

## **Table of Contents**

1.0	Description of the Service.....	1
2.0	Eligible Recipients .....	1
2.1	General Provisions .....	1
2.2	EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age .....	1
3.0	When the Service Is Covered.....	2
4.0	When the Service Is Not Covered.....	2
5.0	Requirements for and Limitations on Coverage .....	3
6.0	Providers Eligible to Bill for the Service .....	3
7.0	Additional Requirements .....	3
8.0	Billing Guidelines .....	3
8.1	Claim Type .....	3
8.2	Diagnosis Codes that Support Medical Necessity .....	3
8.3	Procedure Codes .....	3
8.4	Reimbursement Rate.....	3
9.0	Policy Implementation/Revision Information.....	4

## **1.0 Description of the Service**

A preventive medicine health assessment consists of a comprehensive unclothed physical examination, comprehensive health history, anticipatory guidance/risk factor reduction interventions, and the ordering of gender- and age-appropriate laboratory and diagnostic procedures.

## **2.0 Eligible Recipients**

### **2.1 General Provisions**

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

### **2.2 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination\*\* (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary 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 a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

- a. that is unsafe, ineffective, or experimental/investigational.
- b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure will correct or 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.

**\*\*EPSDT and Prior Approval Requirements**

- a. 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.
- b. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the Basic Medicaid Billing Guide, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

*Basic Medicaid Billing Guide:* <http://www.ncdhhs.gov/dma/medbillcaguide.htm>

**EPSDT provider page:** <http://www.ncdhhs.gov/dma/EPSDTprovider.htm>

### **3.0 When the Service Is Covered**

**IMPORTANT NOTE:** EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below 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]; that is, documentation shows how the service, product, or procedure will correct or 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.

**EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED.** For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

The annual health assessment is covered once per year.

### **4.0 When the Service Is Not Covered**

**IMPORTANT NOTE:** EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below 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]; that is, documentation shows how the service, product, or procedure will correct or 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.

**EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED.** For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

The annual health assessment is not covered when the medical criteria listed in **Section 3.0** are not met. The annual health assessment is not covered when the recipient has an illness or specific health care need that results in a definitive medical diagnosis with medical decision-making and the initiation of treatment, and when the policy guidelines listed in **Section 5.0** below are not met.

## 5.0 Requirements for and Limitations on Coverage

**IMPORTANT NOTE:** EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below 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]; that is, documentation shows how the service, product, or procedure will correct or 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.

**EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED.** For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

- a. Recipients 21 years of age and older may receive one annual health assessment per 365 days.
- b. The annual health assessment is included in the legislated 24-visit limit per year.
- c. Injectable medications and ancillary studies for laboratory and radiology are the only CPT codes that are separately billable when an annual health assessment is billed.
- d. An annual health assessment and an office visit cannot be billed on the same date of service.

## 6.0 Providers Eligible to Bill for the Service

Physicians, clinics and non-physician practitioners enrolled in the N.C. Medicaid program, functioning within their scope of practice, who perform this service may bill for this service.

## 7.0 Additional Requirements

There are no additional requirements.

## 8.0 Billing Guidelines

Reimbursement requires compliance with all Medicaid guidelines, including obtaining appropriate referrals for recipients enrolled in Medicaid managed care programs.

### 8.1 Claim Type

Providers bill professional services on the CMS-1500 (HCFA-1500) claim form.

### 8.2 Diagnosis Codes that Support Medical Necessity

ICD-9-CM diagnosis code V700, "General medical examination," must be billed.

### 8.3 Procedure Codes

CPT codes that are covered by N. C. Medicaid include 99385, 99386, 99387, 99395, 99396, and 99397.

### 8.4 Reimbursement Rate

Providers must bill their usual and customary charges.

## 9.0 Policy Implementation/Revision Information

**Original Effective Date:** January 1, 1980

**Revision Information:**

<b>Date</b>	<b>Section Updated</b>	<b>Change</b>
12/01/03	Section 1.0	The statement that a preventive medicine health assessment includes the ordering of gender appropriate laboratory and diagnostic procedures was revised to read “. . . gender and age appropriate . . .”
12/01/03	Section 4.0	The sentence “The annual health assessment is not covered when the medical criteria listed in Section 3.0 are not met.” was added to this section.
12/01/03	Section 5.0	The section was renamed from Policy Guidelines to Requirements for and Limitations on Coverage.
12/01/03	Section 6.0	A sentence was added to the section stating that providers must comply with Medicaid guidelines and obtain referrals where appropriate for Managed Care enrollees.
12/01/03	Section 8.0	This section was reformatted into four subsections; there was no change to the content.
9/1/05	Section 2.0	A special provision related to EPSDT was added.
9/1/05	Section 8.0	The sentence stating that providers must comply with Medicaid guidelines and obtain referral where appropriate for Managed Care enrollees was moved from Section 6.0 to Section 8.0.
12/1/05	Section 2.2	The web address for DMA’s EDPST policy instructions was added to this section.
12/1/06	Sections 2 through 5	A special provision related to EPSDT was added.
5/1/07	Sections 2.2, 3.0, 4.0, and 5.0	EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age