriented exam can be billed separately, accompanied by modifier 25 (separate significantly identifiable E/M service). The problem must require additional moderate-level evaluation to qualify as a separate service on the same date. IHCP reimbursement is allowed at the lesser of the submitted charge or the maximum fee for each code; however, the total billed charge must not be more than the provider charges for similar services provided to private-pay patients.

Table 2 – Billing for EPSDT Visit Concurrent With Sick Visit

Visit Type	Procedure Codes	Diagnosis Coding	Reimbursement
Preventive visit (EPSDT) **plus** sick visit	Two visit codes: • EPSDT visit code (see Table 1), **and** • Sick-visit code (99203–99205 or 99213–99215) with modifier 25	Z00.121 or Z00.129 must be used as the primary diagnosis on the claim and must be indicated for the preventive EPSDT visit service. For the sick visit, use the appropriate diagnosis codes for the presenting problem.	Additional reimbursement for sick visits depends on complexity and doctor/patient relationship (new/established)

Missed Appointment Procedures

Claim submission for missed appointments is not required. Any claims submitted for missed appointments are used for data gathering only. There is no reimbursement for missed appointments by any IHCP member, whether that member is enrolled in managed care or not.

Members enrolled under Hoosier Healthwise who miss EPSDT appointments or follow-up appointments must be identified and their names forwarded to the member's MCE or the Hoosier Healthwise Helpline at 800-889-9949. Providers should refer all HIP and Hoosier Care Connect members with missed appointments to the appropriate MCE for education. For MCE contact information, see the *IHCP Quick Reference Guide* available at in.gov/medicaid/providers.

Reimbursement for EPSDT Services

To offer EPSDT services, the provider must be licensed to perform an unclothed physical exam, as well as other screening components of the EPSDT examination. IHCP-enrolled providers must adhere to screening and documentation procedures to claim the EPSDT screening reimbursement rate.

Enhanced reimbursement for the initial patient exam is limited to the first EPSDT screening performed by a screening provider during the participant's lifetime. If additional claims are received for initial screening from the same provider, reimbursement is allowed at the resource-based relative value scale (RBRVS) rate on file for the billed CPT code, not the higher EPSDT rate.

Initial and established EPSDT exams are reimbursed when submitted with Z00.121 or Z00.129 as the primary diagnosis, and are subject to the 30-office-visits-per-year limitation without prior authorization. Claims submitted with charges other than the designated amounts for screening exams are paid at the EPSDT rate or the charged amount, whichever is lower. Examinations that do not contain the EPSDT screening components are not considered EPSDT visits and can be billed using the appropriate diagnosis and CPT codes for those visits.

To receive appropriate reimbursement, all procedure codes must be accompanied by a diagnosis code. For an EPSDT visit, screening, immunization or stand-alone vaccine counseling, **diagnosis code Z00.121 or Z00.129 must be used as the primary diagnosis code.**

Third-Party Liability

Federal regulations allow for the bypass of third-party liability (TPL) claim edits when EPSDT screening procedures are submitted for payment to the IHCP billing contractor (either Gainwell Technologies or an MCE). EPSDT procedure codes are not subject to TPL edits when submitted in conjunction with the primary diagnosis code Z00.121 or Z00.129.

Prior Authorization

Prior authorization (PA) is not required for screening services. Individual treatment services may require prior authorization. EPSDT exams are subject to the 30-office-visits-per-year limitation without PA. For additional information about services that require PA, consult the IHCP Covered Services and Limitations Rule, *Indiana Administrative Code 405 IAC 5.*

For general information about requesting PA for fee-for-service members, see the *Prior Authorization* module. For authorization of services provided under a managed care program, consult the member's MCE for requirements.

Section 3: History, Measurements and Physical Examination

This section presents details about the history, measurements and physical examination to be completed as part of each Early and Periodic Screening, Diagnostic and Treatment (EPSDT) visit. See the Bright Futures/American Academy of Pediatrics (AAP) periodicity schedule at aap.org for more information.

Family and Medical History

The history of the patient is an important factor in making a proper assessment of the patient's health. The EPSDT screening physician has the responsibility of obtaining a family and medical history as part of the EPSDT screening examination.

This section outlines the categories that should be covered during the history-taking portion of the EPSDT screening. Modifications should be made that are appropriate for the age and gender of the child. Significant findings should be noted on the child's medical record.

The following is a suggested outline for the health and development history or database:

- Reason for visit
- Identification of caregivers and initial observations of parent, child and family interactions
- Perinatal history (of child)
  - *Pregnancy*:
    - Prenatal care (including trimester when initiated)
    - Habits (including use of drugs, alcohol or tobacco)
    - Illnesses
    - Accidents
    - Hospitalizations, planned or unplanned
  - *Birth*:
    - Description of labor and delivery
    - Anesthesia
    - Complications
    - Location of birth
    - Full term or premature (gestational age of child)
  - *Neonatal*:
    - Condition at birth
    - Measurements
    - Nursery course
    - Length of stay
    - Complications or problems
    - Treatment
    - Breast or bottle fed
- Developmental history
- Medical history
- Body systems review

- Family health history

  Make a notation of the presence of diseases, such as the following, in maternal and paternal families:
  - Allergy
  - Anemia
  - Arthritis
  - Asthma
  - Cancer
  - Congenital anomalies
  - Cystic fibrosis
  - Diabetes mellitus
  - Emphysema
  - Heart disease
  - Hemoglobin disorder
  - Hereditary or familial conditions
  - Hypertension
  - Kidney disease
  - Mental illness
  - Mental retardation
  - Migraine
  - Obesity
  - Seizures
  - Sexually transmitted disease
  - Stroke
  - Substance use or abuse
  - Tuberculosis
- Psychosocial and lifestyle history
- Child's mental and emotional health
- Family household and environment

Measurements

The following measurements are recommended when performing an EPSDT exam:

- Height/length
- Weight
- Weight for length (birth through 18 months)
- Head circumference (birth through 2 years)
- Body mass index (BMI) (beginning at 2 years)
- Blood pressure (beginning at 3 years; or earlier for infants and children with specific risk conditions)

Height, Weight and Head Circumference

Guidelines for obtaining measurements:

- *Height/length is required at each visit for all ages.* Infants and children as old as 2 years old and children with low birth weight, failure to thrive or certain developmental disorders, or who cannot stand, should be measured supine on a firm surface using a fixed headboard and footboard when possible. For older children who are able to stand without support, use a nonstretchable measuring tape fixed to a true vertical surface.
- *Weight is required at each visit for all ages.* Infants and small children should be weighed on a table-model beam scale. Older children who can stand without support can be weighed on a floor-model beam scale. Scales should be balanced prior to weighing and should be checked and adjusted for accuracy according to the manufacturer's specifications.
- Head circumference must be measured at every visit for infants and children through 2 years old.
  - Measure the head with a cloth, steel or disposable paper tape.
  - Apply the tape around the head from the supraorbital ridges anteriorly to the posterior point (usually the external occipital protuberance) giving the maximum circumference.

See the Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS) percentile standards. If significant deviation is present, conduct further evaluation and, if necessary, make a referral. These growth charts are available from the CDC NCHS website at cdc.gov.

Body Mass Index

Providers should calculate and plot children's BMI annually, beginning at age 2. The AAP *Pediatrics* journal article *Clinical Practice Guideline for the Evaluation and Treatment of Children and Adolescents with Obesity* is recommended to provide screening guidelines.

Providers must submit claims with the following ICD-10 diagnosis codes for BMI to be reimbursed:

- Pediatric diagnosis codes Z68.51–Z68.54 for members 2 through 19 years of age
- Adult diagnosis codes Z68.1–Z68.45 for members 15 years of age and older

Blood Pressure

Blood pressure must be checked at every screening visit for all children 3 years of age and older. However, blood pressure can be taken on younger children if a provider decides it is appropriate.

- Take the blood pressure with the appropriately sized pediatric or adult cuff.
- Record the reading in the patient chart.

The American Academy of Pediatrics (AAP) publishes current percentile charts for the normal blood pressure for various ages. Any significant deviation is a basis for further evaluation and, if necessary, referral. See the AAP website at aap.org.

Physical Examination

A complete physical exam must be given each time an EPSDT screening is performed, with infants totally unclothed and older children undressed and suitably draped. Physicians should always communicate the scope and nature of the physical examination to be performed to the pediatric patient and the parent. This communication should address the use of chaperones and issues of patient comfort, confidentiality and privacy. The use of a chaperone should be a shared decision between the patient and physician.

Suspect or positive findings should be summarized and discussed with the parent and child, and a plan of care should be developed.

Section 4: Developmental/Social/Behavioral/ Mental Health

This section covers the developmental, social, behavioral and mental health checks to be completed as part of each Early and Periodic Screening, Diagnostic and Treatment (EPSDT) visit. See the Bright Futures/American Academy of Pediatrics (AAP) periodicity schedule at aap.org for more information.

Development Surveillance

Developmental surveillance is an ongoing process of observations over time, which must be completed as part of each EPSDT exam (except for the 9-, 18- and 30-month visits). The purpose of developmental surveillance is to consistently observe and determine whether a child's acquisition of developmental milestones is progressing within a typical developmental range of achievement according to age and cultural background. Parents should be able to give an accurate history of the child's development; however, a developmental assessment is required. For regular patients, an ongoing recording in the child's chart of developmental milestones may be sufficient to make a judgment about developmental progress.

Children Younger Than 5 Years Old

For children younger than 5 years old, see the Centers for Disease Control and Prevention (CDC) *Developmental Milestones* page at cdc.gov for milestones for motor language and social development. Children develop at their individual, unique rate. These milestones are meant to demonstrate typical developmental stages:

- *Motor skills* – Although practice of motor movements has a slight influence on the rate of development, maturation usually plays a much greater role. The newborn infant can perform a number of motor movements mainly of a reflex type.

  Motor development involving the hands tends to proceed along a definite sequential course. The child first looks from the hand to the object, and then attempts to grasp objects with two hands. Grasping with the palm of the hand is learned first, using the ulnar side of the hand initially, and later the radial side. Eventually, grasping with the thumb and index finger is mastered.

- *Social activity and behavior* – Questions should be asked to determine how the child relates to family and peers and whether there is any noticeable deviation in any behavior. Observe for similar behavior in the office.

- *Speech development* – Attention should be paid to the child's speech pattern to see whether it is appropriate for the child's age. Language remains the best predictor of future intellectual endowment and should serve as the common denominator comparing its rate of development with other areas, including gross motor, problem solving, adaptive and social skills. If a provider decides during the screening process that further evaluation is needed, then one of the standard speech and language tests may be given.

- *Developmental tests* – After observing the child in the various areas of development, the provider may decide that a more in-depth evaluation is needed. The provider can elect to use an objective developmental screening test and receive additional reimbursement. Developmental testing is recommended from 6 months through 4 years old.

If developmental delay is a concern, a referral to First Steps for children birth to 3 years old is recommended. For additional information concerning the First Steps program, see the *Indiana's First Steps Program* section or contact First Steps as follows:

- Local offices:
  - For contact information, go to the *First Steps Offices* page at in.gov/fssa/firststeps and select the cluster that serves the county in which the member resides.
- State office:

  MS51
  First Steps State Administration
  Bureau of Child Development Services
  402 W. Washington St., Room W453
  Indianapolis, IN 46204-2739

  Telephone: 800-545-7763
  Fax: 317-234-6701
  Email: FirstStepsWeb@fssa.in.gov

Developmental Screening

EPSDT providers are allowed to bill for a developmental screening in addition to an EPSDT screening at the 9-month, 18-month and 30-month visit. Providers also have the option of conducting the developmental screening anytime that surveillance (medical history of developmental risk factors, parental/caregiver concern) identifies a need. Providers are encouraged to use standardized screening tools that have a moderate to high sensitivity, specificity and validity level and are culturally sensitive. The following CPT code, which is limited to two units per date of service (two different screening tools used), may be used when billing for standardized screening:

> 96110 – *Developmental screening (e.g., developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument*

Examples of screening tools allowed for this code include but are not limited to:

- Ages and Stages Questionnaire (ASQ)
- Ages and Stages Questionnaire/Social Emotional (ASQ-SE)
- Denver DST/Denver II
- Battelle Developmental Screener
- Bayley Infant Neurodevelopment Screener (BINS)
- Parents Evaluation of Development (PEDS)
- Early Language Accomplishment Profile (ELAP)
- Brigance Screens II
- Vanderbilt Rating Scales
- Behavior Assessment Scale for Children-Second Edition (BASC-II)

EPSDT providers must document the screening tool utilized, with interpretation and report, in the child's medical record.

Autism Spectrum Disorder Screening

EPSDT providers are allowed to bill for an autism spectrum disorder screening in addition to an EPSDT screening at the 18-month and 24-month visits. Providers also have the option of conducting the developmental screening anytime that surveillance (medical history of developmental risk factors, parental/caregiver concern) identifies a need. Providers are encouraged to use standardized screening tools that have a moderate to high sensitivity, specificity and validity level and are culturally sensitive. The following CPT code, which is limited to two units per date of service (two different screening tools used), may be used when billing for standardized screening:

> 96110 – *Developmental screening (e.g., developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument*

Examples of screening tools allowed for this code include:

- Checklist for Autism in Toddlers (CHAT)
- Modified Checklist for Autism in Toddlers (M-CHAT)
- Screening Tool for Autism in Toddlers and Young Children (STAT)
- Pervasive Developmental Disorders Screening Test-II, Primary Care Screener (PDDST-II PCS)

EPSDT providers must document the screening tool utilized, with interpretation and report, in the child's medical record.

If screening leads to an autism spectrum disorder diagnosis, a referral for applied behavioral analysis (ABA) therapy is required. See the *Behavioral Health Services* module for PA and billing instructions.

Behavioral/Social/Emotional Assessment

The federal EPSDT mandate requires regularly scheduled screenings of all EPSDT-eligible children to identify physical and mental health problems. A behavioral/social/emotional assessment should be conducted annually, from the newborn visit through age 21. Per the U.S. Preventive Services Task Force (USPSTF), children should be screened for anxiety beginning at age 8. Repeated screening may be more productive in children/adolescents with risk factors or potential symptoms of anxiety (see the *Anxiety in Children and Adolescents: Screening*).

See the Bright Futures/American Academy of Pediatrics (AAP) periodicity schedule at aap.org for more information and supporting resources related to this screening.

To make early identification of behavioral, social and emotional problems easier and cost-effective for busy physicians, a screening questionnaire can be used as part of routine primary care to facilitate early recognition. Many regularly used tools are available in English and Spanish.

Tobacco, Alcohol or Drug Use Assessment

Urine testing to establish drug abuse seems a tempting and objective means of overcoming the problems of denial, unreliable histories, and the less-than-clear-cut signs and symptoms. However, there are problems of sensitivity and specificity in urine screens. False negatives occur because of innocent confounding substances. The physician's role in substance abuse screening, through obtaining a history of the patient, is identification and referral. A verbal assessment for tobacco, alcohol or drug use should be completed at each annual EPSDT visit beginning at the 11-year visit.

Depression and Suicide Risk Screening

All adolescents should be screened for depression and suicide risk at each annual EPSDT visit, beginning at the 12-year visit. Providers should make every effort to preserve confidentiality of the adolescent. If a depression screen is positive, further evaluation should be considered. Annual depression screening should be billed with Healthcare Common Procedure Coding System (HCPCS) code G0444 – *Annual depression screening, 15 minutes*.

Maternal Depression Screening

It is important for women to understand what postpartum depression is, to know that many women experience similar feelings, and to realize that it should not go untreated. Maternal depression screening should be done at the child's 1-, 2-, 4- and 6-month EPSDT visit, and it is reimbursable on the child's EPSDT claim, using Current Procedural Terminology (CPT) code 96161 – *Administration of caregiver-focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument*.

If the screening warrants significant concerns, a referral for treatment should be made to address the mother-child dyad relationship.

This screening and referral option is available to fathers as well.

Section 5: Sensory Screenings – Vision and Hearing

Vision and hearing screenings or risk assessments should be performed at each Early and Periodic Screening, Diagnostic and Treatment (EPSDT) visit, as described in this section. See the Bright Futures/American Academy of Pediatrics (AAP) periodicity schedule at aap.org for more information.

Vision Observation and Screening

Undetected vision problems occur in 5%–10% of preschool children. The most serious of these problems is amblyopia, a loss of visual acuity and binocular vision that becomes irreversible after 5 years old.

Each EPSDT screening must include a visual observation with an external eye examination and a risk assessment or screening for visual acuity. See the Bright Futures/American Academy of Pediatrics (AAP) periodicity schedule at aap.org for timing of required screenings. This visual observation and risk assessment or screening are components of an EPSDT visit and are not separately billable.

See *Visual System Assessment in Infants, Children, and Young Adults by Pediatricians* and *Procedures for the Evaluation of the Visual System by Pediatricians* for additional information.

External Eye Examination

The external eye examination should include general inspection of the lids and eyeballs, noting prominence, size and position, as well as growths, inflammations, discharge or vascular injection. Forward protrusion (exophthalmos) or retraction (enophthalmos) of the globe should be noted.

Abnormalities that cannot be adequately evaluated and treated by the screening physician should be referred to a specialist for further evaluation.

Routine Screening for Visual Acuity

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 ages 3 through 5 years.

Note:	*Screening results from school should be documented in the patient's record. Vision screens should be completed within the public schools as a requirement of the Indiana Department of Education in grades 1, 3 and 8. Parents may be able to share results, which may include a formal referral for additional testing.*

Visual acuity screening procedures and passing criteria should be followed as advised in the AAP publication, *Procedures for the Evaluation of the Visual System by Pediatricians*. In the online publication, see *Table 1 – Eye Examination Guidelines* (pages 6–7) and *Table 2 – Amblyopia Risk Factor Targets Recommended by the American Association for Pediatric Ophthalmology and Strabismus* (page 7).

Visual Acuity – Infants

Visual acuity is difficult to evaluate in infants. Providers should observe whether an infant follows a light or a bright attractive toy in different directions of gaze. Each eye should be tested separately. If the infant fails to respond to such testing, the provider should observe the pupillary responses for reaction to direct light stimulus.

Infants can be tested by alternately covering each eye. If visual acuity is poor in one eye, the infant resists actively when the good eye is covered and vision is disturbed, but is much less affected when the eye with decreased vision is covered.

Visual Acuity – Children 36–59 Months

The most direct way to detect amblyopia (monocular decreased vision) in 3- and 4-year-old children is to assess monocular visual acuity. Recommended tests include Lea symbols, or tumbling E charts, because they allow screening of younger children. Isolated optotypes with surround bars are also acceptable. Stereopsis testing is recommended to detect strabismus as an amblyopiogenic factor.

Vision Referral Standards

Referrals to an appropriate eye or vision specialist must be made when screening methods indicate that a referral is warranted. A child may also be referred if parental complaints warrant a referral. Children failing a test for hyperopia can be referred for additional diagnosis and treatment.

Hearing Observation and Screening

The AAP supports the goal of universal detection of hearing loss in infants before 3 months of age, with appropriate intervention no later than 6 months of age. Universal detection of hearing loss requires universal screening of all infants. Screening tests that vary according to age must be part of the EPSDT screening. See the Bright Futures/AAP periodicity schedule for timing of required screenings and related guidance.

To help identify children who need early and more frequent assessments, providers can reference the Joint Committee on Infant Hearing's *Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs*.

The most critical period for learning language is during the first 2 years of life. If hearing problems are not detected until after this time, lost ground in language development may never fully be regained. The early detection of hearing loss is an urgent duty of any physician caring for young children.

> *Note: Children between the ages of newborn through 3 years old identified as deaf or hard of hearing may qualify for early intervention services through First Steps. See the Indiana's First Steps Program section for more information.*

Newborn Hearing Screening

Indiana legislation mandates that every infant must be given a physiologic hearing screening examination at the earliest feasible time for the detection of hearing impairments:

- Newborns must be screened at the birth hospital before the infant is discharged. The IHCP does not allow hospitals to bill separately for initial newborn screening.
- Providers that deliver, at locations *other than in the hospital,* newborns that are not hospitalized at birth may use the appropriate Current Procedural Terminology (CPT) codes to bill for the newborn hearing screening.

Newborns that do not pass the newborn hearing screen should have their hearing evaluated by an audiologist as soon as possible. This evaluation is done to determine how a baby is hearing, as well as look for possible causes of hearing loss.

> *Note: The universal newborn hearing screening (UNHS) is designed to identify infants with hearing deficits, ensure appropriate follow-up intervention and collect information on the evidence of hearing loss. When the UNHS identifies a newborn with a possible hearing deficit, the Indiana Department of Health (IDOH) Early Hearing Detection and Intervention (EHDI) program follows up to encourage further diagnostic testing. For further information, see the Early Hearing Detection and Intervention (EHDI) page at in.gov/health.*

For any follow-up diagnostic testing resulting from detection of possible hearing impairment during the newborn screening process, providers should bill the same way they bill other audiological testing. Providers should obtain PA, if applicable.

Diagnostic testing uses the automated auditory brainstem test and other tests to determine how a baby hears. The tests can be done at various loudness levels and at different pitches (high sounds and low sounds). If testing is done before 3 months of age, the tests can usually be completed while the baby sleeps. For older or more active babies, medicine may be needed to help the baby sleep during the tests. It is important for babies to be quiet and not move much during testing, so the results of the diagnostic testing are accurate.

Infant Hearing Screening

Noisemakers can be used to screen an infant's hearing. High frequencies can be tested with a squeaky toy or small bell, and middle frequencies with a rattle or piece of tissue paper. While the infant is distracted with a visual stimulus, such as a toy or brightly colored object, the noisemaker is sounded outside the field of vision. Normal responses are as follows:

- At 4 months, there is a widening of the eyes, a cessation of previous activity and possibly a slight turning of the head in the direction of the sound.
- At 9 months or older, the child should usually be able to locate sound, whether it comes from above or below.

Many hearing tests, such as banging pots together or hearing a low-flying airplane, can falsely give normal results. Most children with significant hearing deficits have residual hearing and respond to very loud noises. However, they are educationally and socially deaf if they cannot hear normal speech sounds.

Hearing Screening of Older Children

See the Bright Futures/AAP periodicity schedule for timing of required screenings and related guidance.

Hearing screening should be completed within the public schools as a requirement of the Indiana Department of Education in grades 1, 4, 7 and 10. Some schools also test kindergarten children. These screening efforts should not be duplicated unless the child is at risk and the situation warrants rescreening. Screening results from the school should be documented in the patient's medical records. Parents may be able to share results, which may include a formal referral for additional testing.

Hearing Referral Standards

When a chronic hearing deficit is suspected or has been confirmed, an appropriate referral should be arranged to do precise testing. If the hearing deficit is confirmed, the patient should be referred to an otolaryngologist for examination in an attempt to determine what treatment may be necessary.

Section 6: Procedures, Lab Tests and Immunizations

Providers must provide or arrange for all the appropriate Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services for each child at each age level in a timely manner, and properly document and bill the services. The Indiana Health Coverage Programs (IHCP) and managed care entities (MCEs) closely monitor all claims submitted to ensure that appropriate procedures are provided and to give the provider feedback concerning age-specific Bright Futures/American Academy of Pediatrics (AAP) periodicity schedule at aap.org.

Newborn Screening

The Bright Futures/AAP periodicity schedule indicates that 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. Newborns discharged less than 48 hours after delivery should be examined within 48 hours of discharge, per *Hospital Stay for Healthy Term Newborn Infants*. Breastfeeding newborns should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in *Policy Statement: Breastfeeding and the Use of Human Milk*. For information and recommendations related to jaundice screening, see the AAP *Pediatrics* journal article *Clinical Practice Guideline Revision: Management of Hyperbilirubinemia in the Newborn Infant 35 or More Weeks of Gestation.*

Indiana's newborn screening law requires that babies born in Indiana be tested (through heel-stick/blood spot screening, hearing screening and pulse oximetry screening) for over 50 conditions, including sickle cell anemia, cystic fibrosis, hearing loss, critical congenital heart disease (CCHD), severe combined immunodeficiency and spinal muscular atrophy. State requirements for newborn screenings can be found in *Indiana Administrative Code 410 IAC 3-3*.

> *Note: Early detection of sickle cell is important because oral prophylactic penicillin should be started by 2 months old to prevent life-threatening infections. See the Immunizations section for special immunization information for children with sickle cell.*

For details about the newborn screening program, see the Indiana Department of Health (IDOH) *Newborn Screening Program* page at in.gov/health. Newborn screenings are to be given within the IDOH required time frame.

Under contract with the IDOH, blood samples for the newborn screening are sent to Indiana University (IU) Laboratory. See the *Inpatient Hospital Services* module for information about newborn screening blood sample collection and submission.

> *Note: For information about newborn **hearing** screening, see the Newborn Hearing Screening section.*

Billing and Reimbursement

Reimbursement for the newborn screening is included in the diagnosis-related group (DRG) that the IHCP pays for the newborn hospitalization, as described in the *Inpatient Hospital Services* module. The IHCP does not require EPSDT providers to report newborn screening on the professional claim (*CMS-1500* claim form or electronic equivalent).

Reviewing and Reporting Results

Newborn screening results must be recorded in the patient record for infants younger than 1 year old. Providers must determine whether valid newborn screening test results have been obtained for the infant. If a valid test has been obtained for the infant and the test results were normal, no further testing is required. The newborn screening process is complete.

For information about registering for online access to the newborn screening results, see the *Indiana Newborn Screening Tracking & Education Program (INSTEP)* page at in.gov/health.

The Indiana Birth Defects and Problems Registry (IBDPR) is a population-based surveillance system that seeks to promote fetal, infant and child health. It is every physician's responsibility to report to the IBDPR using the Physicians Reporting Tool. Conditions reported to IBDPR are both reportable and targeted; reportable conditions are mandated by law. See the *IBDPR-Indiana Birth Defects and Problems Registry* page at in.gov/health for details.

Rescreenings and Second Screenings

If a rescreening is needed because the first screening was invalid, additional testing of serums is needed because test results were abnormal, or there is no record that newborn screening was done, providers should call IDOH to work out the best method of accomplishing newborn screening. Generally, the IDOH recommends that the infant be taken back to the birth hospital to have that hospital perform newborn screening or rescreening; however, providers should consult with the IDOH on how best to proceed with newborn screening when there is an invalid or abnormal test. If additional information is needed, contact the following:

Genomics and Newborn Screening Program
Indiana Department of Health
2 N. Meridian St., 2E
Indianapolis, IN 46204

Telephone: 888-815-0006
Fax: 317-234-2995
Email: ISDHNBS@isdh.in.gov

Because newborns can be released from hospitals prior to reaching the age (in hours) required for a valid screening result, an increasing number of newborns require a second screening. Families are generally asked to bring the newborn back to the birth hospital as an outpatient, or the hospital requests that a nurse make a follow-up visit to obtain the sample for newborn screening. In either case, the hospital could potentially bill the IHCP separately for newborn screening, even though reimbursement for these services is included in the DRG for the newborn hospitalization. However, separate reimbursement will not be made for these services, even when billed separately.

There are occasions when hospitals are requested to perform newborn screening for newborns born in *another* Indiana hospital. For example, when distance precludes a trip to the birth hospital, the infant should be taken to the nearest hospital with birthing facilities so that newborn screening can be completed. To prevent the second hospital from being charged by the IU Laboratory for the second screen, the hospital must indicate on the filter paper card, in the space provided, the name of the birth hospital and the submitting hospital. The IU Laboratory attempts to match the infant's second screen with the first screen so that the hospital is not charged. If the infant's name or birth date has been changed, the original name and date of birth must be included in the information sent to the IU Laboratory to facilitate a match.

Immunizations

Immunizations should be provided or arranged for each child according to the schedule recommended by the AAP. Every EPSDT visit should be an opportunity to update and complete a child's immunizations.

> *Note: Children with sickle cell should be immunized as recommended by the AAP immunization schedule. They should also receive pneumococcal vaccine at 2 years old.*

Vaccines for Children Program

The federal Vaccines for Children (VFC) program makes available, at no cost to providers, certain vaccines for administration to IHCP members 18 years old and younger. If an EPSDT provider chooses not to participate in the VFC program, the provider must document the IHCP-enrolled patient's immunization history.

If a vaccine is available through the VFC program, the IHCP will not reimburse the use of a non-VFC vaccine (referred to as "private stock" vaccine) for members under age 19. This policy applies to members in fee-for-service (FFS) and managed care delivery systems. Providers that are not currently enrolled in the VFC program are encouraged to enroll in the VFC program to ensure members do not experience a disruption in care.

See the Centers for Disease Control (CDC) Vaccine Price List at cdc.gov for information on what vaccines are covered under the VFC program.

See the *Injections, Vaccines and Other Physician-Administered Drugs* module for billing requirements for vaccines supplied through the VFC program. IHCP reimbursement for these vaccines is limited to the vaccine administration fee and the EPSDT visit code, if applicable.

For more information about the VFC program, see the *Vaccines for Children* page at in.gov/health.

Stand-Alone Vaccine Counseling

Stand-alone vaccine counseling refers to when a patient or caregiver receives counseling about a vaccine from a healthcare practitioner, but the patient does not receive the vaccine dose at the same time as the counseling (that is, there is no actual delivery or injection of a vaccine during the practitioner visit) because it is not appropriate to provide the vaccine dose at that time (such as when a patient or caregiver does not consent to the patient receiving the vaccine dose). If the patient agrees to the administration of the vaccine and it is administered during that same visit, the provider would bill for the vaccination **instead of** the counseling.

The IHCP covers the following procedure codes for stand-alone vaccine counseling as part of the EPSDT benefit:

- G0312 – *Immunization counseling by a physician or other qualified health care professional when the vaccine(s) is not administered on the same date of service for ages under 21, 5 to 15 mins time*
- G0313 – *Immunization counseling by a physician or other qualified health care professional when the vaccine(s) is not administered on the same date of service for ages under 21, 16-30 mins time*
- G0314 – *Immunization counseling by a physician or other qualified health care professional for COVID-19, ages under 21, 16-30 mins time*
- G0315 – *Immunization counseling by a physician or other qualified health care professional for COVID-19, ages under 21, 5-15 mins time*

These procedure codes are reimbursable when the service is rendered during an EPSDT visit by a physician specialty, advanced practice registered nurse (APRN) or physician assistant, and billed as described in the *EPSDT Billing Procedures* section, including use of diagnosis code Z00.121 or Z00.129.

> *Note: Pharmacy reimbursement for stand-alone COVID-19 vaccine counseling ended effective Oct. 1, 2024, as a result of the expiration of the American Rescue Plan Act of 2021.*

Lead

Through its Lead and Healthy Homes Division, the IDOH tracks the prevalence of lead exposure in Indiana children and supports local health departments and community partners in promoting primary prevention efforts through education, proactive screening, treatment, case management and the remediation of lead hazards.

Children from 6 months through 6 years of age are at greatest risk for elevated blood lead levels. The IDOH Lead and Healthy Homes Division has identified the following four steps to a successful lead poisoning prevention program:

1. Early identification of children with excessive lead absorption through screening programs
2. Treatment of children with abnormal blood lead levels
3. Prompt termination of further excessive lead exposure (environmental investigation and abatement)
4. Intensive parent and public education about lead poisoning (see the *Education Regarding Lead Poisoning for Pregnant Women and Children 6 Years Old or Younger* section)

For more information and resources, see the IDOH Lead and Healthy Homes Division website at in.gov/health/leadsafe.

Required Blood Lead Tests

Screening for blood lead toxicity for all children enrolled in Medicaid is a federal requirement.

The Indiana Family and Social Services Administration (FSSA) requires that all children enrolled in Medicaid be tested as follows:

- Children should receive a blood lead test between the ages of **9 months and 15 months**, or as close as reasonably possible to the patient's appointment.
- Children should have *another* blood lead test between the ages of **21 months and 27 months**, or as close as reasonably possible to the patient's appointment.
- Any child between the ages of **28 months and 72 months** who does not have a record of any prior blood lead test must have a blood lead test performed as soon as possible.

If a provider can verify, via the Children's Health and Immunization Registry Program (CHIRP), or the records from another provider, that blood lead testing has occurred at the required intervals, they are not obligated to repeat the procedure.

From 6 months through 6 years of age, all children should be assessed for the risk of lead exposure at each EPSDT visit, as described in the *Verbal Risk Assessment* section. If a child is determined to be at high risk for lead exposure, a blood lead test should be performed (as early as 6 months of age), in addition to the tests required between ages 9–15 months and 21–27 months.

The IDOH Lead and Healthy Homes Division monitors lead poisoning in Indiana children. Both providers and laboratories are required to report *all* results of blood lead tests to the IDOH no later than one week after completing the examination. The IDOH Lead and Healthy Homes Division provides medical and environmental case management follow-up for children who are identified with elevated levels of lead in their blood. For information on interpreting blood lead testing results and required follow-up activities, see *Childhood Blood Lead Medical Management Guidelines for Providers in Indiana*, available on the IDOH Lead and Healthy Homes Division website at in.gov/health/leadsafe (under Healthcare Providers > Medical Management Requirements for Providers).

> *Note: If a parent or guardian refuses to allow their child to be tested, providers are encouraged to document the refusal in writing and have the parent or guardian sign an attestation of refusal. A sample refusal attestation is available on the IDOH Lead and Healthy Homes Division website at in.gov/health/leadsafe (under Healthcare Providers > Testing Requirements). Providers are expected to keep a copy of the refusal, either digital or hard copy, with the patient record until the child reaches age 7 years. Providers are only required to keep a single refusal on file if a parent or guardian indicates they will not allow initial or follow-up testing.*

Verbal Risk Assessment

In addition to performing the required blood lead tests as described in the previous section, providers should assess all children ages 6 months to 6 years at every EPSDT visit for risk of lead exposure by asking the parent or guardian the following questions:

- Does your child live in or regularly visit a building with potential lead exposure, such as peeling or chipping paint, recent or ongoing renovation or remodeling, or high levels of lead in the drinking water?
- Has your child spent any significant time outside the U.S. in the past year?
- Does your child currently have a sibling, housemate or playmate with an elevated blood lead level, and your child has not been tested?
- Does your child have developmental disabilities and/or exhibit behaviors that puts him/her at higher risk for lead exposure?
- Does your child have frequent contact with an adult whose job or hobby involves exposure to lead?
- Does your family use traditional medicine, health remedies, cosmetics, powders, spices, or food from other countries?
- Does your family cook, store, or serve food in crystal, pewter, or pottery from other countries?

If the answer to any of these questions is “Yes” or “I don’t know,” the child is considered at high risk for high doses of lead exposure, and a blood lead test should be performed.

Subsequent verbal risk assessments can change a child’s risk category. If, as a result of a verbal risk assessment, a previously low-risk child is recategorized as high-risk, that child must be given a blood lead level test.

Procedures for Sending Blood Samples for Lead Testing

The FSSA recommends that blood samples for lead screening be sent to the IDOH Laboratory to ensure that testing is done on atomic absorption spectrophotometers (AAS) and to ensure that the results are known to the IDOH Lead and Healthy Homes Division.

The IDOH provides filter paper cards, postage-paid business reply envelopes and venous mailing tubes at no charge to healthcare providers for specimen collection and transport in support of the Maternal and

Child Health Program. See the *Blood Lead* page at in.gov/health/laboratories for additional details, including contact information.

Filter paper card specimens can be mailed to the lab in the provided postage-paid, preprinted envelopes. Venous blood samples should be sent in the venous mailing tubes to:

Blood Lead Lab
Indiana Department of Health Laboratory
550 W. 16th St., Suite B
Indianapolis, IN 46202

When forwarding blood samples to the IDOH Laboratory, IHCP primary medical providers (PMPs) must include their National Provider Identifier (NPI) and authorization code for members on the paperwork accompanying the sample. If the member is enrolled in a managed care program, include the MCE PMP authorization and referral information.

Billing for Blood Lead Testing Services

The coverage and reimbursement rate for CPT code 83655 – *Lead, quantitative, blood* is expanded to include tests administered using filter paper (U1 modifier) and handheld testing devices (U2 modifier) in the office setting.

When a venous blood sample is required, providers can bill procedure code 36415 – *Collection of venous blood by venipuncture* to indicate that a blood draw was made. A distinction must be made by diagnosis code to differentiate between individuals being tested to confirm a high fingerstick result and those that have been diagnosed with or are being treated for lead poisoning. When a follow-up blood lead test is performed, subsequent to the confirmation test, ICD-10 diagnosis code **Z77.011 – *Contact with and (suspected) exposure to lead*** should be used in addition to the primary EPSDT diagnosis code of Z00.121 or Z00.129.

Providers that use the IDOH's postage-paid kit cannot bill the IHCP a handling and/or conveyance fee for conveying samples to the lab. Providers that send blood samples to private labs for testing should use the following codes if the provider incurs an expense associated with the conveyance:

- 99000 – *Handling and/or conveyance of specimen for transfer from the office to a laboratory*
- 99001 – *Handling and/or conveyance of specimen for transfer from the patient in other than office to a laboratory (Distance may be indicated)*

Follow-Up Services: Environmental Lead Testing and Case Management

The IHCP covers certain follow-up services, as described in the following sections, for members with a confirmed blood lead reference value (BLRV) at or greater than 3.5 µg/dl. To be eligible for reimbursement of these services, providers must be enrolled in the IHCP as a public health agency (provider type 13) with specialty 130 – *County Health Department*.

Comprehensive Environmental Lead Investigation

The IHCP covers initial and follow-up comprehensive environmental lead investigation services for members with a confirmed BLRV of 3.5 µg/dl or higher. For additional coverage requirements and billing information, see the *Laboratory Services* module.

Targeted Case Management

The IHCP covers targeted case management for members with elevated blood lead levels. Lead targeted case management is authorized in accordance with *Code of Federal Regulations 42 CFR 440.169*. This service is for members who had a blood lead screening test conducted in accordance with the EPSDT

periodicity schedule and are found to have a confirmed BLRV of 3.5 µg/dl or higher. The service is limited to the EPSDT age range (birth through 20 years of age).

Reimbursement for blood lead targeted case management is available to IHCP-enrolled county health departments through HCPCS code T1016 – *Case Management, 15 minutes* when billed with modifier EP – *Service provided as part of Medicaid early periodic screening diagnosis and treatment (EPSDT) program*.

Reimbursement is limited to no more than 26 15-minute units per member per 12-month period. Prior authorization is required for additional units of medically necessary targeted case management after the threshold of 26 15-minute units, per 12-month period is met.

Anemia

The purpose of screening for anemia is to uncover correctable nutritional anemia, such as iron deficiency anemia. Providers should follow current clinical standards for diagnosis of anemia based upon age of the child.

The risk assessment or screening for anemia should be performed as appropriate, beginning at 4 months of age, in accordance with recommendations in the Bright Futures/AAP periodicity schedule. All children should be tested for anemia at age 12 months. Hematocrit or hemoglobin testing is recommended.

Dyslipidemia

Dyslipidemia screening should be done once during each of these age-range visits:

- Between the 9-year and 11-year visits
- Between 17-year and 21-year visits

In addition, the Bright Futures/AAP periodicity schedule indicates intervals for performing a risk assessment, beginning at 24 months of age, to determine whether further action is required.

For more information, including recommendations for lipid and lipoprotein assessment in childhood and adolescence, see *Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents* from the National Heart, Lung and Blood Institute.

Tuberculosis

Information published by the AAP indicates that the most reliable tuberculosis control program is based on aggressive, expedient contact investigations, rather than routine skin test screening. The AAP recommends that an assessment of risk of exposure to tuberculosis be included in the 1-, 6-, 12- and 24-month visit as well as in all annual visits beginning at 3 years of age.

Only children deemed to have increased risk of exposure to persons with tuberculosis should be considered for tuberculin (Mantoux) skin testing. For children who receive a tuberculosis assessment that results in a skin test, use ICD-10 diagnosis code Z20.1 – *Contact with and (suspected) exposure to tuberculosis.*

The frequency of such skin testing should be according to the degree of risk of acquiring tuberculosis infection, as detailed in the following paragraphs. Routine tuberculin skin testing of children with no risk factors and residing in low-prevalence communities is not indicated.

- Children for whom immediate skin testing is indicated:
  - Children with contacts to persons with confirmed or suspected infectious tuberculosis, including contact to family members or associates in jail or prison in the last five years
  - Children with radiographic or clinical findings suggesting tuberculosis

  - Children immigrating from endemic areas, such as Asia, Africa, the Middle East and Latin America
  - Children with travel histories to endemic countries or significant contact with indigenous persons from such countries

- Children who should be tested annually for tuberculosis:
  - Children infected with human immunodeficiency virus (HIV)
  - Incarcerated adolescents

> *Note: Children infected with HIV should have a tuberculin skin test or an Interferon-Gamma Release Assay (IGRA) blood test. Tuberculin skin test is preferred over IGRAs for children under 5 years old.*

- Children who should be tested every two to three years:
  - Children exposed to the following individuals who are HIV-infected: homeless residents of nursing homes, institutionalized adolescents or adults, users of illicit drugs, incarcerated adolescents or adults, and migrant farm workers

Children who have no risk factors but who reside in high-prevalence regions and children whose histories for risk factors are incomplete or unreliable should be considered for tuberculin skin testing at 4 to 6 years old and 11 to 16 years old. The decision to test should be based on the local epidemiology of tuberculosis in conjunction with advice from regional tuberculosis control officials.

Family investigation is indicated whenever a tuberculin skin test result of a parent converts from negative to positive (indicating recent infection). Children of healthcare workers are not at increased risk of acquiring tuberculosis infection unless the workers' tuberculin skin test results convert to positive or the workers have diagnoses of tuberculosis disease.

The skin test interpretation guidelines for indurations of 5, 10 and 15 mm in diameter remain appropriate for decisions about contact investigations, tuberculosis control measures and preventive therapy.

Sexually Transmitted Infections

All sexually active adolescents must be considered at high risk for most sexually transmitted infections (STIs). The Bright Futures/AAP periodicity schedule suggests performing a risk assessment for STIs annually, beginning at 11 years of age to age 21, to determine whether testing is appropriate.

The most sensitive and specific tests for chlamydia and gonorrhea are those involving deoxyribonucleic acid (DNA) or ribonucleic acid (RNA) amplification (ligase chain reaction [LCR] and polymerase chain reaction [PCR]). Informed consent must be obtained from the individual. Culture of urine for these organisms is unsatisfactory. Antigen detection (Enzyme-Linked ImmunoSorbent Assay [ELISA] or direct fluorescent antibody) for chlamydia or gonorrhea is less sensitive than other methods.

Asymptomatic pyuria (white blood cells in urine) can be detected using dipsticks for leukocyte esterase. Among sexually active adolescents, the likelihood of infection with an STI is increased when leukocyte esterase is detected. Subsequent evaluation to identify the etiology of the pyuria is indicated. Chlamydia urethritis must be considered when leukocyte esterase is identified in the urine of adolescent males.

HIV

Providers should assess the risk factors of members outside of screening age recommendations to determine whether testing should be offered to those at increased risk. HIV testing should be completed once between the ages of 15 and 21 years. Individuals found to be 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 at least annually or more frequently, as per the AAP *Pediatrics* journal article *Adolescents and Young Adults: The Pediatrician's Role in HIV Testing and Pre- and Postexposure HIV Prophylaxis*.

Common HIV tests use protein products of the virus to detect antibodies produced by the infected host. The two antibody tests used most commonly are Enzyme-Linked ImmunoSorbent Assay (ELISA) and Western Blot.

These tests are not 100% sensitive and require the production of antibody by the host and the absence of cross-reaching antibodies. Newer methodologies have been developed to divide HIV-1 tests into several groups:

- Virus culture techniques
  - Peripheral blood mononuclear cells (PBMC) co-culture for HIV-1 isolation
  - Quantitative cell culture
  - Quantitative plasma culture
- Antibody detection tests
- Antigen detection tests
- Viral genome amplification tests
- Immune function tests

False positive ELISA reactions generally result from cross-reaching antibodies, such as those against class II human leukocyte antigens that are most often observed in multiparous women or in a person who has received multiple units of transfused blood. A common misconception is that a false positive ELISA will always be corrected by the confirmatory Western Blot test.

The most important parameter when interpreting HIV tests is the positive predictive value. The probability of a positive test result occurring in a truly infected individual is critically dependent on the prevalence of HIV infection of the population tested. In testing HIV drug users from a major U.S. city in which the seroprevalence is 50%, the positive predictive value would approach 100%. Conversely, in screening female schoolteachers from a rural area where the seroprevalence is 0.01%, 50% of the women testing positive would have a false positive result. The likelihood of two false negative tests (ELISA and Western Blot) is very low, even in areas where seroprevalence is low.

Hepatitis B Virus Infection

Providers should perform a risk assessment for hepatitis B virus (HBV) infection from newborn through 21 years old per the U.S. Preventive Services Task Force (USPSTF) and the AAP. Testing for the HBV infection should be performed if risk assessment determines the need.

Hepatitis C Virus Infection

Screening for hepatitis C virus (HCV) infection should occur at least once between the ages of 18 and 79 years (to be consistent with recommendations of the USPSTF and the CDC.

Those at increased risk of HCV infection, including those who are persons with past or current injection drug use, should be tested for HCV infection and reassessed annually.

Sudden Cardiac Arrest/Death

Risk assessment for sudden cardiac arrest or death should be performed between the ages of 11 and 21 years per the Bright Futures/AAP periodicity schedule. Providers should perform a risk assessment, as appropriate.

Cervical Dysplasia

The USPSTF recommends against screening for cervical cancer in women younger than 21 years.

Indications for pelvic examinations prior to age 21 are noted in *Gynecologic Examination for Adolescents in the Pediatric Office Setting*, from the AAP *Pediatrics* journal.

Section 7: Oral Health – Risk Assessment, Referral and Preventive Dental Care

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) providers are required to perform oral health risk assessments and make referrals for dental services as indicated on the Bright Futures/American Academy of Pediatrics (AAP) periodicity schedule at aap.org.

Preventive Fluoride Care

EPSDT providers should recommend brushing with fluoride toothpaste in the proper dosage for the child's age. After teeth are present, fluoride varnish may be applied every three to six months, in either the primary care or dental office.

> *Note: Reimbursement for physician-administered topical fluoride varnish is available from first tooth eruption until the age of 4; for more information see the Dental Services module.*

If the child's primary water source is deficient in fluoride, providers should consider oral fluoride supplementation for the 6-, 9-, 12-, 18-, 24- and 30-month visits, as well as at yearly visits for ages 3 through 16.

Dental Exam Recommendations

Children should visit a dentist as early as the first tooth eruption and no later than 12 months of age. The first examination by a dentist can reveal decay, unerupted or missing teeth, and the need for prophylaxis or treatment. Dental visits for preventive care for should continue every six months after the first visit.

Table 3 shows recommendations for pediatric dental examinations.

Table 3 – IHCP EPSDT Dental Periodicity Schedule, Adapted from the American Academy of Pediatric Dentistry (AAPD)

	6–12 months	12–24 months	2–6 years	6–12 years	>12 years
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]	■	■	■	■	■

	6–12 months	12–24 months	2–6 years	6–12 years	>12 years
Counseling for speech/language development	■	■	■		
Assessment and treatment of developing malocclusion			■	■	■
Assessment for pit and fissure sealants[11]			■	■	■
Substance abuse counseling				■	■
Counseling for intraoral/perioral piercing				■	■
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 six 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; then, when learning to walk, sports and routine playing, including the importance of mouth guards.*

[10] *At first, discuss the need for additional sucking: digits versus 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.*

Note: Table 3 is a recommendation; see the member's benefit plan for covered services.

Section 8: Health Education and Anticipatory Guidance

Health education, including anticipatory guidance, is a required component of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. At the outset, the physical or dental screening provides the initial context for providing health education. Health education and counseling to parents or guardians and to children is required and is designed to assist in understanding what to expect in terms of the child's development. Health education provides information about the benefits of healthy lifestyles and practices as well as accident and disease prevention.

The *Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents* (see the *Bright Futures Guidelines and Pocket Guide* page at aap.org) outlines sample questions for each visit under the EPSDT schedule, to address the expert panel's anticipatory guidance priorities for early childhood, middle childhood and adolescence. The intention of this resource is to invite discussion, gather information, address needs and concerns, and build a partnership with each family member.

At each screening visit, provide age-appropriate education and guidance concerning such topics as the following:

- Auto safety – Car seats, seat belts, air bags, positioning young or lightweight children in the backseat
- Recreational safety – Helmets and protective padding, playground equipment
- Home hazards – Poisons; accidental drowning; weapons; matches and lighters; staying at home alone; and use of detectors for smoke, radon gas and carbon monoxide
- Exposure to sun and secondhand smoke
- Alcohol and tobacco use
- Substance abuse
- Adequate sleep
- Exercise and nutrition, including eating habits and disorders
- Sexual activity
- Peer pressure
- Immunization and blood testing as required

Dental Health Education for Parents

Among the many dental conditions affecting children, dental caries (tooth decay) is the preeminent concern in the context of Medicaid services because of its substantial prevalence in the low-income population. Tooth decay continues to be the single most common chronic disease among U.S. children, despite the fact that it is highly preventable through early and sustained home care and regular professional preventive services.

Parents should be counseled on the importance of taking care of their babies' teeth. Teeth are susceptible to decay as soon as they appear in the mouth. Teeth can be brushed as soon as they appear.

Printed information about baby bottle tooth decay is available from the Indiana Department of Health (IDOH):

Oral Health
Indiana Department of Health
2 N. Meridian St., Section 7G
Indianapolis, IN 46204

Webpage: *Oral Health* at in.gov/health
MOMS Helpline: 844-MCH-MOMS (844-624-6667)

Dental caries are generally considered to be reversible or capable of being arrested in the earliest stages through a variety of proven interventions. Beyond the early stages, the decay process generally tends to advance and become more difficult and costly to repair the longer it remains untreated. Therefore, treatment initiated early in the course of dental caries development will almost always be easier for both child and dentist, less expensive, and more successful than treatment begun at a later time.

Dental care is one of the most commonly unmet treatment needs in children. Lower-income children have more untreated dental disease than more affluent children who obtain care on a regular periodic basis. Reasons for this disparity include the fact that low-income children are more likely to experience dental disease and frequently only access care on an episodic or urgent basis when decayed teeth cause pain or swelling.

It is generally recommended by the American Academy of Pediatric Dentistry (AAPD) that children receive dental care at six-month intervals or as indicated by the patient's needs or risk for disease. See the *Oral Health – Risk Assessment, Referral and Preventive Dental Care* section of this document for detailed recommendations regarding the periodicity of professional dental services for children.

Education Regarding Lead Poisoning for Pregnant Women and Children 6 Years Old or Younger

Lead poisoning is preventable. The key to successful prevention is to educate parents with young children about the potential sources of lead poisoning. The IDOH Lead and Healthy Homes Division offers information and resources for families, healthcare providers and local health departments.

See the IDOH Lead and Healthy Homes Division website at in.gov/health/leadsafe for lead-related brochures and fact sheets (in both English and Spanish) that may be viewed online or ordered by local health departments.

Referrals to Other Healthcare Programs

The following sections provide information about two other programs that may provide healthcare coverage or services for eligible children, in addition to Indiana Health Coverage Programs (IHCP) EPSDT.

Children's Special Health Care Services

Children's Special Health Care Services (CSHCS) is a medical coverage program that provides financial assistance for needed medical treatment to reduce complications and promote maximum quality of life for children, from birth to 21 years of age, with serious and chronic medical conditions.

Eligibility for CSHCS is based on both medical and financial criteria. Medical eligibility requires that a child be under 21 years of age and have a severe chronic medical condition that meets one of the following requirements:

- Has lasted (or is expected to last) at least two years
- Will produce disability or disfigurement or limits on function

- Requires a special diet or devices
- Would produce a chronic disabling physical condition if untreated

A family with an income (before taxes) at or below 250% of the federal poverty level may qualify.

Individuals can be enrolled in both the IHCP *and* CSHCS if they qualify for both programs. The EPSDT services must first be billed to the IHCP network (fee-for-service or managed care) to which the child is assigned before submitting the claim to CSHCS.

For more information about CSHCS, call 317-233-1351 or 800-475-1355, send an email to cshcscarecoordinatio@isdh.in.gov, or visit the CSHCS website at in.gov/health.

Indiana's First Steps Program

Indiana's First Steps early intervention system is a comprehensive, family-centered, community-based program that provides early intervention services to infants and young children with disabilities and those who are at risk for developmental delays. The First Steps program can provide a multidisciplinary evaluation and developmental assessment when children are referred. Early intervention services and/or supports are provided if the child is eligible; the services and supports are not income-based.

Families who are eligible to participate in the Indiana First Steps program include any child, from birth to 3 years old, who:

- Is experiencing developmental delays
- Has a diagnosed condition that has a high probability of resulting in a developmental delay
- Is at risk of having substantial developmental delay because of biological risk factors

All early intervention services must be agreed upon in advance by the child's parents, included on an Individualized Family Service Plan (IFSP) and be provided by qualified personnel. An IFSP is the written plan detailing the early intervention services or supports the child will receive.

All infants and toddlers are entitled to evaluation to determine eligibility, ongoing assessment and case management. The following services are specifically listed in the regulations. If appropriate for the child and family, they are included in the family's IFSP:

- Audiology
- Case management/service coordination
- Family training, counseling and home visits
- Health services necessary to enable the infant or toddler to benefit from the early intervention services
- Medical services only for diagnostic and evaluation purposes
- Nursing services
- Nutrition services
- Occupational therapy
- Physical therapy
- Psychological services
- Social work services
- Special instruction

- Speech-language pathology
- Transportation (direct and related costs of travel)

Although most First Steps agencies can provide all the early intervention services needed by children with developmental delays, IHCP members have the freedom of choice of providers for IHCP-covered services. Families can choose to receive IHCP-covered services from a provider not affiliated with the First Steps program.

In addition to the services children and their families can receive, it is important to get children with suspected or diagnosed developmental delays enrolled in the First Steps program for the following two special reasons:

- To enable eligible children and their families to receive early intervention services based on an IFSP
- To enable eligible children and their families to receive transitioning services when the child turns 3 years old and the Department of Education then becomes responsible for providing services for these children, if eligible, through an Individualized Education Plan (IEP)

For more information about the First Steps program, call 800-545-7763, email FirstStepsWeb@fssa.in.gov or visit the *First Steps* page at in.gov/fssa.

Services authorized by First Steps for children who are not enrolled in the IHCP are billable only to First Steps. If the child is enrolled in the IHCP and First Steps covers the service, providers should bill First Steps first, and First Steps will coordinate billing the IHCP (and CSHCS, if applicable). Non-First-Steps services billed for IHCP members follow normal protocol for each delivery system.

Section 9: Documentation Resources

Documentation for the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screenings should be incorporated into the documentation routinely kept for well-child check-ups. Because only a few activities differentiate EPSDT screening components and well-child services, it is imperative that those differences be reflected in the member's health record.

When screenings reveal the need for more frequent health exams or monitoring than recommended by the periodicity schedule, interperiodic screenings may be performed. The Indiana Health Coverage Programs (IHCP) covers interperiodic office visits and EPSDT screening exams up to the 30-office-visit maximum per individual, per year.

Review the *Evaluation and Management Services* and *Claim Submission and Processing* modules for information about billing non-EPSDT office visits and the office visit benefit limitation. Additional office visits, other than EPSDT screening exams, must be billed with appropriate evaluation and management (E/M) procedure codes for visits that are not full EPSDT screenings and **should *not* be billed using Z00.121 or Z00.129** as the primary diagnosis, so that they are reimbursed accordingly. If present and applicable, commercial insurance should be billed first.

The following sections present tools available for physicians' use in simplifying documentation of EPSDT screening components in medical records.

American Academy of Pediatrics

The Committee on Practice and Ambulatory Medicine publishes the Academy's preventive care guidelines, which can be accessed from the *Preventive Care/Periodicity Schedule* page at aap.org. Also known as the periodicity schedule, the guidelines set forth recommendations for the periodicity of the well-child visits and the types of screens and health assessments that should be conducted at each visit.

The Family and Social Services Administration (FSSA) has identified the American Academy of Pediatrics (AAP) periodicity schedule to be "best practice" and supports the schedule as the appropriate guidelines for EPSDT services.

If you have any questions, contact the Council on Community Pediatrics toll-free at 800-433-9016 or see the American Academy of Pediatrics website at aap.org.

Bright Futures

Bright Futures is a national health promotion initiative dedicated to the principle that every child deserves to be healthy and that optimal health involves a trusting relationship between the health professional, the child, the family and the community as partners in health practice.

The history of the patient is an important factor in making a proper assessment of the patient's health. The EPSDT screening physician has the responsibility of obtaining a family and medical history as part of the EPSDT screening examination.

The *Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents* at brightfutures.aap.org has resources for documenting the components of EPSDT services for all ages.

Certainly, no health provider has the time to do every intervention discussed in the Bright Futures guidelines for each age visit. The FSSA has committed to put into practice the guidelines set forth by the AAP, as described in the *Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents.*

For complete information about Bright Futures, see the *Bright Futures* page at aap.org. Inquiries may be submitted to the Bright Futures National Center using the *Contact Bright Futures* page or by mail at the following address:

Bright Futures at AAP
American Academy of Pediatrics
Bright Futures National Center
345 Park Blvd
Itasca, IL 60143

The following information can be obtained at the *Bright Futures* page:

- Previsit Questionnaires
- Supplemental Questionnaires
- Visit Documentation Forms
- Medical Screening Questionnaires
- Parent/Patient Education Handouts
- Guidelines for Health Supervision

Centers for Disease Control and Prevention, National Center for Health Statistics

A detailed medical growth chart designed for each age group is available from the Centers for Disease Control and Prevention (CDC) National Center for Health Statistics (NCHS). The CDC can be contacted in one of the following ways:

Centers for Disease Control and Prevention
1600 Clifton Rd.
Atlanta, GA 30329-4027

Toll-Free Telephone: 800-232-4636
Webpage: *CDC Growth Charts* at cdc.gov/growthcharts

Providers are also encouraged to periodically check the CDC NCHS website at cdc.gov for announcements and updates about distribution and training materials.

Indiana Department of Health

For the care of children who are receiving competent parenting, have no manifestations of any major health problems, and are growing and developing in satisfactory fashion, the Indiana Department of Health (IDOH) uses the *Recommendations for Preventive Pediatric Health Care* (also known as the periodicity schedule), accessible from the *Preventive Care/Periodicity Schedule* page at aap.org. These guidelines represent a consensus by the Committee of Practice and Ambulatory Medicine in consultations with the national committees and sections of the AAP.

For more information, contact:

Indiana Department of Health
Maternal and Child Health Division
2 N. Meridian St.
Indianapolis, IN 46204

Telephone: 317-233-7940
Email: ISDHMCH@isdh.in.gov
Webpage: *Maternal and Child Health* at in.gov/health/mch

U.S. Preventive Services Task Force

The U.S. Preventive Services Task Force (USPSTF) makes evidence-based recommendations to primary care professionals about preventive services such as screenings, behavioral counseling and preventive medications. For more information and to search through recommendations, see the USPSTF website.