pennsylvania
DEPARTMENT OF HUMAN SERVICES

MEDICAL ASSISTANCE BULLETIN

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SUBJECT

Updates to the 2017 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program Periodicity Schedule

BY

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Office of Medical Assistance Programs

IMPORTANT REMINDER: All providers must revalidate the Medical Assistance (MA) enrollment of each service location every 5 years. Providers should log into PROMISe™ to check the revalidation dates of each service location and submit revalidation applications at least 60 days prior to the revalidation dates. Enrollment (revalidation) applications may be found at: http://www.dhs.pa.gov/provider/promise/enrollmentinformation/S_001994.

PURPOSE:

The purpose of this bulletin is to:

- Notify providers of updates to *Pennsylvania's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program Periodicity Schedule and Coding Matrix,* including the addition of certain diagnosis codes,
- Issue an updated periodicity schedule, and
- Issue updated pages for the *CMS-1500 Billing Guide for PROMISe™ Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services* and the *CMS-1500 Billing Guide for PROMISe™ Rural Health Clinics (RHCs) & Federally Qualified Health Centers (FQHCs)*.

SCOPE:

This bulletin applies to all providers enrolled in the Medical Assistance (MA) Program who provide EPSDT screens for MA beneficiaries in the Fee-for-Service (FFS) and managed care delivery systems. Providers rendering services in the managed care delivery system should address any payment related questions to the appropriate MA managed care organization.

BACKGROUND/DISCUSSION:

On August 7, 2017, the Department of Human Services (Department) issued MA Bulletin 99-17-10 announcing updates to *Pennsylvania's Early and Periodic Screening,*

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

The appropriate toll free number for your provider type

Visit the Office of Medical Assistance Programs Web site at
http://www.dhs.pa.gov/provider/healthcaremedicalassistance/index.htm

Diagnosis and Treatment (EPSDT) Program Periodicity Schedule and Coding Matrix that incorporated recommendations for preventive pediatric health care made by the American Academy of Pediatrics (AAP) in the February 2017 publication of its periodicity schedule, https://www.aap.org/en-us/Documents/periodicity_schedule.pdf. Since then, the Department has received significant feedback from providers prompting further review and updates to Pennsylvania's EPSDT periodicity schedule. The updates to Pennsylvania's EPSDT periodicity schedule are as follows:

3-5 Day Periodicity

The MA Program covers medically necessary screenings from a child's birth through its first month of life. The Department has added the 3-5 day periodicity to Pennsylvania's EPSDT periodicity schedule consistent with the 3-5 day periodicity recommended by the AAP. The AAP notes both the importance of this first follow-up visit after discharge from the hospital and that many newborns are not receiving this care. AAP guidance (*Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 4th ed., 2017) regarding the exact timeframe for this visit varies based on method of delivery, maternal or neonatal complications, and resulting length of stay in the hospital. For those infants with a hospital stay of 96 hours or longer, this visit should take place within one week after discharge.

Maternal Depression Screens

The Department has also updated Pennsylvania's EPSDT periodicity schedule by replacing the common procedural terminology (CPT) code used for the maternal depression screens, 96160 (Administration of patient-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument) with CPT 96161 (Administration of caregiver-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument). CPT 96161 better reflects that the screening is focused on the mental health of the caregiver but performed for the benefit of the child. In the event that a provider is not able to complete this service, modifier 52 should be used (see footnote 3 on Pennsylvania's EPSDT periodicity schedule).

Vision Screens

Universal screening for vision begins at the 3-year periodicity. Previous editions of *Bright Futures* and AAP's periodicity schedule have indicated screening for visual acuity using traditional methods (e.g., Snellen chart). With the publication of its 2017 periodicity schedule, the AAP included instrument-based screening for visual acuity and other ocular risk factors. The Department has added CPT 99174 (Instrument-based ocular screening, bilateral; with remote analysis and report) and CPT 99177 (Instrument-based ocular screening, bilateral; with on-site analysis) to Pennsylvania's EPSDT periodicity schedule to reflect these additional screening methods. While the AAP suggests that instrument-based screenings may be used between three and five years of age, the Department has expanded the use of instrument-based screenings to the 6, 8, 10, 12 and 15-year periodicities so instrument-based screenings may be used if visual acuity cannot be assessed reliably using traditional screening methods.

Hearing Screens

The AAP's recommendation that all newborns receive a hearing screening prior to their discharge from the hospital is consistent with standards set forth in the Infant Hearing Education, Assessment, Reporting and Referral Act and the US Department of Health and Human Services' *Healthy People 2020* initiative. Pennsylvania's EPSDT periodicity schedule indicates that a hearing screening is to be performed during the newborn screening and if not, must be completed by the 2-3 month periodicity. The periodicity schedule no longer indicates a specific CPT code to be used for this screening to acknowledge the variety of screening methods that may be used for newborns.

Diagnosis Coding

The Department has expanded the list of ICD-10 diagnosis codes that may be used when billing EPSDT screens. These additional diagnosis codes, identified in the "Procedure" section below, allow providers to use codes that more accurately reflect the age, type of birth, and place of birth of a patient. These diagnosis codes are included in the *CMS-1500 Billing Guide for PROMISe™ Early and Periodic Screening, Diagnosis, and Treatment Services* and the *CMS-1500 Billing Guide for PROMISe™ Rural Health Clinics (RHCs) & Federally Qualified Health Centers (FQHCs)*.

PROCEDURE:

Effective January 3, 2018, providers should use the *Pennsylvania's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program Periodicity Schedule and Coding Matrix* attached to this bulletin when providing and billing EPSDT screens, which was updated as discussed above and follows:

- The 3-5 day periodicity has been added and providers should provide the first follow-up visit for the MA beneficiary after discharge from the hospital.
- CPT 96161 has been added and providers should now use this code when maternal depression screening is performed as part of an EPSDT screen. Providers should use modifier 52 if this service is not completed.
- CPT 99174 and 99177 have been added to reflect the instrument-based vision screening methods.
- Specific procedure codes for hearing screening performed during infancy have been removed and providers should continue to perform the hearing screen, as indicated on the periodicity schedule.

Additionally,

- Footnote 3 was revised to add maternal depression screening and change visual acuity screening to vision screening to address the ocular risk factor screening that is accomplished through instrument-based screening.

- Footnote 17 was added to reflect that instrument-based screening may be used to detect amblyopia, strabismus, and/or high refractive error in children who are unable or unwilling to cooperate with traditional screening.

Providers may use the following additional ICD-10 diagnosis codes in conjunction with ESPDT claims:

- Z00.110 (Health examination for newborn under 8 days old)
- Z00.111 (Health examination for newborn 8 to 28 days old)
- Z38.01 (Single liveborn infant, delivered by cesarean)
- Z38.1 (Single liveborn infant, born outside hospital)
- Z38.3-Z38.8 (Range of codes for multiple births)

The *CMS-1500 Billing Guide for PROMISe™ Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services* and the *CMS-1500 Billing Guide for PROMISe™ Rural Health Clinics (RHCs) & Federally Qualified Health Centers (FQHCs)* have been updated to include these additional codes. Please refer to these billing guides, attached and available online at: http://www.dhs.pa.gov/publications/forproviders/promiseproviderhandbooksandbillingguides/index.htm for a complete listing of referral codes, modifiers and diagnosis codes that apply to the EPSDT Program.

ATTACHMENTS:

Pennsylvania's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program Periodicity Schedule and Coding Matrix (Effective January 3, 2018)

Updated pages for the *CMS-1500 Billing Guide for PROMISe™ Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services*

Updated pages for the *CMS-1500 Billing Guide for PROMISe™ Rural Health Clinics (RHCs) & Federally Qualified Health Centers (FQHCs)*

Pennsylvania's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program
Periodicity Schedule and Coding Matrix – Effective 01/03/2018

Services	Newborn (Inpatient)	3-5 d	By 1 mo	2-3 mo	4-5 mo	6-8 mo	9-11 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 y	4 y
Complete Screen: [1]	**A completed screen requires a code from each service required for that age. Report only one CPT code if multiple CPT codes are listed per service, except for immunizations.**													
New Patient	99460 EP [9] / 99463 EP [10]	99381 EP	99381 EP	99381 EP	99381 EP	99381 EP	99381 EP	99382 EP	99382 EP	99382 EP	99382 EP	99382 EP	99382 EP	99382 EP
Established Patient		99391 EP	99391 EP	99391 EP	99391 EP	99391 EP	99391 EP	99392 EP	99392 EP	99392 EP	99392 EP	99392 EP	99392 EP	99392 EP
Newborn Metabolic Hemoglobin Screening [2]	←----------	----------	----------	----------→										
Newborn Bilirubin	•													
Critical Congenital Heart Defect Screening [2]	•													
Developmental Surveillance [12]	•	•	•	•	•	•		•	•		•		•	•
Psychosocial/Behavioral Assessment[14]	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Tobacco, Alcohol or Drug Use Assessment														
Maternal Depression Screening [3]			96161	96161	96161	96161								
Developmental Screening							96110			96110		96110		
Autism Screening										96110 U1	96110 U1			
Vision [3]	Assessed through observation or through health history/physical.													
• Visual acuity screen													99173	99173
• Instrument-based screening[17]													99174	99174
													99177	99177
Hearing [3, 16]	•	•[11]	•[11]	•[11]	Assessed through observation or through health history/physical.									
• Audio Screen													★	92551
• Pure tone-air only														92552
Dental [6, 13]						★[5]	★[5]	• or★[5]		• or★[5]	• or★[5]	• or★[5]	•[5]	•[5]
Anemia [3, 4]														
• Hematocrit (spun)					★[7]		85013[7]	85013[11]	If indicated by risk assessment and/or symptoms.					
• Hemoglobin							85018[7]	85018[11]						
Venous Lead [3, 4]							83655	83655[11]	83655[11]	83655[11]	83655	83655[11]	83655[11]	83655[11]
Tuberculin Test [3]	If indicated by history and/or symptoms.													
Sickle Cell														
Sexually Transmitted Infections [8]														
Dyslipidemia [3, 4]														
Immunizations	Administer immunizations according to the ACIP schedule. For children 18 years and younger, these immunization codes are collected for administration purposes to document antigens given. Because the PA Department of Health provides vaccines free of charge to providers through the Vaccines for Children Program (see MA Bulletins 01-00-10, 10-00-03, 11-00-05, 26-00-04), only a vaccine administration fee will be reimbursed.													

Pennsylvania's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program
Periodicity Schedule and Coding Matrix
Effective 01/03/2018

Services	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y
Complete Screen: [1]	**A completed screen requires a code from each service required for that age. Report only one CPT code if multiple CPT codes are listed per service, except for immunizations.**															
New Patient	99383 EP	99383 EP	99383 EP	99383 EP	99383 EP	99383 EP	99383 EP	99384 EP	99384 EP	99384 EP	99384 EP	99384 EP	99384 EP	99385 EP	99385 EP	99385 EP
Established Patient	99393 EP	99393 EP	99393 EP	99393 EP	99393 EP	99393 EP	99393 EP	99394 EP	99394 EP	99394 EP	99394 EP	99394 EP	99394 EP	99395 EP	99395 EP	99395 EP
Developmental Surveillance[12]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Psychosocial/Behavioral Assessment [14]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Tobacco, Alcohol or Drug Use Assessment							Through risk assessment									
Developmental Screening Autism Screening	If indicated by risk assessment and/or symptoms.															
Depression Screening								•	•	•	•	•	•	•	•	•
Vision [3]																
• Visual acuity screen	99173	99173	★	99173	★	99173	★	99173	★	★	99173	★	★	★	★	★
• Instrument-based screening[17]	99174 99177	99174 99177		99174 99177		99174 99177		99174 99177			99174 99177					
Hearing [3]																
• Audio Screen	92551	92551	★	92551	★	92551	←		92551	→	←	92551	→	←		92551
• Pure tone-air only	92552	92552		92552		92552			92552			92552				92552
Dental [6, 13]	•[5]	•[5]	•[5]	•[5]	•[5]	•[5]	•[5]	•[5]	•[5]	•[5]	•[5]	•[5]	•[5]	•[5]	•[5]	•[5]
Anemia [3, 4] • Hematocrit (spun) • Hemoglobin	If indicated by risk assessment and/or symptoms. See Recommendations to prevent and control iron deficiency in the United States. *MMWR*. 1998;47(RR-3):1-36. Beginning at 12 years of age for females, do once after onset of menses and if indicated by history and/or symptoms.															
Venous Lead [3, 4]	83655[11]	83655[11]														
Tuberculin Test [3] Sickle Cell Sexually Transmitted Infections [8]	If indicated by history and/or symptoms.															
HIV Screening [15]							★	★	★	★	←		•	→	★	★
Dyslipidemia [3, 4]		★		★	80061	80061[11]	80061[11]	If indicated by history and/or symptoms.					80061	80061[11]	80061[11]	80061[11]
Immunizations	Administer immunizations according to the ACIP schedule. For children 18 years and younger, these immunization codes are collected for administration purposes to document antigens given. Because the PA Department of Health provides vaccines free of charge to providers through the Vaccines for Children Program (see MA Bulletins 01-00-10, 10-00-03, 11-00-05, 26-00-04), only a vaccine administration fee will be reimbursed.															

Please refer to the EPSDT Program Periodicity Schedule and Coding Matrix Legend.

EPSDT Program Periodicity Schedule and Coding Matrix

LEGEND

[1] Included in the complete screen: a comprehensive history and physical examination; counseling/anticipatory guidance/risk factor reduction interventions; age-appropriate nutritional counseling; the calculation of Body Mass Index (BMI); newborn metabolic/hemoglobin screening and follow-up; newborn bilirubin screening; growth measurements and head circumference; an oral dental exam; blood lead (BL) risk assessment; blood pressure risk assessment; developmental and autism screenings; developmental surveillance; psychosocial/behavioral assessments; maternal depression screening; alcohol and drug use assessment; and the ordering of appropriate laboratory/diagnostic procedures as recommended by the current AAP guidelines.
[2] Newborn metabolic and hemoglobinopathy and Congenital Heart Defect (CHD) screenings should be done according to state law. According to AAP recommendations, Newborn metabolic and hemoglobinopathy screenings should take place between newborn and 2 months of age. Newborns should be screened for critical congenital heart disease using pulse oximetry before leaving the hospital.
[3] Use CPT modifier -52 EPSDT Screening Services/Components Not Completed *plus* CPT code for standard testing method for objective vision/hearing testing, maternal depression screening, anemia, dyslipidemia, lead and tuberculin testing not completed. If a screening service/component is reported with modifier 52, the provider must complete the screening service/component during the next screening opportunity according to the Periodicity Schedule for ages that require vision screening or hearing screening.
[4] Use CPT modifier -90 Reference Outside Lab *plus* CPT code when laboratory procedures are performed by a party other than the treating or reporting physician.
[5] • Indicates referral to a dental home, ★ indicates administer oral health risk assessment. Assess need for fluoride supplementation. Determine whether the patient has a dental home. If the patient does not have a dental home, a referral should be made to one.
[6] Dental Periodicity Schedule: Per the American Academy of Pediatric Dentistry, the first examination is recommended at the time of the eruption of the first tooth and no later than 12 months of age. Repeat every 6 months or as indicated by the child's risk status/susceptibility to disease. www.aapd.org/media/Policies_Guidelines/G_Periodicity.pdf
[7] Initial measurement of hemoglobin or hematocrit is recommended between 9 and 12 months of age. Additionally, AAP recommends risk assessment for hematocrit or hemoglobin at ages 15 and 30 months of age.
[8] All sexually active patients should be screened for sexually transmitted infections (STI).
[9] Procedure code 99460 and modifier EP are to be used for a newborn screen performed in the hospital, but not on the same day as hospital discharge.
[10] Procedure code 99463 and modifier EP are to be used for a newborn screen performed in the hospital on the same day as hospital discharge.
[11] Provide at times noted, unless done previously.
[12] Developmental Surveillance is required for all periods, except when developmental screenings are required.
[13] All referrals to a dental home must be reported using the YD referral code.
[14] Assessment should be family centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health.
[15] 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.
[16] All newborns should receive an initial hearing screening before being discharged from hospital. If the hearing screening was not completed in hospital, the hearing screening should occur by 3 months of age.
[17] Instrument-based screening may be completed to detect amblyopia, strabismus, and/or high refractive error in children who are unable or unwilling to cooperate with traditional screening.

Key
• = to be performed
★ = risk assessment to be performed with appropriate action to follow, if positive

1. CMS-1500 Billing Guide for PROMISe™ Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services

Purpose of the document

The purpose of this document is to provide a block-by-block reference guide to assist the following provider types in successfully completing the CMS-1500 Claim Form:

- **Certified Nurse Midwife**
- **Certified Registered Nurse Practitioners**
- **Hospital Based Clinics**
- **Independent Medical/Surgical Clinics**
- **Physicians**

Document format

This document contains a table with four columns. Each column provides a specific piece of information as explained below:

- **Block Number** – Provides the block number as it appears on the claim.
- **Block Name** – Provides the block name as it appears on the claim.
- **Block Code** – Lists a code that denotes how the claim block should be treated. They are:

  M – Indicates that the claim block must be completed.

  A – Indicates that the claim block must be completed, if applicable.

  O – Indicates that the claim block is optional.

  LB – Indicates that the claim block should be left blank.

  ***** – Indicates special instruction for block completion.

- **Notes** – Provides important information specific to completing the claim block. In some instances, the Notes section will indicate provider specific block completion instructions.

Message for Hospitals

If hospitals bill for complete EPSDT screens on the UB-04 or in the 837I electronic format, **the Medical Assistance (MA) fee for a complete EPSDT screening will not be received**.

1. CMS-1500 Billing Guide for PROMISe™ Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services

IMPORTANT INFORMATION FOR CMS-1500 CLAIM FORM COMPLETION

Note #1: If you are submitting handwritten claim forms you must use **blue** or **black** ink.

Note #2: **Font Sizes** — Because of limited field size, either of the following type faces and sizes are recommended for form completion:

- **Times New Roman, 10 point**
- **Arial, 10 Point**

Other fonts may be used, but ensure that all data will fit into the fields, or the claim may not process correctly.

Note #3: When completing the following blocks of the CMS-1500, **do not use decimal points and be sure to enter dollars and cents**:

1. Block 24f ($Charges)
2. Block 29 (Amount Paid)

If you fail to enter both dollars and cents, your claim may process incorrectly. For example, if your usual charge is sixty-five dollars and you enter 65, your usual charge may be read as .65 cents.

Example #1: When completing Block 24f, enter your usual charge to the general public, without a decimal point. You must include the dollars and cents. If your usual charge is fifteen dollars, enter:

24f	
$CHARGES	
15	00

Example #2: When completing Block 29, you are reporting patient pay assigned by the County Assistance Office (CAO). Enter patient pay as follows, including dollars and cents:

29	
Amount Paid	
50	00

1. CMS-1500 Billing Guide for PROMISe™ Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services

Complete EPSDT Screens

All providers billing for complete Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screens must bill using the CMS-1500 Claim Form or electronically using the 837P format.

Providers choosing to bill for EPSDT screens via the CMS-1500 Claim Form must bill using all of the individual age-appropriate procedure codes, including immunizations, for a complete screen. Please consult the **Pennsylvania's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program Periodicity Schedule and Coding Matrix (Periodicity Schedule)** and the **Age Range Requirements for Screening Visits Desk Guide** as well as the **Recommended Childhood and Adolescent Immunization Schedules (Immunization Schedules)** for screening eligibility information and the services required to bill for a complete EPSDT screen.

Note: The **Periodicity Schedule** and the **Immunization Schedules** are updated *periodically* and published in Medical Assistance Bulletins (MABs). Please use the most recent schedules when providing EPSDT screens.

Please review the instructions in the billing guide for the following blocks when submitting a claim form for a complete EPSDT screen:

- **Block 10d (Claim codes (Designated by NUCC))** – This Block **MUST** be completed when a referral was made as a result of the screen, including where required according to the Periodicity Schedule. Use the appropriate EPSDT Referral Code(s) when you refer a child to another practitioner as a result of the EPSDT screen.

  Please Note: **The YD referral code for Dental referrals is required for all complete EPSDT screens delivered to children 3 through 20 years of age.**

- **Block 21 (Diagnosis or Nature of Illness or Injury)** – The diagnosis (DX) code in block 21 must be **Z00110**, **Z00111, Z00121, Z00129, Z761, Z762, Z0000 or Z0001** for an EPSDT screen. When applicable, you may enter up to eleven additional diagnosis codes. Please note that you are **not required** to use immunization diagnosis codes.
- **Block 21** also requires the completion of an ICD Indicator. When billing for ICD-10-CM codes, enter a zero (0) in the ICD Ind. space.
- **Block 24h** – Enter Visit Code **03** to indicate that you are billing for an EPSDT service.

The EPSDT complete screen and modifier EP must be reported on the first claim line of Block 24d. Please list all of the required components of an EPSDT screen, which were provided, in Block 24d on lines 2 through 6. If more than six claim lines are necessary to report the components of a

1. CMS-1500 Billing Guide for PROMISe™ Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services

complete EPSDT screen, **please use two claim forms**. If a second CMS-1500 Claim Form is necessary, use the second CMS-1500 Claim Form to report any additional procedure codes (e.g., immunizations).

The following provides an example of how to complete the CMS-1500 for an EPSDT screen.

Example:

A 4-year old child comes into your office/hospital clinic for an EPSDT screen. As per the Periodicity Schedule, the **required components** for a 4-year EPSDT screen are:

- A periodic preventative medicine evaluation (new patient – Procedure Code 99382) or reevaluation (established patient – Procedure Code 99392);
- Vision screen (Procedure Code 99173, 99174 or 99177),
- Hearing – Audio screen or pure tone-air only (Procedure Code 92551 or 92552)
- Referral to a dental home.

Enter the required components of the EPSDT screen, which were performed.

For example:

- **Claim Line 1, Block 24d** – Enter **99392 EP**
- **Claim Line 2, Block 24d** – Enter **99173**
- **Claim Line 3, Block 24d** – Enter **92551**
- **Block 10d, YD referral code**

Utilize a second CMS-1500 Claim Form if more than six claim lines are required to report the components of the EPSDT screen.

1. CMS-1500 Billing Guide for PROMISe™ Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services

MA Fee for Complete/ Incomplete EPSDT Screen

The MA fees for complete EPSDT screens are paid by the Department when a complete EPSDT screen has been performed and billed according to the Pennsylvania's EPSDT Program Periodicity Schedule and Coding Matrix, with the appropriate use of modifiers, referral codes and diagnosis codes. Incomplete EPSDT screens may be paid at the MA Program Fee Schedule rate for the complete screen (as represented by the MA Program Fee Schedule) and/or MA Program Fee Schedule rate for each component code reported. The combined MA fee for all required individual service components will not equal or exceed the MA fee for a complete EPSDT screen which is assigned to the specific screening period.

Incomplete EPSDT Screens

Incomplete EPSDT screens are office visits where the provider did not complete all of the required components listed on the Periodicity Schedule for the child's screening period. This includes use of applicable modifiers, diagnosis codes and required referral codes.

Independent Medical/Surgical Clinic providers who wish to bill for the office visit components/incomplete EPSDT screen should bill the service as a clinic visit with procedure code T1015, with their pricing modifier U7 and informational modifier EP. This service should also be billed on the CMS 1500 / 837P.

Outpatient hospital clinics wishing to bill individual EPSDT components/incomplete screens should refer to the MA Program Fee Schedule and the **UB-04 Billing Guide for PROMISe™ Hospitals** for instructions.

1. CMS-1500 Billing Guide for PROMISe™ Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services

You must follow these instructions to complete the CMS-1500 Claim Form when billing the Department of Human Services. **Do not imprint, type, or write any information on the upper right hand portion of the form.** This area is used to stamp the Internal Control Number (ICN), which is vital to the processing of your claim. Do not submit a photocopy of your claim to DHS.

Block No.	Block Name	Block Code	Notes
1	Type of Claim	M	Place an **X** in the Medicaid box.
1a	Insured's ID Number	M	Enter the 10-digit beneficiary number found on the ACCESS card. If the beneficiary number is not available, access the Eligibility Verification System (EVS) by using the beneficiary's Social Security Number (SSN) and date of birth (DOB). The EVS response will then provide the 10-digit beneficiary number to use for this block.
2	Patient's Name	A	It is recommended that this field be completed to enable Medical Assistance (MA) to research questions regarding a claim. ***This field is required when billing for newborns using the mother's patient number.** Enter the newborn's name. If the first name is not available, you are permitted to use Baby Boy or Baby Girl.
3	Patient's Birthdate and Sex	A	Enter the patient's date of birth using an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 02151978) and indicate the patient's gender by placing an **X** in the appropriate box. ***Same as the special instruction for Block 2.** Enter the newborn's date of birth in an eight-digit format.
4	Insured's Name	A	If the patient has health insurance other than MA, list the name of the insured here. Enter the name of the insured except when the insured and the patient are the same - then the word **SAME** may be entered. If there is no other insurance other than MA, leave this block blank.
5	Patient's Address	O	Enter the patient's address.

1. CMS-1500 Billing Guide for PROMISe™ Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services

Block No.	Block Name	Block Code	Notes
6	Patient's Relationship to Insured	A	Check the appropriate box for the patient's relationship to the insured listed in Block 4.
7	Insured's Address	A	Enter the insured's address and telephone number except when the address is the same as the patient's, then enter the word **SAME**. Complete this block only when Block 4 is completed.
8	Reserved for NUCC Use	LB	Do not complete this block.
9	Other Insured's Name	A	If the patient has another health insurance secondary to the insurance named in Block 11, enter the last name, first name, and middle initial of the insured if it is different from the patient named in Block 2. If the patient and the insured are the same, enter the word **SAME.** If the patient has MA coverage only, leave the block blank.
9a	Other Insured's Policy or Group Number	A	This block identifies a secondary insurance other than MA, **and** the primary insurance listed in 11a–d. Enter the policy number and the group number of any secondary insurance that is available. Only use Blocks 9, 9a and 9d, if you have completed Blocks 11a, 11c and 11d , and a secondary policy is available. (For example, the patient may have both Blue Cross and Aetna benefits available.)
9b	Reserved for NUCC Use	LB	Do not complete this block.
9c	Reserved for NUCC Use	LB	Do not complete this block.
9d	Insurance Plan Name or Program Name	A	Enter the other insured's insurance plan name or program name.

1. CMS-1500 Billing Guide for PROMISe™ Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services

Block No.	Block Name	Block Code	Notes
10a-10c	Is Patient's Condition Related To:	A	Complete the block by placing an **X** in the appropriate **YES** or **NO** box to indicate whether the patient's condition is related to employment, auto accident, or other accident (e.g., liability suit) as it applies to one or more of the services described in Block 24d. For auto accidents, enter the state's two-digit postal code for the state in which the accident occurred in the PLACE block (e.g., PA for Pennsylvania).
10d	Claim Codes (Designated by NUCC)	A	**This Block MUST be completed** when a referral was made as a result of the screen, including where required according to the Periodicity Schedule. This block is used for federal reporting purposes. **Please note: The YD referral code for Dental referrals is required for all complete EPSDT screens delivered to children 3 through 20 years of age.** Enter the applicable two-character EPSDT Referral Code in UPPERCASE / CAPITAL LETTERS for referrals made or needed as a result of the screen: **YM** – Medical Referral **YD** – Dental Referral **YV** – Vision Referral **YH** – Hearing Referral **YB** – Behavioral Health Referral **YO** – Other Referral For a complete listing and explanation of EPSDT Referral Codes, please refer to the *CMS-1500 Claim Form Desk Reference*, located in Appendix A of the handbook.
11	Insured's Policy Group or FECA Number	A/A	Enter the policy number and group number of the primary insurance other than MA.

1. CMS-1500 Billing Guide for PROMISe™ Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services

Block No.	Block Name	Block Code	Notes
11a	Insured's Date of Birth and Sex	A/A	Enter the insured's date of birth in an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 03011978) and insured's gender if it is different than Block 3.
11b	Other Claim ID (Designated by NUCC)	LB	Do not complete this block.
11c	Insurance Plan Name or Program Name	A	List the name and address of the primary insurance listed in Block 11.
11d	Is There Another Health Benefit Plan?	A	If the patient has another resource available to pay for the service, bill the other resource before billing MA. If the **YES** box is checked, Blocks 9, 9a and 9d must be completed with the information on the additional resource.
12	Patient's or Authorized Person's Signature and Date	M/M	The patient's signature or the words **Signature Exception** must appear in this field. Also, enter the date of claim submission in an 8-digit MMDDCCYY format (e.g., 03012004) with no slashes, hyphens, or dashes. **Note:** Please refer to Section 6 of the PA PROMISe™ Provider Handbook for the 837 Professional/CMS-1500 Claim Form for additional information on obtaining patients signatures.
13	Insured's or Authorized Person's Signature	O	If completed, this block should contain the signature of the insured, if the insured is not the patient.
14	Date of Current Illness, Injury or Pregnancy (LMP)	O	If completed, enter the date of the current illness (first symptom), injury (accident date), or pregnancy in an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 03012004).

1. CMS-1500 Billing Guide for PROMISe™ Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services

Block No.	Block Name	Block Code	Notes
15	Other Date	O	If the patient has had the same or similar illness, list the date of the first onset of the illness in an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 03012002).
16	Dates Patient Unable to Work in Current Occupation	O	If completed, enter the **FROM** and **TO** dates in an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 03012003), only if the patient is unable to work due to the current illness or injury. This block is only necessary for Worker's Compensation cases. It must be left blank for all other situations.
17	Name of Referring Provider or Other Source	A	Enter the name and degree of the referring or prescribing practitioner, when applicable.
17a	I.D. Number of Referring Provider	A	In the first portion of this block, enter a two-digit qualifier that indicates the type of ID: **0B** = License Number **G2** = 13-digit Provider ID number (Legacy Number) In the second portion, enter the **license number** of the referring or prescribing practitioner named in Block 17 (e.g., MD123456X). If the practitioner's license number was issued after June 29, 2001, enter the number in the new format (e.g., MD123456). If an out-of-state provider orders the service, enter the two-letter State abbreviation, followed by six "9"s, and an "X". For example, a prescribing practitioner from New Jersey would be entered as NJ999999X.
17b	NPI #	M	Enter the 10-digit National Provider Identifier number of the referring provider, ordering provider, or other source.
18	Hospitalization Dates Related to Current Services	LB	Do not complete this block.

1. CMS-1500 Billing Guide for PROMISe™ Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services

Block No.	Block Name	Block Code	Notes
19	Additional Claim Information (Designated by NUCC)	A/A	This field must be completed with attachment type codes, when applicable. Attachment type codes begin with the letters "**AT**" followed by a two-digit number (i.e., **AT05**). Enter up to four, 4-character alphanumeric attachment type codes. When entering more than one attachment type code, separate the codes with a comma (,). When using "**AT05**" indicating a Medicare payment, please remember to properly complete and **attach** the "Supplemental Medicare Attachment for Providers" form MA 539 . When using "**AT10**" indicating a payment from a Commercial Insurance, please remember to properly complete and **attach** the "Supplemental Attachment for Commercial Insurance for Providers" form MA 538 . Attachment Type Code "**AT99"** indicates that remarks are attached. Remarks must be placed on an 8-1/2" x 11" sheet of white paper clipped to your claim. Remember, when you have a remarks sheet attached, include your provider number and the beneficiary's number on the top left-hand corner of the page (i.e., Enter **AT26, AT99** if billing for newborns that have temporary eligibility under the mother's beneficiary number. On the remarks sheet, include the mother's full name, date of birth, and social security number.). If submitting an adjustment to a previously paid CMS-1500 claim (as referenced in Block 22), you must paper clip an 8-1/2" by 11" sheet of paper to the paper claim form containing an explanation as to why you are submitting the claim adjustment. For a complete listing and description of Attachment Type Codes, please refer to the *CMS-1500 Claim Form Desk Reference*, located in Appendix A of the handbook. *For additional information on completing CMS-1500 Claim Form adjustments, please refer to Section 2.10 – Claim Adjustments of the 837 Professional/CMS-1500 Claim Form Handbook.*
		A	**Qualified Small Businesses**

1. CMS-1500 Billing Guide for PROMISe™ Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services

Block No.	Block Name	Block Code	Notes
			Qualified small businesses must always enter the following message in Block 19 (Additional Claim Information (Designated by NUCC)) of the CMS-1500, in addition to any applicable attachment type codes: "**(Name of Vendor) is a qualified small business concern as defined in 4 Pa Code §2.32.**"
Note: If the beneficiary has coverage through Medicare Part B and MA, this claim should automatically cross over to MA for payment of any applicable deductible or co-insurance. If the claim does not cross over from Medicare and you are submitting the claim directly to MA, enter **AT05** in Block 19 and attach a completed "Supplemental Medicare Attachment for Providers" form to the claim. Please refer to MA 539 for additional information.			
20	Outside Lab	LB	Do not complete this block.
21	Diagnosis or Nature of Illness or Injury	M/A	**When billing for EPSDT screens,** diagnosis (DX) code Z00110, Z00111, Z00121, Z00129, Z761, Z762, Z0000 or Z0001 (Routine Infant or Child Health Check) must be used in this block. **EXCEPTION** when billing for newborns in an inpatient setting (Place of Service 21). Please use diagnosis code Z3800, Z3801, Z381, Z382 or Z3830-Z388 in the primary field with Z00110, Z00111, Z00121, Z00129, Z761 or Z762 in the secondary field when submitting an EPSDT screen performed in an inpatient hospital setting. The ICD indicator (ICD Ind) is required. If a valid "0" indicator is not entered into the ICD Ind. space, claims will be returned to the provider as incomplete. For dates of service **on or after** October 1, 2015, enter the ICD-10-CM code (indicator "0") that describes the diagnosis. The primary diagnosis block (21.A) must be completed. The second through twelfth diagnosis codes (B-L) must be completed if applicable. An appropriate diagnosis code must be included for each referral.

1. CMS-1500 Billing Guide for PROMISe™ Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services

Block No.	Block Name	Block Code	Notes
			When reporting the administration of preventative pediatric immunizations, the appropriate CPT code is required along with the diagnosis code Z23 (Need for prophylactic vaccination against bacterial, viral, and other communicative diseases).
22	Resubmission Code	A/A	This block has two uses: 1) When resubmitting a rejected claim. If resubmitting a rejected claim, enter the 13-digit internal control number (ICN) of the **ORIGINAL** rejected claim in the right portion of this block (e.g., | 1103123523123). 2) When submitting a claim adjustment for a previously approved claim**.** If submitting a claim adjustment, enter ADJ in the left portion of the block and the **LAST APPROVED** 13-digit ICN, a space and the 2-digit line number from the RA Statement in the right portion of the block (e.g., ADJ | 1103123523123 01).
23	Prior Authorization Number	LB	Do not complete this block.
24a	Date(s) of Service	M/M	Enter the applicable date(s) of service. If billing for a service that was provided on one day only, complete either the From or the To column (but not both.). If the same service was provided on consecutive days, enter the first day of the service in the From column and the last day of service in the To column. Use an eight-digit (MMDDCCYY) format to record the From and To dates, (e.g. 03012004). If the dates are not consecutive, separate claim lines must be used.
24b	Place of Service	M	Enter the two-digit place of service code that indicates where the service was performed. **11** – Office **21** – Inpatient Hospital **22** – Outpatient Hospital

1. CMS-1500 Billing Guide for PROMISe™ Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services

Block No.	Block Name	Block Code	Notes
			49 – Independent Clinic
24c	EMG	LB	Do not complete this block**.**
24d	Procedures, Services, or Supplies (CPT/HCPCS & Modifier)	M/A/A	Review the applicable CPT code(s) for all services provided. Refer to the Periodicity Schedule and Coding Matrix for all required components of a complete EPSDT screen. The EPSDT complete screen and modifier EP must be reported on the first line. List the remaining procedure code(s) for the service(s) being rendered and any applicable modifier(s) on the remaining lines. In the second and third sections of the block, enter up to four applicable modifiers. *If you were unable to provide a required service, please use the appropriate procedure code with modifier 52. Providers should make every effort possible to complete that service at the next screening opportunity.* *If you have referred a child to an outside laboratory, please use the appropriate procedure code with modifier 90.* *Note: For all procedure codes reported with modifiers 52 or 90, a zero dollar ($0) billed amount must be reported.* *For compensable procedure code modifier combinations, please refer to the PA* PROMISe™ *fee schedule accessible via the DHS Internet site.*
24e	Diagnosis Pointer	M	This block may contain up to four letters. Enter the corresponding letter(s) (A – L) that identify the diagnosis code(s) in Block 21. If the service provided was for the primary diagnosis (in Block 21A), enter A. If provided for the secondary diagnosis, enter B. If provided for the third through twelfth diagnosis, enter the letter that corresponds to the applicable diagnosis.

1. CMS-1500 Billing Guide for PROMISe™ Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services

Block No.	Block Name	Block Code	Notes
			Note: The primary diagnosis pointer must be entered first.
24f	$Charges	M	Enter your usual charge to the general public for the service(s) provided. If billing for multiple units of service, multiply your usual charge by the number of units billed and enter that amount. For example, if your usual charge is sixty-five dollars, enter **6500**.
24g	Days or Units	M	Enter the number of units, services, provided.
24h	EPSDT/Family Planning	A	**Enter Visit Code 03 when providing EPSDT screening services.**
24i	ID Qualifier	A	Enter the two-digit ID Qualifier: **G2** = 13-digit Provider ID Number (legacy #)
24j (a)	Rendering Provider ID #	A	Complete with the **Rendering Provider's** Provider ID number (nine-digit provider number and the applicable four-digit service location – 13-digits total). **Note**: Only one rendering provider per claim form.
24j (b)	NPI	M	Enter the 10-digit NPI number of the rendering provider.
25	Federal Tax I.D. Number	M	Enter the provider's Federal Tax Employer Identification Number (EIN) or SSN and place an **X** in the appropriate block.
26	Patient's Account Number	O	**Use of this block is strongly recommended**. It can contain up to ten alpha, numeric, or alphanumeric characters and can be used to enter the patient's account number or name. Information in this block will appear in the first column of the Detail Page in the RA Statement and will help identify claims if an incorrect patient number is listed.
27	Accept Assignment	LB	Do not complete this block.

1. CMS-1500 Billing Guide for PROMISe™ Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services

Block No.	Block Name	Block Code	Notes
28	Total Charge	LB	Do not complete this block.
29	Amount Paid	LB	Do not complete this block.
30	Reserved for NUCC Use	LB	Do not complete this block.
31	Signature of Physician or Supplier Including Degree or Credentials	M/M	This block must contain the signature of the provider rendering the service. A signature stamp is acceptable, except for abortions, if the provider authorizes its use and assumes responsibility for the information on the claim. If submitting by computer-generated claims, this block can be left blank; however, a Signature Transmittal Form (MA 307) must be sent with the claim(s). Enter the date the claim was submitted in this block in an eight-digit (MMDDCCYY) format (e.g. 03012004).
32	Service Facility Location Information	LB	Do not complete this block.
32a		LB	Do not complete this block.
32b		LB	Do not complete this block.
33	Billing Provider Info & Ph.#	A/A& M/M	Enter the billing provider's name, address, and telephone number **Do not use slashes, hyphens, or spaces.** **Note:** If services are rendered in the patient's home or facility, enter the service location of the provider's main office.
33a		M	Enter the 10-digit NPI number of the billing provider.
33b		M/A	Enter the 13-digit Group/Billing Provider ID number (Legacy #)

1. CMS-1500 Billing Guide for PROMISe™ Rural Health Clinics (RHCs) & Federally Qualified Health Centers (FQHCs)

Purpose of the document

The purpose of this document is to provide a block-by-block reference guide to assist the following provider types in successfully completing the CMS-1500 Claim Form:

- **Rural Health Clinics (RHCs)/Federally Qualified Health Centers (FQHCs) – Provider Type 08**

Document format

This document contains a table with four columns. Each column provides a specific piece of information as explained below:

- **Block Number** – Provides the block number as it appears on the claim.
- **Block Name** – Provides the block name as it appears on the claim.
- **Block Code** – Lists a code that denotes how the claim block should be treated. They are:

  M – Indicates that the claim block must be completed.

  A – Indicates that the claim block must be completed, if applicable.

  O – Indicates that the claim block is optional.

  LB – Indicates that the claim block should be left blank.

  *** –** Indicates special instruction for block completion.
- **Notes** – Provides important information specific to completing the claim block. In some instances, the Notes section will indicate provider specific block completion instructions.

CMS-1500 Claim Form Completion for PROMISe™ RHCs & FQHCs

IMPORTANT INFORMATION FOR CMS-1500 CLAIM FORM COMPLETION

Note #1: If you are submitting handwritten claim forms, you must use **blue** or **black** ink.

Note #2: **Font Sizes** — Because of limited field size, either of the following type faces and sizes are recommended for form completion:

- **Times New Roman, 10 point**
- **Arial, 10 Point**

Other fonts may be used, but ensure that all data will fit into the fields, or the claim may not process correctly.

Note #3: When completing the following blocks of the CMS-1500, **do not use decimal points and be sure to enter dollars and cents**:

1. Block 24F ($Charges)
2. Block 29 (Amount Paid)

If you fail to enter both dollars and cents, your claim may process incorrectly. For example, if your usual charge is ninety-five dollars and you enter 95, your usual charge may be read as .95 cents.

Example #1: When completing Block 24F, enter your usual charges, without a decimal point. You must include the dollars and cents. If your usual charge is thirty-five dollars, enter:

24F	
$CHARGES	
35	00

Example #2: When completing Block 29, you are reporting patient pay assigned by the County Assistance Office (CAO). Enter patient pay as follows, including dollars and cents:

29	
Amount Paid	
50	00

CMS-1500 Claim Form Completion for PROMISe™ RHCs & FQHCs

EPSDT Screens

Providers billing for complete Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screens may bill using the CMS-1500 Claim Form or electronically using the 837P format.

FQHCs/RHCs may not bill for partial EPSDT screens.

Providers choosing to bill for EPSDT screens via the CMS-1500 Claim Form must bill using Procedure Code T1015 with modifier EP in addition to all of the individual age-appropriate procedure codes from the Periodicity Schedule. These age-appropriate procedure codes must be entered on the CMS-1500 Claim Form in conjunction with the all-inclusive FQHC/RHC EPSDT visit, T1015 and Modifier EP. The age appropriate procedure codes from the Periodicity Schedule must also be billed with informational modifier EP and any other applicable modifiers.

Providers choosing to bill for EPSDT screens via the CMS-1500 Claim Form must bill using all of the individual age-appropriate procedure codes, including immunizations, for a complete screen. Please consult the **Pennsylvania's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program Periodicity Schedule and Coding Matrix (Periodicity Schedule)** and the **Age Range Requirements for Screening Visits Desk Guide** as well as the **Recommended Childhood and Adolescent Immunization Schedules (Immunization Schedules)** for screening eligibility information and the services required to bill for a complete EPSDT screen.

Note: The **Periodicity Schedule** and the **Immunization Schedules** are updated *periodically* and published in Medical Assistance Bulletins (MABs). Please use the most recent schedules when providing EPSDT screens.

Please review the instructions in the billing guide for the following blocks when submitting a claim form for a complete EPSDT screen:

FQHCs/RHCs must complete the CMS-1500 Claim Form as follows when billing for a **complete EPSDT screen**:

- **Block 10d (Claim Codes (Designated by NUCC))** – This Block **MUST** be completed when a referral was made as a result of the screen, including where required according to the Periodicity Schedule. Use the appropriate EPSDT Referral Code(s) when you refer a child to another practitioner as a result of the EPSDT screen.

  Please note: **The YD referral code for Dental referrals is required for all complete EPSDT screens delivered to children 3 through 20 years of age.**

- **Block 21 (Diagnosis or Nature of Illness or Injury)** – The diagnosis (DX) code in block 21 must be **Z00110**, **Z00111, Z00121, Z00129, Z761, Z762, Z0000 or Z0001** for an EPSDT screen. When applicable, you may enter up

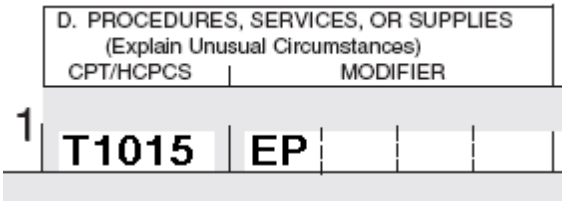
CMS-1500 Claim Form Completion for PROMISe™ RHCs & FQHCs

to eleven additional diagnosis codes. Please note that you are **not required** to use immunization diagnosis codes.

- **Block 21** also requires the completion of an ICD Indicator. When billing for ICD-10-CM codes, enter a zero (0) in the ICD Ind. space.
- **Block 24d** – The EPSDT complete screen and modifier EP must be reported on the first claim line of Block 24d. Please list all of the required components of an EPSDT screen, which were provided, in Block 24d on lines 2 through 6. If more than six claim lines are necessary to report the components of a complete EPSDT screen, **please use two claim forms**. If a second CMS-1500 Claim Form is necessary, use the second CMS-1500 Claim Form to report any additional procedure codes (e.g., immunizations).

For example, Block 24D would be completed as follows:

Block 24D (Procedures, Services, or Supplies [CPT/HCPCS & Modifier]) – Enter Procedure Code **T1015** in the first portion of this block, followed by Modifier **EP** in the second portion of this block on Claim Line 1.



Enter your usual charge in Block 24F (Charges) of Claim Line 1.
You must enter all of the **required components** of the complete EPSDT screen that were performed on Claim Lines 2 through 6 in order to receive credit for performing a complete EPSDT screen. This includes use of required modifiers, diagnosis codes and referral codes. If more than six claim lines are needed to report the **additional components** of the EPSDT screen, you must complete a second CMS-1500 Claim Form.

Please Note: To insure correct documentation of a complete EPSDT screen, you must list all of the required components of a complete EPSDT screen on the claim where you report **T1015 EP** on Claim Line 1.

Use modifier **EP** on Claim Line 2 with the appropriate "complete screen" code for the screening period.
Use referral code YD for all children age 3 and older for whom you have made the required referral to a dental home. The YD referral code is placed in Field 10D of the CMS 1500.

Use modifier **52 (EPSDT Screening Services/Components Not Completed)** with the CPT code for standard testing method for objective vision/hearing testing, maternal depression screening, anemia, dyslipidemia, lead and tuberculin testing not completed.

CMS-1500 Claim Form Completion for PROMISe™ RHCs & FQHCs

Use modifier **90** (reference outside lab) with the CPT code when laboratory procedure(s) are performed by a party other than the treating or reporting physician.

The following provides an example of how to complete the CMS-1500 for an EPSDT screen.

Example:

A 4-year old child comes into your clinic for an EPSDT screen. As per the Periodicity Schedule, the **required components** for a 4-year EPSDT screen are:

- A periodic preventative medicine evaluation (new patient – Procedure Code 99382) or reevaluation (established patient – Procedure Code 99392);
- Vision screen (Procedure Code 99173, 99174 or 99177);
- Hearing – Audio Screen or Pure tone-air only (Procedure Code 92551 or 92552); and
- Referral to a dental home.

Enter the required components of the EPSDT screen which were performed.

For example:

Claim Line 1, Block 24d – Enter T1015 EP

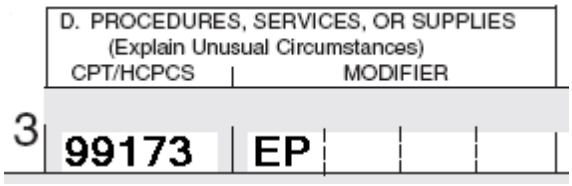
Claim Line 2, Block 24d – Enter 99392 EP

Claim Line 3, Block 24d – Enter 99173 EP

Claim Line 4, Block 24d – Enter 92551 EP

Block 10d, YD referral code

In this example, Block 24D, **line 3** would be completed as follows:



Enter 0000 in Block 24F (Charges) on claims lines 2 through 6.
Utilize a second CMS-1500 Claim Form if more than six lines are required to report the components of the EPSDT screen (for example: immunizations).

Please note you must add the YD, dental referral code to Block 10D for all children 3 years of age and older for whom you have provided the **required** dental referral.

- **Block 24h** – Enter Visit Code **03** to indicate that you are billing for an EPSDT service.

CMS-1500 Claim Form Completion for PROMISe™ RHCs & FQHCs

You must follow these instructions to complete the CMS-1500 Claim when billing the Department of Human Services. **Do not imprint, type, or write any information on the upper right hand portion of the form.** This area is used to stamp the Internal Control Number (ICN), which is vital to the processing of your claim. Do not submit a photocopy of your claim to Medical Assistance.

BlockNo.	Block Name	Block Code	Notes
1	Type of Claim	M	Place an **X** in the Medicaid box.
1a	Insured's ID Number	M	Enter the 10-digit beneficiary number found on the ACCESS card. If the beneficiary number is not available, access the Eligibility Verification System (EVS) by using the beneficiary's Social Security Number (SSN) and date of birth (DOB). The EVS response will then provide the 10-digit beneficiary number to use for this block.
2	Patient's Name	A	It is recommended that this field be completed to enable Medical Assistance (MA) to research questions regarding a claim. ***This field is required when billing for newborns using the mother's beneficiary number.** Enter the newborn's name. If the first name is not available, you are permitted to use Baby Boy or Baby Girl.
3	Patient's Birthdate and Sex	A	Enter the patient's date of birth using an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 02151978) and indicate the patient's gender by placing an **X** in the appropriate box. ***Same as the special instruction for Block 2.** Enter the newborn's date of birth in an eight-digit format.

CMS-1500 Claim Form Completion for PROMISe™ RHCs & FQHCs

BlockNo.	Block Name	Block Code	Notes
4	Insured's Name	A	If the patient has health insurance other than MA, list the name of the insured here. Enter the name of the insured except when the insured and the patient are the same; then the word **SAME** may be entered. If there is no other insurance other than MA, leave this block blank.
5	Patient's Address	O	Enter the patient's address.
6	Patient's Relationship to Insured	A	Check the appropriate box for the patient's relationship to the insured listed in Block 4.
7	Insured's Address	A	Enter the insured's address and telephone number except when the address is the same as the patient's, then enter the word **SAME**. Complete this block only when Block 4 is completed.
8	Reserved for NUCC Use	LB	Do not complete this block.
9	Other Insured's Name	A	If the patient has another health insurance secondary to the insurance named in Block 11, enter the last name, first name, and middle initial of the insured if it is different from the patient named in Block 2. If the patient and the insured are the same, enter the word **SAME.** If the patient has MA coverage only, leave the block blank.

CMS-1500 Claim Form Completion for PROMISe™ RHCs & FQHCs

BlockNo.	Block Name	Block Code	Notes
9a	Other Insured's Policy or Group Number	A	This block identifies a secondary insurance other than MA, **and** the primary insurance listed in 11a–d. Enter the policy number and the group number of any secondary insurance that is available. Only use Blocks 9, 9a and 9d, if you have completed Blocks 11a, 11c and 11d , and a secondary policy is available. (For example, the patient may have both Blue Cross and Aetna benefits available.)
9b	Reserved for NUCC Use	LB	Do not complete this block.
9c	Reserved for NUCC Use	LB	Do not complete this block.
9d	Insurance Plan Name or Program Name	A	Enter the other insured's insurance plan name or program name.
10a-10c	Is Patient's Condition Related To:	A	Complete the block by placing an **X** in the appropriate **YES** or **NO** box to indicate whether the patient's condition is related to employment, auto accident, or other accident (for example, liability suit) as it applies to one or more of the services described in Block 24d. For auto accidents, enter the state's two-character postal code for the state in which the accident occurred in the PLACE block (for example, PA for Pennsylvania).
10d	Claim Codes (Designated by NUCC)	A	**This Block MUST be completed** when a referral was made as a result of the screen, including where required according to the Periodicity Schedule. This block is used for federal reporting purposes. This block has two uses: 1) It is optional to enter the nine-digit social security number of the policyholder if the policyholder is not the beneficiary.

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BlockNo.	Block Name	Block Code	Notes
			2) When billing for an EPSDT screen, enter the applicable two-character EPSDT Referral Code for referrals made or needed as a result of the screen: Enter the applicable two-character EPSDT Referral Code in UPPERCASE / CAPITAL LETTERS. **YM** – Medical Referral **YD** – Dental Referral **(a required component for all children 3 years of age and above)** **YV** – Vision Referral **YH** – Hearing Referral **YB** – Behavioral Health Referral **YO** – Other Referral For a complete listing and explanation of EPSDT Referral Codes, please refer to the *CMS-1500 Claim Form Desk Reference*, located in Appendix A of the handbook.
11	Insured's Policy Group or FECA Number	A/A	Enter the policy number and group number of the primary insurance other than MA.
11a	Insured's Date of Birth and Sex	A/A	Enter the insured's date of birth in an eight-digit MMDDCCYY (month, day, century, and year) format (for example, 03011978) and insured's gender if it is different than Block 3.
11b	Other Claim ID (Designated by NUCC)	LB	Do not complete this block.
11c	Insurance Plan Name or Program Name	A	List the name and address of the primary insurance listed in Block 11.

CMS-1500 Claim Form Completion for PROMISe™ RHCs & FQHCs

BlockNo.	Block Name	Block Code	Notes
11d	Is There Another Health Benefit Plan?	A	If the patient has another resource available to pay for the service, bill the other resource before billing MA. If the **YES** box is checked, Blocks 9, 9a and 9d must be completed with the information on the additional resource.
12	Patient's or Authorized Person's Signature and Date	M/M	The beneficiary's signature or the words **Signature Exception** must appear in this field. Also, enter the date of claim submission in an 8-digit MMDDCCYY format (for example, 03012004) with no slashes, hyphens, or dashes.) **Note:** Please refer to Section 6 of the PA PROMISe™ Provider Handbook for the 837 Professional/CMS-1500 Claim Form for additional information on obtaining patients signatures.
13	Insured's or Authorized Person's Signature	O	If completed, this block should contain the signature of the insured, if the insured is not the patient.
14	Date of Current Illness, Injury or Pregnancy (LMP)	O	If completed, enter the date of the current illness (first symptom), injury (accident date), or pregnancy in an eight-digit MMDDCCYY (month, day, century, and year) format (for example, 03012004).
15	Other Date	O	If the patient has had the same or similar illness, list the date of the first onset of the illness in an eight-digit MMDDCCYY (month, day, century, and year) format (for example, 03012002).
16	Dates Patient Unable to Work in Current Occupation	O	If completed, enter the **FROM** and **TO** dates in an eight-digit MMDDCCYY (month, day, century, and year) format (for example, 03012003), only if the patient is unable to work due to the current illness or injury.

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BlockNo.	Block Name	Block Code	Notes
			This block is only necessary for Worker's Compensation cases. It must be left blank for all other situations.
17	Name of Referring Provider or Other Source	M	Enter the name and degree of the referring or prescribing practitioner, when applicable.
17a	I.D. Number of Referring Provider	M	In the first portion of this block, enter a two-digit qualifier that indicates the type of ID: **0B** = License Number **G2** = 13-digit Provider ID number (Legacy Number) In the second portion, enter the **license number** of the referring or prescribing practitioner named in Block 17 (for example, MD123456X). If the practitioner's license number was issued after June 29, 2001, enter the number in the new format (for example, MD123456). If an out-of-state provider orders the service, enter the two-letter State abbreviation, followed by six 9's, and an X. For example, a prescribing practitioner from New Jersey would be entered as NJ999999X.
17b	NPI #	M	Enter the 10-digit National Provider Identifier number of the referring provider, ordering provider, or other source.
18	Hospitalization Dates Related to Current Services	LB	Do not complete this block.
19	Additional Claim Information (Designated by NUCC)	A/A	This field must be completed with attachment type codes, when applicable. Attachment type codes begin with the letters "**AT**" followed by a two-digit number (for example, **AT05**).

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BlockNo.	Block Name	Block Code	Notes
			Enter up to four, 4-character alphanumeric attachment type codes. When entering more than one attachment type code, separate the codes with a comma (,). When using "**AT05**" indicating a Medicare payment, please remember to properly complete and **attach** the "Supplemental Medicare Attachment for Providers" form MA 539 . When using "**AT10**" indicating a payment from a Commercial Insurance, please remember to properly complete and **attach** the "Supplemental Attachment for Commercial Insurance for Providers" form MA 538. Attachment Type Code "**AT99"** indicates that remarks are attached. Remarks must be placed on an 8-1/2" x 11" sheet of white paper clipped to your claim. Remember, when you have a remarks sheet attached, include your provider number and the beneficiary's number on the top left-hand corner of the page (for example, Enter **AT26, AT99** if billing for newborns that have temporary eligibility under the mother's beneficiary number. On the remarks sheet, include the mother's full name, date of birth, and social security number.). If submitting an adjustment to a previously paid CMS-1500 claim (as referenced in Block 22), you must paper clip an 8-1/2" by 11" sheet of paper to the paper claim form containing an explanation as to why you are submitting the claim adjustment. *For a complete listing and description of Attachment Type Codes, please refer to the CMS-1500 Claim Form Desk Reference, located in Appendix A of the handbook.* *For additional information on completing CMS-1500 Claim Form adjustments, please refer to*

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BlockNo.	Block Name	Block Code	Notes
			Section 2.10 – Claim Adjustments of the 837 Professional/CMS-1500 Claim Form Handbook.
		A	**Qualified Small Businesses** Qualified small businesses must always enter the following message in Block 19 (Additional Claim Information (Designated by NUCC)) of the CMS-1500, in addition to any applicable attachment type codes: "**(Name of Vendor) is a qualified small business concern as defined in 4 Pa Code §2.32.**"
***Note:** If the beneficiary has coverage through Medicare Part B and MA, this claim should automatically cross over to MA for payment of any applicable deductible or co-insurance. If the claim does not cross over from Medicare and you are submitting the claim directly to MA, enter **AT05** in Block 19 and attach a completed "Supplemental Medicare Attachment for Providers" form to the claim. Please refer to MA 539 for additional information.			
20	Outside Lab	LB	Do not complete this block.
21	Diagnosis or Nature of Illness or Injury	M/A	**When billing for EPSDT screens,** diagnosis (DX) code Z00110, Z00111, Z00121, Z00129, Z761, Z762, Z0000 or Z0001 (Routine Infant or Child Health Check) must be used in this block. **EXCEPTION** when billing for newborns in an inpatient setting (Place of Service 21). Please use diagnosis code Z3800, Z3801, Z381, Z382 or Z3830-Z388 in the primary field with Z00110, Z00111, Z00121, Z00129, Z761 or Z762 in the secondary field when submitting an EPSDT screen performed in an inpatient hospital setting. The ICD indicator (ICD Ind) is required. If a valid "0" indicator is not entered into the ICD Ind. space, claims will be returned to the provider as incomplete. For dates of service **on or after** October 1, 2015, enter the ICD-10-CM code (indicator "0") that describes the diagnosis.

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BlockNo.	Block Name	Block Code	Notes
			The primary diagnosis block (21.A) must be completed. The second through twelfth diagnosis codes (B-L) must be completed if applicable. An appropriate diagnosis code must be included for each referral. When reporting the administration of preventative pediatric immunizations, the appropriate CPT code is required along with the diagnosis code Z23 (Need for prophylactic vaccination against bacterial, viral, and other communicative diseases).
22	Resubmission Code	A/A	This block has two uses: 1) When resubmitting a rejected claim. If resubmitting a rejected claim, enter the 13-digit internal control number (ICN) of the **ORIGINAL** rejected claim in the right portion of this block (for example, | 1103123523123). 2) When submitting a claim adjustment for a previously approved claim**.** If submitting a claim adjustment, enter ADJ in the left portion of the block and the **LAST APPROVED** 13-digit ICN, a space and the 2-digit line number from the RA Statement in the right portion of the block (for example, ADJ | 1103123523123 01).
23	Prior Authorization Number	A	Enter the 10-digit prior authorization number when applicable. Refer to Section 7 of the CMS-1500 Provider Handbook for additional information regarding prior authorization for your specific provider type. **Note:** EPSDT Expanded Services, such as mobile therapy, behavioral health consultant, and therapeutic staff support services must be prior authorized and are billable by FQHCs/RHCs having special enrollment indicators on file with

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BlockNo.	Block Name	Block Code	Notes
			DHS and OMHSAS licensure. For more information, contact the Bureau of Fee-for-Service Programs.
24a	Date(s) of Service	M/M	Enter the applicable date(s) of service. If the same service was provided on consecutive days, enter the first day of the service in the **From** column and the last day of service in the **To** column. Use an eight-digit (MMDDCCYY) format to record the From and To dates, (e.g. 03012004). If the dates are not consecutive, separate claim lines must be used.
24b	Place of Service	M	Enter the 2-digit place of service code that indicates where the service was performed. **RHCs:** **72** – Rural Health Clinic **12** – Home **21** – Inpatient Hospital **99** – Other (Community) **FQHCs:** **50** – Federally Qualified Health Center **12** – Home **21** – Inpatient Hospital **99** – Other (Community) For specific provider type/specialty/procedure code/modifier/place of service combinations see the following bulletin: *MA Program Fee Schedule Procedure Code Changes for FQHC's and Rural Health Clinics Bulletin.*
24c	EMG	A	Enter **1** if the service provided was in response to an emergency, **2** if urgent. Otherwise, leave this item blank.

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BlockNo.	Block Name	Block Code	Notes
24d	Procedures, Services, or Supplies (CPT/HCPCS & Modifier)	M/AAAA	Enter Procedure Code T1015 in the first section of this block. In the second portion of this block, enter the pricing modifier first if required to pay the claim. Use the third portion of this block to indicate up to three additional informational modifiers, when applicable. If no pricing modifier is required, enter up to four additional / informational modifier(s) using the second and third portions of this block. Failure to use the appropriate modifier(s) will result in inappropriate claims payment or denial. **Note:** When billing for complete EPSDT screens, you are required to enter Procedure Code T1015 and Modifier EP on the first claim line. **For claim line 1**, **please refer to block 24f for instructions on entering your usual charge.** You must enter all of the required age-appropriate procedure codes, with **Modifier EP** on claim lines 2-6. Enter **0000** in Block 24F ($Charges) **for claim lines 2-6.** If a second claim form is required, include only the **additional** components of the complete EPSDT screening on the second claim form.
24e	Diagnosis Pointer	M	This block may contain up to four letters. Enter the corresponding letter(s) (A – L) that identify the diagnosis code(s) in Block 21. If the service provided was for the primary diagnosis (in Block 21A), enter A. If provided for the secondary diagnosis, enter B. If provided for the third through twelfth diagnosis, enter the letter that corresponds to the applicable diagnosis. Note: The primary diagnosis pointer must be entered first.

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BlockNo.	Block Name	Block Code	Notes
24f	$Charges	M	Enter your usual charge to the general public for the service(s) provided. If billing for multiple units of service, multiply your usual charge by the number of units billed and enter that amount. For example, if your usual charge is sixty-five dollars, enter **6500**.
24g	Days or Units	M	Enter the number of units or services provided.
24h or 24h	Family Planning **EPSDT**	A	Enter the 2-digit visit code, if applicable. Visit codes are especially important if providing services that do not require copay (i.e., for a pregnant beneficiary or long term care resident.) **When billing for EPSDT screening services, enter Visit Code 03.** *For a complete listing and description of Visit Codes, please refer to the CMS-1500 Claim Form Desk Reference, located in Appendix A of the handbook.*
24i	ID Qualifier	A	Enter the two-digit ID Qualifier: **G2** = 13-digit Provider ID Number (legacy #)
24j (a)	Rendering Provider ID #	LB	Do not complete this block.
24j (b)	NPI	LB	Do not complete this block.
25	Federal Tax I.D. Number	M	Enter the provider's Federal Tax Employer Identification Number (EIN) or SSN and place an **X** in the appropriate block.
26	Patient's Account Number	O	**Use of this block is strongly recommended**. It can contain up to 10 alpha, numeric, or alphanumeric characters and can be used to enter the patient's account number or name. Information in this block will appear in the first column of the Detail Page in the RA Statement and will help

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BlockNo.	Block Name	Block Code	Notes
			identify claims if an incorrect beneficiary number is listed.
27	Accept Assignment	LB	Do not complete this block.
28	Total Charge	LB	Do not complete this block.
29	Amount Paid	A	If a patient is to pay a portion of their medical bills as determined by the local County Assistance Office (CAO), enter the amount to be paid by the patient. Patient pay is only applicable if notification is received from the local CAO on a PA 162RM form. **Do not enter copay in this block.**
30	Reserved for NUCC Use	LB	Do not complete this block.
31	Signature of Physician or Supplier Including Degree or Credentials	M/M	This block must contain the signature of the provider rendering the service. A signature stamp is acceptable, if the provider authorizes its use and assumes responsibility for the information on the claim. If submitting by computer-generated claims, this block can be left blank; however, a Signature Transmittal Form (MA 307) must be sent with the claim(s). Enter the date the claim was submitted in this block in an 8-digit (MMDDCCYY) format (for example, 03012004).
32	Service Facility Location Information	LB	Do not complete this block.
32a		LB	Do not complete this block.
32b		LB	Do not complete this block.
33	Billing Provider Info & Ph.#	A/A & M/M	Enter the billing provider's name, address, and telephone number **Do not use slashes, hyphens, or spaces.**

CMS-1500 Claim Form Completion for PROMISe™ RHCs & FQHCs

BlockNo.	Block Name	Block Code	Notes
			Note: If services are rendered in the patient's home or facility, enter the service location of the provider's main office. **Note:** RHCs/FQHCs ***are not permitted to have payee arrangements.*** FQHCs/RHCs **must utilize the RHC's or FQHC's** 9-digit provider number and 4-digit service location in this block. *FQHCs/RHCs are **not permitted** to utilize the practitioner's (i.e., physician, CRNP, or nurse) PA PROMISe™ provider number and service location to submit claims for payment.*
33a		M	Enter the 10-digit NPI number of the billing provider.
33b		M/A	Enter the 13-digit Group/Billing Provider ID number (Legacy #)