

North Carolina Medicaid Special Bulletin

An Information Service of the Division of Medical
Assistance

Visit DMA on the web at <http://www.ncdhhs.gov/dma>

Published by HP Enterprise Services, Fiscal Agent for the North Carolina
Medicaid Program

Number 1

July 2012



Attention: Health Check Providers

Effective July 1, 2012



**Health Check
Billing Guide
2012**

EPSDT POLICY INSTRUCTIONS 1
 Background 1
 EPSDT Features 2
 EDPST Criteria 3

IMPORTANT POINTS ABOUT EPSDT COVERAGE 3
 General 3
 EPSDT Coverage and CAP Waivers 6
 EPSDT Coverage and Mental Health/Developmental Disability/Substance Abuse (MH/DD/SA) Services 8

PROCEDURE FOR REQUESTING EPSDT SERVICES 9
 Covered State Medicaid Plan Services 9
 Services Formerly Covered by Children’s Special Health Services (CSHS) 9
 Non-Covered State Medicaid Plan Services 10

PROVIDER DOCUMENTATION 11

FOR FURTHER INFORMATION ABOUT EPSDT 11

ATTACHMENTS 11
 Listing of EPSDT Services 11
 Non-Covered State Medicaid Plan Services Request Form for Recipients Under 21 Years Old 13

MEDICAID RECIPIENT DUE PROCESS 13
(RIGHT TO APPEAL PRIOR APPROVAL DECISIONS)

HEALTH CHECK OVERVIEW 17
 Health Check/EPSDT Periodicity Schedule 18
 Periodic and Interperiodic Health Check Screening Assessments 19

HEALTH CHECK SCREENING ASSESSMENT COMPONENTS 19
 State Laboratory of Public Health for Blood Lead Testing 32

IMMUNIZATIONS 33
 General Billing Guidance for Immunization Administration Codes 33
 North Carolina Immunization Program/Vaccines for Children Program 38

HEALTH CHECK BILLING REQUIREMENTS 44
 Requirement 1: Identify and Record Diagnosis Code(s) 44
 Periodic Health Check Screening Assessment 44
 Interperiodic Health Check Screening Assessment 44
 Requirement 2: Identify and Record Preventive Medicine Code and Component Code 45
 Requirement 3: Health Check Modifier – EP 45
 Requirement 4: Record Referrals 45

Requirement 5: Next Screening Date46
 Provider-Entered Next Screening Date.....46
 Systematically Entered Next Screening Date46
Requirement 6: Identify and Record Immunization Administration CPT Code(s)
 and the EP Modifier46
Health Check Related ICD-9-CM and CPT Codes.....47
Preventive Medicine CPT Codes48

TIPS FOR BILLING.....49
 All Health Check Providers49
 Private Sector and Local Health Department Health Check Providers49
 Federally Qualified Health Center and Rural Health Clinic Providers Only.....50

HEALTH CHECK COORDINATION51

HEALTH CHECK CLAIM DENIALS – EXPLANATION OF BENEFITS52

HEALTH CHECK BILLING QUICK REFERENCE SHEET52

IMMUNIZATION BILLING REFERENCE SHEET54

RESOURCE LIST 60

HEALTH CHECK CMS-1500 CLAIM FORM EXAMPLES63

N.C. HEALTH INFORMATION SYSTEM SCREEN EXAMPLES.....75

N.C. HEALTH CHECK PERIODICITY SCHEDULE & CODING MATRIX.....80

Effective with date of service July 1, 2012, please replace the April 2012 Special Bulletin II, *Health Check Billing Guide 2012*, with this Special Bulletin. For your convenience key words and phrases have been **bolded** and new information for 2012 has been highlighted in gray.

In the state of North Carolina, the EPSDT services program is administered under the name Health Check, which is the Medicaid Program for Children.

EPSDT POLICY INSTRUCTIONS

Background

Federal Medicaid law at 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act] requires state Medicaid programs to provide Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for recipients under 21 years of age. Within the scope of EPSDT benefits under the federal Medicaid law, states are required to cover any service that is medically necessary “to correct or ameliorate a defect, physical or mental illness, or a condition identified by screening,” whether or not the service is covered under the North Carolina State Medicaid Plan. The services covered under EPSDT are limited to those within the scope of the category of services listed in the federal law at 42 U.S.C. § 1396d (a) [1905(a) of the Social Security Act]. The listing of EPSDT/Medicaid services is appended to this instruction.

EPSDT services include any medical or remedial care that is medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem]. This means that EPSDT covers most of the treatments a recipient under 21 years of age needs to stay as healthy as possible, and North Carolina Medicaid must provide for arranging for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment the need for which is disclosed by such child health screening services. “Ameliorate” means to improve or maintain the recipient’s health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Even if the service will not cure the recipient’s condition, it must be covered if the service is medically necessary to improve or maintain the recipient’s overall health.

EPSDT makes short-term and long-term services available to recipients less than 21 years of age without many of the restrictions Medicaid imposes for services under a waiver OR for adults (recipients 21 years of age and over). For example, a service must be covered under EPSDT if it is necessary for immediate relief (e.g., pain medication). It is also important to note that treatment need not ameliorate the recipient’s condition taken as a whole, but need only be medically necessary to ameliorate one of the recipient’s conditions. The services must be prescribed by the recipient’s physician, therapist, or other licensed practitioner and often must be approved in advance by Medicaid. Refer to the *Basic Medicaid Billing Guide*, Section 6, Prior Approval, and the prior approval web page, respectively at the addresses specified below for further information about EPSDT and prior approval requirements.

- <http://www.ncdhhs.gov/dma/provider/library.htm>
- <http://ncdhhs.gov/dma/provider/priorapproval.htm>

EPSDT Features

Under EPSDT, there is:

1. No Waiting List for EPSDT Services

EPSDT does not mean or assure that physicians and other licensed practitioners or hospitals/clinics chosen by the recipient and/or his/her legal representative will not have waiting lists to schedule appointments or medical procedures. However, Medicaid cannot impose any waiting list and must provide coverage for corrective treatment for recipients less than 21 years of age.

2. No Monetary Cap on the Total Cost of EPSDT Services*

A child under 21 years of age financially eligible for Medicaid is entitled to receive EPSDT services without any monetary cap provided the service meets all EPSDT criteria specified in this policy instruction. If enrolled in a Community Alternatives Program (CAP), then the recipient under 21 years of age may receive BOTH waiver and EPSDT services. However, it is important to remember that the conditions set forth in the waiver concerning the recipient's budget and continued participation in the waiver apply. (See "EPSDT Coverage and CAP Waivers" for further detail.)

*EPSDT services are defined as Medicaid services within the scope of the category of services listed in the federal law at 42 U.S.C. § 1396d (a) [1905(a) of the Social Security Act]. See attached listing.

3. No Upper Limit on the Number of Hours or Units under EPSDT

For clinical coverage policy limits to be exceeded, the provider's documentation must address why it is medically necessary to exceed the limits in order to correct or ameliorate a defect, physical or mental illness, or condition [health problem].

4. No Limit on the Number of EPSDT Visits to a Physician, Therapist, Dentist, or Other Licensed Clinician

To exceed such limits, the provider's documentation must address why it is medically necessary to exceed the limits in order to correct or ameliorate a defect, physical or mental illness, or condition [health problem].

5. No Set List that Specifies When or What EPSDT Services or Equipment May Be Covered

Only those services within the scope of those listed in the federal law at 42 U.S.C. § 1396d (a) [1905(a) of the Social Security Act] can be covered under EPSDT. See attached listing. However, specific limitations in service definitions, clinical policies, or DMA billing codes MAY NOT APPLY to requests for services for children under 21 years of age.

6. No Co-payment or Other Cost to the Recipient**7. Coverage for Services That Are Never Covered for Recipients over 21 Years of Age**

Only those services within the scope of those listed in the federal law at 42 U.S.C. § 1396d (a) [1905(a) of the Social Security Act] can be covered under EPSDT. See attached listing. Provider documentation must address why the service is medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem].

8. Coverage for Services Not Listed in the N.C. State Medicaid Plan

Only those services within the scope of those listed in the federal law at 42 U.S.C. § 1396d (a) [1905(a) of the Social Security Act] can be covered under EPSDT. See attached listing.

EPSDT Criteria

It is important to note that the service can only be covered under EPSDT if all criteria specified below are met.

1. EPSDT services must be **coverable services** within the scope of those listed in the federal law at 42 U.S.C. § 1396d (a) [1905(a) of the Social Security Act]. For example, “rehabilitative services” are a covered EPSDT service, even if the particular rehabilitative service requested is not listed in DMA clinical policies or service definitions.
2. The service **must be medically necessary** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] diagnosed by the recipient’s physician, therapist, or other licensed practitioner. By requiring coverage of services needed to correct or ameliorate a defect, physical or mental illness, or a condition [health problem], EPSDT requires payment of services that are medically necessary to sustain or support rather than cure or eliminate health problems to the extent that the service is needed to correct or ameliorate a defect, physical or mental illness, or condition [health problem].
3. The requested service must be determined to be **medical in nature**.
4. The service must be **safe**.
5. The service must be **effective**.
6. The service must be generally recognized as an **accepted method of medical practice or treatment**.
7. **The service must not be experimental / investigational**.

Additionally, services can only be covered if they are provided by a North Carolina Medicaid enrolled provider for the specific service type. This may include an out-of-state provider who is willing to enroll if an in-state provider is not available.

Important Points about EPSDT Coverage

General

1. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does NOT eliminate the requirement for prior approval.
2. EPSDT services must be coverable within the scope of those listed in the federal law at 42 U.S.C. § 1396d (a) [1905(a) of the Social Security Act]. EPSDT requires Medicaid to cover these services if they are medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]. “Ameliorate” means to improve or maintain the recipient’s health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.
3. Recipients under 21 must be afforded access to the full panoply of EPSDT services, including case management. Case management must be provided to a Medicaid eligible child if medically necessary to correct or ameliorate the child’s condition regardless of eligibility for CAP waiver services.

4. EPSDT services need not be services that are covered under the North Carolina State Medicaid Plan or under any of the Division of Medical Assistance's (DMA) clinical coverage policies or service definitions or billing codes.
5. Under EPSDT, North Carolina Medicaid must make available a variety of individual and group providers qualified and willing to provide EPSDT services.
6. EPSDT operational principles include those specified below.
 - a. When state staff or utilization review (UR) vendors review a covered state Medicaid plan services request for prior approval or continuing authorization for an individual under 21 years of age, the reviewer will apply the EPSDT criteria to the review. This means that:
 - (1) Requests for EPSDT services do NOT have to be labeled as such. Any proper request for services for a recipient under 21 years of age is a request for EPSDT services. For recipients under 21 years of age enrolled in a CAP waiver, a request for services must be considered under EPSDT as well as under the waiver if the requested service is both a waiver service and a service within the scope of the category of services listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]
 - (2) The decision to approve or deny the request will be based on the recipient's medical need for the service to correct or ameliorate a defect, physical [or] mental illness, or condition [health condition].
 - b. The specific coverage criteria (e.g., particular diagnoses, signs, or symptoms) in the DMA clinical coverage policies or service definitions do NOT have to be met for recipients under 21 years if the service is medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problems] if approved under the auspices of EPSDT.
 - c. The specific numerical limits (number of hours, number of visits, or other limitations on scope, amount or frequency) in DMA clinical coverage policies, service definitions, or billing codes do NOT apply to recipients under 21 years of age if more hours or visits of the requested service are medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem]. This includes the hourly limits and location limits on Medicaid Community Support Services (CSS), a non-covered state Medicaid plan service, for example.
 - d. Other restrictions in the clinical coverage policies, such as the location of the service, prohibition on multiple services on the same day or at the same time (e.g., day treatment and residential treatment) must also be waived under EPSDT as long as the services are medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem].
 - e. Out-of-state services are NOT covered if similarly efficacious services that are medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problems] are available anywhere in the state of North Carolina. Services delivered without prior approval will be denied. There is no retroactive prior approval for services that require prior approval, unless there is retroactive Medicaid eligibility. Refer to the *Basic Medicaid Billing Guide*, Section 6, Prior Approval, for further information regarding the provision of out-of-state services.

- f.** Providers or family members may write directly to the Assistant Director for Clinical Policy and Programs, Division of Medical Assistance, requesting a review for a specific service. However, DMA vendors and contractors must consider any request for state Medicaid plan services for a recipient less than 21 years of age under EPSDT criteria when the request is made by the recipient's physician, therapist, or other licensed practitioner in accordance with the Division's published policies. If necessary, such requests will be forwarded to DMA or the appropriate vendor.
- g.** Requests for prior approval for services must be fully documented to show medical necessity. This requires current information from the recipient's physician, other licensed clinicians, the requesting qualified provider, and/or family members or legal representative. If this information is not provided, Medicaid or its vendor will have to obtain the needed information, and this will delay the prior approval decision. See procedure below for requesting EPSDT services regarding further detail about information to be submitted.
- h.** North Carolina Medicaid retains the authority to determine how an identified type of equipment, therapy, or service will be met, subject to compliance with federal law, including consideration of the opinion of the treating physician and sufficient access to alternative services. Services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner, the determination process does not delay the delivery of the needed service, and the determination does not limit the recipient's right to free choice of North Carolina Medicaid enrolled providers who provide the approved service. It is not sufficient to cover a standard, lower cost service instead of a requested specialized service if the lower cost service is not equally effective in that individual case.
- i.** Restrictions in CAP waivers such as no skilled nursing for the purpose of monitoring do not apply to EPSDT services if skilled monitoring is medically necessary. Nursing services will be provided in accordance with 21 NCAC 36.0221 (adopted by reference).
- j.** Durable medical equipment (DME), assistive technology, orthotics, and prosthetics do NOT have to be included on DMA's approved lists or be covered under a CAP waiver program in order to be covered under EPSDT subject to meeting the criteria specified in this policy.
- k.** Medicaid will cover treatment that the recipient under 21 years of age needs under this EPSDT policy as long as the requested service is within the scope of the category of services listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]
- l.** North Carolina Medicaid will enroll providers, set reimbursement rates, set provider qualifications, and assure the means for claims processing when the service is not already established in the North Carolina State Medicaid Plan.
- m.** Requests for prior approval of services are to be decided with reasonable promptness, usually within 15 business days. No request for services for a recipient under 21 years of age will be denied, formally or informally, until it is evaluated under EPSDT.

- n. If services are denied, reduced, or terminated, proper written notice with appeal rights must be provided to the recipient and copied to the provider. The notice must include reasons for the intended action, citation that supports the intended action, and notice of the right to appeal. Such a denial can be appealed in the same manner as any Medicaid service denial, reduction, or termination. See the section of this manual entitled Medicaid Recipient Due Process (Right to Appeal Prior Approval Decision).
- o. The recipient has the right to continued Medicaid payment for services currently provided pending appeal. This includes the right to reinstatement of services if the re-authorization was submitted prior to the expiration of the current authorization.

EPSDT Coverage and CAP Waivers

1. Waiver services are available only to participants in the Community Alternatives Program (CAP) and are not a part of the EPSDT benefit unless the waiver service is ALSO an EPSDT service (e.g. durable medical equipment).
2. Any request for services for a CAP recipient under age 21 must be evaluated under BOTH the waiver and EPSDT if the requested service is a service within the scope of the category of services listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]
3. Additionally, a child financially eligible for Medicaid outside of the waiver is entitled to elect EPSDT services without any monetary cap instead of waiver services.
4. ANY child enrolled in a CAP program can receive BOTH waiver services and EPSDT services. However, if enrolled in CAP program, approval of the waiver services as well as the delivery and cost of the recipient's services must be in compliance with the requirements established by the waiver and this policy. Relative to cost of the services, cost neutrality must be maintained in accordance with waiver requirements. While a recipient may exceed waiver limits, prior approval must be obtained as specified below.
 - a. CAP for Children (CAP/C) and CAP for Disabled Adults (CAP/DA):
For a service that is both a waiver service and EPSDT service, the recipient may exceed the limit on that individual service, and prior approval is required before the limit is exceeded. If the service is a waiver service only, the limit may not be exceeded. Cost neutrality must be maintained in accordance with waiver requirements.
 - b. CAP for Persons with Intellectual and Other Developmental Disabilities (CAP/IDD):
Prior approval to exceed \$100,000 per year must be obtained from the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS). Cost neutrality must be maintained in accordance with waiver requirements.
5. A recipient under 21 years of age on a waiting list for CAP services, who is an authorized Medicaid recipient without regard to approval under a waiver, is eligible for necessary EPSDT services without any waiting list being imposed by Medicaid. For further information, see "No Waiting List for EPSDT".

6. EPSDT services must be provided to recipients less than 21 years of age in a CAP program under the same standards as other children receiving Medicaid services. For example, some CAP recipients under 21 years of age may need daily in-school assistance supervised by a licensed clinician through Community Support Services (CSS), a non-covered* state Medicaid plan service, or In-Home Care for children (IHCC), a covered* state Medicaid plan service. It is important to note that Medicaid services coverable under EPSDT may be provided in the school setting, including to CAP/IDD recipients. Services provided in the school and covered by Medicaid must be included in the recipient's budget.
7. CAP/DA case managers can deny a request for CAP/DA waiver services. If a CAP/DA case manager denies, reduces, or terminates a CAP/DA waiver service, it is handled in accordance with DMA's prior approval and due process procedures. No other case manager can deny a service request supported by a licensed clinician, either formally or informally.
8. When a recipient under 21 years of age is receiving CAP services, case managers must request covered state Medicaid plan services as indicated below:
 - a. CAP/C: Requests for medical, dental, and behavioral health services covered under the North Carolina State Medicaid Plan that require prior approval must be forwarded to the appropriate vendor. Please refer to the Utilization Review Contractor table on the prior approval web page at <http://ncdhhs.gov/dma/provider/priorapproval.htm> to locate the appropriate vendor in the recipient's county/catchment area and/or service type. A plan of care revision for waiver services must be submitted to the CAP/C consultant as well.
 - b. CAP/DA: Requests for medical, dental, and behavioral health services covered under the North Carolina State Medicaid Plan that require prior approval must be forwarded to the appropriate vendor. Please refer to the Utilization Review Contractor table on the prior approval web page at <http://ncdhhs.gov/dma/provider/priorapproval.htm> to locate the appropriate vendor in the recipient's county/catchment area and/or service type. A plan of care revision for waiver services must be submitted to the CAP/DA case manager as well. All EPSDT requests must be forwarded to the CAP/DA consultant at DMA.
 - c. CAP/IDD: Requests for medical, dental, and behavioral health services covered under the North Carolina State Medicaid Plan. Please refer to the Utilization Review Contractor table on the prior approval web page at <http://ncdhhs.gov/dma/provider/priorapproval.htm> to locate the appropriate vendor in the recipient's county/catchment area and/or service type. Plan of care revisions must be submitted in accordance with the policies and procedures published by DMA or the vendor (statewide or LME) reviewing the plan of care request.

NOTE: Do not submit medical and dental requests to the statewide vendor or the LME for review.
 - d. All EPSDT and covered state Medicaid plan requests for *behavioral health services* must be forwarded to the statewide vendor or the LME responsible for utilization review in the recipient's county/catchment area as indicated in

the Utilization Review Contractor table on the prior approval web page at <http://ncdhhs.gov/dma/provider/priorapproval.htm>. This includes requests for children not in a waiver who have a case manager. Requests for medical and dental services covered under the North Carolina State Medicaid Plan must be forwarded to the appropriate vendor (medical or dental) for review and approval. Plan of care revisions must be submitted in accordance with the policies and procedures published by DMA or the vendor (statewide or LME) reviewing the plan of care request.

9. An appeal under CAP must also be considered under EPSDT criteria as well as under CAP provisions if the appeal is for a Medicaid recipient under 21 years of age and the service under appeal is both a waiver service and a service within the scope of the category of services listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]

EPSDT Coverage and Mental Health/Developmental Disability/Substance Abuse (MH/DD/SA) Services

1. Staff employed by LMEs CANNOT deny requests for services, formally or informally. Requests must be forwarded to appropriate utilization vendor (statewide or LME responsible for utilization review in the recipient's county/catchment area as indicated in the Utilization Review Contractor table on the prior approval web page at <http://ncdhhs.gov/dma/provider/priorapproval.htm>.) if supported by a licensed clinician.
2. LMEs may NOT use the Screening, Triage, and Referral (STR) process or IDD eligibility process as a means of denying access to Medicaid services. Even if the LME STR screener does not believe the child needs enhanced services, the family must be referred to an appropriate Medicaid provider to perform a clinical evaluation of the child for any medically necessary service.
3. Requests for prior approval of MH/DD/SA services for recipients under 21 must be sent to statewide vendor or the LME responsible for utilization review in the recipient's county/catchment area as indicated in the Utilization Review Contractor table on the prior approval web page at <http://ncdhhs.gov/dma/provider/priorapproval.htm>. If the request needs to be reviewed by DMA clinical staff, the utilization review vendor will forward the request to the Assistant Director for Clinical Policy and Programs.
4. If a recipient under 21 years of age has a developmental disability diagnosis, this does not necessarily mean that the requested service is habilitative and may not be covered under EPSDT. The EPSDT criteria of whether the service is medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem] apply. Examples include dual diagnoses and behavioral disorders. All individual facts must be considered.
5. All EPSDT requirements (except for the procedure for obtaining services) fully apply to all behavioral health utilization review vendors.

Procedure for Requesting EPSDT Services

Covered State Medicaid Plan Services

Should the service, product, or procedure require prior approval, the fact that the recipient is under 21 years of age does NOT eliminate the requirement for prior approval. If prior approval is required and if the recipient does not meet the clinical coverage criteria or needs to exceed clinical coverage policy limits, submit documentation with the prior approval request that shows how the service at the requested frequency and amount is medically necessary and meets all EPSDT criteria, including to correct or ameliorate a defect, physical or mental illness, or condition [health problem], to the appropriate vendor or DMA staff. When requesting prior approval for a covered service, refer to the *Basic Medicaid Billing Guide*, Section 6. If the request for service needs to be reviewed by DMA clinical staff, the vendor will forward the request to the Assistant Director for Clinical Policy and Programs. Should further information be required, the provider will be contacted. See the Provider Documentation section of these instructions for information regarding documentation requirements.

In the event prior approval is not required for a service and the recipient needs to exceed the clinical coverage policy limitations, prior approval from a vendor or DMA staff is required. See the Provider Documentation section of these instructions for information regarding documentation requirements.

Services Formerly Covered by Children's Special Health Services (CSHS)

Previously, requests for pediatric mobility systems, cochlear implants and accessories, ramps, tie-downs, car seats, vests, DME, orthotics and prosthetics, home health supplies, not listed on DME fee schedules for recipients under 21 years of age, oral nutrition, augmentative and alternative communication devices, and over-the counter medications were approved and processed by CSHS. These services have been transferred from CSHS to Medicaid as specified below.

- Pediatric Mobility Systems, including non-listed components – Send to HP Enterprise Services using the Certificate of Medical Necessity/Prior Approval (CMN/PA Form). Refer to Clinical Coverage Policy 5A, *Durable Medical Equipment*, for details (on DMA's web site at <http://www.ncdhhs.gov/dma/mp/>).
- Cochlear/Auditory Brainstem Implants and Accessories – Fax all requests for external parts replacement and repair, in letter format, to the appropriate cochlear or auditory brainstem implant manufacturer. The manufacturer will process requests, obtain prior approval for external speech processors, and file claims. Guidelines for the letter requesting external parts replacement or repair can be obtained from the cochlear or auditory brainstem manufacturer.
- Oral Nutrition Formula on DMA Fee Schedules – Send requests to HP Enterprise Services. Refer to Clinical Coverage Policy 5A, *Durable Medical Equipment*, for details (on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/>). For those formulas not included on the DMA fee schedule and that have not been assigned Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes, submit the request to the Assistant Director, Clinical Policy and Programs as specified on the Non-Covered State Medicaid Plan Services Request Form for Recipients under 21 Years of Age located on DMA's Web site at <http://www.ncdhhs.gov/dma/provider/forms.htm>.
- Augmentative and Alternative Communication Devices on DMA Fee Schedules – Send requests to HP Enterprise Services. Refer to Clinical Policy 5A, *Durable*

Medical Equipment, for details (on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/>).

- Ramps, Tie Downs, Car Seats, and Vests – Effective with date of request September 1, 2008, CSHS no longer authorizes payment for ramps, tie-downs, car seats, and vests. These items are not included in the DME covered by Medicaid, nor are they covered under EPSDT services, which cover medical equipment and supplies suitable for use in the home for Medicaid recipients under the age of 21. However, if the recipient is covered under a Medicaid waiver, these items may be considered if covered under the waiver.

Non-Covered State Medicaid Plan Services

Requests for non-covered state Medicaid plan services are requests for services, products, or procedures that are not included at all in the North Carolina State Medicaid Plan but are coverable under federal Medicaid law, 1905(r) of the Social Security Act, for recipients under 21 years of age. *See attached listing.* Requests for non-covered state Medicaid plan services that have been assigned CPT and HCPCS codes should be submitted to the appropriate vendor. Medical, dental, and behavioral health service requests for non-covered state Medicaid plan services, and requests for a review when there is no established review process for a requested services that have not been assigned CPT and HCPCS codes and requests for a review when there is no established review process for a requested service should be submitted to the Assistant Director, Clinical Policy and Programs, Division of Medical Assistance at the address or facsimile (fax) number specified on the Non-Covered State Medicaid Plan Services Request Form for Recipients under 21 Years of Age. To decrease delays in reviewing non-covered state Medicaid plan requests, providers are asked to complete this form. A review of a request for a non-covered state Medicaid plan service includes a determination that ALL EPSDT criteria specified in these instructions are met.

Requests for the services listed below should be sent to the Assistant Director, Clinical Policy and Programs, DMA and should be submitted on the Non-Covered State Medicaid Plan Services Request Form for Recipients under 21 Years of Age as specified at the end of this section and unless otherwise specified.

- **Any other service not listed on the DMA fee schedules for recipients under 21 years of age that appears at 1905(a) of the Social Security Act.**
- **Over-the-Counter (OTC) Medications**—If the OTC has a National Drug Code (NDC) number and the manufacturer has a valid rebate agreement with the Centers for Medicare and Medicaid Services (CMS), but the drug does not appear on DMA's approved coverage listing of OTC medications.

Send requests for the services immediately above, any other non-covered state Medicaid plan services that are coverable under 1905(a) of the Social Security Act, or requests for a review when there is no established review process for a requested service on the Non-Covered State Medicaid Plan Services Request Form for Recipients under 21 Years of Age and mail or fax to:

Assistant Director for Clinical Policy and Programs
 Division of Medical Assistance
 2501 Mail Service Center
 Raleigh NC 27699-2501
 FAX: 919-715-7679

PROVIDER DOCUMENTATION

Documentation for either covered or non-covered State Medicaid plan services should show how the service will correct or ameliorate a defect, physical or mental illness, or a condition [health problem]. This includes:

1. documentation showing that medical necessity and policy criteria are met;
2. documentation to support that all EPSDT criteria are met; and
3. evidence-based literature to support the request, if available.

Should additional information be required, the provider will be contacted.

FOR FURTHER INFORMATION ABOUT EPSDT

- Important additional information about EPSDT and prior approval is found in the *Basic Medicaid Billing Guide*, **Sections 2 and 6**, and on the DMA EPSDT provider page. The web page addresses are specified below.
Basic Medicaid Billing Guide: <http://www.ncdhhs.gov/dma/basicmed/>
Health Check Billing Guide: <http://www.ncdhhs.gov/dma/healthcheck/>
EPSDT Provider Page: <http://www.ncdhhs.gov/dma/epsdt/>
- DMA and its vendors will conduct ongoing training for employees, agents, and providers on this instruction. Training slides are available on the EPSDT provider page on DMA's website at <http://www.ncdhhs.gov/dma/epsdt/>.

ATTACHMENT

- Listing of Medicaid (EPSDT) Services Found in the Social Security Act at 1905(a) [42 U.S.C. § 1396d(a)]

Listing of EPSDT Services Found at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]

- Inpatient hospital services (other than services in an institution for mental disease)
- Outpatient hospital services
- Rural health clinic services (including home visits for homebound individuals)
- Federally qualified health center services
- Other laboratory and X-ray services (in an office or similar facility)
- EPSDT (**Note:** EPSDT offers periodic screening services for recipients under age 21 and Medicaid covered services necessary to correct or ameliorate a diagnosed physical or mental condition)

- Family planning services and supplies
- Physician services (in office, recipient's home, hospital, nursing facility, or elsewhere)
- Medical and surgical services furnished by a dentist
- Home health care services (nursing services; home health aides; medical supplies, equipment, and appliances suitable for use in the home; physical therapy, occupation therapy, speech pathology, audiology services provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services)
- Private duty nursing services
- Clinic services (including services outside of clinic for eligible homeless individuals)
- Dental services
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders
- Prescribed drugs
- Dentures
- Prosthetic devices
- Eyeglasses
- Services in an intermediate care facility for the mentally retarded
- Medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law, specified by the Secretary (also includes transportation by a provider to whom a direct vendor payment can appropriately be made)
- Other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level
- Inpatient psychiatric hospital services for individuals under age 21
- Services furnished by a midwife, which the nurse midwife is legally authorized to perform under state law, without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider throughout the maternity cycle
- Hospice care
- Case management services
- TB-related services
- Respiratory care services

- Services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner, which the practitioner is legally authorized to perform under state law
- Personal care services (in a home or other location) furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease
- Primary care case management services

Definitions of the above federal Medicaid services can be found in the Code of Federal Regulations 42 CFR 440.1-440.185 at

<http://www.gpo.gov/fdsys/search/pagedetails.action?collectionCode=CFR&searchPath=Title+42%2FChapter+IV%2FSubchapter+C%2FPart+440%2FSubpart+A&granuleId=&packageId=CFR-2006-title42-vol1&oldPath=Title+42%2FChapter+IV%2FSubchapter+C%2FPart+440&fromPageDetails=true&collapse=true&ycord=570>.

Non-Covered State Medicaid Plan Services Request Form for Recipients Under 21 Years Old can be downloaded at

<http://www.ncdhhs.gov/dma/provider/forms.htm>

MEDICAID RECIPIENT DUE PROCESS (RIGHT TO APPEAL A PRIOR APPROVAL DECISION)

Medicaid is an entitlement program, and it is a recipient's constitutional right to appeal a Medicaid decision that denies, reduces, terminates, or suspends a request for Medicaid services. The Medicaid prior approval and recipient hearing processes are described below.

FILING A RECIPIENT HEARING REQUEST FORM: Medicaid recipients or their legal representative, guardian, responsible party have the right to appeal adverse decisions of the State Medicaid agency and receive a fair hearing pursuant to the Social Security Act, 42 C.F.R. 431.200 *et seq.* and N.C.G.S. §108A-70.9. If the recipient decides to appeal Medicaid's decision to deny, terminate, reduce, or suspend the services requested by his/her provider, the recipient must sign and date the appeal request form and send it to the Office of Administrative Hearings (OAH) **and** the Department of Health and Human Services (DHHS) by mail or fax within **30 days of the date the notice was mailed**. The mailing addresses and telephone and fax numbers for OAH and DHHS are located on the appeal request form. Providers may not file appeals on behalf of recipients unless the recipient lists the provider as the representative on the appeal request form.

UNDERSTANDING THE APPEAL PROCESS: If the recipient/legal representative, guardian, responsible party chooses to appeal, he/she may represent himself/herself during the appeal process, hire an attorney, or ask a relative, friend, or other spokesperson to speak for them. The recipient's/legal representative's, guardian's, responsible party's case will begin as soon as the completed recipient hearing request form is **received and filed** with the OAH. The recipient/legal representative, guardian, responsible party will

be contacted by OAH or the Mediation Network of North Carolina to discuss his/her case and to be offered an opportunity for mediation in an effort to resolve the appeal. Contact is made by telephone or **trackable mail**. So, it is important for the recipient/legal representative, guardian, responsible party to accept all **trackable mail** from OAH or the mediation center. **NOTE: New information about the recipient's request that was not provided to Medicaid previously may be submitted at any time during the mediation and appeal processes.**

Mediation is an informal process where the recipient /legal representative, guardian, responsible party and Medicaid have an opportunity to discuss the case with a mediator in hopes that the hearing issues will be resolved. If mediation resolves the case, the hearing will be dismissed, and services will be provided as specified during the mediation process. The recipient/legal representative, guardian, responsible party may participate by telephone or in-person. Medicaid representatives will participate by telephone. Please note the important points below about mediation.

- If the recipient/legal representative, guardian, responsible party appoints a spokesperson, the spokesperson cannot overrule the wishes of someone who is competent and who understands the proceedings. The recipient's or his/her legal representative's, guardian's, responsible party's wishes are paramount at all times.
- The parties to the mediations are the recipient or his/her legal representative, guardian, responsible party and Medicaid representatives, and no appointed spokesperson shall control or interfere with this dynamic.
- Mediators control the mediations, not the appointed spokesperson.
- **Mediation is confidential and legally binding.**

If the recipient/legal representative, guardian, responsible party does not accept the offer of mediation or the results of mediation, the case will proceed to hearing and will be heard by an administrative law judge with OAH. The recipient/legal representative, guardian, responsible party will be notified by **trackable mail** of the date, time, and location of the hearing. The administrative law judge will make a decision and will send a written decision by **trackable mail** to the recipient and all petitioners identified by OAH (usually those individuals listed on the appeal request form). If the recipient/legal representative, guardian, responsible party does not agree with the decision, he/she may ask for a judicial review in superior court. The hearing process must be completed within 90 days of OAH's receipt of the recipient's completed Recipient Hearing Request Form.

IMPLEMENTING THE HEARING DECISION:

Decisions which uphold the agency action:

A hearing decision which dismisses the appeal or upholds the Medicaid agency action shall be implemented no later than three business days from the date the decision was mailed to the petitioner(s) identified by OAH at the time the appeal was filed.

Decisions which reverse in part or in full the agency action:

If the hearing decision or a mediated settlement holds that all or part of the requested

services were medically necessary, payment for those services as approved in the decision or settlement will be authorized by Medicaid within five business days of receipt of the decision for at least 20 prospective calendar days after the date of the decision. If the recipient needs to continue the service beyond these 20 prospective calendar days, a new request for prior authorization is required to be received by Medicaid within 15 calendar days of the decision date in order to avoid an interruption in services. Upon receipt by Medicaid of a request for service authorization within 15 calendar days from the date of the decision which holds that all or part of the requested services were medically necessary, authorization for payment will remain in effect without interruption for at least 10 calendar days following the mailing of the notice of decision on the new request for prior authorization. If the request is denied or reduced, it will be treated as a timely request for reauthorization and maintenance of services pending appeal will apply.

PROVIDING SERVICES DURING THE APPEAL PROCESS (Maintenance of Services): Maintenance of services means that for a **reauthorization or continuing or concurrent request** that was denied, reduced, or terminated, the recipient is entitled to receive services during the pendency of the appeal **and** as long as he/she remains otherwise Medicaid eligible as described below, unless the recipient/legal representative, guardian, responsible party gives up this right.

1. If the recipient/legal representative, guardian, responsible party appeals within **10 days of the date the notice was mailed**, payment authorization for services will continue without a break in service. Authorization for payment must be at the level required to be authorized on the day immediately preceding the adverse determination or the level requested by the provider, whichever is less.
2. If the recipient/legal representative, guardian, responsible party appeals more than ten calendar days but within 30 calendar days of the date the notice is mailed, authorization for payment must be reinstated, retroactive to the date the completed appeal request form is received by the OAH. Authorization for payment must be at the level required to be authorized on the day immediately preceding the adverse determination or the level requested by the provider, whichever is less.

Maintenance of services (authorization of payment during the pendency of the appeal) will **not** be authorized if:

1. The recipient/legal representative, guardian, responsible party appeals more than 30 days after the date the notice was mailed.
2. The recipient's service request was submitted after his/her current authorization for services expired. Medicaid will treat this request as an initial rather than a reauthorization or continuing or concurrent request. Maintenance of services does not apply to initial requests.

CHANGING PROVIDERS DURING THE APPEAL PROCESS: Medicaid recipients/legal representative, guardian, responsible party have the right to change providers as indicated below.

1. For Medicaid recipients/legal representative, guardian, responsible party who:

- a. have appealed an adverse decision, or
 - b. whose provider agency is going out of business, or
 - c. have changed providers for CAP services or
 - d. are changing providers for another service with an authorization period of six months or more, the current authorization for services will transfer to the new provider within five (5) business days of notification by the new provider to the appropriate utilization vendor and upon submission of written attestation that provision of the service meets Medicaid policy and the recipient’s condition meets coverage criteria and acceptance of all associated responsibility; and either written permission of recipient/legal representative, guardian, responsible party; or copy of discharge from previous provider.
2. Authorization shall be effective the date the new provider submits a copy of the written attestation.
 3. Following the appeal or prior to the end of the current authorization period, the new provider must submit a request for reauthorization of the service in accordance with the clinical coverage policy requirements and **these procedures**.

OBTAINING LEGAL ASSISTANCE: For questions regarding legal assistance, please contact Legal Aid of North Carolina at 919-856-2564 or toll-free at 1-866-369-6923. Recipients with disabilities also will be informed they may contact Disability Rights of North Carolina at 1-877-235-4210.

QUESTIONS ABOUT THE MEDICAID PRIOR APPROVAL AND MEDICAID RECIPIENT HEARING PROCESSES: For questions concerning the decision Medicaid makes about the provider’s request for service, please contact Medicaid. Questions about the appeal process may be addressed to OAH or the Appeals Section, Division of Medical Assistance (Medicaid), or you may visit the provider prior approval web page at <http://www.ncdhhs.gov/dma/provider/priorapproval.htm>.

Agency contact information appears in the box below.

AGENCY	MAILING ADDRESS	OFFICE NUMBER
Office of Administrative Hearings (OAH)	Clerk 6714 Mail Service Center Raleigh, NC 27699-6714	919-431-3000
Division of Medical Assistance (Medicaid)	Appeals Section Clinical Policy and Programs 2501 Mail Service Center Raleigh, NC 27699-2501	919-855-4350 Toll-free: 1-800-662-7030 Ask for your call to be transferred to the DMA Appeals Unit, Clinical Policy and Programs.

HEALTH CHECK/EPSDT OVERVIEW

All of the child health services that can be covered through Medicaid are outlined in federal legislation (42 U.S.C. § 1396d(r) [1905(r) of the *Social Security Act* : “Early and Periodic Screening, Diagnosis and Treatment Services”, or EPSDT). This comprehensive menu of covered medical services is available to Medicaid eligible children when those services are appropriate and meet carefully applied and individualized standards of pediatric medical necessity. This menu of services includes a requirement for all children under the age of 21 years of age to receive early and regular medical and developmental (including physical and mental health) screenings, dental screenings, and ongoing surveillance as part of Well Child care assessment visits. Federal EPSDT law requires that medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening assessment must be made available to all Medicaid eligible children.

In North Carolina the preventive health services/periodic screening portion of Medicaid (EPSDT) program for children from birth to 21 years of age is known as *Health Check*. Health Check screening services are performed during Well Child visits and are reimbursed by the North Carolina Medicaid program. The NC EPSDT program provides Well Child assessments, referred to above, and medically necessary care to correct or ameliorate defects, physical or mental illness, or conditions identified through a screening assessment. When a screening assessment (performed as a required component of a Well Child visit) discloses a need for further evaluation of an individual’s health, diagnostic and treatment services must be provided. Referrals should be arranged for without delay and there should be follow-up to ensure the enrollee receives a complete diagnostic evaluation.

All Health Check services are available free of charge to a Medicaid eligible recipient. The Health Check program also has an explicit obligation to make preventive health services as well as other required services available.

Each and every health care professional providing Health Check Well Child screening assessments (with all of the required components) is responsible for:

- assisting families in scheduling appointments for timely assessments,
- implementing an effective system for follow-up with families whose children miss preventive health care check-ups,
- completing and following up on appropriate referrals and requests for medically necessary health care services to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening assessment.

Each Health Check component that is required in each Well Child screening assessment is vital for measuring and monitoring over time a child’s physical, mental, and developmental growth. Families are encouraged to have their children receive Health

Check screening assessments and immunizations on a regular schedule. All healthcare professionals who provide a Health Check Well Child visit are required to complete all components of the visit (developmental/medical screenings, required screening laboratory tests, required immunizations and assessments) and to provide documentation of those assessments, results and recommendations in the child’s medical record.

The components of periodic preventive health screening assessments required by the NC Health Check program are based on the American Academy of Pediatrics (AAP) *Recommendations for Preventive Pediatric Health Care*. The components represent evidence-informed preventive care as set forth in the *Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents* as supported by the AAP, AAFP, AMA and other child health advocacy organizations. The *Bright Futures Recommendations for Preventive Pediatric Health Care* summary table may be found by visiting the American Academy of Pediatrics weblink below.

<http://pediatrics.aappublications.org/cgi/data/120/6/1376/DC1/1>

Periodic Schedule for Well Child visits:

The NC Health Check Program recommends regular medical screening assessments (Well Child check-ups) for recipients as indicated in the table below. The Periodicity Schedule is only a guideline; if a recipient needs to have assessments on a different schedule, the visits are still covered.

Periodic Schedule for Screening Assessments	
Within 1st month	9 or 15 months
2 months	12 months
4 months	18 months
6 months	For children ages 2 through 20, annual visits are recommended

Please Note: In 2010, the periodic schedule for screening assessments was amended to better align North Carolina Health Check program guidelines with new standards, based on guidelines established by *Bright Futures*. Assessments are *strongly recommended annually* from 2 years of age through 20 years of age.

Periodic and Interperiodic Health Check Screening Assessments

Periodic Health Check screening assessments require all age-appropriate components as recommended by *Bright Futures guidelines*, including:

- comprehensive health history, measurements,
- vision and hearing screening/assessment,
- dental screening,
- laboratory tests as clinically indicated (including blood lead screening test at 12 and 24 months of age),
- nutritional assessment,
- developmental screening/assessment (including physical and mental development),
- comprehensive unclothed physical assessment,

- immunizations,
- anticipatory guidance, and follow-up/referral as indicated.

Refer to the **Periodicity Schedule** listed above for the recommended age intervals for periodic screening assessments.

Interperiodic Health Check screening assessments require all age-appropriate components **except developmental, hearing, and vision screenings/risk assessments** and **may be performed outside of the Periodicity Schedule (Periodic Screening Schedule), located on page 18, for reasons including but not limited to:**

- When a child requires a school-related or sports physical outside the recommended schedule.
- When a child's previously diagnosed physical, mental, or developmental illnesses or conditions require closer monitoring.
- When further assessment, diagnosis, or treatment is needed due to physical or mental illness.
- Upon referral by a health, developmental, or educational professional based on physical or clinical assessment.

Note: Providers must document in the medical record the reason necessitating an Interperiodic screening assessment. *All electronically submitted claims should list referral code indicator "E" when a referral is made for follow-up on a defect, physical or mental illness, or a condition identified through a Health Check screening assessment.*

HEALTH CHECK SCREENING ASSESSMENT COMPONENTS

A complete Health Check Well Child screening assessment consists of the age-appropriate components identified below.

- **Comprehensive Unclothed Physical Assessment**
To be performed at every Health Check screening assessment. A complete physical appraisal of the unclothed child/adolescent must be performed to distinguish any observable deviations from normal, expected findings. The assessment will use techniques of inspection, palpation, percussion, and auscultation.
- **Comprehensive Health History**
To be performed at every Health Check screening assessment. At the time of the initial evaluation, this will include a medical history, family history, social history, and review of systems. This information must be updated at subsequent visits.
- **Nutritional Assessment**
To be performed at every Health Check screening assessment. The nutritional assessment may include a combination of physical, laboratory, health risk assessment, and dietary determinations that will yield information in assessing the nutritional status of the child or youth. Further assessment or an appropriate

management plan with referral and follow-up is indicated when dietary practices suggest risk factors for co-morbidities, dietary inadequacy, obesity, disordered eating practices (pica, eating disorders, or excessive supplementation) or other nutritional problems.

The resources specified below are offered to assist with preventive counseling and management approaches:

- *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, Third Edition, Chapters 4-5 at:

http://brightfutures.aap.org/3rd_Edition_Guidelines_and_Pocket_Guide.html

- The Eat Smart Move More “Prescription for Health—5-3-2-1-Almost None” guide at:

<http://www.eatsmartmovemorenc.com/PediatricObesityTools/PediatricObesityTools.html>

- “MyPlate” food group recommendations at:

<http://www.choosemyplate.gov/food-groups/>

- The *Pediatric Obesity Prevention and Treatment Algorithm* (NC Design Team, Contributors, and Reviewers) and related tools are available at:

<http://www.eatsmartmovemorenc.com/PediatricObesityTools/PediatricObesityTools.html>

It is also recommended that all female adolescents of childbearing age take a multivitamin with folic acid. Please visit supporting research at:

<http://jama.ama-assn.org/cgi/content/full/279/18/1430>

<http://www.getfolic.com/>

- **Anticipatory Guidance and Health Education**
To be performed at every Health Check screening assessment.

The Bright Futures 2008 Pocket Guide provides a quick reference tool for anticipatory guidance topics by age, and can be found by visiting:

http://brightfutures.aap.org/pdfs/BF3%20pocket%20guide_final.pdf

- **Measurements, Blood Pressure, and Other Vital Signs**
At every Health Check screening assessment, height, weight, head circumference, BMI/BMI percentile must be measured and/or calculated as indicated by age of the child and plotted on a gender and age-appropriate growth chart. BMI / BMI percentile are required for children ages two years and above. Weight for length

must be assessed for all recipients *less than* two years of age. Vital signs should be measured as appropriate and it is recommended that providers reference tables of age-normed vital signs as needed. Blood pressure is required as part of the screening assessment visit for children ages three years and older. However, blood pressure measurement in infants and children with specific risk conditions should be considered and performed before three years of age as medically necessary/clinically indicated.

- **ICD-9-CM Coding for BMI**

The American Academy of Pediatrics has identified childhood obesity as a significant health issue, both for its documented risks to health and well-being during childhood and its implications for health problems as an adult. Helping primary care clinicians and families to prevent and treat childhood obesity and overweight conditions is a priority of the Academy.

Measurement and follow-up of body mass index (BMI) is a core Health Information Data and Information Set (HEDIS) measure for quality of care. In December of 2009, the Agency for Healthcare Research and Quality (AHRQ) included BMI measurement in its set of 24 child health indicators for state Medicaid and CHIP programs. In order to measure rates of documentation of body mass index (BMI) as part of the CCNC Quality Measures and Feedback, providers should include appropriate ICD-9-CM diagnosis codes on claims billed for each Health Check visit.

To promote quality of care, the coding of BMI percentile by appropriate V code will become a routine part of coding for Health Check visits (age three years and up) along with the V20.2 code. ***CCNC and DMA strongly encourage all primary care providers to begin incorporating the appropriate BMI V codes*** into their office processes for Well Child care.

The following diagnosis codes associated with the ranges of BMI percentile should be incorporated into Health Check billing documentation for children and adolescents, ages three and above:

V85.51	<5 percentile	Failure to Thrive
V85.52	5 – 85 percentile	
V85.53	85 – 95 percentile	overweight
V85.54	≥ 95 percentile	obese

- **Developmental Surveillance; Structured Screening for Developmental Delays and Autism Spectrum Disorders (ASDs); and, Psychosocial and Behavioral or Mental Health Assessments for Children and Adolescents**

Developmental surveillance and screening for developmental delays and ASDs should be conducted at intervals which meet the standards of medical practice as established by recognized medical organizations involved in child health care, primarily the AAP. **In the 2008 Bright Futures Guidelines, the AAP**

recommends that providers conduct developmental surveillance on all children of all ages (including pre-teen and adolescents) as an integral component of the general health assessment performed during every preventive care office visit or Well Child Checkup screening visit. The AAP also recommends that the screens at 9 months, 18 months, and 30 months of age include structured screening for developmental delays and that the screens at 18 months and 24 months include structured screening for ASDs.

Collaborative efforts among the North Carolina DHHS Division of Medical Assistance, North Carolina Department of Public Health, Community Care of North Carolina (CCNC) and the state's Assuring Better Child Development (ABCD) Project have resulted in recommendations that developmental screenings be performed during periodic Well Child checkups at ages 6, 12, and 18 or 24 months, and at ages 3, 4 and 5 years, using a standardized validated screening tool. Providers must also perform routine screening for autism spectrum disorders (ASDs) using a validating screening tool at 18 and 24 months of age. **When providers identify a child at any age presenting with a risk factor for developmental delays or an ASD, providers should conduct structured screening outside of the recommended screening periodicities (if medically necessary) by using a scientifically validated screening tool.**

- **Developmental Surveillance:**

According to the AAP, developmental surveillance is the observation of a child to identify whether the child may be at risk of developmental delay. Developmental surveillance is required to be conducted at every *Health Check* Well Child checkup, (except when structured developmental screening is conducted in lieu of surveillance) and is *included in the fee* for the office visit. The AAP recommends that providers perform and document the following as part of surveillance:

- elicit and attend to parent concerns about their child's development;
- update the child's developmental progress;
- make accurate and informed observations of the child in the areas of language and cognitive abilities, social and emotional health, and physical development which are appropriate to the child's age and developmental stage;
- identify the presence of risk and protective factors; and
- document all surveillance activities and findings.

- **Structured Screening for Developmental Delays and ASDs:**

Developmental screening is to be performed during Well Child visits at ages 6, 12 and 18 or 24 months, and at 3, 4 and 5 years of age, using a *standardized and scientifically validated* screening tool, as recommended by the AAP.

Additionally, providers must perform routine screening for Autistic Spectrum Disorders (ASD's) using a validated screening tool at 18 and 24 months of age.

A number of validated screening tools have been developed for identifying developmental delays and ASDs. As additional research and testing is conducted, new scientifically validated new tools may become available. **Providers are**

responsible for ensuring that they continue to use tools that are scientifically validated at the time they conduct the structured screening and appropriate for the age of the child being screened. Providers may select a specific, validated screening tool that is best suited to the provider's practice.

Current validated screening tools most commonly used by NC *Health Check* providers to identify children at risk of general developmental delays include:

- Ages and Stages Questionnaire (ASQ); and
- Parents' Evaluation of Developmental Status (PEDS).

The **ASQ** and **PEDS** are parent-completed screening tools scored by a medical professional. The **ASQ** focuses on age-specific communication, gross motor, fine motor, problem-solving and personal adaptive skills. The **PEDS** is designed to screen for developmental and behavioral problems which may require further surveillance and / or evaluation.

The Ages and Stages Questionnaires, Social-Emotional (ASQ-SE) is the most common tool used in primary care for screening social-emotional development of infants and children. The ASQ-SE is validated for routine screening of children ages 3 months to 65 months in domains of self-regulation, compliance, communication, adaptive functioning, autonomy, affect, and interpersonal interaction. Other tools for screening of social-emotional development can be found at:

www.dbped.org or <https://www.firstsigns.org/screening/tools/rec.htm>

Current validated screening tools used to identify children at risk for ASD include:

- Modified Checklist for Autism in Toddlers (**M-CHAT**);
 - for children between 16 and 30 months of age, screen for ASD;
- Social Communication Questionnaire (**SCQ**),
 - for children over 4 years of age, with mental age of over 2 years;
- Autism Spectrum Screening Questionnaire (**ASSQ**).
 - for children between 7 and 16 years of age, for Asperger Syndrome and other high functioning ASDs.

The above mentioned tools, scoring information and additional resources may be found at: <https://www.firstsigns.org/screening/tools/rec.htm>.

- **Diagnostic Evaluation:**

When the *screening* indicates a need for a full *diagnostic evaluation*, a provider shall promptly refer the child for early intervention services or to a health care specialist in an appropriate specialty/discipline. The *diagnostic evaluation* is a specialized procedure designed to identify specific developmental disorders or biological reasons for delayed development and to identify appropriate therapeutic interventions, The provider completing the Well Child checkup shall refer

promptly and follow up on the referral in a timely manner to assure service linkage.

- **Psychosocial and Behavioral or Mental Health Assessments for Children and Adolescents:**

Bright Futures guidelines recommend psychosocial-behavioral health assessment for all infants, children and adolescents. The *Health Check* Program recommends screening specifically for behavioral-mental health concerns using an age appropriate, evidence-based behavioral-mental health screening tool (e.g. ASQ-SE, PSC; PSC-Y; SDQ; Vanderbilt; PHQ-9 Modified for Teens: PHQ-A; and/or the Beck's Depression Inventory-Primary Care Version) especially when concerns about the infant, child or adolescent are raised by the parent, caregiver, child or adolescent. Providers should arrange appropriate follow-up and/or referral for social-emotional development or mental health diagnostic evaluations for infants, children and adolescents with suspected behavioral or mental health problems.

North Carolina's *Health Check* Program also recommends using an adolescent health risk assessment tool to screen for a variety of psychosocial and health risks in adolescents between 11 years of age to 18 years. Risks include but are not limited to alcohol and drug use, low self esteem, tobacco use, sexually transmitted infections, pregnancy, violence, injury, poor nutrition and physical activity. Strengths are also assessed for reinforcement, including good nutrition, positive relationships with peers, some mastery of a skill, talent or sport, family supports, school engagement, community involvement, and delay of sexual activity.

There are several recommended health risk screening assessment tools for adolescents, including:

- Bright Futures Tool Kit/GAPS/HEADSSS, and
- Alcohol and Substance Abuse Screening and Brief Intervention CRAFFT.

If concerns are identified on the health risk screening, providers should arrange for prompt and appropriate follow up and referral for evaluation and treatment.

For any screening, providers are required to:

- **document** all referrals in the child's medical record, and to;
- **coordinate** with other health care providers to provide follow-up care.

- **Billing Structured Screening for Developmental Delays, ASDs and Psychological/Behavioral or Mental Health Assessments for Children and Adolescents:**

Providers are required to report the following CPT codes and modifiers when a structured developmental screening, ASD screening, behavioral or mental health screening, or health risk assessment has been conducted during a Periodic Well Child visit:

CPT Code	Modifier	Description
96110	EP	Screening for Developmental Delay (i.e., PEDS, ASQ)
99420	EP	<ul style="list-style-type: none"> • Screening for ASDs (i.e, M-CHAT, SCQ, ASSQ); • Screening for Social-Emotional Development or Behavioral or Mental Health Concerns (i.e., ASQ-SE, PSC, SDQ, PHQ-A, Beck's Depression Inventory) • Health Risk Assessment (i.e., HEADSSS, GAPS, Bright Futures Adolescent Supplemental Questionnaire)
99406	EP	Smoking & Tobacco Use Cessation Counseling
99407	EP	Smoking & Tobacco Use Cessation Counseling
99408	EP	Alcohol and Substance Abuse Screening and Brief Intervention / CRAFFT
99409	EP	Alcohol and Substance Abuse Screening and Brief Intervention / CRAFFT

- **Additional Resources and Clinical Recommendations for Screening for Developmental Delays, ASDs and Psychosocial and Behavioral or Mental Health Assessments for Children and Adolescents:**

Please refer to the resources indicated below.

- *Bright Futures Pocket Guide* for clinical recommendations on developmental surveillance for each periodic screening visit at: http://brightfutures.aap.org/pdfs/BF3%20pocket%20guide_final.pdf
- The National AAP Policy Statement: *Identification and Evaluation of Children With Autism Spectrum Disorders*, may be found online at: <http://pediatrics.aappublications.org/content/120/5/1183.full.html>
- The National AAP Policy Statement: *Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening* may be found on-line at: <http://pediatrics.aappublications.org/content/118/1/405.full.html>

- **Immunizations**

All necessary immunizations *must* be administered by the provider delivering the Health Check Well Child visit/periodic or inter-periodic screening assessment. **The immunization portion of the Well Child visit may not be referred to another provider, i.e. local health departments.**

The Recommended Immunization Schedules for Persons Aged 0 through 18--United States, 2011, approved by the Advisory Committee on Immunization

Practices (ACIP), American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP) may be found at:

<http://www.cdc.gov/vaccines/recs/schedules/child-schedule.htm>.

Note: Please refer to pages 30 through 42 in this guide for additional immunization information.

- **Vision Screenings:**

Objective screenings must be performed during **every** periodic screening assessment beginning at age three through age 10 years. Starting at age 11 years, vision screenings must be performed once every three years. Selectively screen vision at other ages based on the provider's assessment of risk, including any academic difficulties. For guidance on vision risk assessment/screening for children and youth, go to AAP Policy Statement on "Eye Examination in Infants, Children and Young Adults by Pediatricians" at:

<http://aappolicy.aappublications.org/cgi/reprint/pediatrics;111/4/902.pdf>.

For children who are uncooperative with a vision screening, providers may ask the parent or legal guardian to bring the child back into the office within a few days for a second attempt at the vision screening. **Children who cannot be tested after repeated attempts must be referred to an ophthalmologist or optometrist for a comprehensive vision examination. The repeated attempts and referral to an ophthalmologist/optometrist must be documented in the medical record.**

For children who are uncooperative, blind, or have an autism spectrum disorder, providers must:

- Document in the patient's medical record the date of service and the reason(s) why the provider was unable to perform the vision screening and
- Submit the claim to HP ENTERPRISE SERVICES without the vision CPT code.

HP ENTERPRISE SERVICES will process the claim.

- **Hearing Screenings:**

Objective screenings using an otoacoustic auditory emission (OAE) tool or audiometer (auditory sweep) must be performed annually for children ages four through 10.

At all other ages, the provider's assessment of risk drives the decision to screen. Screening *must* occur if the parent is concerned about the child's hearing, speech or language or if the child is exposed to potentially damaging noise levels, head trauma with loss of consciousness, recurring ear infections, acute/chronic disease that could contribute to hearing loss, ototoxic medications or reports problems including academic difficulties.

For further guidance go to:

http://www.medicalhomeinfo.org/how/clinical_care/hearing_screening/#pubs.

For children who are uncooperative with a hearing screening, the provider may ask the parent or legal guardian to bring the child back into the office within a few days for a second attempt at the hearing screening. **Children who cannot be tested after repeated attempts must be referred to an audiologist for a hearing evaluation. The repeated attempts and referral to an audiologist must be documented in the medical record.**

For children who are uncooperative, deaf, or have an ASD, providers must:

- Document in the patient's medical record the date of service and reason(s) why the provider was unable to perform the hearing screening, and
- Submit the claim to HP ENTERPRISE SERVICES without the hearing CPT code.

HP ENTERPRISE SERVICES will process the claim.

- **Dental Screenings:**

An oral screening must be performed at every Health Check screening assessment. **In addition, referral to a dentist is recommended for every child before age one and required beginning at age three.** An oral screening performed during a physical assessment *is not a substitute for an examination by a dentist*, that results from a direct referral. The initial dental referral **must** be provided regardless of the periodicity schedule unless it is known that the child is already receiving dental care. Thereafter, dental referrals should, at a minimum, conform to the dental service periodicity schedule, which is currently one routine dental examination every six months. **When any screening indicates a need for dental services at an earlier age (such as baby bottle caries), referrals must be made for needed dental services and documented in the child's medical record.** The periodicity schedule for dental examinations is not governed by the schedule for regular health check-ups. Refer to the Oral Health Periodicity Schedule on DMA's website at:

<http://www.ncdhhs.gov/dma/dental/DentalPeriodicitySchedule11012011.pdf>.

For a list of dental providers by county who accept Medicaid, go to:

<http://www.ncdhhs.gov/dma/dental/dentalprov.htm>.

Note: Although not a requirement of a Health Check screening assessment, providers who perform a Health Check screening assessment and dental varnishing *may bill for both services*. For billing codes and guidelines, refer to Clinical Coverage Policy # 1A-23, *Physician Fluoride Varnish Services*, on DMA's website at:

<http://www.ncdhhs.gov/dma/mp/>.

Laboratory Procedures:

Required laboratory procedures as a component of an age-determined Well Child include hemoglobin or hematocrit, newborn metabolic/sickle cell screening, tuberculin skin test, and lead testing.

*Medicaid will not reimburse separately for these **routine** laboratory tests* when performed during a Health Check screening assessment. Other laboratory tests, as medically necessary, may be performed and billed. (e.g. dyslipidemia screening, pregnancy testing and sexually transmitted disease screening for sexually active youth).

Providers are encouraged to follow the 2010 Centers for Disease Control and Prevention Sexually Transmitted Diseases Treatment Guidelines for screening and treatment of adolescents:

<http://www.cdc.gov/std/treatment/2010/specialpops.htm>.

Hemoglobin or Hematocrit:

Hemoglobin or hematocrit **must** be measured once during infancy (**preferably** between the ages of nine and 12 months) for all children. An assessment of risk for anemia should be performed at other visits and a hemoglobin or hematocrit done, only as appropriate.

Risk factors for anemia in infants include prematurity, low birth weight and early introduction of cow's milk. For other children and adolescents, previous diagnosis of iron deficiency anemia, limited access to food, a low iron diet, strict vegetarian diet without receiving an iron supplement, or risk of iron deficiency due to special health care needs may be risk factors for anemia. In adolescent females (ages 11 to 21 years) an annual hemoglobin or hematocrit **must** be performed if any of the following risk factors are present: extensive menstrual or other blood loss, low iron intake, or a previous diagnosis of iron deficiency anemia. **In the absence of risk factors for anemia, hemoglobin or hematocrit screening is no longer recommended as a "routine" screening test for children over one year of age and adolescents.**

If there is a documented normal result of a hemoglobin or hematocrit performed by another provider within three months prior to the date of the Health Check screening assessment, repeating the hemoglobin or hematocrit is not required as part of the Health Check screening assessment unless the provider believes that this test is needed. **The result and source of the test must be documented in the child's medical record.**

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) has specific guidelines for hematocrit/hemoglobin testing. Sharing the test results between the WIC Program and the primary care provider (PCP) is encouraged with appropriate release of information. For more information on requirements and time frames, call the local WIC office.

Newborn Metabolic/Sickle Cell Screening:

North Carolina hospitals are required to screen all newborns for sickle cell disease and a number of other genetic and metabolic conditions prior to discharge from the hospital. **Those results from the State Laboratory of Public Health must be documented in the child's medical record as soon as possible.** This ideally should be a print out of the results from the state lab's website for that child. To link to the State Laboratory of Public Health website, go to:

<http://slph.ncpublichealth.com>.

It is important to confirm the newborn metabolic/sickle cell screening has been done as soon as possible. Contact the hospital of birth if the results are not available online within two weeks to confirm that the screening was done. An infant without documentation of being screened at birth should have the screening test as soon as possible.

Resources available to you if a screening test is positive include:

- Children with Special Health Care Needs Help Line at; 1-800-737-3028;
- genetic centers at the tertiary care centers; and;
- The N.C. Sickle Cell Program (http://www.ncsicklecellprogram.org/SC_Resources.htm).

• **Tuberculin Test:**

Reviewing perinatal histories, family and personal medical histories, significant events in life and other components of the social history will identify children and adolescents for whom tuberculosis (TB) testing is indicated. **If none of the screening criteria listed below are present, routine TB screening is not recommended.**

TB testing should be performed as clinically indicated for children and adolescents at increased risk of exposure to tuberculosis, via Purified Protein Derivative (PPD) intradermal injection/Mantoux method – *not Tine Test*. An interferon gamma release assay (blood test, either Quantiferon Gold in-tube® test or T-SPOT TB® test) can be used in place of the tuberculin skin test for children 5 years and older, but the PPD is preferred for children under 5 years of age. Criteria for screening children and adolescents of all ages for TB, according to the North Carolina Tuberculosis Control Branch, are specified below.

1. Children or adolescents reasonably suspected of having tuberculosis disease based on clinical symptoms

2. Children or adolescents who present for care with the following risk factors should have a **baseline screen**:
 - a. Foreign-born individuals from high prevalence areas: Asia, Africa, the Caribbean, Latin America, Mexico, South America, Pacific Islands, the Middle East or Eastern Europe. Low prevalence countries for tuberculosis disease are the USA, Canada, Japan, Australia, New Zealand and countries in Western Europe;
 - b. Children or adolescents who are migrants, seasonal farm workers, homeless or were previously incarcerated;
 - c. Children or adolescents who are HIV-infected;
 - d. Children or adolescents who inject illicit drugs or use crack cocaine;
 - e. Children or adolescents who have traveled outside the United States and who have stayed with family or friends who live in high-incidence areas, for more than one month, cumulatively spent one month or more in a high incidence area; and
 - f. Children or adolescents who have been exposed to adults at high-risk (those who are homeless, incarcerated, or HIV positive or who have past or present history of substance abuse).

Subsequent TB skin testing (or blood testing) is not necessary unless there is a continuing risk of exposure to persons with tuberculosis disease.

The North Carolina Tuberculosis Control Branch (919-733-7286) is responsible for oversight of testing of household and other close contacts of active cases of pulmonary and laryngeal tuberculosis. Questions related to policy interpretation or other questions related to TB skin testing should be directed to the local health departments.

• **Lead Testing:**

Federal regulations require that all Medicaid-enrolled children have a blood lead test at 12 and 24 months of age. Providers must document results in the medical records. **Children between 36 and 72 months of age must be tested** if they have not been previously tested. Providers should also perform lead testing when otherwise clinically indicated.

Medical follow-up begins with a blood lead level greater than or equal to 5 ug/dL. Capillary blood level samples are adequate for the initial testing. Venous blood level samples should be collected for confirmation of all blood lead test results ≥ 5 ug/dL.

FOLLOW-UP SCHEDULE FOR DIAGNOSTIC/CONFIRMED LEAD LEVELS FOR CHILDREN UNDER THE AGE OF SIX	
Blood Lead Level	Response
<5 µg/dL	<ul style="list-style-type: none"> • Report blood lead test result to parent and document notification. • Educate family about lead sources / prevention of lead exposure. • Perform another blood lead test at age 2, earlier if risk of exposure Increases.

<p><i>All diagnostic (i.e. confirmation) tests should be performed as soon as possible within the time periods listed below. If diagnostic test result falls in a lower category - follow response for that risk category. If diagnostic or follow-up test result falls in a higher category – conduct another diagnostic test based on the higher risk category.</i></p>	
<p>5-9 µg/dL (Diagnostic test within 3 months)</p>	<ul style="list-style-type: none"> • Report blood lead test result to parent and document notification. • Educate family about lead sources and prevention of lead exposure. <p>If diagnostic test result is 5-9 µg/dL:</p> <ul style="list-style-type: none"> • Conduct nutritional assessment. • Take environmental history to identify sources of lead exposure. • Continue follow-up testing every three months until two consecutive venous or capillary tests are <5 µg/dL. • Test other children under the age of six in same household.
<p>10-19 µg/dL (Diagnostic test within 1 month)</p>	<ul style="list-style-type: none"> • Report blood lead test result to parent and document notification. • Educate family about lead sources and prevention of lead exposure. <p>If diagnostic test result is 10-19 µg/dL:</p> <ul style="list-style-type: none"> • Conduct nutritional assessment and refer to WIC Program. • Take environmental history to identify sources of lead exposure. • Refer to local health department for environmental investigation. • Continue follow-up testing every one to three months until two consecutive venous or capillary tests are <5 µg/dL. • Test other children under the age of six in same household.
<p>20-69 µg/dL (Diagnostic test within 1 week at 2044 µg/dL within 48 hours at 45-59 µg/dL 20-69 µg/dL cont. within 24 hours at 60-69 µg/dL)</p>	<ul style="list-style-type: none"> • Report blood lead test result to parent and document notification. • Educate family about lead sources and prevention of lead exposure. <p>If diagnostic test 20-69 µg/dL:</p> <ul style="list-style-type: none"> • Conduct nutritional assessment and refer to WIC Program. • Take environmental history to identify sources of lead exposure. • Refer to local health department for required environmental investigation. • Provide clinical management. • Refer children ages birth to 36 months to CDSA* Early Intervention. • Refer children ages three to five years to CSC**. • Refer to Social Services as needed for housing or additional medical assistance. • Continue follow-up testing every one month until two consecutive venous or capillary tests are <5 µg/dL. • Test other children under the age of six in same household.
<p>≥70 µg/dL (Diagnostic test immediately as emergency lab test)</p>	<ul style="list-style-type: none"> • Report blood lead test result to parent and document notification. • Educate family about lead sources and prevention of lead exposure. <p>If diagnostic test ≥70 µg/dL:</p> <ul style="list-style-type: none"> • Hospitalize child and begin medical treatment immediately. • Conduct nutritional assessment and refer to WIC Program. • Take environmental history to identify sources of lead exposure. • Refer to local health department for required environmental investigation. • Refer children ages birth to 36 months to CDSA* Early Intervention. • Refer children ages three to five years to CSC**. • Refer to Social Services as needed for housing or additional medical Assistance. • Continue follow-up testing every one month until two consecutive venous or capillary tests are <5 µg/dL.

*Children's Developmental Service Agency
**Child Service Coordination Program

State Laboratory of Public Health for Blood Lead Testing:

The State Laboratory of Public Health will analyze blood lead specimens for all children less than six years of age at no charge. Providers requiring results from specimens of children outside this age group should contact the State Laboratory of Public Health at 919-733-3937.

Lead testing results also can be obtained at the *North Carolina State Laboratory of Public Health Clinical Lab Result Reporting*; at the following web address indicated below.

<https://slphreporting.ncpublichealth.com/lims/ClinicalLims/Login.aspx>

Records are retained at the State Laboratory for two years and are filed by date of receipt in the Laboratory.

For additional information about lead testing and follow-up refer to the *North Carolina Childhood Lead Testing and Follow Up Manual* found at:

http://www.deh.enr.state.nc.us/ehs/Children_Health/2009printedversionleadmanual.pdf.

Follow-Up and Referral:

In a family-centered medical home, the health care team works in partnership with a child and a child's family to assure that all of the medical and non-medical needs of the child are met. To assure continuity of care, if the Health Check screening assessment is not performed in the child's medical home, then the results of the visit and recommendations for follow-up should be shared in a timely manner with the child's medical home.

For children and youth with suspected or identified problems that are not treated in-house by the provider of the Health Check visit, those children and youth must be referred to and receive consultation from an appropriate source. A requirement of Health Check/EPSTD is that children be referred for and receive medically necessary health care services to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening assessment.

If a communicable disease has been diagnosed as a result of a Health Check Screening Assessment, report the disease using the *Confidential Communicable Disease Report – Part 1* Form at:

http://www.epi.state.nc.us/epi/gcdc/manual/reportforms/Morb_Card.pdf.

The provider should assist in the youth's transition from pediatric to adult health care by encouraging their involvement in health care decision making. Support the parent's role in promoting the development of the youth's self-management skills. Transition resources for families who have youth with special health care needs are available at

<http://www.fpg.unc.edu/~ncodh/ChildandAdolescentHealth/> and <http://hctransitions.ichp.ufl.edu/>.

Discuss timing for the next Health Check screening assessment appointment and schedule a visit, if appropriate.

IMMUNIZATIONS

Immunization Billing Overview

The North Carolina Immunization Program (NCIP)/Vaccines for Children (VFC) Program provides, at no charge, all recommended vaccines for all children birth through 18 years of age present in North Carolina who are VFC-eligible, including Medicaid children. **Medicaid recipients are automatically eligible for VFC vaccine, even those who are dually covered by Medicaid and another insurance plan.** Vaccines are provided in accordance with the recommendations of the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC). Because of the availability of VFC vaccines for Medicaid children, Medicaid does not reimburse for vaccines available from the NCIP/VFC program. Medicaid does, however, reimburse for the administration of these vaccines.

Health Choice recipients are considered *insured*; therefore, they are not eligible for VFC vaccines, **with one exception. Health Choice recipients who are American Indian or Alaska native are entitled to VFC vaccines—Health Choice will only reimburse an administration fee for these recipients. Refer to individual Health Choice articles in the general Medicaid bulletin and the *Basic Medicaid and NC Health Choice Billing Guide, Section 12*, for details regarding the NCHC eligibility groups and the billing and claims processing of Health Choice claims.**

Providers must use purchased vaccines for Health Check recipients ages 19 and 20, who (because of their age) are not routinely eligible for NCIP/VFC vaccines. When purchased vaccine is administered to this age group, Medicaid will reimburse providers for the vaccine product and the administration fee. Note that some NCIP vaccines may be administered to patients ages 19 and older, in which case Medicaid will cover the administration fee. **In that case, the CPT vaccine code for the NCIP vaccine must be reported with \$0.00.** Vaccine procedure codes must always be included on the claim. **National Drug Codes (NDCs) should NOT be reported for vaccines.**

Note: The EP modifier must always be appended to the immunization administration CPT procedure code when billing for Medicaid recipients from birth through 20 years of age. The EP modifier should NOT be appended to the immunization administration CPT procedure code for Health Choice recipients.

EPSDT PROVISION: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions and without meeting the specific criteria in this section when such services are **medically necessary health care services**

to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]. This includes EPSDT coverage of additional codes/procedures as it relates to immunization administration. Documentation must show how the service, product or procedure will correct, improve or maintain the recipient’s health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Use the *Non-covered State Medicaid Plan Services Request Form* found at <http://www.ncdhhs.gov/dma/provider/forms.htm> to submit the request.

The immunization administration codes currently covered are CPT procedure codes 90471 through 90474. Their descriptors are as follows:

Procedure Code	Description
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid)
90472+ (add-on-code)	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid) each additional vaccine (single or combination vaccine/toxoid) List separately in addition to code for primary procedure
90473	Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid)
90474+* (add-on-code)	Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) List separately in addition to code for primary procedure

* **Currently, 90474 cannot be billed with 90473 because there are no two oral and/or intranasal vaccines or combination of an oral and intranasal vaccine that would be given to a recipient.**

Private Sector Providers and Local Health Departments

An immunization administration fee may be billed if it is the only service provided that day or if any immunizations are provided in addition to a Health Check assessment or an office or sick visit.

- Administration of one injectable vaccine is billed with CPT code 90471 (one unit) with the **EP** modifier.
- Additional injectable immunization administrations are billed with CPT code 90472 with the **EP** modifier. The appropriate number of units must be billed for each additional immunization administration CPT procedure code, with the total charge for all units reflected on the detail.
- Administration of **one vaccine** that is an **intranasal/oral** immunization is billed with the administration CPT code 90473 with the EP modifier. **Note: CPT code 90473 can only be billed if the intranasal/oral vaccine is the only immunization provided on that date of service. CPT code 90473 cannot be billed with another immunization administration code on that date of service.**

See guidance in next bullet for further clarification. A *second* intranasal/oral immunization cannot be billed at this time.

- Administration of an intranasal or oral vaccine provided **in addition to** one or more injectable vaccines is billed with CPT code 90474 with the EP modifier.
- CPT vaccine product codes for the vaccines administered must be reported or billed, as appropriate, even if administration codes are not being billed.

Federally Qualified Health Center or Rural Health Clinic Providers

An immunization administration fee may be billed if it is the only service provided that day or if any immunizations are provided in addition to a Health Check visit.

- Administration of one injectable vaccine is billed with CPT code 90471 (one unit) with the **EP** modifier.
- Additional injectable immunization administrations are billed with CPT code 90472 with the **EP** modifier. The appropriate number of units must be billed for each additional immunization administration CPT procedure code with the total charge for all units reflected on the detail.
- Administration of **one** vaccine that is an **intranasal/oral** immunization is billed with the administration CPT code or 90473 with the EP modifier. **Note: CPT code 90473 can only be billed if the intranasal/oral vaccine is the only immunization provided on that date of service. Neither code can be billed with another immunization administration code on that date of service. See guidance in next bullet for further clarification. A *second* intranasal/oral immunization cannot be billed at this time.**
- Administration of an intranasal or oral vaccine provided **in addition to** one or more injectable immunization administrations is billed with CPT code 90474 with the EP modifier.
- CPT vaccine codes for the vaccines administered must be reported or billed, as appropriate, even if administration codes are not being billed.
- An immunization administration fee cannot be billed in conjunction with a core visit. Report the CPT vaccine product code(s) without billing the administration fee.

Guiding Principles for Billing the Immunization Administration Codes

1. Effective with date of service July 1, 2011, the **ONLY** immunization administration codes covered for Medicaid recipients in the Health Check age range, 0 through 20 years of age, are CPT codes 90471 through 90474.
2. Claims billed with CPT immunization administration codes 90460 and 90461 (effective for dates of service on and after January 1, 2011, for Medicaid recipients through 18 years of age) on and after July 1, 2011, will deny.
3. Append modifier EP to all CPT immunization administration codes billed for Medicaid recipients in the Health Check age range, 0 through 20 years of age.
4. Do NOT append the EP modifier to the CPT vaccine product codes.
5. Do NOT report the National Drug Code (NDC) with the CPT vaccine product code.
6. All of the units billed for CPT codes 90471EP, 90472EP, 90473EP, and 90474EP must be billed on **ONE** detail to avoid duplicate audit denials. Currently, 90474EP cannot be billed with 90473EP because there are no two oral/intranasal

vaccines that would be given to a recipient. Only one unit of either 90473EP or 90474EP is allowed.

7. CPT vaccine codes for the vaccines administered **must** be reported or billed, as appropriate, even if administration codes are not being billed.
8. **For Medicaid recipients 21 years of age and older (above the Health Check age range), the immunization administration codes have not changed. Bill the series of CPT codes 90471 through 90474 without the EP modifier.**
9. Refer to individual bulletin articles on specific vaccines for additional billing guidelines.
10. Note that some NCIP vaccines may be administered to recipients ages 19 and older, in which case Medicaid will cover the administration fee. Any time an NCIP vaccine is provided, the CPT vaccine code must be reported with \$0.00.
11. Remember, for NCHC recipients, do NOT append the EP modifier to the CPT immunization administration code (90471-90474).

Billing Examples for Claims Regarding Health Check Recipients

1. Billing for a two-month old infant based on the current immunization schedule, when an oral immunization is included:

Vaccines Provided	Administration Codes	CPT Vaccine Codes
DTaP (diphtheria, tetanus, pertussis)	90471	90700
Inactivated poliovirus	90472	90713
Pneumococcal conjugate vaccine, 13 valent	90472	90670
Rotavirus (oral)	90474	90681

Coding on the claim:

90471	EP modifier	1 unit	There would be a billed amount.
90472	EP modifier	2 units	There would be a billed amount.
90474	EP modifier	1 unit	There would be a billed amount.
90700		1 unit	There would be a \$0.00 billed amount.
90713		1 unit	There would be a \$0.00 billed amount.
90670		1 unit	There would be a \$0.00 billed amount.
90681		1 unit	There would be a \$0.00 billed amount.

2. Billing for a four year old child when all vaccines are injectable:

Vaccines Provided	Administration Codes	CPT Vaccine Codes
DTaP	90471	90700

PCV13	90472	90670
Influenza, split virus, preservative free, 3 years and older	90472	90656

Coding on the claim:

90471	EP modifier	1 unit	There would be a billed amount.
90472	EP modifier	2 units	There would be a billed amount.
90700		1 unit	There would be a \$0.00 billed amount.
90670		1 unit	There would be a \$0.00 billed amount.
90656		1 unit	There would be a \$0.00 billed amount.

3. Billing for a male recipient who is 19 years of age who receives a purchased injectable vaccine.

Vaccines Provided	Administration Codes	CPT Vaccine Codes
HPV	90471	90649

Coding on the claim:

90471	EP modifier	1 unit	There would be a billed amount.
90649	EP modifier	1 unit	There would be a billed amount.

Billing of Immunization Administration Codes by Private Sector Providers and Local Health Departments

An immunization administration fee code(s) may be billed if it is the only service provided that day, or if any immunizations are provided in addition to a Health Check assessment or an office or sick visit.

Billing of Immunization Administration Codes by Federally Qualified Health Centers or Rural Health Centers

An immunization administration fee code(s) may be billed if it is the only service provided that day, or it any immunizations are provided in addition to a Health Check assessment. An immunization administration fee code(s) cannot be billed in addition to a core visit code. Report the CPT vaccine code(s) without billing the administration fee.

Note: Please refer to the general Medicaid Bulletins at <http://www.ncdhhs.gov/dma/bulletin/> for updates on immunizations and administration codes. Refer to the appropriate fee schedule at <http://www.ncdhhs.gov/dma/fee/> under *Physician Services (CPT/HCPCS)* for CPT administration code and vaccine product rates. The drugs and biologics, including vaccine products, are found toward the end of the fee schedule.

North Carolina Immunization Program/Vaccines for Children Program

The North Carolina Immunization Program (NCIP)/Vaccines for Children (VFC) Program provides, at no charge, all recommended vaccines for all children birth through 18 years of age present in North Carolina who are VFC-eligible, including Medicaid

children. Vaccines are provided in accordance with the recommendations of the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC). Because of the availability of these vaccines for Medicaid children, Medicaid does not routinely reimburse for vaccines available from the NCIP/VFC program. Medicaid does; however, reimburse for the administration of these vaccines.

Health Choice recipients are considered *insured* and are not eligible for the VFC vaccines, with one exception. Health Choice recipients who are American Indian or Alaska native are entitled to VFC vaccines—Health Choice will only reimburse an administration fee for these recipients. Refer to individual Health Choice articles in the general Medicaid bulletin and the *Basic Medicaid and NC Health Choice Billing Guide, Section 12*, for details regarding the NCHC eligibility groups and the billing and claims processing of Health Choice claims.

In **rare** instances, due to recalls or true shortages of vaccines, Medicaid may reimburse for purchased vaccine that is normally provided through the NCIP/VFC program. In those instances, specific billing instructions will be provided in the general Medicaid bulletin in a vaccine-specific article.

Providers must use purchased vaccines for Health Check recipients ages 19 and 20, who (because of their age) are not routinely eligible for NCIP/VFC vaccines. When purchased vaccines are administered to this age group, Medicaid will reimburse providers for vaccines and their administration. Note that some NCIP vaccines, provided at no charge, may be administered to patients ages 19 and older, in which case Medicaid will cover the administration fee. CPT codes for vaccine products must **always** be included on the claim **without the EP modifier**. Remember that some purchased vaccines require the SC modifier. See the specific billing guidance in the General Medicaid Bulletins.

Vaccine-specific guidance is usually published in individual articles in the Medicaid bulletin (e.g., CPT 90714, CPT 90734). Note: If the SC modifier is required on a claim detail for a Medicaid recipient, the SC modifier IS required on the claim detail for an NCHC recipient.

A listing of NCIP/VFC vaccines provided to children through 18 years of age who are present in North Carolina and who are VFC eligible appears in the table below. **Medicaid recipients are automatically eligible for VFC vaccine, even those who are dually covered by Medicaid and another insurance plan.** All of these vaccines are available to Medicaid children through 18 years of age. Because vaccines have other criteria which must be met **and vaccine criteria are subject to change**, it is recommended that providers go to the Immunization Branch web site at <http://www.immunize.nc.gov>. Select “Healthcare Providers;” then select “NCIP coverage criteria” under the heading North Carolina Immunization Program (NCIP Requirements), or call the Immunization Branch at 1-877-873-6247.

The following is a list of NCIP/VFC vaccines:

Codes	Vaccine CPT Code Descriptions	Diagnosis Codes	NCIP/VFC Specifics
90633	Hepatitis A vaccine, pediatric/adolescent dosage – two dose schedule, for intramuscular (IM) use	V05.3	12 months through 18 years of age
90636*	Hepatitis A and hepatitis B vaccine (HepA-HepB), adult dosage, for IM use	V06.8	18 years of age and above in local health departments (LHDs), FQHCs, and RHCs
90647	Hemophilus influenza b vaccine (Hib), PRP-OMP conjugate (3 dose schedule), for IM use	V03.81	Brand name - <i>PedvaxHIB</i> Routine – two months to less than five years of age High risk – greater than 59 months through 18 years of age
90648	Hemophilus influenza b vaccine (Hib), PRP-T conjugate (four dose schedule), for IM use	V03.81	Brand name - <i>ActHIB</i> Routine – two months to less than five years of age High risk – greater than 59 months through 18 years of age Brand name – <i>Hiberix</i> Approved for the booster dose in children 15 months through – four years of age
90649	Human papilloma virus (HPV) vaccine, types 6, 11, 16, 18 (quadrivalent), three dose schedule, for intramuscular (IM) use	V04.89	Brand name – <i>Gardasil</i> Females and males 9 years through 18 years of age
90650	Human papilloma virus (HPV) vaccine, types 16, 18, bivalent, three dose schedule for intramuscular use	V04.89	Brand name – <i>Cervarix</i> Females nine years through 18 years of age
90655+	Influenza virus vaccine, split virus, preservative free when administered to children six - 35 months of age, for IM use	V04.81	six months through 35 months of age

Codes	Vaccine CPT Code Descriptions	Diagnosis Codes	NCIP/VFC Specifics
90656+	Influenza virus vaccine, preservative free, when administered to individuals three years and older, for IM use	V04.81	three years through 18 years of age
90657+	Influenza virus vaccine, split virus, when administered to children six -35 months of age, for IM use	V04.81	six months through 35 months of age
90658+	Influenza virus vaccine, when administered to individuals three years of age and older, for IM use	V04.81	three years through 18 years of age
90660+	Influenza virus vaccine, live, for intranasal use	V04.81	two years through 18 years of age
90670	Pneumococcal conjugate vaccine, 13 valent, for IM use	V03.82	<p>Routine -- two months through 59 months of age</p> <p>High risk -- 60 months through 18 years age with certain underlying medical conditions</p>
90680	Rotavirus vaccine, pentavalent, three dose schedule, live, for oral use	V04.89	Brand name – <i>Rotateq</i> six weeks through seven months of age
90681	Rotavirus vaccine, human, attenuated, two dose schedule, live, for oral use	V04.89	Brand name – <i>Rotarix</i> six weeks through seven months of age
90696	Diphtheria, tetanus toxoids, acellular pertussis vaccine and poliovirus vaccine, inactivated (DTaP-IPV), when administered to children four through six years of age, for IM use	V06.3	four years through six years of age, for booster dose only of DTaP and polio vaccines
90698	Diphtheria, tetanus toxoids, acellular pertussis vaccine, haemophilus influenza Type B, and poliovirus vaccine, inactivated (DTaP-Hib-IPV), for IM use	V06.8	two months through four years of age
90700	Diphtheria , tetanus toxoids, and acellular pertussis vaccine	V06.1	two months through six

Codes	Vaccine CPT Code Descriptions	Diagnosis Codes	NCIP/VFC Specifics
	(DTaP), when administered to individuals younger than seven years, for IM use		years of age
90702	Diphtheria and tetanus toxoids (DT) adsorbed when administered to individuals younger than seven years, for IM use	V06.5	two months through six years of age
90707*	Measles, mumps and rubella vaccine (MMR), live, for subcutaneous (SC) use	V06.4	12 months through 18 years of age
90710	Measles, mumps, rubella and varicella vaccine (MMRV), live, for SC use	V06.8	12 months through 12 years of age
90713	Poliovirus vaccine, inactivated (IPV), for SC or IM use	V04.0	two months through 17 years of age
90714*	Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, when administered to individuals 7 years or older, for IM use	V06.5	seven years through 18 years of age
90715*	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to individuals seven years or older, for IM use	V06.1	seven years through 18 years of age
90716	Varicella virus vaccine, live, for SC use	V05.4	12 months through 18 years of age
90723	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B, and poliovirus vaccine, inactivated (DTaP-HepB-IPV), for IM use	V06.8	two months through six years of age
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals two years or older, for SC or IM use	V03.82	Only for high risk children two years through 18 years of age

Codes	Vaccine CPT Code Descriptions	Diagnosis Codes	NCIP/VFC Specifics
90734*	Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for IM use	V03.89	High risk – nine months through 10 years of age Routine – 11 years through 18 years of age
90744*	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for IM use	V05.3	Birth through 18 years of age* Exception: If the first dose of hepatitis B vaccine is administered prior to age 19, NCIP vaccine may be used to complete the series prior to the 20 th birthday.
90748	Hepatitis B and Hemophilus influenza b vaccine (HepB-Hib) for intramuscular use	V06.8	six weeks through 15 months of age

*Providers should refer to the Immunization Branch website at <http://www.immunize.nc.gov> for detailed information regarding vaccines. Certain vaccines are provided for those recipients 19 years of age and older through the NCIP. Questions about current coverage may also be addressed by calling the NCIP at 1-877-873-6247.

+Each influenza season, ACIP issues recommendations for the administration of flu vaccine. Based on these recommendations, NCIP issues coverage criteria announcements at the beginning of the season. Additional guidance may be issued throughout the flu season if the availability of vaccine changes.

About the North Carolina Immunization Program

NCIP providers must submit to the requirements of the NCIP program. These requirements include but are not limited to:

- Signing a legally-binding program agreement annually (only physicians licensed to practice medicine in North Carolina may sign an NCIP Provider Agreement),
- Allowing N.C. Immunization Branch staff to perform periodic site visits,
- Administering vaccines according to required guidelines,
- Maintaining correct storage and handling procedures for vaccines, and
- Accounting for every dose of state-supplied vaccine received.

NCIP participants are not required to enroll in the [North Carolina Immunization Registry](#), although its use is strongly encouraged.

For additional information on the NCIP, see the program and policy documents listed below on the NCIP website (www.immunize.nc.gov).

- [Provider Vaccine Agreement](#) (PDF, 29 KB)
- [Responsibilities of Provider Office](#) (PDF, 29 KB)
- [Disaster Recovery Plan](#) (PDF, 35 KB)
- [Financial Restitution](#) (PDF, 2.37 MB)
- [Borrowing Policy Memo](#) (PDF, 127 KB) and [Borrowing Policy Form](#) (PDF 61, KB)
- [NCIP Vaccine Enrollment FAQs](#) (PDF, 18 KB)
- [Re-Enrollment Statement](#) (PDF, 21 KB)
- [Withdrawing from NCIP](#) (PDF, 8 KB)

Who Should Join the NCIP

Health care providers who administer vaccines to children eligible for the federal Vaccines for Children (VFC) program should join the NCIP program. To be eligible for VFC vaccine, children through 18 years of age must meet at least one of the ng criteria stated below.

Medicaid enrolled - a child who is eligible or enrolled in the Medicaid program.

Uninsured - a child who has no medical insurance coverage.

American Indian or Alaskan Native

Underinsured - children who have commercial (private) health insurance but the coverage does not include vaccines, children whose insurance covers only selected vaccines (VFC-eligible for non-covered vaccines only), or children whose insurance caps vaccine coverage at a certain amount - once that coverage amount is reached, these children are categorized as underinsured.

How to Join

N.C. Medicaid providers who are not enrolled in NCIP or who have questions concerning the program should call the N.C. Division of Public Health's Immunization Branch at 1-877-873-6247. Please note that providers who serve only adult patients or insured children cannot join the NCIP.

Out-of-state providers may obtain VFC vaccines by calling their state's VFC program office. VFC program telephone numbers for the states bordering North Carolina are listed below:

- **Georgia** 1-404-657-5013
- **South Carolina** 1-800-277-4687
- **Tennessee** 1-615-741-7343
- **Virginia** 1-804-864-8055

HEALTH CHECK BILLING REQUIREMENTS

Effective with date of processing October 2, 2009, the N.C. Medicaid Program required all providers to file claims **electronically**. Claims received on or after October 2, 2009, are subject to denial if the claim is not in compliance with the electronic claim mandate. Instructions for billing a Health Check screening assessment are the same as when billing for other medical services except for these six critical requirements. The six billing **requirements** specific to the Health Check Program are specified below.

Requirement 1: Identify and Record Diagnosis Code(s).

Place diagnosis code(s) in the correct order in block 21. Medical diagnosis codes should **always** be listed before immunization diagnosis codes. Immunization diagnoses (e.g. V04.81 for influenza) are required when billing immunization(s) only.

Periodic Health Check Screening Assessment – Use V20.2 as the Primary Diagnosis

The primary diagnosis V20.2 is always listed first. Medical diagnoses, if applicable, are listed after the primary diagnosis (V20.2) and **always** before immunization diagnoses. An immunization diagnosis code is required when one or more immunizations are provided as the only service.

Interperiodic Health Check Screening Assessment – Use V70.3 as the Primary Diagnosis

The primary diagnosis V70.3 is always listed first. Medical diagnoses, if applicable, are listed after the primary diagnosis (V70.3) and **always** before immunization diagnoses. An immunization diagnosis code is required when one or more immunizations are provided as the only service.

Requirement 2: Identify and Record Preventive Medicine Code and Component Codes.

The preventive medicine CPT code with the EP modifier for Health Check screening assessments should be billed as outlined below. In addition to billing the preventive medicine code, developmental screening, vision and hearing CPT codes must be listed based on the Health Check Assessment Components requirements noted on pages 15 through 20.

- A developmental screening CPT code with the EP modifier **must** be listed in addition to the preventive medicine CPT codes for a periodic Health Check screening assessment when age appropriate. No additional reimbursement is allowed for this code. Providers may refer to the claim samples in this guide.
- Vision CPT codes with the EP modifier **must** be listed on the claim form format in addition to the preventive medicine CPT codes for a periodic Health Check screening assessment for children ages three through ten years of age and for other children as appropriate based on age or assessment of risk. No additional

reimbursement is allowed for these codes. Providers may refer to the sample claims located at the end of this guide.

- Hearing CPT codes with the EP modifier **must** be listed on the claim form format in addition to the preventive medicine CPT codes for a periodic Health Check screening assessment for children ages four through ten years of age and for other children as appropriate based on an assessment of risk. No additional reimbursement is allowed for these codes. Providers may refer to the sample claims in this guide.

Requirement 3: Health Check Modifier – EP.

The Health Check CPT codes for periodic and interperiodic screening assessments must have the **EP** modifier listed in block 24D of the CMS-1500 claim form format. Additionally, the vision, hearing, and developmental screening CPT codes must have the **EP** modifier listed in block 24D of the CMS-1500 claim form format. **EP is a required modifier for all Health Check claim details except codes for vaccine products.**

Requirement 4: Record Referrals.

N.C. Medicaid is HIPAA-compliant and is able to receive standard electronic HIPAA transactions.

Providers billing electronically using the services of a vendor or clearinghouse may reference the National HIPAA Implementation Guide and the North Carolina 837 Professional Claim Transaction Companion Guide for values regarding follow up-visits. The National HIPAA Implementation Guide for the 837 Claim Transaction can be accessed at <http://www.wpc-edi.com>.

The North Carolina Medicaid 837 Companion Guide can be accessed on the DMA website at <http://www.ncdhhs.gov/dma/hipaa/837prof.pdf>.

Claims submitted via NCECSWeb should list referral code indicator “E” when a referral is made for follow-up on a defect, physical or mental illness, or a condition identified through a Health Check screening assessment. List referral code indicator “F” when a referral is made for Family Planning services.

Requirement 5: Next Screening Date.

Providers may enter the next screening date (NSD) or have the NSD systematically entered according to the predetermined Medicaid periodicity schedule. Below is an explanation of options for the NSD in block 15 of the CMS-1500 claim form format.

Provider-Entered Next Screening Date

Providers have the option of entering the NSD in block 15. If this date is within the periodicity schedule, the system will keep this date. In the event the NSD is OUT of range with the periodicity schedule, the system will override the provider’s NSD and the appropriate NSD (based upon the periodicity schedule) will be automatically entered during claims processing.

Note: Providers billing electronically are not required to enter a screening date (NSD) for health check screening claims.

Systematically Entered Next Screening Date

Providers have the choices stated below for block 15 of the CMS-1500 claim form format with a Health Check screening assessment. All of these choices will result in an automatically entered NSD.

- **Leave block 15 blank.**
- **Place all zeros in block 15 (00/00/0000).**
- **Place all ones in block 15 (11/11/1111).**

Claims with systematically entered NSDs will be tracked per the Medicaid periodicity schedule.

Requirement 6: Identify and Record Immunization Administration CPT Code(s) and the EP Modifier, and Report/Bill the CPT Code for the Vaccine Product.

Providers should refer to the *Immunizations* section beginning on page 30, paying particular attention to the *Guiding Principles for Immunization Administration Codes* section beginning on page 33.

Providers may also refer to the claim examples at the end of this guide.

When reporting or billing vaccine administration codes, providers must use the appropriate CPT code(s) with the EP modifier listed in field 24D of the CMS-1500 claim form, or in the appropriate field on the 837P or HP Enterprise Services' Web tool. Remember: No EP modifier is required on NCHC claims.

Claims must be filed electronically unless they meet one of the ECS-mandated exceptions.

The CPT code for the vaccine product must be reported or billed **without** the EP modifier appended.

National Drug Codes (NDCs) are **not** required to be billed with CPT codes for vaccine products. NDCs should not be submitted for vaccine CPT codes to prevent denials of those details.

Providers must bill the appropriate number of units on the detail along with the total charge of **all** units billed for that code.

Notes:

In **rare** instances, because of vaccine recalls or because of true shortages of vaccines, Medicaid may reimburse for purchased vaccine that is normally provided through the NCIP/VFC program. In those instances, specific billing instructions will be provided in the general Medicaid bulletin. **Because the NCIP/VFC provides vaccines for Medicaid recipients under 19 years of age, claims for purchased vaccines administered to this age group that are available through VFC will be denied.**

Providers must use purchased vaccines for Health Check recipients ages 19 and 20, who (because of their age) are not routinely eligible for NCIP/VFC vaccines. **When purchased vaccines are administered to this age group, Medicaid will reimburse providers for vaccines and their administration.** Note that some NCIP vaccines, provided at no charge, may be administered to patients ages 19 and older, in which case Medicaid will cover the administration fee. CPT codes for vaccine products must always be included on the claim (**without the EP modifier**). Remember that some purchased vaccines require the SC modifier. Refer to billing guidance on specific vaccines in the General Medicaid bulletin. **Note:** If the SC modifier is required on a claim detail for a Medicaid recipient, the SC modifier **IS required** on the claim detail for an NCHC recipient.

If the **EP** modifier is not listed in block 24D for those Health Check age recipients through 20 years of age, the reimbursement rate for the CPT codes 90471, 90472, 90473, or 90474 is \$0.00.

Health Check Related ICD-9-CM and CPT Codes

The table below lists ICD-9 and CPT codes related to Health Check screening assessments.

	Preventive CPT Codes and Modifier	Diagnoses Codes
Periodic Examination	<p>CPT Codes 99381-99385; 99391-99395 EP Modifier is required in block 24D</p> <p>Developmental Screening CPT Code 96110; at six, 12, 18 or 24 months of age, at age three, four, and five years of age EP Modifier is required in block 24D</p> <p>Autism Screening CPT Code: 99420 EP Modifier is required in block 24D</p> <p>Health Risk Assessments, CPT Code 99420 (GAPS/HEADSSS) and Behavioral/Mental Health Screening (PSC/SDQ/PSQ-A/Beck’s); CPT 99406-99407 for Smoking/Tobacco Use Cessation; and CPT 99408-99409 for Alcohol/Substance Abuse Structured Screening and Brief Intervention (CRAFFT) are currently reimbursed. EP Modifier is required in block 24D</p> <p>Vision CPT Code 99172 or 99173; for children ages 3-10, and then as appropriate based on age and risk.</p>	V20.2 Primary Diagnosis

	EP Modifier is required in block 24D Hearing CPT Code 92551, 92552, or 92587; for children 4-10 and then as appropriate based on risk. EP Modifier is required in block 24D	
Interperiodic Examination	CPT codes 99381-99385; 99391-99395 EP Modifier is required in block 24D	V70.3 Primary Diagnosis

Preventive Medicine CPT Codes

The table below lists Preventive Medicine CPT codes that must be listed on the CMS-1500 claim form format when filing a claim for a Periodic (V20.2) or an Interperiodic (V70.3) examination. The EP modifier must be listed in block 24D of the CMS-1500 claim form format with the appropriate preventive medicine code.

Age	New Patient	Established Patient	Append EP Modifier
Under age one year	99381	99391	Yes
One four years	99382	99392	Yes
Five through 11 years	99383	99393	Yes
12 through 17 years	99384	99394	Yes
18 through 20 years	99385	99395	Yes

TIPS FOR BILLING

All Health Check Providers

- Two Health Check screening assessments on different dates of service cannot be billed on the same claim form.
- CPT codes: 99406 EP, 99407 EP, 99408 EP, 99409 EP can be billed when performed during a periodic Health Check assessment or during an interperiodic Health Check screening assessment for adolescents ages 11 through 20.
- CPT code 99420 EP can be billed when performed during a periodic Health Check screening assessment or during an interperiodic Health Check screening assessment for children ages birth through 20.
- Immunizations and therapeutic injections may be billed on the same date of service and on the same claim.

- A formal, standardized developmental screening tool **must** be used during periodic screening assessments for children ages six, 12, 18 or 24 months, and three, four, and five years of age.
- If the required vision and/or hearing screenings cannot be performed during a periodic screening assessment due to a condition such as blindness, deafness, autism, or uncooperative child, providers must:
 - Document in the patient’s medical record the date of service and the reason(s) why the provider was unable to perform the vision and/or hearing screening.
 - Submit the claim to HP ENTERPRISE SERVICES without the vision and/or hearing CPT code.

HP ENTERPRISE SERVICES will process the claim.

- Report payments received from third party insurance in block 29 of the CMS-1500 claim form format when preventive services (Well Child assessments) are covered. If third party insurance does not cover preventive services, clearly document in the medical record and submit the claim to Medicaid.
- All electronically submitted claims should list referral code indicator “E” when a referral is made for follow-up on a defect, physical or mental illness, or a condition identified through a Health Check screening assessment.

Private Sector and Local Health Department Health Check Providers

- A Health Check screening assessment and an office or sick visit with different dates of service cannot be billed on the same claim form.
- A Health Check screening assessment and an office visit cannot be paid initially on the same date of service. One claim will pay and the other will deny. For the denied claim to be reconsidered, it must be submitted as an adjustment with medical justification and a copy of the Remittance and Status Report (RA) denial attached.
- Immunization administration CPT codes 90471EP, 90472EP, 90473EP or 90474EP may be billed with a Health Check screening assessment, office or sick visit or if the vaccine administration is the only service provided that day. When billing in conjunction with an examination code or an office or sick visit code, an immunization diagnosis is **not required** in block 21 of the claim form. When billing an administration code for immunizations as the **only** service for that day, providers **are required** to use an immunization diagnosis code in block 21 of the claim form. Always list the CPT vaccine product codes when billing these administration codes with the EP modifier. Refer to the claim examples at the end of this guide.
- When checking claim status using the Automated Voice Response (AVR) system (1-800-723-4337), AVR requires providers to enter the total amount billed. Due to each Health Check claim being divided into two separate claims for tracking purposes, the total amount billed must also be split between the amount billed for

the Health Check screening assessment and the amount billed for immunizations and any other service billed on the same date of service. Thus, it is necessary to check claim status for two separate claims.

- A formal, standardized developmental screening tool **must** be used during periodic examinations for children ages six months, 12 months, 18 or 24 months, and three, four, and five years of age.

Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Providers Only

- Providers may bill a core behavioral health visit (T1015 HI) and a Health Check screening assessment on the same date of service on separate claims.
- A Health Check screening assessment and a core visit (T1015) cannot be paid initially on the same date of service. One claim will pay and the other will deny. For the denied claim to be reconsidered, it must be submitted as an adjustment with medical justification and a copy of the Remittance and Status Report (RA) denial attached.
- Immunization administration CPT codes 90471EP, 90472EP, 90473EP or 90474EP can be billed with a Health Check screening assessment or if the vaccine administration is the only service provided that day. When billing in conjunction with an examination code, an immunization diagnosis is **not** required in block 21 of the claim form format. When billing an administration code for immunizations as the **only** service for that day, an immunization diagnosis code **is** required to be entered in block 21 of the claim form format. An administration code for immunizations (90471EP – 90474EP) cannot be billed in conjunction with a core visit. For reporting purposes, list CPT vaccine codes in the appropriate block on the claim form format. Always list CPT vaccine **product** codes when billing any immunization administration code with the EP modifier. Refer to the claim examples at the end of this guide.

HEALTH CHECK COORDINATION

Health Check Coordination is the responsibility of the 14 Community Care of North Carolina (CCNC) regional networks. Under the direction of the CCNC networks, the Health Check Coordinators (HCCs) are available to assist both **parents** and **providers** in assuring that Medicaid-eligible children have access to Health Check services.

HCCs provide education and outreach services in 100 North Carolina counties and the Qualla Boundary. HCCs are stationed at certain regional CCNC network sites, local health departments, community and rural health centers, and other community agencies. A list of counties with HCCs is available on the DMA website at: <http://www.ncdhhs.gov/dma/ca/hcc.pdf>.

The role and responsibilities of the HCC include but are not limited to those specified below.

- Using the Health Check Automated Information and Notification System (AINS) for identifying and following Medicaid-eligible children, birth through 20 years of age, with regard to services received through the health care system
- Educating families about the importance of establishing a medical home **that provides ongoing, comprehensive, family-centered, and accessible care** for their children **and youth**
- Assisting families to use the health care services in a consistent and responsible manner
- Assisting with scheduling appointments or securing transportation
- Acting as a local information, referral, and resource person for families
- Providing advocacy services in addressing social, educational or health needs of the recipient
- Initiating follow-up as requested by providers when families need special assistance or fail to bring children in for Health Check or follow-up examinations
- Promoting Health Check and health prevention with other public and private organizations

Physicians, primary care providers (PCPs), and their office staff are encouraged to establish a close working relationship with HCCs. Ongoing communication significantly enhances recipient participation in Health Check and helps make preventive health care services more timely and effective.

HEALTH CHECK CLAIM DENIALS – EXPLANATION OF BENEFITS (EOB)

EOB	Message	Tip
010	Diagnosis or service invalid for recipient age. Verify MID, diagnosis, procedure code or procedure code/modifier combination for errors. Correct and submit as a new claim.	Verify the recipient’s Medicaid identification (MID) number, date of birth (DOB), diagnosis, and procedure codes. Make corrections, if necessary, and resubmit to HP ENTERPRISE SERVICES as a new claim. If all information is correct, send the claim and RA to the DMA Claims Analysis Unit, 2501 Mail Service Center, Raleigh, NC 27699-2501.
079	This type of service is not payable to your provider type or specialty.	Check your claim for keying errors, make corrections if necessary. Verify the provider type and specialty for your Medicaid provider number by contacting a Health Check Consultant at 919-855-4780.
082	Service is not consistent with/or not covered for this diagnosis/or description does not match diagnosis.	Verify diagnosis code is V20.2 or V70.3 for the Health Check screening assessment according to the billing guidelines on page 36. Correct claim and resubmit.
349	Health Check Screen and related service not allowed same day, same provider, or member of same group.	Resubmit as an adjustment with documentation supporting unrelated services.
685	Health Check services are for Medicaid recipients birth through age 20 only.	Verify recipient’s age. Only recipients age birth through 20 years of age are eligible for Health Check services.
1036	Thank you for reporting vaccines. This vaccine was provided at no charge through VFC Program. No payment allowed.	Vaccines are available at no charge through the NCIP/VFC Program.
1058	The only Well Child exam billable through the Medicaid program is a Health Check screening assessment. For information about billing Health Check, please call 1-800-688-6696.	Bill periodic examination with primary diagnosis V20.2 and Interperiodic examinations with primary diagnosis V70.3. Check the preventive medicine code entered in block 24D of the claim form and append the EP modifier.
1422	Immunization administration not allowed without the appropriate immunization. Refer to the most recent Health Check Special Bulletin.	Check the claim to ensure that immunization procedure codes are billed on the same claim as immunization administration codes. Make corrections and resubmit as a new day claim.
1769	No additional payment made for vision, hearing and/or developmental screening services.	Payment is included in Health Check reimbursement.
1770	Invalid procedure/modifier/diagnosis code combination for Health Check or Family Planning services. Correct and resubmit as a new claim.	Health Check services must be billed with the primary diagnosis code V20.2 or V70.3 and the EP modifier. Verify the correct diagnosis code, procedure code and modifier for the service rendered. Family planning services must be billed with the FP modifier and the diagnosis code V25.9.

HEALTH CHECK BILLING REFERENCE SHEET

Date of Service _____

Patient's Name		Next Examination Date (optional)	
Medicaid ID number		Date of Birth	
Health Check Diagnosis Code			
Periodic Health Check Screening Assessment		Periodic Health Check Screening V20.2	
Interperiodic Health Check Screening Assessment		Interperiodic Health Check screening assessment V70.3	
Health Check screening assessment Code			
Description	Preventive Medicine Codes	Diagnosis Code	✓
Regular Periodic Examination- Birth through 20 years	99381-9985; 99391-99395 With EP Modifier	V20.2	
Developmental Screening based on age	Development Screening CPT Code 96110 With EP Modifier		
Autism Screening based on age	Autism Screening CPT Code: 99420 With EP Modifier		
Adolescent Health Risk Assessment and B/MH Screening	CPT 99420 With EP Modifier		
Vision Screening based on age	Vision Screening CPT Code 99172 or 99173 With EP Modifier		
Hearing Screening based on age	Hearing Screening CPT Code 92551, 92552 or 92587 With EP Modifier		
Interperiodic Examination – Birth through 20 years	99381-99385; 99391-99395 With EP Modifier	V70.3	
Second Diagnosis _____ (if applicable)			

Description	Indicator		✓
Follow-up with HC provider or another provider	E or F – Providers billing electronically		
Third Diagnosis _____ (if applicable)			
Description	Indicator		✓
Follow-up with HC provider or another provider	E or F – Providers billing electronically		
Fourth Diagnosis _____ (if applicable)			
Description	Indicator		✓
Follow-up with HC provider or another provider	E or F – Providers billing electronically		
Description	CPT Codes	Unit	
Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)	90471 with EP modifier	1 unit	
	OR		
Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)	90473 with EP modifier	1 unit	
Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)	90472 with EP Modifier	1 or more units	
	OR		
	90474 with EP modifier	1 unit	

IMMUNIZATION BILLING REFERENCE SHEET

Notes:

Do not bill Medicaid for the cost of a vaccine or immune globulin on this table if the product was provided at no charge through the NCIP/VFC program or another source. Only the administration code should be billed. In that case, the CPT vaccine or immune globulin product code should be reported with \$0.00.

When billing for SOME immune globulins and most drugs/biologicals, the NDC code must be reported. These are indicated in the Physician's Drug Program Fee Schedule with asterisks (***) **Refer to the fee schedule at <http://www.ncdhhs.gov/dma/fee/> under *Physician Services (CPT/HCPCS)* for CPT administration code and vaccine product rates. The drugs and biologics, including vaccine products, are found toward the end of the fee schedule.**

Do **NOT** report NDC codes for CPT vaccine product codes.

Only rebatable drugs/biologicals must be billed to Medicaid. Refer to the March 2009 Special Bulletin, *National Drug Code Implementation, Phase III*, on DMA's website (<http://www.ncdhhs.gov/dma/bulletin/>) for additional instructions.

IMMUNIZATION BILLING REFERENCE SHEET

Code	CPT Description	Diagnosis	NCIP/VFC Vaccine Specifics
90291	Cytomegalovirus immune globulin (CMV-IgIV), human, for intravenous (IV) use	V07.2	
J1460	Injection, gamma globulin, intramuscular (IM); 1 cc .	V07.2	Limited distribution to health depts. (LHDs) only, and only during outbreaks.
J1560	Injection, gamma globulin, IM, over 10 cc	V07.2	
90371	Hepatitis B immune globulin (HBIg), human, IM	V07.2	
J1571	Injection, hepatitis B immune globulin (HepaGam B), IM, 0.5 ml	V07.2	
J1573	Injection, hepatitis B immune globulin (HepaGam B), IV, 0.5 ml	V07.2	
J1559	Injection, immune globulin, (hizentra), 100 mg	V07.2	
J1561	Injection, immune globulin, (Gamunex), IV, non-lyophilized (e.g. liquid), 500 mg	V07.2	
J1562	Injection, immune globulin, (Vivaglobin),	V07.2	

Code	CPT Description	Diagnosis	NCIP/VFC Vaccine Specifics
	100 mg		
J1566	Injection, immune globulin, IV, lyophilized (e.g., powder), NOS, 500 mg	V07.2	
J1568	Injection, immune globulin, (Octagam), IV, non-lyophilized (e.g. liquid), 500 mg	V07.2	
J1569	Injection, immune globulin, (Gammagard liquid), IV, non-lyophilized (e.g., liquid), 500 mg	V07.2	
J1572	Injection, immune globulin, (Flebogamma/Flebogamma DIF), IV, non-lyophilized (e.g., liquid), 500 mg	V07.2	
J2788	Injection, Rho D immune globulin, human, minidose, 50 mcg (250 i.u.)	V07.2	
J2790	Injection, Rho D immune globulin, human, full dose, 300 mcg (1500 i.u.)	V07.2	
J2791	Injection, Rho D immune globulin, (human) (Rhophylac) IM or IV, 100 IU	V07.2	
J2792	Injection, Rho D immune globulin, IV, human, solvent detergent, 100 IU	V07.2	
J7504	Lymphocyte immune globulin, antithymocyte globulin, equine, parenteral, 250 mg Brand name - <i>Atgam</i>	V07.2	
90375	Rabies immune globulin, (RIg), human, for IM and/or subcutaneous (SC) use	V07.2	
90378	Respiratory syncytial virus, monoclonal antibody, recombinant, for IM use, 50 mg, each Brand name - <i>Synagis</i> Note: <i>Synagis</i> is not covered in the Physician's Drug Program but is covered only through the Outpatient Pharmacy Program. CPT code 96372 may be billed for <i>Synagis</i> administration,	V07.2	
90389	Tetanus immune globulin (TIG), human, for IM use	V07.2	
90585	Bacillus Calmette-Guerin vaccine (BCG) for tuberculosis, live for percutaneous use	V03.2	
90632	Hepatitis A vaccine, adult dosage, for IM use	V05.3	19 years of age and above Limited distribution to LHDs only, and

Code	CPT Description	Diagnosis	NCIP/VFC Vaccine Specifics
			only during outbreaks.
90633	Hepatitis A vaccine, pediatric/adolescent dosage – 2 dose schedule, for IM use	V05.3	12 months of age through 18 years of age
90636*	Hepatitis A and B combination (HepA-HepB), adult dosage, for IM use	V06.8	18 years of age and above only in LHDs, FQHCs, and RHCs*
90647	Hemophilus influenza b vaccine (Hib), PRP-OMP conjugate (3 dose schedule), for IM use	V03.81	Brand name - PedvaxHIB Routine – 2 months to less than 5 years of age High risk - greater than 59 months through 18 years of age.
90648	Hemophilus influenza b vaccine (Hib), PRP-T conjugate (4 dose schedule), for IM use	V03.81	Brand name – ActHIB Routine – 2 months to less than 5 years of age; High risk – greater than 59 months through 18 years of age. Brand name – Hiberix Approved for the booster dose in children 15 months through 4 years of age
90649	Human papilloma virus (HPV) vaccine, types 6, 11, 16, 18 (quadrivalent), 3 dose schedule, for intramuscular (IM) use	V04.89	Brand name – Gardasil Females and males 9 years through 18 years of age
90650	Human papilloma virus (HPV)	V04.89	Brand name –

Code	CPT Description	Diagnosis	NCIP/VFC Vaccine Specifics
	vaccine, types 16, 18, bivalent, 3 dose schedule, for IM use		Cervarix Females 9 through 18 years of age
90655+	Influenza virus vaccine, split virus, preservative free when administered to children 6-35 months of age, for IM use	V04.81	6 months through 35 months of age
90656+	Influenza virus vaccine, preservative free, when administered to individuals 3 years and older	V04.81	3 years through 18 years of age
90657+	Influenza virus vaccine, split virus, when administered to children 6-35 months of age, for IM use	V04.81	6 months through 35 months of age
90658+	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for IM use	V04.81	3 years through 18 years of age
90660+	Influenza virus vaccine, live, for intranasal use	V04.81	2 years through 18 years of age
90670	Pneumococcal conjugate vaccine, 13 valent, for IM use	V03.82	Brand name – Prennar 13 Routine – 2 months through 59 months of age High risk – 60 months through 18 years of age with certain underlying medical conditions
90675	Rabies vaccine for IM use	V04.5	
90680	Rotavirus vaccine, pentavalent, 3 dose schedule, live, for oral use	V04.89	Brand name – Rotateq 6 weeks through 7 months of age
90681	Rotavirus vaccine, human, attenuated, 2 dose schedule, live, for oral use	V04.89	Brand name – Rotarix 6 weeks through 7 months of age
90696	Diphtheria, tetanus toxoids, acellular pertussis vaccine and poliovirus	V06.3	4 years through 6 years of age for the

Code	CPT Description	Diagnosis	NCIP/VFC Vaccine Specifics
	vaccine, inactivated (DTaP-IPV), when administered to children 4 through 6 years of age, for IM use		booster dose only of DTaP and polio vaccines
90698	Diphtheria, tetanus toxoids, acellular pertussis vaccine, haemophilus influenza Type B, and poliovirus vaccine, inactivated (DTaP-Hib-IPV), for IM use	V06.8	2 months through 4 years of age
90700	Diphtheria , tetanus toxoids, and acellular pertussis vaccine (DTap), when administered to individuals younger than 7 years, for IM use	V06.1	2 months through 6 years of age
90702	Diphtheria and tetanus toxoids (DT) adsorbed when administered to individuals younger than 7 years, for IM use	V06.5	2 months through 6 years of age
90703	Tetanus toxoid adsorbed, for IM use	V03.7	
90707*	Measles, mumps, and rubella virus vaccine (MMR), live, for SC use	V06.4	12 months through 18 years of age*
90710	Measles, mumps, rubella, and varicella vaccine (MMRV), live, for SC use	V06.8	12 months through 12 years of age
90713	Polio virus vaccine, inactivated (IPV), for SC or IM use	V04.0	2 months through 17 years of age
90714*	Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, when administered to individuals 7 years or older, for IM use	V06.5	7 years through 18 years of age*
90715*	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older, for IM use	V06.1	7 years through 18 years of age*
90716	Varicella virus vaccine, live, for SC use	V05.4	12 months through 18 years of age
90723	Diphtheria, tetanus toxoids, and acellular pertussis vaccine, Hepatitis	V06.8	2 months through 6 years of age

Code	CPT Description	Diagnosis	NCIP/VFC Vaccine Specifics
	B, and poliovirus vaccine, inactivated (Dtap-HepB-IPV), for IM use		
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for SC or IM use	V03.82	Only for high-risk children two years through 18 years of age
90733	Meningococcal polysaccharide vaccine (any group(s), for SC use	V04.89	
90734*	Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for IM use	V01.89	High risk – 9 months through 10 years of age Routine – 11 through 18 years of age
90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3-dose schedule), for IM use	V05.3	
90744*	Hepatitis B vaccine pediatric/adolescent dosage (3 dose schedule), for IM use	V05.3	Birth through 18 years of age* Exception: If the first dose of hepatitis B vaccine is administered prior to age 19, NCIP vaccine may be used to complete the series prior to the 20th birthday*.
90746*	Hepatitis B vaccine, adult dosage, for IM use	V05.3	20 years of age and older, only in LHDs*
90747	Hepatitis B vaccine dialysis or immunosuppressed patient dosage (4-dose schedule), for IM use	V05.3	
90748	Hepatitis B and Hemophilus influenza b vaccine (HepB-Hib), for intramuscular use	V06.8	6 weeks through 15 months of age

*Providers should refer to the Immunization Branch website at <http://www.immunize.nc.gov> for detailed information regarding vaccines. Certain

vaccines are provided for recipients 19 years of age and older through the NCIP. Questions about current coverage may also be addressed by calling the NCIP at 1-877-873-6247.

+Each influenza season, ACIP issues recommendations for the administration of flu vaccine. Based on these recommendations, NCIP issues coverage criteria announcements at the beginning of the season. Additional guidance may be issued throughout the flu season if the availability of vaccine changes.

Note: This list is subject to change. Updates regarding vaccines are published in the general Medicaid bulletins on DMA's website at <http://www.ncdhhs.gov/dma/bulletin/>.

RESOURCE LIST

Children with Special Health Care Needs Helpline

1-800-737-3028

Dental Varnishing

Clinical Coverage Policy #1A-23, *Physician Fluoride Varnish Services*

<http://www.ncdhhs.gov/dma/mp/>

Developmental Screening standardized and validated screening tools

<http://www.dbpeds.org>

<http://www.brightfutures.aap.org>

Developmental Surveillance and Screening

<http://aappolicy.aappublications.org/cgi/reprint/pediatrics;118/1/405.pdf>

DMA Customer Services Center

1-888-245-0179

Due Process (Medicaid Recipient Appeals)

<http://ncdhhs.gov/dma/provider/priorapproval.htm>

HP Enterprise Services Provider Services

1-800-688-6696 or 919-851-8888

Health Check Coordinator Contact List

<http://www.ncdhhs.gov/dma/ca/hcc.pdf>

National HIPAA Implementation Guide

<http://www.wpc-edi.com/hipaa>

NC Healthy Start Foundation

<http://www.nchealthystart.org/>

North Carolina 837 Professional Claim Transaction Guide

<http://www.ncdhhs.gov/dma/hipaa/837prof.pdf>

North Carolina Immunization Branch

North Carolina Immunization Program/Vaccines for Children (NCIP/VFC)

<http://www.immunize.nc.com>

North Carolina Lead Screening and Follow Up Manual

http://www.deh.enr.state.nc.us/ehs/Children_Health/2009printedversionleadmanual.pdf

December 2005 Special Bulletin, Medicaid for Children, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and Health Check

<http://www.ncdhhs.gov/dma/bulletin/>

Basic Medicaid Billing Guide

<http://www.ncdhhs.gov/dma/basicmed/>

EPSDT Provider Page

<http://www.ncdhhs.gov/dma/epsdt/>

Physicians' Fee Schedule

<http://www.ncdhhs.gov/dma/fee/>

Policy Instructions: Early and Periodic Screening, Diagnostic and Treatment

<http://www.ncdhhs.gov/dma/epsdt/>

Prior Approval Process and Request Form for Non-Covered Services

<http://www.ncdhhs.gov/dma/provider/forms.htm>

<http://www.ncdhhs.gov/dma/basicmed/>

<http://ncdhhs.gov/dma/provider/priorapproval.htm>

Recommended Childhood and Adolescent Immunization Schedule, by Vaccine and Age - United States, 2012

<http://www.cdc.gov/vaccines/recs/schedules/child-schedule.htm>

Printable versions of the schedule can be found at:

<http://www.cdc.gov/vaccines/recs/schedules/child-schedule.htm#printable>

Recommendations for Preventive Pediatric Health Care

<http://pediatrics.aappublications.org/cgi/data/120/6/1376/DC1/1>

2008 Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents, Third Edition: Bright Futures 3rd Edition Pocket Guide: Bright Futures Tool and Resource Kit

http://brightfutures.aap.org/pdfs/BF3%20pocket%20guide_final.pdf

U.S. Preventive Services Task Force Recommendations

<http://www.ahrq.gov/clinic/USpstfix.htm>

1500

Private Provider
Periodic Examination

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>														
1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (MemberID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 123456789K														
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Patient, Joanna										3. PATIENT'S BIRTH DATE MM DD YY 03 22 11					SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>									
5. PATIENT'S ADDRESS (No., Street) 123 Fun Street										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>														
CITY Fun Town					STATE NC					7. INSURED'S ADDRESS (No., Street)					CITY					STATE				
ZIP CODE 11111					TELEPHONE (Include Area Code) (555) 555-5555					8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>					9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:														
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO														
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)														
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO														
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE														
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.										11. INSURED'S POLICY GROUP OR FECA NUMBER														
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.														
SIGNED _____										SIGNED _____														
DATE _____										DATE _____														
14. DATE OF CURRENT: <input type="checkbox"/> ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY														
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES. FROM MM DD YY TO MM DD YY														
17a. _____										17b. NPI _____														
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES														
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.														
1. V20.2										23. PRIOR AUTHORIZATION NUMBER														
2. _____										24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #														
3. _____										4. _____														
5. _____										6. _____														
25. FEDERAL TAX I.D. NUMBER SSN EIN										26. PATIENT'S ACCOUNT NO.														
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 80.33														
29. AMOUNT PAID \$										30. BALANCE DUE \$ 80.33														
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Signature on File										32. SERVICE FACILITY LOCATION INFORMATION 123 That St That City, NC 27606-1234														
33. BILLING PROVIDER INFO & PH # Dr J P Provider 123 Any St Any City, NC 27523-5678										a. NPI NPI b. ZZ Taxonomy														
SIGNED _____										SIGNED _____														
DATE _____										DATE _____														

1500

Private Provider
Periodic Examination
Developmental Screening

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Form with multiple sections: 1. MEDICARE/MEDICAID/TRICARE/CHAMPVA/OTHER; 2. PATIENT'S NAME; 3. PATIENT'S BIRTH DATE; 4. INSURED'S NAME; 5. PATIENT'S ADDRESS; 6. PATIENT RELATIONSHIP TO INSURED; 7. INSURED'S ADDRESS; 8. PATIENT STATUS; 9. OTHER INSURED'S NAME; 10. IS PATIENT'S CONDITION RELATED TO; 11. INSURED'S POLICY GROUP OR FECA NUMBER; 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE; 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE; 14. DATE OF CURRENT ILLNESS; 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS; 16. DATES PATIENT UNABLE TO WORK; 17. NAME OF REFERRING PROVIDER; 18. HOSPITALIZATION DATES; 19. RESERVED FOR LOCAL USE; 20. OUTSIDE LAB?; 21. DIAGNOSIS OR NATURE OF ILLNESS; 22. MEDICAID RESUBMISSION; 23. PRIOR AUTHORIZATION NUMBER; 24. A. DATE(S) OF SERVICE; B. PLACE OF SERVICE; C. EMG; D. PROCEDURES, SERVICES, OR SUPPLIES; E. DIAGNOSIS POINTER; F. CHARGES; G. DAYS OR UNITS; H. EPSTD; I. ID. QUAL; J. RENDERING PROVIDER ID. #; 25. FEDERAL TAX I.D. NUMBER; 26. PATIENT'S ACCOUNT NO.; 27. ACCEPT ASSIGNMENT?; 28. TOTAL CHARGE; 29. AMOUNT PAID; 30. BALANCE DUE; 31. SIGNATURE OF PHYSICIAN OR SUPPLIER; 32. SERVICE FACILITY LOCATION INFORMATION; 33. BILLING PROVIDER INFO & PH #.

1500

Private Provider With Immunizations

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

<input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 123456789K	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Patient, Joe					3. PATIENT'S BIRTH DATE 02^M 14^{DD} 05^{YY}			4. INSURED'S NAME (Last Name, First Name, Middle Initial)			
5. PATIENT'S ADDRESS (No., Street) 123 Fun Street					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street)			
CITY Fun Town		STATE NC		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>			CITY		STATE		
ZIP CODE 11111		TELEPHONE (Include Area Code) (555) 555-5555			Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>			ZIP CODE		TELEPHONE (Include Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:			11. INSURED'S POLICY GROUP OR FECA NUMBER			
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO			a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)			b. EMPLOYER'S NAME OR SCHOOL NAME			
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME			
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.			
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.											
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.						
SIGNED _____ DATE _____					SIGNED _____						
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY			15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE					17a. _____ 17b. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY				
19. RESERVED FOR LOCAL USE					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.						
1. V06.8 2. V06.1					23. PRIOR AUTHORIZATION NUMBER						
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. ERSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 05 05 11 05 05 11 11		11	90471	EP		13.71	1	ZZ	NPI	Taxonomy	
2 05 05 11 05 05 11 11		11	90472		EP	13.71	1	ZZ	NPI	Taxonomy	
3 05 05 11 05 05 11 11		11	90710		0.00	1	ZZ	NPI	Taxonomy	NPI Number	
4 05 05 11 05 05 11 11		11	90700		0.00	1	ZZ	NPI	Taxonomy	NPI Number	
5		NPI									
6		NPI									
25. FEDERAL TAX I.D. NUMBER			SSN EIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$	29. AMOUNT PAID \$	30. BALANCE DUE \$
							<input type="checkbox"/> YES <input type="checkbox"/> NO		27.42		27.42
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)					32. SERVICE FACILITY LOCATION INFORMATION 123 That St That City, NC 27606-1234			33. BILLING PROVIDER INFO & PH # () Dr J P Provider 123 Any St Any City, NC 27523-5678			
SIGNED Signature on File DATE					a. NPI			b. ZZ Taxonomy			

CARRIER PATIENT AND INSURED INFORMATION PHYSICIAN OR SUPPLIER INFORMATION

1500

Private Provider
Interperiodic Screening
Immunizations

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Form with multiple sections: 1. MEDICARE/MEDICAID/TRICARE/CHAMPVA/OTHER; 2. PATIENT'S NAME; 3. PATIENT'S BIRTH DATE; 4. INSURED'S NAME; 5. PATIENT'S ADDRESS; 6. PATIENT RELATIONSHIP; 7. INSURED'S ADDRESS; 8. PATIENT STATUS; 9. OTHER INSURED'S NAME; 10. IS PATIENT'S CONDITION RELATED TO; 11. INSURED'S POLICY GROUP OR FECA NUMBER; 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE; 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE; 14. DATE OF CURRENT ILLNESS; 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS; 16. DATES PATIENT UNABLE TO WORK; 17. NAME OF REFERRING PROVIDER; 18. HOSPITALIZATION DATES; 19. RESERVED FOR LOCAL USE; 20. OUTSIDE LAB?; 21. DIAGNOSIS OR NATURE OF ILLNESS; 22. MEDICAID RESUBMISSION; 23. PRIOR AUTHORIZATION NUMBER; 24. A. DATE(S) OF SERVICE; B. PLACE OF SERVICE; C. EMG; D. PROCEDURES, SERVICES, OR SUPPLIES; E. DIAGNOSIS POINTER; F. CHARGES; G. DAYS OR UNITS; H. EPSDI; I. ID. QUAL; J. RENDERING PROVIDER ID. #; 25. FEDERAL TAX I.D. NUMBER; 26. PATIENT'S ACCOUNT NO.; 27. ACCEPT ASSIGNMENT?; 28. TOTAL CHARGE; 29. AMOUNT PAID; 30. BALANCE DUE; 31. SIGNATURE OF PHYSICIAN OR SUPPLIER; 32. SERVICE FACILITY LOCATION INFORMATION; 33. BILLING PROVIDER INFO & PH #.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Private Provider – Split Claim
Periodic Examination
Developmental, Vision, and
Hearing Screening
(Block 24H) Referral Indicator "R"
Immunizations

Form with multiple sections: 1. MEDICARE/MEDICAID/TRICARE/CHAMPVA/OTHER; 2. PATIENT'S NAME; 3. PATIENT'S BIRTH DATE; 4. INSURED'S NAME; 5. PATIENT'S ADDRESS; 6. PATIENT RELATIONSHIP; 7. INSURED'S ADDRESS; 8. PATIENT STATUS; 9. OTHER INSURED'S NAME; 10. IS PATIENT'S CONDITION RELATED TO; 11. INSURED'S POLICY GROUP OR FECA NUMBER; 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE; 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE; 14. DATE OF CURRENT ILLNESS; 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS; 16. DATES PATIENT UNABLE TO WORK; 17. NAME OF REFERRING PROVIDER; 18. HOSPITALIZATION DATES; 19. RESERVED FOR LOCAL USE; 20. OUTSIDE LAB?; 21. DIAGNOSIS OR NATURE OF ILLNESS; 22. MEDICAID RESUBMISSION; 23. PRIOR AUTHORIZATION NUMBER; 24. DATE(S) OF SERVICE; 25. FEDERAL TAX I.D. NUMBER; 26. PATIENT'S ACCOUNT NO.; 27. ACCEPT ASSIGNMENT?; 28. TOTAL CHARGE; 29. AMOUNT PAID; 30. BALANCE DUE; 31. SIGNATURE OF PHYSICIAN OR SUPPLIER; 32. SERVICE FACILITY LOCATION INFORMATION; 33. BILLING PROVIDER INFO & PH #.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> PICA										PICA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>																													
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</small>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 123456789K																													
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Patient, Joe										3. PATIENT'S BIRTH DATE SEX 03 02 07 M <input checked="" type="checkbox"/> F <input type="checkbox"/>																													
5. PATIENT'S ADDRESS (No., Street) 123 Fun Street										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>																													
CITY Fun Town					STATE NC					7. INSURED'S ADDRESS (No., Street)					CITY STATE																								
ZIP CODE 11111					TELEPHONE (Include Area Code) (555) 555-5555					8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>					9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)																								
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO					11. INSURED'S POLICY GROUP OR FECA NUMBER					11. INSURED'S POLICY GROUP OR FECA NUMBER																								
a. OTHER INSURED'S POLICY OR GROUP NUMBER					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH SEX MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					b. EMPLOYER'S NAME OR SCHOOL NAME																								
b. OTHER INSURED'S DATE OF BIRTH SEX MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					c. INSURANCE PLAN NAME OR PROGRAM NAME					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO # if yes, return to and complete item 9 a-d.																								
c. EMPLOYER'S NAME OR SCHOOL NAME					10d. RESERVED FOR LOCAL USE					d. INSURANCE PLAN NAME OR PROGRAM NAME					12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____																								
d. INSURANCE PLAN NAME OR PROGRAM NAME					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____					READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																								
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. _____ 17b. NPI _____										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																			
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. V03.82 2. V06.1										23. PRIOR AUTHORIZATION NUMBER										24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #																			
1 05 02 11 05 02 11 11 90471 EP 13.71 1 ZZ Taxonomy NPI Number										2 05 02 11 05 02 11 11 90472 EP 27.42 2 ZZ Taxonomy NPI Number										3 05 02 11 05 02 11 11 90713 0.00 1 ZZ Taxonomy NPI Number																			
4 05 02 11 05 02 11 11 90700 0.00 1 ZZ Taxonomy NPI Number										5 05 02 11 05 02 11 11 90707 0.00 1 ZZ Taxonomy NPI Number										6 _____ NPI																			
25. FEDERAL TAX I.D. NUMBER SSN EIN										26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL AMOUNT PAID \$ 41.13 \$ 41.13									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Signature on File SIGNED _____ DATE _____										32. SERVICE FACILITY LOCATION INFORMATION 123 That St That City, NC 27606-1234										33. BILLING PROVIDER INFO & PH # Dr J P Provider 123 Any St Any City, NC 27523-5678																			
a. NPI										b. ZZ Taxonomy										a. NPI NPI b. ZZ Taxonomy																			

1500

HEALTH INSURANCE CLAIM FORM

Private Provider
 Periodic Examination
 Vision & Hearing Screenings
 (Block 24H) Referral Indicator "E"

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA										PICA																																		
1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 123456789K																																		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Patient, Joanna										3. PATIENT'S BIRTH DATE MM DD YY 01 03 11					SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)																								
5. PATIENT'S ADDRESS (No., Street) 123 Fun Street										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street)																								
CITY Fun Town					STATE NC					8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>										CITY					STATE																			
ZIP CODE 11111					TELEPHONE (Include Area Code) (555) 555-5555					9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					11. INSURED'S POLICY GROUP OR FECA NUMBER																			
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>										b. EMPLOYER'S NAME OR SCHOOL NAME																								
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>										c. EMPLOYER'S NAME OR SCHOOL NAME										c. INSURANCE PLAN NAME OR PROGRAM NAME																								
c. EMPLOYER'S NAME OR SCHOOL NAME										d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE																								
d. INSURANCE PLAN NAME OR PROGRAM NAME										11. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																								
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										SIGNED _____ DATE _____										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																								
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																								
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. _____					17b. NPI _____					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																								
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																								
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. V20.2										23. PRIOR AUTHORIZATION NUMBER										24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. ERSOI Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #																								
2. _____										3. _____										4. _____																								
3. _____										4. _____										5. _____																								
4. _____										5. _____										6. _____																								
5. _____										6. _____										6. _____																								
6. _____										6. _____										6. _____																								
25. FEDERAL TAX I.D. NUMBER SSN EIN										26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>										28. TOTAL CHARGE \$ 80.33					29. AMOUNT PAID \$					30. BALANCE DUE \$ 80.33				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Signature on File										32. SERVICE FACILITY LOCATION INFORMATION 123 That St That City, NC 27606-1234										33. BILLING PROVIDER INFO & PH # () Dr J P Provider 123 Any St Any City, NC 27523-5678																								
SIGNED _____ DATE _____										a. NPI					b. ZZ Taxonomy					a. NPI					b. ZZ Taxonomy																			

1500

**FQHC/RHC
Interperiodic Examination
(Block 24H) Referral Indicator "F"**

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</small>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 123456789K							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Patient, Joanna					3. PATIENT'S BIRTH DATE MM DD YY 07 15 92 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
5. PATIENT'S ADDRESS (No., Street) 123 Fun Street					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street)									
CITY Fun Town		STATE NC		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>					CITY		STATE						
ZIP CODE 11111		TELEPHONE (Include Area Code) (555) 555-5555			Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>			ZIP CODE		TELEPHONE (Include Area Code)							
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:					11. INSURED'S POLICY GROUP OR FECA NUMBER							
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>							
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)					b. EMPLOYER'S NAME OR SCHOOL NAME							
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					c. INSURANCE PLAN NAME OR PROGRAM NAME							
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO # yes, return to and complete item 9 a-d.							
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.																	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.							
SIGNED _____ DATE _____										SIGNED _____							
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY			15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY											
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE					17a. _____ 17b. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES. FROM MM DD YY TO MM DD YY										
19. RESERVED FOR LOCAL USE																	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. V70.3																	
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER																	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY			B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER			E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	05 15 11		05 15 11		11		99395		EP		80.33		1	F	NPI	Taxonomy	
2																	
3																	
4																	
5																	
6																	
25. FEDERAL TAX I.D. NUMBER			SSN EIN		26. PATIENT'S ACCOUNT NO.			27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$ 80.33		29. AMOUNT PAID \$		30. BALANCE DUE \$ 80.33			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Signature on File					32. SERVICE FACILITY LOCATION INFORMATION 123 That St That City, NC 27606-1234					33. BILLING PROVIDER INFO & PH # The JP Provider Clinic 123 Any St Any City, NC 27523-5678							
SIGNED _____ DATE _____					a. NPI		b. ZZ Taxonomy		a. NPI		b. ZZ Taxonomy						

1500

FQHC/RHC
Immunizations Only

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA <input type="checkbox"/>												PICA <input type="checkbox"/>																																			
1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)												1a. INSURED'S I.D. NUMBER (For Program in Item 1) 123456789K																																			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Patient, Joe												3. PATIENT'S BIRTH DATE MM DD YY 11 22 09 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>																																			
5. PATIENT'S ADDRESS (No., Street) 123 Fun Street												6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>																																			
CITY Fun Town						STATE NC						7. INSURED'S ADDRESS (No., Street)						CITY						STATE																							
ZIP CODE 11111						TELEPHONE (Include Area Code) (555) 555-5555						8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>						ZIP CODE						TELEPHONE (Include Area Code) ()																							
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO:												11. INSURED'S POLICY GROUP OR FECA NUMBER																							
a. OTHER INSURED'S POLICY OR GROUP NUMBER												a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO												a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> SEX																							
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> SEX												b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)												b. EMPLOYER'S NAME OR SCHOOL NAME																							
c. EMPLOYER'S NAME OR SCHOOL NAME												c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO												c. INSURANCE PLAN NAME OR PROGRAM NAME																							
d. INSURANCE PLAN NAME OR PROGRAM NAME												10d. RESERVED FOR LOCAL USE												d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO # yes, return to and complete item 9 a-d.																							
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.																																															
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																																			
SIGNED _____												DATE _____												SIGNED _____																							
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY												15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY												16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE												17a. _____												18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																							
19. RESERVED FOR LOCAL USE												17b. NPI												20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)												22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.												23. PRIOR AUTHORIZATION NUMBER																							
1. V03.81												3. V05.4												F. \$ CHARGES																							
2. V04.0												4. V06.1												G. DAYS OR UNITS																							
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY												B. PLACE OF SERVICE												C. EMG																							
D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)												E. DIAGNOSIS POINTER												H. EPSDT Family Plan																							
I. ID. QUAL.												J. RENDERING PROVIDER ID. #												\$ CHARGES																							
1. 05 05 11 05 05 11 11 90471 EP 13.71 1 ZZ Taxonomy												NPI Number												2. 05 05 11 05 05 11 11 90472 EP 41.13 3 ZZ Taxonomy																							
3. 05 05 11 05 05 11 11 90713 0.00 1 ZZ Taxonomy												NPI Number												4. 05 05 11 05 05 11 11 90716 0.00 1 ZZ Taxonomy																							
5. 05 05 11 05 05 11 11 90647 0.00 1 ZZ Taxonomy												NPI Number												6. 05 05 11 05 05 11 11 90700 0.00 1 ZZ Taxonomy																							
25. FEDERAL TAX I.D. NUMBER SSN EIN												26. PATIENT'S ACCOUNT NO.												27. ACCEPT ASSIGNMENT? (For gov't claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>																							
28. TOTAL CHARGE \$ 54.84												29. AMOUNT PAID \$												30. PATIENT CO-PAY \$ 54.84																							
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Signature on File												32. SERVICE FACILITY LOCATION INFORMATION 123 That St That City, NC 27606-1234												33. BILLING PROVIDER INFO & PH # The JP Provider Clinic 123 Any St Any City, NC 27523-5678																							
SIGNED _____												DATE _____												a. NPI NPI												b. ZZ Taxonomy											

1500

FQHC/RHC Core Visit with Immunizations

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1) 123456789K	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Patient, Joe	3. PATIENT'S BIRTH DATE 07th 05th 09th SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street) 123 Fun Street	6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	7. INSURED'S ADDRESS (No., Street)
CITY Fun Town STATE NC	8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	CITY STATE
ZIP CODE 11111 TELEPHONE (Include Area Code) (555) 555-5555	Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>	ZIP CODE TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO # yes, return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.		
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YEAR.	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. _____ 17b. NPI _____	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 382.9 3. V06.4 2. V06.1 4. V05.4	23. PRIOR AUTHORIZATION NUMBER	25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. ERSOT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #	28. TOTAL CHARGE \$ 65.00 29. AMOUNT PAID \$ 30. BALANCE DUE \$ 65.00	31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED Signature on File DATE
1 05 20 11 05 20 11 11 T1015 65.00 1 ZZ Taxonomy NPI Number	2 05 20 11 05 20 11 11 90700 0.00 1 ZZ Taxonomy NPI Number	3 05 20 11 05 20 11 11 90707 0.00 1 ZZ Taxonomy NPI Number
4 05 20 11 05 20 11 11 90716 0.00 1 ZZ Taxonomy NPI Number	5 NPI	6 NPI
32. SERVICE FACILITY LOCATION INFORMATION 123 That St That City, NC 27606-1234	33. BILLING PROVIDER INFO & PH # Dr J P Provider 123 Any St Any City, NC 27523-5678	a. NPI b. ZZ Taxonomy

1500

HEALTH INSURANCE CLAIM FORM

Private Provider Immunizations Only Purchased Vaccines

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (MemberID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1) 123456789K	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Patient, Joe		3. PATIENT'S BIRTH DATE 03 26 92 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>
5. PATIENT'S ADDRESS (No., Street) 123 Fun Street		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>
CITY Fun Town	STATE NC	7. INSURED'S ADDRESS (No., Street)
ZIP CODE 11111	TELEPHONE (Include Area Code) (555) 555-5555	CITY
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>
a. OTHER INSURED'S POLICY OR GROUP NUMBER	b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>	10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO
c. EMPLOYER'S NAME OR SCHOOL NAME	d. INSURANCE PLAN NAME OR PROGRAM NAME	11. INSURED'S POLICY GROUP OR FECA NUMBER
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
19. RESERVED FOR LOCAL USE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. V04.89 2. V06.1		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER
1		F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #
2		13.71 1 ZZ Taxonomy NPI Number
3		13.71 1 ZZ Taxonomy NPI Number
4		135.73 1 ZZ Taxonomy NPI Number
5		39.49 1 ZZ Taxonomy NPI Number
6		NPI
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 202.64
29. AMOUNT PAID \$		30. BALANCE DUE \$ 202.64
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Signature on File		32. SERVICE FACILITY LOCATION INFORMATION 123 That St That City, NC 27606-1234
33. BILLING PROVIDER INFO & PH # Dr J P Provider 123 Any St Any City, NC 27523-5678		a. NPI b. ZZ Taxonomy

Example 1:

Health Check Periodic Screening Assessment for Six-Month Old Child
 Developmental Screening
 Immunization

	Service Status	Program	Service Code	Mod 1	Medical Diagnosis	Me 2	Me 3	Me 4	Practitioner	Discipline	Duration / Units
1	Billable (B)	Health Check-Hend...	*99381EP-INIT PM E/M, ...		V20.2 ROUTINE ...				NURSE,ROSTER...	Rostered ...	
2	Billable (B)	Health Check-Hend...	90471EP-IMMUNIZATIO...		V20.2 ROUTINE ...				NURSE,ROSTER...	Rostered ...	1
3	Reportable (R)	Health Check-Hend...	96110EP-DEVELOPME...		V20.2 ROUTINE ...				NURSE,ROSTER...	Rostered ...	
4	Reportable (R)	Health Check-Hend...	*90700-DTAP VACCINE, ...		V20.2 ROUTINE ...				NURSE,ROSTER...	Rostered ...	

Example 2 –

Health Check Periodic Screening Assessment for 18-Year Old
 Risk Assessment
 Vision Screening
 Hearing Screening
 Diagnosis warrants a referral for a follow-up visit, designated with
 ”ST/S2”

	Service Status	Program	Service Code	Mod 1	Medical Diagnosis	Me 2	Me 3	Me 4	Practitioner	Discipline	Dura / Uni	Place
1	Billable (B)	Health Check-Hend...	"99385EP-PREV VISIT, ...		V20.2 ROUTINE ...				NURSE,ROST...	Rostered Nurs...		State
2	Reportabl...	Health Check-Hend...	99173EP-VISUAL ACUIT...		V20.2 ROUTINE ...				NURSE,ROST...	Rostered Nurs...		State
3	Reportabl...	Health Check-Hend...	"92552EP-PURE TONE ...		V20.2 ROUTINE ...				NURSE,ROST...	Rostered Nurs...		State
4	Reportabl...	Health Check-Hend...	99420EP-HEALTH RISK...		V20.2 ROUTINE ...				NURSE,ROST...	Rostered Nurs...		State
5	Reportabl...	Health Check-Hend...	87801-DETECT AGENT ...		690.1 SEBORRH...				NURSE,ROST...	Rostered Nurs...		State

Example 3 –

Health Check Periodic Screening Assessment for Four-Year Old Child With Developmental Screening, Vision Screening, Hearing Screening

PHTRAIN (803) - TODDLER,GIRL (949737349)/Encounter Recording

Page 1 of 1

TODDLER,GIRL CNDS/ID Number: ; Sex: Female

Encounter Charge Input

	Service Status	Program	Service Code	Mod	Medical Diagnosis	Me Dia	Me Dia	Me Dia	Practitioner	Discipline	Dural / Unit
					1	2	3	4			
1	Billable (B)	Health Check-Hend...	"99392EP-PREV VISIT, ...		V20.2 ROUTINE ...				NURSE,ROST...	Rostered Nurs...	
2	Reportable (R)	Health Check-Hend...	96110EP-DEVELOPME...		V20.2 ROUTINE ...				NURSE,ROST...	Rostered Nurs...	
3	Reportable (R)	Health Check-Hend...	99172EP-OCULAR FUN...		V20.2 ROUTINE ...				NURSE,ROST...	Rostered Nurs...	
4	Reportable (R)	Health Check-Hend...	92587EP-EVOKED AUDI...		V20.2 ROUTINE ...				NURSE,ROST...	Rostered Nurs...	

Example 4 –

Health Check Periodic Screening Assessment for Two-Year Old Child
 Risk Assessment
 Developmental Screening
 Immunization

PHTRAIN (803) - JONES,BABY (949823940)/Encounter Recording

Page 1 of 1

JONES,BABY CNDS/ID Number: ; Sex: Male

Encounter Charge Input

	Service Status	Program	Service Code	Mo	Medical Diagnosis	Me Dia	Me Dia	Me Dia	Practitioner	Discipline	Du / U	Place Of
					1	2	3	4				
1	Billable (B)	Health Check-...	"99382EP-INIT PM...		V20.2 ROUTINE ...				NURSE,ROST...	Rostered Nurs...		State or I
2	Reportable (R)	Health Check-...	96110EP-DEVELOPME...		V20.2 ROUTINE ...				NURSE,ROST...	Rostered Nurs...		State or I
3	Reportable (R)	Health Check-...	99420EP-HEALTH RISK...		V20.2 ROUTINE ...				NURSE,ROST...	Rostered Nurs...		State or I
4	Reportable (R)	Health Check-...	"90707-MMR VAC...		V20.2 ROUTINE ...				NURSE,ROST...	Rostered Nurs...		State or I
5	Billable (B)	Health Check-...	90471EP-IMMUNIZATIO...		V20.2 ROUTINE ...				NURSE,ROST...	Rostered Nurs...	1	State or I

Example – 5
 Immunization Administration with Vaccine Injections Only for 15-Month Old Child

PHTRAIN (803) - TODDLER,JOHN (949823941)/Encounter Recording

Page 1 of 1

TODDLER,JOHN CNDS/ID Number: ; Sex: Male

Encounter Charge Input

	Service Status	Program	Service Code	Mod	Medical Diagnosis	Me Dia	Me Dia	Me Dia	Practitioner	Discipline	Durat / Units
					1	2	3	4			
1	Billable (B)	Immunization-Hend...	90471EP-IMMUNIZATIO...		V06.8 NEED VAC...				NURSE,ROST...	Rostered Nurs...	1
2	Billable (B)	Immunization-Hend...	*90472EP-IMMUNIZATIO...		V06.8 NEED VAC...				NURSE,ROST...	Rostered Nurs...	3
3	Reportable (R)	Immunization-Hend...	*90723-DTAP-HEP B-IP...		V06.8 NEED VAC...				NURSE,ROST...	Rostered Nurs...	
4	Reportable (R)	Immunization-Hend...	*90707-MMR VACCINE, ...		V06.4 NEED VAC...				NURSE,ROST...	Rostered Nurs...	
5	Reportable (R)	Immunization-Hend...	*90716-CHICKEN POX ...		V05.4 NEED VAC...				NURSE,ROST...	Rostered Nurs...	
6	Reportable (R)	Immunization-Hend...	*90648-HIB VACCINE, P...		V03.81 NEED VA...				NURSE,ROST...	Rostered Nurs...	

Example 6 – Office Visit with One Vaccine Injection for Two-Year Old

PHTRAIN (803) - TODDLER,PAUL (949834331)/Encounter Recording

Page 1 of 1

TODDLER,PAUL CNDS/ID Number: ; Sex: Male

Encounter Charge Input

	Service Status	Program	Service Code	Mod	Medical Diagnosis	Me Dia	Me Dia	Me Dia	Practitioner	Discipline	Durat / Units
					1	2	3	4			
1	Billable (B)	Child Health-Hende...	99211-OFFICE/OUTPAT...		382.9 UNSP OTI...				PHYSICIAN,FA...	Physician (PHY)	
2	Billable (B)	Child Health-Hende...	90471EP-IMMUNIZATIO...		V04.81 NEED VA...				NURSE,ROST...	Rostered Nurs...	1
3	Reportable (R)	Health Check-Hend...	90655-FLU VACCINE N...		V04.81 NEED VA...				NURSE,ROST...	Rostered Nurs...	

Example 7-

Immunization Only for Eight-Week Old Child
 Immunization Administration Fee for Oral Vaccine
 Immunization Administration Fee with Vaccine Injection

	Service Status	Program	Service Code	Mod	Medical Diagnosis	M Dia	M Dia	M Dia	Practitioner	Discipline	Duration / Units
				1	1	2	3	4			
1	Billable (B)	Immunization-Hend...	90471EP-IMMUNIZATIO...		V03.81 NEED VA...				NURSE,ROST...	Rostered Nurs...	1
2	Reportable (R)	Immunization-Hend...	*90647-HIB VACCINE, P...		V03.81 NEED VA...				NURSE,ROST...	Rostered Nurs...	
3	Billable (B)	Immunization-Hend...	90474EP-IMMUNE ADMI...		V04.89 NEED VA...				NURSE,ROST...	Rostered Nurs...	1
4	Reportable (R)	Immunization-Hend...	*90680-ROTOVIRUS VA...		V04.89 NEED VA...				NURSE,ROST...	Rostered Nurs...	

Example 8 –

Immunizations Only for Two-Month Old Child
 Administration for Oral Vaccine
 Administration for Vaccine Injection

	Service Status	Program	Service Code	Mod	Medical Diagnosis	Me Dia	Me Dia	Me Dia	Practitioner	Discipline	Duration / Units
				1	1	2	3	4			
1	Billable (B)	Immunization-...	90471EP-IMMUNIZATIO...		V05.3 NEED VAC...				NURSE,ROST...	Rostered Nurs...	1
2	Billable (B)	Immunization-...	*90472EP-IMMUNIZATIO...		V06.1 NEED VAC...				NURSE,ROST...	Rostered Nurs...	4
3	Billable (B)	Immunization-...	90474EP-IMMUNE ADMI...		V04.89 NEED VA...				NURSE,ROST...	Rostered Nurs...	1
4	Reportable (R)	Immunization-...	90744-HEPB VACC PE...		V05.3 NEED VAC...				NURSE,ROST...	Rostered Nurs...	
5	Reportable (R)	Immunization-...	*90700-DTAP VACCINE...		V06.1 NEED VAC...				NURSE,ROST...	Rostered Nurs...	
6	Reportable (R)	Immunization-...	*90648-HIB VACCINE, P...		V03.81 NEED VA...				NURSE,ROST...	Rostered Nurs...	
7	Reportable (R)	Immunization-...	90670-PNEUMOC CON...		V03.82 NEED VA...				NURSE,ROST...	Rostered Nurs...	
8	Reportable (R)	Immunization-...	*90713-POLIOVIRUS, IP...		V04.0 NEED VAC...				NURSE,ROST...	Rostered Nurs...	
9	Reportable (R)	Immunization-...	*90680-ROTOVIRUS VA...		V04.89 NEED VA...				NURSE,ROST...	Rostered Nurs...	

Example 9 –

Office Visit with Oral Vaccine for Two-month Old Child

PHTRAIN (803) - INFANT,GIRL (949823937)/Encounter Recording

File Edit Favorites Avatar PH Avatar CWS Avatar MSO Help

Page 1 of 1

INFANT,GIRL CNDS/ID Number: ; Sex: Female

Encounter Charge Input

	Service Status	Program	Service Code	Mod	Medical Diagnosis	M Dia	Me Dia	Me Dia	Practitioner	Discipline	Duration / Units
1	2	3	4								
1	Billable (B)	Child Health-Hende...	99211-OFFICE/OUTPAT...		382.9 UNSP OTI...				PHYSICIAN,FA...	Physician (...)	
2	Billable (B)	Health Check-Hend...	90473EP-IMMUNE ADMI...		382.9 UNSP OTI...				NURSE,ROST...	Rostered N...	1
3	Reportable (R)	Health Check-Hend...	*90680-ROTOVIRUS VA...		382.9 UNSP OTI...				NURSE,ROST...	Rostered N...	



**North Carolina's Periodicity Schedule and Coding Matrix
for the Health Check Program
(a.k.a. Periodicity Schedule and Screening Components)
Effective: July 1, 2012**

Components / Screening Services	Within 1st month	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	2 years	
<p>A complete Health Check Well Child Checkup requires all age related components/screening services to be done, documented in the medical record and billed with the appropriate CPT Code / Modifier Combination as listed below for each service required for that age.</p> <ul style="list-style-type: none"> • Report the appropriate CPT codes with the EP Modifier when billing a <i>Health Check Well Child Checkup</i>. • Report the primary diagnosis code V20.2 for all Periodic Visits. • Report the primary diagnosis code V70.3 for all Interperiodic Visits. • Reference the <i>Health Check Billing Guide</i> for additional billing instructions, additional modifiers, appropriate diagnosis codes, referral codes, as well as CPT codes for reporting immunizations and immunization administration. 										
Assessment: New Patient ¹	99381 + EP	99381 + EP	99381 + EP	99381 + EP	99381 + EP	99382 + EP	99382 + EP	99382 + EP	99382 + EP	
Assessment: Established Patient ¹	99391 + EP	99391 + EP	99391 + EP	99391 + EP	99391 + EP	99392 + EP	99392 + EP	99392 + EP	99392 + EP	
Developmental Surveillance ²	✓	✓	✓	Footnote ²	✓	Footnote ²	✓	Footnote ²	Footnote ²	
Developmental Screenings ³				96110 + EP		96110 + EP		96110 + EP required at 18 mo or 2 years		
Autism Screenings ³								99420 + EP	99420 + EP	
Psychosocial / Behavioral Assessment	<ul style="list-style-type: none"> ▪ Assessment required for all infants, children and adolescents. ▪ A behavioral health assessment beyond a general developmental screening is recommended when there are provider or family concerns. 									
Vision Screenings	Based on risk factors									
Hearing Screenings	Based on risk factors If performed, report one of the following codes with the EP modifier: <ul style="list-style-type: none"> ▪ 92551 + mod for Hearing Screening: pure tone, air only ▪ 92552 + mod for Hearing Test: Pure tone audiometry [threshold]; air only ▪ 92587 + mod for Hearing Test: Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3–6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report 									
Oral Health Screenings ⁴	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Hemoglobin or Hematocrit ⁵	Based on risk factors				Required at 9 or 12 mo		Based on risk factors			
Lead Screening ⁶						Required			Required	
TB Testing	Should be performed as clinically indicated for children and adolescents at increased risk of exposure to tuberculosis. Reference the <i>Health Check Billing Guide</i> for criteria for screening children and adolescents of all ages.									
Dyslipidemia	Follow established best practice guidelines for Lipid Screening. Perform Lipid Screening based on risk assessment.									
Immunizations	Follow the recommendations of the Advisory Committee on Immunization Practices (ACIP) for age appropriate immunization guidelines and the Centers for Disease Control and Prevention (CDC) Child, Adolescent and Catch-Up Immunization Schedules found at: http://www.cdc.gov/vaccines/schedules/index.html . Refer to the <i>Health Check Billing Guide</i> for billing instructions. Refer to the North Carolina Immunization Branch for additional information. The immunization portion of the preventive health visit may not be referred to another provider, i.e. local health departments.									



**North Carolina's Periodicity Schedule and Coding Matrix
for the Health Check Program
(a.k.a. Periodicity Schedule and Screening Components)
Effective: July 1, 2012**

<p>A complete Health Check Well Child Checkup requires all age related components/screening services to be done, documented in the medical record and billed with the appropriate CPT Code / Modifier Combination as listed below for each service required for that age.</p> <ul style="list-style-type: none"> • Report the appropriate CPT codes with the EP Modifier when billing a Health Check Well Child Checkup. • Report the primary diagnosis code V20.2 for all Periodic Visits. • Report the primary diagnosis code V70.3 for all Interperiodic Visits. • Reference the Health Check Billing Guide for additional billing instructions, additional modifiers, appropriate diagnosis codes, referral codes, as well as CPT codes for reporting immunizations and immunization administration. 						
Components / Screening Services	3 years	4 years	5 years	6-11 years	12-17 years	18-20 years
Assessment: New Patient ¹	99382 + EP	99382 + EP	99383 + EP	99383 + EP	99384 + EP	99385 + EP
Assessment: Established Patient ¹	99392 + EP	99392 + EP	99393 + EP	99393 + EP	99394 + EP	99395 + EP
Developmental Surveillance ²	Footnote ²	Footnote ²	Footnote ²	✓	✓	✓
Developmental Screenings ³	96110 + EP	96110 + EP	96110 + EP	Based on risk factors		
Autism Screenings ³	Based on risk factors					
Psychosocial / Behavioral Assessment	Assessment required for all children and adolescents. Use a behavioral or mental health screening tool to screen for mental health concerns in children and adolescents. Use an adolescent health risk assessment tool to screen for a variety of possible psychosocial and health risks/strengths in adolescents beginning at 11 years of age and up. If performed, report one of the following codes with the EP modifier: <ul style="list-style-type: none"> ▪ 99420 + mod for Adolescent Health Risk Assessment (GAPS/HEADSSS) and Behavioral/Mental Health Screening (PSC/SDQ/PSQ-A/Beck's) ▪ 99406 or 99407 + mod for Smoking/Tobacco Use Cessation ▪ 99408 or 99409 + mod for Alcohol/Substance Abuse Structured Screening and Brief Intervention (CRAFTT) 					
Vision Screenings	99172 or 99173 + EP	99172 or 99173 + EP	99172 or 99173 + EP	99172 or 99173 + EP	Once every 3 yrs or based on risk factors 99172 or 99173 + EP	
Hearing Screenings	Based on risk factors	92551 or 92552 + EP	92551 or 92552 + EP	92551 or 92552 + EP	Based on risk factors	
Oral Health Screenings ⁴	Refer to Dentist ⁴	✓	✓	✓	✓	✓
Hemoglobin or Hematocrit ⁵					Annually for females w/ risk factors. Follow the recommendations of the 2008 Bright Futures Guidelines.	
Lead Screening ⁶	Children between 36 -72 months of age must be tested if they have not been previously tested; children new to Medicaid that have never been tested for blood lead should be tested at any age.					
TB Testing	Should be performed as clinically indicated for children and adolescents at increased risk of exposure to tuberculosis. Reference the Health Check Billing Guide for criteria for screening children and adolescents of all ages.					
Dyslipidemia	Follow established best practice guidelines for Lipid Screening. Perform Lipid Screening based on risk assessment and at 18 – 20 years					
Immunizations	Follow the recommendations of the Advisory Committee on Immunization Practices (ACIP) for age appropriate immunization guidelines and the Centers for Disease Control and Prevention (CDC) Child, Adolescent and Catch-Up Immunization Schedules found at: http://www.cdc.gov/vaccines/schedules/index.html Refer to the Health Check Billing Guide for billing instructions. Refer to the North Carolina Immunization Branch for additional information. The immunization portion of the preventive health visit may not be referred to another provider, i.e. local health departments.					



Footnotes:

- 1: Assessments include: Comprehensive unclothed physical assessment; Newborn Metabolic / Sickle Cell / Hemoglobin / Hematocrit Screenings; Anticipatory guidance and education; Comprehensive Health History, length as age appropriate; Development Surveillance (required at every WCC except when Developmental Screenings are required); Nutritional Assessment; Vital signs and recording BMI begins at age 2 through 20; BP begins at age 3 continuing through age 20 (please note: these services are not billable separately from the New Patient or Established Patient assessment codes listed above)
 - An infant without documentation of Newborn Metabolic and/or Sickle Cell screenings at birth should have the screening test as soon as possible. Refer to Health Check Billing Guide, pages 28 – 29, for further instructions.
 - DMA strongly encourages all primary care providers to begin incorporating the appropriate BMI diagnosis codes (Dx) into their office processes for well-child care.
- 2: Developmental Surveillance: Conduct Surveillance at every preventive health visit, except when Developmental Screening or Screening for Autism Spectrum Disorders are required.
- 3: Scientifically validated screening tools designed for identifying risk factors of developmental delays and Autism Spectrum Disorders (ASDs) must be used when performing screening for developmental delays and ASDs. Providers must keep appropriate documentation of the screening tool in the child’s medical records, document the results and necessary referrals, and are required to coordinate follow-up care if risk factors are identified. Refer to the Health Check Billing Guide for further instructions, medical documentation requirements, examples of specific validated screening tools and additional resources.
- 4: Oral Health:
 - o The Centers for Medicare and Medicaid Services (CMS) defines “dental services” as services provided by or under the supervision of a dentist. Additionally, CMS defines “oral health services” as services that are not provided by or under the supervision of a dentist. Oral health screenings, services such as fluoride applications and referrals to a Dental Home are performed by Primary Care Physicians and Pediatricians as an integral component of preventive health visits. North Carolina requires an Oral Health Screening at every preventive health visit. Refer to the Health Check Billing Guide for further instructions.
 - o Although not a requirement of a Health Check screening assessment, providers who perform a Health Check Well Child Checkup and dental varnishing may bill for both services. For billing codes and guidelines, refer to Clinical Coverage Policy # 1A-23, *Physician Fluoride Varnish Services*, on DMA’s website at: <http://www.ncdhhs.gov/dma/mp/>
- 5: Hemoglobin / Hematocrit: **Must** be measured once during infancy between the ages of 9 and 12 months for all children. For adolescent females (ages 11 to 21 years) an annual hemoglobin or hematocrit **must** be performed if risk factors are present. Refer to Health Check Billing Guide for further instructions. For adolescent females, refer to the 2008 Bright Futures Guidelines for clinical recommendations.
- 6: Lead Screening: Required at 12 months and 2 years. Children between 36 -72 months of age must be tested if they have not been previously tested; children new to Medicaid that have never been tested for blood lead should be tested at any age. **Refer to Health Check Billing Guide for further instructions, medical documentation requirements and clinical recommendations.**

Additional Billing Hints:

Primary DX code on claims for all WC Checkups:

V20.2 DX code for Periodic WCC

Or

V70.3 DX code for Interperiodic WCC

Please note: DX codes V20.31 & V20.32 pertain to newborn evaluations in the inpatient hospital setting



DX codes for Immunizations:

Reference page 39 of the billing guide

Additional DX codes to report for BMI percentiles:

V85.51

V85.52

V85.53

V85.54

Referral Codes for Health Check:

All electronically submitted claims must list referral code indicator “E” when a referral is made for follow-up or an identified condition

CPT Code for Blood Draw:

Report 36415 for Venous blood draw

Capillary blood draw is bundled in the fee for a Complete Well Child Checkup.

Report 96110 (developmental screening) with a Zero billed amount; this service is not paid in addition to the New or Established Patient Assessment.

Report 99420 (Autism Screening) with a billed amount representing your UCC; currently, the allowed amount is \$8.14 in addition to the fee for a complete Well Child Checkup of \$80.33.

For Health Check:

Report all other CPT codes representing component services that were performed (i.e. Psychosocial / Behavioral Assessment Screenings, Vision and Hearing); a claim for a complete Health Check Well Child Checkup is paid at a bundled rate of \$80.33.

For a stand alone copy of the NC Periodicity Schedule Coding Matrix and Required Components please [click here](#)

Michael Watson
Director
Division of Medical Assistance
Department of Health and Human Services

Melissa Robinson
Executive Director
HP Enterprise Services
