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## 200.000 CHILD HEALTH SERVICES (EPSDT) GENERAL INFORMATION

### 201.000 Arkansas Medicaid Participation Requirements for Child Health Services (EPSDT) Providers Except School-Based Child Health Services Providers 2-1-13

The Arkansas Division of Medical Services (DMS) recruits providers for medical, dental, visual, and hearing screenings and treatment services. All Child Health Services (EPSDT) providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program:

Any licensed physician, family practitioner, obstetrician, pediatrician, optometrist, etc., or any outpatient hospital, community or public health clinic, supervised by a licensed physician that is enrolled in the Arkansas Medicaid Program and offers the screening package as outlined in the recommended screening procedures, is eligible to participate in the Child Health Services (EPSDT) Program.

In addition, providers offering screening components, including vision, hearing and dental screens, may enroll as Child Health Services (EPSDT) providers. Such providers may include optometrists, licensed audiologists and others.

In addition to signing the Medicaid application and contract, an eligible Child Health Services (EPSDT) provider must sign an agreement to participate as a Child Health Services (EPSDT) screening provider. [View or print participating EPSDT provider agreement.](#) If interested, please contact the Central Child Health Services (EPSDT) Office. [View or print the Child Health Services \(EPSDT\) contact information.](#) Payment for screens performed by providers who have not signed an agreement will be denied.

When Child Health Services (EPSDT) medical screenings, medical screening components or immunizations are not performed by a physician provider, the screening provider must have a written agreement with a physician who assumes the responsibility for the provision of Child Health Services (EPSDT) screenings and immunizations. The physician must:

- A. Be available on a routine basis for consultation to screening staff,
- B. Ensure that screening staff have appropriate training and adequate skills for performing the procedures for which they are responsible and
- C. Periodically review the staff's level of performance in administering these procedures.

The physician does not have to be physically present in the clinic at all times during the hours of operation. However, the physician must assume responsibility for the clinic's overall operation. All EPSDT comprehensive screenings must be performed by personnel meeting, at a minimum, registered nurse with prescriptive authorization (RNP, APN, PA); immunizations may be given by

a licensed practical nurse (LPN), licensed vocational nurse (LVN), and licensed psychiatric technician nurse (LPTN), each within his or her scope of practice.

**202.000**      **Arkansas Medicaid Participation Requirements for School-Based Child Health Services Providers**      **10-1-06**

School districts and education service cooperatives may provide all Child Health Services (CHS/EPSTD) screening services. A school district or cooperative may participate at one of two levels, as either a comprehensive screening provider who will provide all EPSTD screening components, or as a provider for vision and/or hearing screens.

Schools enrolling as comprehensive screening providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program:

- A. The provider must sign an agreement to participate as a Child Health Services (CHS) screening provider. [View or print participating EPSTD provider agreement.](#)
- B. The provider must be certified as a comprehensive CHS/EPSTD provider by the superintendent of schools. [View or print Certification of Schools to Provide Comprehensive EPSTD Services form.](#)

Schools or education service cooperatives enrolling as screeners for hearing and vision, hearing only or vision only must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program:

- A. The provider must sign an agreement to participate as a CHS screening provider per Section 201.000 of this manual. [View or print participating EPSTD provider agreement.](#)
- B. The provider must employ a licensed registered nurse or licensed practical nurse who has completed training in vision screening conducted by the Arkansas Department of Education, in conjunction with the Arkansas Eye and Vision Commission. The RN or LPN must also have completed training in hearing screening conducted by the regional Educational Service Cooperative's Community Health Nurse Specialist. A copy of the nurse's current license and the certificate of completion of vision and hearing screening training must accompany the application. All vision and hearing screenings must be performed in accordance with the Arkansas State Board of Nursing School Nurse Practice Guidelines.

**NOTE: School districts or education service cooperatives employing a qualified speech pathologist may complete an agreement to participate as a screening provider, using the speech pathology Medicaid provider number. The qualified speech pathologist may perform hearing screens and be reimbursed under the Medicaid provider number for speech pathology.**

In situations where speech pathology services are provided by a qualified speech pathologist who is contracted with a school district or an education service cooperative, the individual qualified speech pathologist may complete the agreement to participate as a CHS screening provider and perform hearing screens under the individual Medicaid number.

**210.000**      **PROGRAM COVERAGE**

**211.000**      **Introduction**      **1-1-18**

A comprehensive medical screening program for all eligible Medicaid children requires the medical provider to assume overall responsibility for detection and treatment of conditions found among these young patients. This means the provider should have knowledge of specialized

referral services available within the community and should maintain continuing relationships with physician specialists. It also requires the provider to work closely with the Arkansas Department of Human Services office staff to ensure that eligible children in need of medical attention take full advantage of the medical services available to them. Some services such as personal care require an Independent Assessment. Please refer to the Independent Assessment Guide for related information.

The screening procedures outlined in Sections 213.000 and 215.000 of this manual are considered the minimal elements of a comprehensive screening. Other procedures may be included depending upon the child's age and health history. Each of the screening procedures is based on recommendations from the federal Department of Health and Human Services and the American Academy of Pediatrics. Each screening should be billed separately, providing the appropriate information for each of the applicable screening components. Other specific procedures may be used at the screener's discretion as long as the following federally mandated components are included in the complete medical screening procedure: observe and measure growth and development, give nutritional advice, immunize, counsel and give health education and perform laboratory procedures applicable for the age of the child.

#### Requirements for Periodic Medical, Visual, Hearing and Dental Screenings

Distinct periodicity schedules have been established for medical screening services, vision services, hearing services and dental services (i.e., each of these services has its own periodicity schedule). Periodic visual, hearing and dental screens should not duplicate prior services.

### 212.000

#### Scope

3-1-06

The Child Health Services (CHS) Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program is a federally mandated child health component of Medicaid. It is designed to bring comprehensive health care to individuals eligible for medical assistance from birth to age 21. Even if the person eligible for medical assistance is a parent, he or she is eligible for Child Health Services (EPSDT) if under age 21. Physicians and other health professionals who provide Child Health Services (EPSDT) screening may diagnose and treat health problems discovered during the EPSDT screening or may refer the child to other appropriate sources for such care.

The following is a broad definition of the components of the Child Health Services EPSDT program.

Early means as soon as possible in the child's life, or as soon as his or her family's eligibility for assistance has been established.

Periodic means at intervals established for screening by medical, dental, visual and other health care experts. The types of screening procedures performed and their frequency will depend on the child's age and health history. In Arkansas, the medical periodic screening schedule has been established following the recommendations of the American Academy of Pediatrics.

Screening is the use of quick, simple procedures to sort out apparently well persons from those who may have a disease or abnormality and to identify those in need of a more definitive examination.

Diagnosis is the determination of the nature or cause of a disease or abnormality through the combined use of health history, physical, developmental and psychological examination, laboratory tests and X-rays.

Treatment means physician, hearing, visual or dental services or any other type of medical care and services recognized under state law to prevent, correct or ameliorate disease or abnormalities detected by screening or by diagnostic procedures. Treatment for conditions discovered through a screen may exceed limits of the Medicaid Program. Services not otherwise covered under the Medicaid Program will be considered for coverage if the services

are prescribed by a physician as a result of an EPSDT screen. The services must be medically necessary and permitted under federal Medicaid regulations.

**212.100**      **Reserved**      **11-1-09**

**212.200**      **EPSDT Minimum Documentation Requirements**      **12-15-12**

The provider must develop and maintain sufficient documentation to support EPSDT services for which billing is made. This documentation, at a minimum, must contain:

- A. The beneficiary's name and Medicaid identification number
- B. Description of the service performed
- C. Date of service
- D. Place where the service was rendered
- E. Brief comment, progress notes, referrals, etc., with an original written or electronic via electronic health/medical records signature by the service provider, including credentials
- F. Physician's order for laboratory tests, test results and all records pertinent to billing.

No standard service logs or documentation forms are required. The documentation must be maintained according to the requirements of Sections 142.300 and 212.100 of this provider manual.

**212.300**      **Electronic Signatures**      **10-8-10**

Medicaid will accept electronic signatures provided the electronic signatures comply with Arkansas Code § 25-31-103 et seq.

**213.000**      **Provider's Role in the Child Health Services (EPSDT) Program**      **1-15-11**

The following steps are necessary in order to complete a Child Health Services (EPSDT) screen:

- A. When a child arrives for a Child Health Services (EPSDT) screening appointment, ask to see the current Medical Assistance Identification Card (Medicaid Card). Verify Medicaid eligibility electronically before services are rendered.
- B. Screen the child according to the procedures outlined in Sections 215.000, 216.000, 217.000, 218.000 or 219.000 of this manual. All elements of the screen must be completed and documented before the screen is considered complete. This includes the evaluation of lab results and the provision of or referral for immunizations.

A full medical screen must, at a minimum, include: a comprehensive health and developmental history (including assessment of both physical and mental health development); a comprehensive unclothed physical exam; appropriate immunizations according to age and health history; laboratory tests (including appropriate blood lead level assessment); and health education (including anticipatory guidance).

All parts of the screening package must be furnished to the Child Health Services (EPSDT) participant in order for the screening to qualify as a full medical Child Health Services (EPSDT) screening service.

Immunizations that are appropriate based on age and health history, but which are contraindicated at the time of the screening, may be rescheduled at an appropriate time or referred to another provider.

- C. Record the screening findings in the patient chart. Also record whether each of the recommended screening procedures required by the periodicity schedule was performed, whether referral was necessary for health problems discovered during the screen and the date of the required referral appointment if one is made.
- D. Talk to the parent about the screening results, explaining in detail the findings and any recommendations for diagnosis and treatment.
- E. If the screener provides treatment as a result of the screening, the charges for the treatment procedures may be submitted on the CMS-1500 claim form.
- F. Treatment services offered as a result of a Child Health Services (EPSDT) screen are not limited to the Medicaid services specified under "Scope of Program" in Section I of this manual. If a condition is diagnosed through a Child Health Services (EPSDT) screen that requires treatment services not normally covered under the Arkansas Medicaid Program, those treatment services will also be considered for reimbursement. See Section 214.200.
- G. The provider may verify whether a periodic screen is due under the appropriate periodicity schedule by means of an electronic eligibility verification transaction. The system's response display will reveal each type of screen, e.g., medical, visual, dental and hearing and the date of the last screen of each type indicated by the provider initiating the eligibility verification transaction.
- H. School districts and education service cooperatives enrolled in the Child Health Services (EPSDT) program and providing Child Health Services (EPSDT) screenings must include a Local Education Agency (LEA) code in field 19 of the CMS-1500 claim form. The LEA code is used to determine federal matching funds to the Child Health Services (EPSDT) program.

An eligible child must be referred by the PCP, if the child is to be screened by a provider who is not the PCP.

#### **214.000 PCP Referral Requirements**

**4-1-09**

The primary care physician (PCP), the PCP entity (e.g., FQHC), or a medically qualified member of the PCP's staff must administer the periodic complete medical screen, or the PCP may make a referral to another qualified Medicaid provider to administer the screen. Qualified Medicaid providers to whom referrals may be made include Medicaid-enrolled nurse practitioners and school based providers certified as comprehensive screening providers. Routine newborn care, dental screens, visual screens, hearing screens and immunizations for childhood diseases are exempt from this referral requirement.

#### **214.100 Freedom of Choice**

**4-1-09**

The medical assistance program provides beneficiaries freedom of choice of local participating Medicaid Child Health Services (EPSDT) providers. The local Department of Human Services (DHS) office is responsible for providing beneficiaries a list of participating Child Health Services (CHS/EPSDT) providers when the beneficiary expresses an interest in the Child Health Services (EPSDT) Program. Beneficiaries have freedom of choice in their selection of a PCP.

#### **214.200 Prescription of Treatment for Child Health Services (EPSDT) Services Not Specifically in the Medicaid State Plan**

**1-15-11**

When a provider performs a Child Health Services (EPSDT) screen and refers the patient to another provider for services not covered by Arkansas Medicaid, the referring provider must give the beneficiary a prescription for the services. The prescription must indicate the services being prescribed and state the services are being prescribed due to a Child Health Services (EPSDT) screen.

The prescription for services must be dated by the provider referring the patient. The prescription for the non-covered service is acceptable if services were prescribed and the prescription is dated within the applicable periodicity schedule, not to exceed a maximum of 12 months.

Treatment services determined to be medically necessary as a result of a Child Health Services (EPSDT) screen are considered for Child Health Services (EPSDT) beneficiaries regardless of whether the service is otherwise included in the Arkansas Medicaid State Plan. PCPs must adhere to the following procedure when prescribing any medically necessary services and/or items that are not specifically included in the Arkansas Medicaid State Plan for Medicaid-eligible beneficiaries under age 21.

The PCP must review the results of the screen found in the patient chart records to determine if additional services are medically necessary. The PCP will prescribe any treatment services and/or items he or she determines to be medically necessary.

For those services that are not included in the Arkansas Medicaid State Plan, (e.g., highly technological wheelchairs and rehab equipment) the PCP must complete form DMS-693, titled Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Prescription/Referral for Medically Necessary Services/Items Not Specifically Included in the Medicaid State Plan. [View or print form DMS-693.](#)

All information requested on form DMS-693 must be provided. The PCP must attach a copy of the Child Health Services (EPSDT) screen results found in the patient chart records. The DMS-693 form must be submitted to the Division of Medical Services, Utilization Review Section, which will review the information for medical necessity. [View or print Utilization Review Section contact information.](#)

Note: If the service or item(s) are specifically included in the Arkansas Medicaid State Plan, the completion of form DMS-693 is not required. **This prescription/referral procedure does not apply to individuals who are eligible only in the ARKids First-B Program as those children are not eligible for services or items that are not covered under the state plan.** Providers may refer to the ARKids First-B program manual for more information.

### 214.300 Foster Care Intake Physical Examination in the EPSDT Program

2-1-22

Arkansas Medicaid beneficiaries entering the Arkansas foster care system are required to receive an intake physical examination within the first seventy two (72) hours. If the EPSDT provider who performs the screening is not the beneficiary's PCP, the intake physical examination should be billed with procedure codes and modifiers **EP** and **H9**.

[View or print the procedure codes and modifiers for Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment \(EPSDT\) services.](#)

Billing with these procedure codes and modifiers will allow the claim to be submitted for payment without a referral from the beneficiary's PCP and will alert the system not to count the screen toward the beneficiary's yearly EPSDT periodic complete medical screening limits.

If the EPSDT provider who performs the screen is the beneficiary's PCP, the intake physical exam should be billed with procedure codes and modifiers **EP** and **H9**. Billing with these procedure codes and modifiers will allow the claim to be submitted for payment and will not count toward the beneficiary's yearly EPSDT periodic complete medical screening limits.

Procedure codes, in conjunction with the **EP and H9 modifiers**, are to be used only for the required intake physical examination for Medicaid beneficiaries in the Arkansas foster care system.

### 215.000 Child Health Services (EPSDT) Screen Information

**215.100**      **Schedule for Child Health Services (EPSDT) Medical/Periodicity Screening**      **1-1-24**

The periodic EPSDT screening schedule has been changed in accordance with the most recent recommendations of the American Academy of Pediatrics.

From birth to 15 months of age, children may receive six (6) periodic screens in addition to the newborn screen performed in the hospital.

Children age 15 months to 24 months of age may receive two (2) periodic screens. Children age 24 months to 30 months may receive one (1) periodic screen, and children 30 months to 3 years old may receive one (1) periodic screen.

When a child has turned 3 years old, the following schedule will apply. One visit per birth year for children ages 3 years through 20 years.

**Age**

3 years	8 years	13 years	18 years
4 years	9 years	14 years	19 years
5 years	10 years	15 years	20 years
6 years	11 years	16 years	
7 years	12 years	17 years	

Most medical and hearing screens for children require a PCP referral before the screens may occur. Routine newborn care, vision screens, dental screens and immunizations for childhood diseases do not require PCP referral. See [Section 242.100](#) for procedure codes.

**215.110**      **Immunization Record**      **6-1-11**

The Arkansas Medicaid Program recommends that EPSDT providers follow the immunization schedule established by the Centers for Disease Control and Prevention (CDC). Providers may access the original chart at <http://www.cdc.gov/vaccines/schedules/index.html>.

At each visit or EPSDT screening, the child's immunization status should be assessed from the child's health record and the immunization registry. If the child needs any immunizations at the time of the screening, then the immunization(s) will be administered as part of the visit. Immunizations that are appropriate, but which are contraindicated at the time of the screening, may be rescheduled at an appropriate time.

Immunizations for childhood diseases are exempt from primary care physician (PCP) referral requirements.

**215.120**      **Vaccines for Children**      **4-1-09**

The Vaccines for Children (VFC) Program was established to enable free access to childhood immunizations for Medicaid-eligible children under age nineteen.

The Arkansas Department of Health oversees the VFC program in Arkansas. To enroll in the VFC Program and obtain the vaccines, providers may contact the Arkansas Department of Health. [View or print the Arkansas Department of Health contact information.](#)

Arkansas Medicaid reimburses an administration fee for immunizations included in the Vaccines for Children (VFC) Program. Providers billing for administration of immunizations should use the appropriate CPT code.

**215.200 Child Health Services (EPSDT) Medical Screening Components****215.210 Health and Developmental History 2-1-22**

A health and developmental history should be obtained from the parent or other responsible adult who is familiar with the child's health history. The child's height and weight should also be recorded and compared with the ranges considered normal for children of that age. See [Section 242.100](#) for procedure codes.

**215.220 Unclothed Physical Examination 2-1-22**

An unclothed physical examination should be performed to note obvious physical defects including orthopedic, genital, skin, and other observable deviations. If there is evidence that the child has been physically abused, this should be reported to the authorities according to state law requirements. See [Section 242.100](#) for procedure codes.

**215.230 Developmental Assessment 2-1-22**

A developmental assessment should be obtained by history and observation of the child or by one of the developmental tests. This portion of the screening could include assessment of eye-hand coordination, gross motor function (walking, hopping, climbing), fine motor skills (use of finger dexterity and hand usage), speech development, daily living personal skills such as dressing, feeding and grooming oneself, behavioral development and proofs of mind with body integration. See [Section 242.100](#) for procedure codes.

**215.240 Visual Evaluation 2-1-22**

A visual evaluation is required for all children receiving Child Health Services (EPSDT) screening. The age-specific procedures (Section 216.000) may be helpful to determine the necessary procedures according to the child's age. This screening does not require Titmus machine or other ophthalmological testing. Subjective testing may be provided as part of a vision screening. See [Section 242.100](#) for procedure codes.

**215.250 Hearing Evaluation 2-1-22**

A hearing evaluation is required for all children receiving a Child Health Services (EPSDT) screening. The age-specific procedures (Section 217.000) may be helpful to determine the necessary procedures according to the child's age. This screening does not require machine audiology testing. Subjective testing may be provided as part of a hearing screening. See [Section 242.100](#) for procedure codes.

**215.260 Oral Assessment 2-1-22**

An oral assessment is considered part of the full Child Health Services (EPSDT) screening. A referral to a dentist for an oral screen is offered beginning at childbirth. See [Section 242.100](#) for procedure codes.

**215.270 Laboratory Procedures (CPT Codes) 2-1-22**

Laboratory procedures should be performed as appropriate for the child's age and population group. See Sections 215.310 through 215.340 for age and testing recommendations. See Section 219.000 for specific blood lead testing and [Section 242.150](#) for CPT codes.

**215.280 Nutritional Assessment 2-1-22**

Physical and laboratory determinations carried out in the screening process will usually yield information useful in assessing nutritional status. A child having any detectable nutritional

deficiencies should be treated or referred to the proper resource for counseling. This component of the medical screen is included in the full Child Health Services (EPSDT) screening. See [Section 242.100](#) for procedure codes.

### 215.290 Health Education

9-1-24

Health education is a required component of screening services and includes anticipatory guidance. The developmental assessment, comprehensive physical examination, visual, hearing or dental screening provides the initial opportunity for providing health education. Health education and counseling to parents (or guardians) and children are required. Health education and counseling are designed to assist in understanding what to expect in terms of the child's development and to provide information about the benefits of healthy lifestyles and practices, as well as accident and disease prevention. See [Section 242.100](#) for procedure codes.

Health education can include but isn't limited to tobacco cessation counseling services to the parent/legal guardian of the child.

#### A. Counseling Visits:

[View or print the procedure codes and modifiers for Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment \(EPSDT\) services.](#)

\* Exempt from PCP referral requirements.

⚠(...)  
This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the service. When using a procedure code with this symbol, the service must meet the indicated Arkansas Medicaid description.

#### B. Referral of patient to an intensive tobacco cessation referral program.

#### C. Can be billed in addition to an office visit or EPSDT.

D. If the beneficiary is under the age of eighteen (18), and the parent/legal guardian smokes, he or she can be counseled as well, and the visit billed under the minor's beneficiary Medicaid number. The provider cannot prescribe meds for the parent under the child's Medicaid number. A parent/legal guardian session will count towards the four (4) counseling sessions limit described in section C above.

#### E. These counseling sessions do NOT require a PCP referral.

F. The provider must complete the counseling checklist and place in the patient records for audit. [View or print the Arkansas Be Well Referral Form.](#)

Refer to Section 257.000 and Section 292.900 of the Physician's manual for more information.

Health education can include vaccine counseling services to parents and legal guardians, and children. New codes for reimbursement for vaccine counseling under EPSDT are available beginning September 1, 2024. Vaccine counseling is allowed up to four (4) times per year, with the ability to request an extension of benefit limit. [View or print DMS contractor information for extension of benefits.](#)

### 215.295 Early Intervention Day Treatment (EIDT) Screening

4-1-24

A developmental screening must be performed prior to signing a DHS-642 ER referring a beneficiary for their initial evaluations to determine eligibility for early intervention day treatment (EIDT) services.

A. A developmental screening is only required prior to initially referring a beneficiary for EIDT services. A developmental screening is not required to be performed on a beneficiary already receiving EIDT services.

- B. The developmental screening must have been administered within the twelve (12) months immediately preceding the date of the DMS-642 ER.
- C. The developmental screen instrument used must be a validated tool recommended by the American Academy of Pediatrics.

**215.300 Exemplary Age-specific Child Health Services (EPSDT) Medical Screening Procedures 10-13-03**

The exemplary age-specific Child Health Services (EPSDT) medical screening procedures are to indicate the scope and depth of the Child Health Services (EPSDT) screening components and the frequency in which these services should be performed. These guidelines are not to be substituted for the physician's or other screener's judgment as to the kinds of services required for individual circumstances. The following are suggested screening schedule components for specific age ranges. If a child comes under care for the first time at any point on the schedule, or if any items are not completed by the suggested age, the schedule should be brought up to date at the earliest possible time.

**215.301 Newborn Screen (Ages 3 to 5 Days) 1-1-20**

- A. History (initial/interval) to be performed.
- B. Measurements to be performed
  - 1. Height and Weight
  - 2. Head Circumference
- C. Physical Examination to be performed at 3 to 5 days of age. At each visit a completed physical examination is essential with the infant totally unclothed.
- D. Developmental/Surveillance and Psychosocial/Behavioral Assessment, to be performed by history and appropriate physical examination and, if suspicious, by specific objective developmental testing. Parenting skills should be fostered at every visit.
- E. Procedures-General

These may be modified depending upon the entry point into the schedule and the individual need.

- 1. Hereditary/Metabolic Screening to be performed at age 1 month, if not performed either during the newborn evaluations or at the preferred age of 3-5 days. Metabolic screening (e.g. thyroid, hemoglobinopathies, PKU, galactosemia) should be done according to state law.
- 2. Immunization(s) to be performed as appropriate. Every visit should be an opportunity to update and complete a child's immunizations.

**215.310 Infancy (Ages 1–9 months) 1-1-24**

- A. History (Initial/Interval) to be performed at ages 1, 2, 4, 6, and 9 months.
- B. Measurements to be performed
  - 1. Height and Weight at ages 1, 2, 4, 6, and 9 months.
  - 2. Head Circumference at ages 1, 2, 4, 6, and 9 months.
- C. Sensory Screening, subjective, by history
  - 1. Vision at ages 1, 2, 4, 6, and 9 months.
  - 2. Hearing at ages 1, 2, 4, 6, and 9 months.

- D. Developmental/Surveillance and Psychosocial/Behavioral Assessment to be performed at ages 1, 2, 4, 6, and 9 months. To be performed by history and appropriate physical examination and, if suspicious, by specific objective developmental testing. Parenting skills should be fostered at every visit.
- E. Physical Examination to be performed at ages 1, 2, 4, 6, and 9 months. At each visit, a complete physical examination is essential with the infant totally unclothed.
- F. Procedures - General
- These may be modified depending upon the entry point into the schedule and the individual need.
1. Hereditary/Metabolic Screening to be performed at age 1 month, if not performed either during the newborn evaluation or at the preferred age of 3-5 days. Metabolic screening (e.g., thyroid, hemoglobinopathies, PKU, galactosemia) should be done according to state law.
  2. Immunization(s) to be performed at ages 1, 2, 4, 6, and 9 months. Every visit should be an opportunity to update and complete a child's immunizations.
  3. Hematocrit or Hemoglobin risk assessment at age 4 months with appropriate testing of high risk factors.
- G. Other Procedures
1. Lead screening risk assessment to be performed at ages 6 and 9 months. Additionally, screening should be done in accordance with state law where applicable.
  2. Tuberculin surveillance to be performed at ages 1 and 6 months per recommendations of the American Academy of Pediatrics (AAP) Committee on Infectious Diseases, published in the current edition of *AAP Red Book: Report of the Committee on Infectious Diseases*. Testing should be performed on recognition of high risk factors.
- H. Anticipatory Guidance to be performed at ages 1, 2, 4, 6, and 9 months. Age-appropriate discussion and counseling should be an integral part of each visit for care.
1. Injury prevention at ages 1, 2, 4, 6, and 9 months.
  2. Violence prevention at ages 1, 2, 4, 6, and 9 months.
  3. Sleep positioning counseling at ages 1, 2, 4, and 6 months. Parents and caregivers should be advised to place healthy infants on their backs when putting them to sleep. Side positioning is a reasonable alternative but carries a slightly higher risk of SIDS.
  4. Nutrition counseling at ages 1, 2, 4, 6, and 9, months. Age-appropriate nutrition counseling should be an integral part of each visit.
- I. Oral Health Risk Assessment:
- The Bright Futures/AAP "Recommendation for Preventative Pediatric Health Care," (i.e., Periodicity Schedule) recommends all children receive a risk assessment at the 6- and 9-month visits. For the 12-, 18-, 24-, 30-month, and the 3- and 6-year visits, risk assessment should continue if a dental home has not been established. [View the Bright/AAP Periodicity Schedule.](#)
- Subsequent examinations should be completed as prescribed by the child's dentist and recommended by the Child Health Services (EPSDT) dental schedule.
- J. One (1) Developmental Screen to be performed before age 12 months using a validated tool recommended by the American Academy of Pediatrics in alignment with the Bright Futures Periodicity Schedule. [View the Bright/AAP Periodicity Schedule.](#)

**215.320 Early Childhood (Ages 12 months–4 years) 4-1-24**

- A. History (Initial/Interval) to be performed at ages 12, 15, 18, 24, and 30\* months and ages 3 and 4 years.
- B. Measurements to be performed
1. Height and Weight at ages 12, 15, 18, 24, and 30 months and ages 3 and 4 years.
  2. Head Circumference at ages 12, 15, 18, and 24 months.
  3. Blood Pressure at 30 months\* and ages 3 and 4 years  
\* Note for infants and children with specific risk conditions.
  4. BMI (Body Mass Index) at ages 24 and 30 months, and ages 3 and 4 years.
- C. Sensory Screening, subjective, by history
1. Vision at ages 12, 15, 18, 24, and 30 months
  2. Hearing at ages 12, 15, 18, 24, and 30 months and age 3 years.
- D. Sensory Screening, objective, by a standard testing method
1. Vision at ages 3 and 4 years. Note: If the 3-year-old patient is uncooperative, re-screen within 6 months.
  2. Hearing at age 4 years.
- E. Developmental/Surveillance and Psychosocial Behavioral Assessment to be performed at ages 12, 15, 18, 24, and 30 months and ages 3 and 4 years. To be performed by history and appropriate physical examination and, if suspicious, by specific objective developmental testing. Parenting skills should be fostered at every visit.
- F. Physical Examination to be performed at ages 12, 15, 18, 24, and 30 months and 3 and 4 years. At each visit, a complete physical examination is essential, with the infant totally unclothed or with the older child undressed and suitably draped.
- G. Procedures – General
- These may be modified depending upon the entry point into the schedule and the individual need.
1. Immunization(s) to be performed at ages 12, 15, 18, 24, and 30 months and 3 and 4 years. Every visit should be an opportunity to update and complete a child's immunizations.
  2. Hematocrit or Hemoglobin risk assessment at 4 months with appropriate testing and follow up action if high risk to be performed at ages 12, 15, 18, 24, and 30 months and ages 3 and 4 years.
- H. Other Procedures
- Testing should be done upon recognition of high-risk factors.
1. Lead screening risk assessment to be performed at ages 12 and 24 months. Additionally, screening should be done in accordance with state law where applicable, with appropriate action to follow if high risk positive.
  2. Tuberculin test to be performed at ages 12 and 24 months and ages 3 and 4 years. Testing should be done upon recognition of high-risk factors per recommendations of the Committee on Infectious Diseases, published in the current edition of *AAP Red Book: Report of the Committee on Infectious Diseases*. Testing should be performed on recognition of high-risk factors.

3. Risk Assessment for Hyperlipidemia to be performed at ages 24 months and 4 years with fasting screen. If family history cannot be ascertained and other risk factors are present, screening should be at the discretion of the physician.
- I. Anticipatory Guidance to be performed at ages 12, 15, 18, 24, and 30 months and at ages 3 and 4 years. Age-appropriate discussion and counseling should be an integral part of each visit for care.
  1. Injury prevention to be performed at ages 12, 15, 18, 24, and 30 months and at 3 and 4 years.
  2. Violence prevention to be performed at ages 12, 15, 18, 24, and 30 months and at 3 and 4 years.
  3. Nutrition counseling to be performed at ages 12, 15, 18, 24, and 30 months and 3 and 4 years. Age-appropriate nutrition counseling should be an integral part of each visit.
- J. Oral Health Risk Assessment:
 

The Bright Futures/AAP “Recommendation for Preventative Pediatric Health Care,” (i.e., Periodicity Schedule) recommends all children receive a risk assessment at the 6- and 9-month visits. For the 12-, 18-, 24-, 30-month, and the 3- and 6-year visits, risk assessment should continue if a dental home has not been established. [View the Bright/AAP Periodicity Schedule.](#)

Subsequent examinations should be as prescribed by the dentist and recommended by the Child Health Services (EPSDT) dental schedule.
- K. Two (2) Developmental Screens to be performed between the ages thirteen (13) months to forty-eight (48) months and a third (3<sup>rd</sup>) developmental screen to be performed between forty-eight (48) and sixty (60) months using validated tools recommended by the American Academy of Pediatrics in alignment with the Bright Futures Periodicity Schedule. [View the Bright/AAP Periodicity Schedule.](#) An extension of benefits is required to bill more than one (1) screening per twelve (12) month period and more than three (3) total screens between thirteen (13) and sixty (60) months of age.
- L. Autism Screen to be performed at ages 18 and 24 months (or 30 months if screen was not completed at 24 months) using a standardized tool such as the Modified Checklist for Autism in Toddlers (M-CHAT) or the Pervasive Developmental Disorders Screening Tests-II (PDDSDT-II) Stage1. Any additional test must be approved by DMS prior to use.

**215.330 Middle Childhood (Ages 5-10 years)****1-1-20**

- A. History (Initial/Interval) to be performed at ages 5, 6, 7, 8, 9, and 10 years.
- B. Measurements to be performed
  1. Height and Weight at ages 5, 6, 7, 8, 9, and 10 years.
  2. BMI (Body Mass Index) at all ages.
  3. Blood Pressure at ages 5, 6, 7, 8, 9, and 10 years.
- C. Sensory Screening, objective, by a standard testing method.
  1. Vision at ages 5, 6, 8, and 10 years.
  2. Hearing at ages 5, 6, 8, and 10 years.
- D. Sensory Screening, subjective, by history.
  1. Vision at ages 7 and 9.

2. Hearing at ages 7 and 9.
- E. Developmental/Surveillance and Psychosocial Behavioral Assessment to be performed at ages 5, 6, 7, 8, 9, and 10 years. To be performed by history and appropriate physical examinations and, if suspicious, by specific objective developmental testing. Parenting skills should be fostered at every visit.
- F. Physical Examination to be performed at ages 5, 6, 7, 8, 9, and 10 years. At each visit, a complete physical examination is essential with the child undressed and suitably draped.
- G. Procedures - General

These may be modified depending upon entry point into schedule and individual need.

1. Immunization(s) to be performed at ages 5, 6, 7, 8, 9, and 10 years. Every visit should be an opportunity to update and complete a child's immunizations.
  2. Hematocrit or Hemoglobin to be performed for patients at high risk at age 5, 6, 7, 8, 9, and 10 years.
  3. High Cholesterol screening to be performed at least once between the ages of 9 and 11, using a non-HDL cholesterol test that does not require fasting. Abnormal results should be followed up with a fasting lipid profile.
- H. Other Procedures

Testing should be done upon recognition of high-risk factors.

1. Tuberculin test to be performed at ages 5, 6, 7, 8, 9, and 10 years. Testing should be done upon recognition of high-risk factors.
  2. Risk Assessment for Hyperlipidemia to be performed at ages 6, 7, 8, 9, and 10 years with fasting. If family history cannot be ascertained and other risk factors are present, screening should be at the discretion of the physician.
  3. Oral Health Risk Assessment:  
The Bright Futures/AAP "Recommendation for Preventative Pediatric Health Care," (i.e., Periodicity Schedule) recommends all children receive a risk assessment at the 6- and 9-month visits. For the 12-, 18-, 24-, 30-month, and the 3- and 6-year visits, risk assessment should continue if a dental home has not been established. [View the Bright/AAP Periodicity Schedule.](#)  
Subsequent examination should be as prescribed by the dentist and recommended by the Child Health Services (EPSDT) dental schedule.
- I. Anticipatory Guidance to be performed at ages 5, 6, 7, 8, 9, and 10 years. Age-appropriate discussion and counseling should be an integral part of each visit for care.
1. Injury prevention to be performed at ages 5, 6, 7, 8, 9, and 10 years.
  2. Violence prevention to be performed at ages 5, 6, 7, 8, 9, and 10 years.
  3. Nutrition counseling to be performed at ages 5, 6, 7, 8, 9, and 10 years. Age-appropriate counseling should be an integral part of each visit.

### 215.340 Adolescence (Ages 11-20 years)

1-1-20

Developmental, psychosocial and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.

- A. History (Initial/Interval) to be performed at ages 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20 years.
- B. Measurements to be performed

1. Height and Weight at ages 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20 years.
  2. Blood Pressure at ages 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20 years.
  3. BMI (Body Mass Index) at all ages.
- C. Sensory Screening, subjective, by history
1. Vision at ages 11, 13, 14, 16, 17, 19, and 20 years.
  2. Hearing at ages 11, 12, 13, 14, 16, 17, 18, 19, and 20 years.
- D. Sensory Screening, objective, by a standard testing method
1. Vision at ages 12, 15, and 18 years.
  2. Hearing at ages 12, 15, and 18 years.
- E. Developmental/ Surveillance and Psychosocial/Behavioral Assessment to be performed at ages 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20 years. To be performed by history and appropriate physical examination, if suspicious, by specific objective developmental testing. Parenting skills should be fostered at every visit.
- F. Physical Examination to be performed at ages 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20 years. At each visit, a complete physical examination is essential, with the child undressed and suitably draped.
- G. Procedures – General

These may be modified, depending upon entry point into schedule and individual need.

1. Immunization(s) to be performed at ages 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20 years. Every visit should be an opportunity to update and complete a child's immunizations.
  2. High Cholesterol screening to be performed at least once between the ages of 17 and 21, using a non-HDL cholesterol test that does not require fasting. Abnormal results should be followed up with a fasting lipid profile.
- H. Other Procedures
- Testing should be done upon recognition of high risk factors.
1. Tuberculin test to be performed at ages 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20 years.
  2. Risk assessment for Hyperlipidemia to be performed annually with fasting screen if family history cannot be ascertained and other risk factors are present. Screening should be at the discretion of the physician.
  3. Sexually Transmitted Infection (STI) screening to be performed at ages 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20 years. All sexually active patients should be screened. Hematocrit or Hemoglobin to be performed for those patients at high risk at ages 11-20 years.
  4. HIV screening to be performed one time between ages 15 and 18 years. Additionally, all adolescents should be screened for HIV, making every effort to preserve confidentiality of the adolescent, according to the AAP statement. [View the AAP screening statement](#). Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.
  5. Depression screening to be performed each year between ages 12 through 20 using screening tools such as the Patient Health Questionnaire (PHQ)-2 or other tools

available in the Guidelines for Adolescent Depression in Primary Care (GLAD-PC) toolkit.

- I. Anticipatory Guidance to be performed at ages 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20 years. Age-appropriate discussion and counseling should be an integral part of each visit for care.
  1. Injury prevention to be performed at ages 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20 years.
  2. Violence prevention to be performed at ages 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20 years.
  3. Nutrition counseling to be performed at ages 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20 years. Age-appropriate nutrition counseling should be an integral part of each visit.

**216.000****Vision Screen****2-1-22**

An EPSDT periodic complete medical screen includes both hearing and vision screens. Providers must not bill an EPSDT periodic vision or hearing screen on the same day, or within seven (7) days of an EPSDT periodic complete medical screen by the same or different providers. The above combinations represent a duplication of services.

The provider must administer an age-appropriate vision assessment. See [Section 242.100](#) for procedure codes.

Vision services are subject to their own periodicity schedule; however, when the periodicity schedule coincides with the schedule for periodic complete medical screen, vision screens must be included as part of the required minimum periodic complete medical screening services. Vision screens are exempt from the PCP referral requirement.

See Sections 215.310 through 215.340 for the age-specific vision screening periodicity schedule.

At a minimum, vision services include diagnosis and treatment for defects in vision, including eyeglasses.

**217.000****Hearing Screen****4-1-09**

An EPSDT periodic complete medical screen includes both hearing and vision screens. Providers must not bill an EPSDT periodic vision or hearing screen on the same day, or within seven (7) days of an EPSDT periodic complete medical screen by the same or different providers. The above combinations represent a duplication of services.

Hearing services are subject to their own periodicity schedule. However, when the periodicity schedule coincides with the schedule for a periodic complete medical screen, hearing screens are to be included as part of the required minimum periodic complete medical screening services. Hearing screens are exempt from the PCP referral requirement.

**218.000****Dental Screening Services****2-1-22**

Although an oral assessment may be part of a medical screen, it does not substitute for examination through direct referral to a dentist. A direct dental referral is required for every child once per state fiscal year (July 1 through June 30). See [Section 242.100](#) for procedure codes.

A Child Health Services (EPSDT) interperiodic dental screen may be completed as often as medically necessary, but must be prior authorized in order for the claim to be paid. Refer to Section 220.000 for an explanation of the prior authorization process.

Dental screens are exempt from the primary care provider (PCP) referral requirement.

### Dental Services

At a minimum, dental services include relief of pain and infections, restoration of teeth and maintenance of dental health. Dental services may not be limited to emergency services. The periodicity schedule for other EPSDT services may not govern the schedule for dental services.

A child should receive his or her first dental screen examination within 6 months after eruption of the first primary tooth but no later than 12 months of age.

## 219.000      **Lead Toxicity Screening**

10-13-03

All children from age six (6) months to six (6) years of age are considered to be at risk and must be screened for blood lead poisoning. Blood lead tests are required for all children at twelve (12) months of age and again at twenty-four (24) months of age, regardless of the child's risk assessment level. A screening blood test also is required for any Medicaid-eligible child 36 to 72 months of age who has not previously been screened for lead poisoning. The blood lead test is required when screening children for lead poisoning (Section 215.270.)

### A. Risk Assessment

Beginning at six (6) months of age and at each visit thereafter, the CHS/EPSDT provider must discuss childhood lead poisoning interventions with the child's parents or guardian and must verbally ask the following questions as part of an EPSDT screen:

1. Does your child live in or regularly visit a house built before 1960? Was your child's daycare, preschool, Head Start center or babysitter's home built before 1960? Does the house or building have peeling or chipping paint?
2. Does your child live in a house built before 1960 with recent, on-going or planned renovation or remodeling?
3. Have any of your children or their playmates had lead poisoning?
4. Does your child frequently come in contact with an adult who works with lead, e.g., construction, welding, pottery or other trades practiced in the child's community where lead is used?
5. Does your child live near a lead smelter, battery recycling plant or other industry likely to release lead, such as ... (give any examples in your community)?
6. Do you give your child any home or folk remedies that may contain lead?
7. Does your child live near a heavily traveled major highway where soil and dust may be contaminated with lead?
8. Does your home's plumbing have lead pipes or copper with lead solder joints?
9. Ask any additional questions which may be specific to situations that exist in a particular community.

The child's EPSDT record must be documented to reflect that these questions were verbally asked at each complete periodic screen between ages six (6) months and six (6) years.

### B. Determining Risk

Risk is determined from the response to the questions on the verbal risk assessment.

If the answers to all questions are negative, a child is considered low-risk for high doses of lead exposure. Children considered as low-risk must receive blood lead screenings at twelve (12) months and twenty-four (24) months of age.

If the answer to any question is positive, a child is considered high-risk for high doses of lead exposure. A blood test must be obtained at the time the child is determined to be high-risk.

Subsequent verbal risk assessments may re-determine a child's risk category. In the event a child previously categorized as low-risk is re-determined as high-risk, the child must be given a blood lead test.

C. Screening Blood Tests

Screening blood tests are blood tests for children who have not previously been tested for lead poisoning with a blood lead test or who have previously been tested and found not to have an elevated blood level.

Children determined to be low-risk must be given screening blood tests at twelve (12) months and twenty-four (24) months of age.

Children determined to be high-risk must be given screening blood tests beginning at six (6) months of age. A screening blood test is required at every visit prescribed in the CHS/EPSTD periodicity schedule through age 72 months (unless the child received a blood lead test within the last six (6) months of the periodic visit) when initial blood lead test results are less than 10 micrograms per deciliter ( $\mu\text{g}/\text{dl}$ ). Blood lead test results equal to or greater than 10  $\mu\text{g}/\text{dl}$  obtained by a capillary specimen must be confirmed by a venous blood sample.

Children between the ages of twenty-four (24) months and six (6) years who have not received a screening blood lead test must receive one immediately regardless of their risk level.

D. Diagnosis, Treatment and Follow-up

In the event a child is found to have blood lead levels  $\geq 10 \mu\text{g}/\text{dl}$ , providers are to use their professional judgment with reference to Centers for Disease Control recommendations for preventing lead poisoning in young children.

See Section 240.000 for specific billing instructions.

## 220.000 PRIOR AUTHORIZATION

1-1-22

Prior authorization is required for the interperiodic dental screen and must be requested on the ADA claim form. Refer to the Dental Provider Manual for details regarding the prior authorization process. See [Section 242.100](#) for procedure codes.

## 230.000 REIMBURSEMENT

### 231.000 Method of Reimbursement

10-13-03

Reimbursement for Child Health Services (EPSTD) screens, immunizations and lab procedures is based on the lesser of the billed amount or the Medicaid maximum.

### 231.010 Fee Schedules

12-1-12

Arkansas Medicaid provides fee schedules on the Arkansas Medicaid website. The fee schedule link is located at <https://medicaid.mmis.arkansas.gov> under the provider manual section. The fees represent the fee-for-service reimbursement methodology.

Fee schedules do not address coverage limitations or special instructions applied by Arkansas Medicaid before final payment is determined.

Procedure codes and/or fee schedules do not guarantee payment, coverage or amount allowed. Information may be changed or updated at any time to correct a discrepancy and/or error. Arkansas Medicaid always reimburses the lesser of the amount billed or the Medicaid maximum.

## 232.000

## Rate Appeal Process

10-13-03

A provider may request reconsideration of a program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following the application of policy and/or procedure or the notification of the provider of its rate. Upon receipt of the request for review, the Assistant Director will determine the need for a program and/or provider conference and will contact the provider to arrange a conference if needed. Regardless of the program decision, the provider will be afforded the opportunity for a conference, if he or she so wishes, for a full explanation of the factors involved and the program decision. Following review of the matter, the Assistant Director will notify the provider of the action to be taken by the division within 20 calendar days of receipt of the request for review or the date of the program and/or provider conference.

If the provider disagrees with the decision of the Assistant Director of the Division of Medical Services, the provider may then appeal the question to a standing rate review panel established by the Director of the Division of Medical Services. The rate review panel will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department of Human Services (DHS) management staff, who will serve as chairperson.

The request for review by the rate review panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director of the Division of Medical Services. The rate review panel will meet to consider the question(s) within 15 calendar days after receipt of a request for the appeal. The question(s) will be heard by the panel and a recommendation will be submitted to the Director of the Division of Medical Services.

## 240.000

## BILLING PROCEDURES

## 241.000

## Introduction to Billing

1-15-11

Providers may bill the Arkansas Medicaid Program for Child Health Services (EPSDT) services provided to eligible Medicaid beneficiaries electronically or on paper, using the CMS-1500 claim form. Each claim may contain charges for only one beneficiary. [View or print a CMS-1500 sample form.](#)

Section III of this manual contains information about Provider Electronic Solutions (PES) and other available options for electronic claim submission.

## 242.000

## CMS-1500 Billing Procedures

1-15-11

## 242.100

## Procedure Codes

2-1-22

The table below contains procedure codes, the associated modifiers to be used with the individual code, and a description of each EPSDT service.

[View or print the procedure codes and modifiers for Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment \(EPSDT\) services.](#)

⚡(...) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the service. When using a procedure code with this symbol, the service must meet the indicated Arkansas Medicaid description.

Other coding information found in the chart:

<sup>1</sup> Exempt from PCP referral requirements

<sup>2</sup> Covered when specimen is referred to an independent lab

Electronic and paper claims require use of modifiers. When filing paper claims for a Child Health Services (EPSDT) screening service, the applicable modifier must be entered on the claim form.

See Section 212.000 for Child Health Services (EPSDT) screening terminology.

#### NOTES

- A. Arkansas Medicaid is no longer able to process both a sick visit and an EPSDT screening visit when performed on the same date of service without the appropriate modifier (Modifier 25). Modifier 25 must be indicated in the first position of the second billed service. This change surpasses the Medicaid policy to not bill modifiers on a sick visit when performed on the same date of service as an EPSDT screening.
- B. New born screenings can be performed by a Certified Nurse Midwife or Nurse Practitioner without a PCP referral.
- C. Procedure codes, used in conjunction with the **EP and H9 modifiers**, are to be used only for the required intake physical examination for Medicaid beneficiaries in the Arkansas foster care system. (See Section 214.300 for more information.)
- D. Claims for EPSDT medical screenings must be billed electronically or by using the CMS-1500 claim form. **May be billed on the CMS-1500 claim form, by paper or electronically.** ([View or print a CMS-1500 sample form.](#)) **May also be billed as EPSDT in the electronic transaction format or on the CMS-1500 paper form.**
- E. Laboratory/X-ray and immunizations associated with a Child Health Services (EPSDT) screen may be billed on the CMS-1500 claim form.
- F. Immunizations and laboratory tests may be billed separately from comprehensive screens.
- G. The verbal assessment of lead toxicity risk is part of the complete Child Health Services (EPSDT) screen. The cost for the administration of the risk assessment is included in the fee for the complete screen.
- H. May be used for billing in the office place of service (11) for the administration of subcutaneous or IM injections **ONLY** when the provider administers, but does not supply the drug.
  - 1. Cannot be billed when the medication is administered orally. No fee is billable for drugs administered orally.
  - 2. Cannot be billed to administer any medication given for family planning purposes.
  - 3. Cannot be billed when the drug administered is not FDA approved.
- I. Procedure code is payable to physicians for supplies and materials (except eyeglasses), provided by the physician over and above those usually included with the office visit or other services rendered. Procedure code must not be billed for the provision of drug supply samples and may not be billed on the same date of service as a surgery code. Claims require National Place of Service code "11". Procedure code is limited to beneficiaries under age twenty-one (21).

#### 242.110

#### Newborn Care

2-1-22

For routine newborn care following a vaginal delivery or C-section, procedure code should be used one time to cover all newborn care visits by the attending physician. Payment of these codes is considered a global rate and subsequent visits may not be billed in addition to codes.

[View or print the procedure codes and modifiers for Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment \(EPSDT\) services.](#)

These procedure codes include the physical exam of the baby and the conference(s) with the newborn's parent(s), which is considered to be the initial newborn care/EPSDT screen in hospital. These procedure codes should not be used for illness care (e.g. neonatal jaundice). Providers may refer to the physician manual for necessary illness codes.

Note the descriptions, modifiers, and required diagnosis range. The newborn care procedure codes require a modifier or modifiers and a primary detail diagnosis for all providers ([View ICD Codes.](#)) Refer to the appropriate manual(s) for additional information about newborn screenings.

#### 242.120 Billing Exceptions

2-1-22

[View or print the procedure codes and modifiers for Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment \(EPSDT\) services.](#)

All EPSDT procedure codes must be billed on the CMS-1500 claim form with the following exceptions.

##### A. Dental Billing

1. Procedure code must be billed on the American Dental Association (ADA) claim form. [View or print the ADA claim form.](#)
2. Prior authorization for procedure code must be requested on the ADA claim form.
3. Procedure code for an interperiodic dental screen must be billed on the ADA claim form.

- B. When billing EPSDT screening codes, providers are not limited to the following diagnosis codes: ([View ICD Codes.](#)) The newborn care procedure codes require a modifier or modifiers and a primary detail diagnosis ([View ICD Codes.](#))

#### 242.130 Reserved

1-15-11

#### 242.140 Vaccines for Children Program

2-1-22

The Vaccines for Children (VFC) Program was established to generate awareness and access for childhood immunizations. To enroll in the VFC Program, contact the Arkansas Department of Health. Providers may also obtain the vaccines to administer from the Arkansas Department of Health. [View or print Arkansas Department of Health contact information.](#)

Vaccines available through the VFC program are covered for Medicaid-eligible children. Only the administrative fee is reimbursed. When filing claims for administering VFC vaccines, providers must use the CPT procedure code for the vaccine administered. Electronic and paper claims require modifiers **EP** and **TJ**.

All procedure codes under the VFC program must be billed electronically or on paper, using either the CMS-1500 claim form or the CMS-1450 claim form.

Medicaid policy regarding immunizations for adults remains unchanged by the VFC program.

**Providers may consult the Physician's manual to view the list of vaccines that are non-VFC but are covered for beneficiaries who are 19 and 20 years of age.** The following list contains the vaccines available through the VFC program.

[View or print the procedure codes and modifiers for Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment \(EPSDT\) services.](#)

#### 242.141 Billing of Multi-Use and Single-Use Vials

1-1-23

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs.

- A. Multiple units may be billed when applicable. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as “take-home drugs.” Refer to payable CPT code ranges.

[View or print the procedure codes and modifiers for Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment \(EPSDT\) services.](#)

- B. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description, the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.
1. **Single-Use Vials:** If the provider must discard the remainder of a **single-use vial** or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered. Discarded drugs shall be billed on a separate detail line with a JW (Drug wastage) modifier.
  2. **Multi-Use Vials:** Multi-use vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the units administered to the beneficiary.
  3. **Documentation:** The provider must clearly document in the patient’s medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.

Remember to verify the milligrams given to the patient and then convert to the proper units for billing.

Follow the Centers for Disease Control (CDC) requirements for safe practices regarding expiration and sterility of multi-use vials.

#### 242.150 [Limitation for Laboratory Procedures Performed as Part of EPSDT Screens](#) 2-1-22

Child Health Services (EPSDT) screens do not include laboratory procedures unless the screen is performed by the beneficiary’s primary care physician (PCP) or is conducted in accordance with a referral from the PCP.

The following tests are exempt from this limitation and may continue to be billed in conjunction with an EPSDT screen performed in accordance with existing Medicaid policy:

[View or print the procedure codes and modifiers for Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment \(EPSDT\) services.](#)

Claims for laboratory tests, other than those specified above, performed in conjunction with an EPSDT screen will be denied, unless the screen is performed by the PCP or in accordance with a referral from the PCP.

The following screens will be affected by this policy.

#### 242.200 [National Place of Service \(POS\) Codes](#) 7-1-07

The national place of service code is used for both electronic and paper billing.

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#### Place of Service

#### POS Codes

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Place of Service	POS Codes
Inpatient Hospital	21
Outpatient Hospital	22
Doctor's Office	11
Patient's Home	12
Other Locations	99

**242.300 Billing Instructions – Paper Only**

2-1-22

To bill for a Child Health Services (EPSDT) screening service, use the CMS-1500 claim form. The numbered items correspond to numbered fields on the claim form. See Section 242.310 for paper billing instructions. [View or print a sample CMS-1500 form.](#)

Each screening should be billed separately, providing the appropriate information for each of the screening components.

[View or print the procedure codes and modifiers for Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment \(EPSDT\) services.](#)

With the exception of codes (office medical services), (home medical services) and (hospital inpatient medical services), specific procedures may be used at the provider's discretion as long as the federally-mandated components (refer to Section 215.000) have been included in the screening package.

Medical services such as immunizations and laboratory procedures may also be billed on the CMS-1500 when provided in conjunction with a Child Health Services (EPSDT) screening, as well as other treatment services provided.

Claims for Child Health Services (EPSDT) dental services are to be billed on the ADA claim form. For dental screening to be paid, the ADA claim form must be completed and the box marked "child" in Field 2 must be checked.

Claims for Child Health Services (EPSDT) visual services are to be billed on the CMS-1500 claim form. The numbered items correspond to numbered fields on the claim form. See Section 242.310 for paper billing instructions. [View or print a sample CMS-1500 form.](#)

Carefully follow these instructions to help the Arkansas Medicaid fiscal agent efficiently process claims. Accuracy, completeness and clarity are essential. Claims cannot be processed if applicable information is omitted. Claims should be typed whenever possible.

Forward completed claim forms to the Claims Department. [View or print the Claims Department contact information.](#)

**NOTE: A provider delivering services without verifying beneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services.**

**242.310 Completion of the CMS-1500 Claim Form**

12-15-14

Field Name and Number	Instructions for Completion
1. (type of coverage)	Not required.
1a. INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.

Field Name and Number	Instructions for Completion
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's or participant's last name and first name.
3. PATIENT'S BIRTH DATE	Beneficiary's or participant's date of birth as given on the individual's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
SEX	Check M for male or F for female.
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name, and middle initial.
5. PATIENT'S ADDRESS (No., Street)	Optional. Beneficiary's or participant's complete mailing address (street address or post office box).
CITY	Name of the city in which the beneficiary or participant resides.
STATE	Two-letter postal code for the state in which the beneficiary or participant resides.
ZIP CODE	Five-digit zip code; nine digits for post office box.
TELEPHONE (Include Area Code)	The beneficiary's or participant's telephone number or the number of a reliable message/contact/ emergency telephone.
6. PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7. INSURED'S ADDRESS (No., Street)	Required if insured's address is different from the patient's address.
CITY	
STATE	
ZIP CODE	
TELEPHONE (Include Area Code)	
8. RESERVED	Reserved for NUCC use.
9. OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial.
a. OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured individual.
b. RESERVED	Reserved for NUCC use.
SEX	Not required.
c. RESERVED	Reserved for NUCC use.
d. INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10. IS PATIENT'S CONDITION RELATED TO:	
a. EMPLOYMENT? (Current or Previous)	Check YES or NO.

Field Name and Number	Instructions for Completion
b. AUTO ACCIDENT?	Required when an auto accident is related to the services. Check YES or NO.
PLACE (State)	If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
c. OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
d. EPSDT PAPER CLAIMS	For all EPSDT paper claim submissions, please enter the letters "EPSDT" in BOX 10d on the CMS-1500 claim form.
11. INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
a. INSURED'S DATE OF BIRTH	Not required.
SEX	Not required.
b. OTHER CLAIM ID NUMBER	Not required.
c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a and 9d. Only one box can be marked.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident.
	Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period.

Field Name and Number	Instructions for Completion
15. OTHER DATE	<p>Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines.</p> <p>The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers:</p> <p>454 Initial Treatment</p> <p>304 Latest Visit or Consultation</p> <p>453 Acute Manifestation of a Chronic Condition</p> <p>439 Accident</p> <p>455 Last X-Ray</p> <p>471 Prescription</p> <p>090 Report Start (Assumed Care Date)</p> <p>091 Report End (Relinquished Care Date)</p> <p>444 First Visit or Consultation</p>
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Primary Care Physician (PCP) referral is required for most Physician/Independent Lab/CRNA/Radiation Therapy Center services provided by non-PCPs. Enter the referring physician's name and title.
17a. (blank)	Not required.
17b. NPI	Enter NPI of the referring physician.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving/billing provider's services charged on this claim are related to a beneficiary's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.
19. ADDITIONAL CLAIM INFORMATION	Identifies additional information about the beneficiary's condition or the claim. Enter the appropriate qualifiers describing the identifier. See <a href="http://www.nucc.org">www.nucc.org</a> for qualifiers.
20. OUTSIDE LAB? \$ CHARGES	Not required. Not required.

Field Name and Number	Instructions for Completion
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	<p>Enter the applicable ICD indicator to identify which version of ICD codes is being reported.</p> <p>Use "9" for ICD-9-CM.</p> <p>Use "0" for ICD-10-CM.</p> <p>Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field.</p> <p>Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.</p>
22. RESUBMISSION CODE ORIGINAL REF. NO.	<p>Reserved for future use.</p> <p>Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids and refunds must follow previously established processes in policy.</p>
23. PRIOR AUTHORIZATION NUMBER	<p>The prior authorization or benefit extension control number if applicable.</p>
24A. DATE(S) OF SERVICE	<p>The "from" and "to" dates of service for each billed service. Format: MM/DD/YY.</p> <ol style="list-style-type: none"> <li>1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month.</li> <li>2. Providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.</li> </ol>
B. PLACE OF SERVICE	<p>Two-digit national standard place of service code. See Section 292.200 for codes.</p>
C. EMG	<p>Enter "Y" for "Yes" or leave blank if "No." EMG identifies if the service was an emergency.</p>
D. PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS MODIFIER	<p>One CPT or HCPCS procedure code for each detail.</p> <p>Modifier(s) if applicable.</p> <p>For anesthesia, when billed with modifier(s) P1, P2, P3, P4, or P5, hours and minutes must be entered in the shaded portion of that detail in field 24D.</p>

Field Name and Number	Instructions for Completion
E. DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F. \$ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other beneficiary of the provider's services.
G. DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
H. EPSDT/Family Plan	<p>EPSDT Reason Codes are required for EPSDT services. Please enter the appropriate 2 byte reason code in the upper shaded part of the detail line.</p> <p>AV – Available – Not Used (patient refused referral)            NU – Not Used (used when no EPSDT patient referral was given)            S2 – Under Treatment (patient is currently under treatment for referred diagnostic or corrective health problem)            ST – New Service Requested (Referral to another provider for diagnostic or corrective treatment/scheduled for another appointment with screening provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service, not including dental referrals.)</p> <p>Family Planning Indicator is not applicable for this claim type.</p>
I. ID QUAL	Not required.
J. RENDERING PROVIDER ID #	Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
NPI	Enter NPI of the individual who furnished the services billed for in the detail.
25. FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26. PATIENT'S ACCOUNT N O.	Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."
27. ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28. TOTAL CHARGE	Total of Column 24F—the sum all charges on the claim.

Field Name and Number	Instructions for Completion
29. AMOUNT PAID	Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. * Do <b>not</b> include in this total the automatically deducted Medicaid or ARKids First-B co-payments.
30. RESERVED	Reserved for NUCC use.
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
32. SERVICE FACILITY LOCATION INFORMATION	If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed.
a. (blank)	Not required.
b. (blank)	Not required.
33. BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
a. (blank)	Enter NPI of the billing provider or
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

**242.400 Special Billing Procedures**

10-13-03

Not applicable to this program.