PART II

POLICIES AND PROCEDURES
for
EARLY & PERIODIC SCREENING, DIAGNOSTIC & TREATMENT (EPSDT) HEALTH CHECK PROGRAM

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION of MEDICAL ASSISTANCE PLANS

Version Date: April 1, 2025

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Policy Revision Record
[from 2024 to Current[1]

REVISION DATE	SECTION	REVISION DESCRIPTION	REVISION TYPE **A**=Added **D**=Deleted **M**=Modified	CITATION (Revision required by Regulation, Legislation, etc.)
04/2025	902.1	Effective April 1, 2025, DCH adopted the AAP 2025 BF Periodicity Schedule. ➢ This schedule reflects recommendations approved in December 2024 and published in February 2025. ➢ No changes have been made to clinical guidance or footnotes in the recommendations published in 2025. ➢ For updates and a list of previous changes made, visit www.aap.org/periodicityschedule	M	AAP DCH
04/2025	902.4.6.1.4	Added Hearing-Targeted Congenital Cytomegalovirus (cCMV) Testing information	A	DCH DPH
04/2025	1003.24	Updated "Other Reimbursement Rates" to include enhanced rates	M	DCH
04/2025	Appendix C	Opened following codes (eff. 8-1-2024): 90623 Penbraya (meningococcal conjugate) 90684 Capvaxive (pneumococcal 21-valent)	A	CDC VFC
04/2025	Appendix L	Revised reimbursement rate tables to reflect current rates only - 'Enhanced' & 'Non-Enhanced'	M	DCH
2/6/2025 01/2025	Appendix L	** HB 916 rates for 99213 and 99214 were corrected; repost date 2/6/2025 Clarifications for reimbursement rates for non-attested providers Reflected HB 916 rates for 99213 and 99214	M	DCH

[1] The revisions outlined in this Table are from 2024 to current. For revisions prior to 2024, please see prior versions of the policy.

10/2024	902	Effective October 1, 2024, DCH adopted the AAP 2024 BF Periodicity Schedule.	M	AAP DCH
10/2024	Appendix C	Updated billing guidance for vaccine administration	M	DCH
10/2024	Appendix C	Added trivalent influenza vaccines, reimbursement effective 8-1-2024 90656 90657 90658 90660 90661 90673	A	CDC VFC DCH
07/2024	902, p. IX-1	Notification – Effective October 1, 2024, DCH will adopt the AAP 2024 BF Periodicity Schedule. The schedule is available at https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf	M	AAP
07/2024	902.2, D.2., p. IX-10-11	Hearing Procedures: - Updated guidance -Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs - Updated program name to Newborn Screening Program (previously Newborn Metabolic Screening Program) - Updates to guidance for newborn hearing rescreens and referrals	M	DPH
07/2024	902.2, E.3., p. IX-14	3. Autism Screening Recommended autism-specific screening tool updated to "The Modified Checklist For Autism in Toddlers, Revised (MCHAT-R)" [previously The Modified Checklist For Autism in Toddlers (MCHAT)].	M	DPH
07/2024	902.2, G.1a-1c., p. IX-16-18	Newborn Screenings Procedures: 1a – Newborn Blood Screening - Revised guidance - Updated link for SendSS registration - Updated link for DPH Newborn Screening eReports Web Portal Access Request Form 1b – Critical Congenital Heart Disease (CCHD) Screening	M	DPH

		- Critical Congenital Heart Disease name change (previous Critical Congenital Heart Defect) - Updated link regarding AAP reference - Revised screening guidance – now detects 12 core CCHD conditions and 6 non-CCHD, secondary conditions (previous screening detected 14 CCHD) - Updated reference guidance for Georgia Newborn Screening Policy and Procedure Manual 1c – Newborn Hearing Screening - added		
07/2024	Appendix C-1, p. C-3	Clarifications on billing guidance when vaccines are administered during a preventive visit along with the E/M visit	M	DCH
07/2024	Appendix C-2, p. C-7	Updated title for PADL reference - Providers' Administered Drug List (Appendix A), published under the Fee Schedule on GAMMIS: www.mmis.georgia.gov and identified as "PADL – Appendix A – Schedule of Maximum Allowable". Previous title: Physicians' Injectable Drug List Manual	M	DCH
07/2024	Appendix H, p. H-13	Updated Peach State Health Plan info for CMO Pharmacy Benefit Managers (PBM), BIN#, PCN#, Group#, Helpdesk#	M	DCH
04/2024	904. p. IX-26, p. IX-29 Table C, p. IX-31 Appendix C-1	Effective 1/1/2024: Updated Health Check policy to allow interperiodic visits 99204, 99205, 99215. Applicable E/M codes 99202-99205, 99211-99215 may be reported along with the preventive visit (99381-99385, 99391-99395).	M	DCH
04/2024	904. Table A-1, p IX-28 Table B, p. IX-30 Table C-1, p. IX-31 1003, 24, p. X-10 Appendix C-1	Rate tables updated to reflect current rates only. The historical list of all the attested rates/HB changes and the non-attested rates will remain housed in Appendix S.	M	DCH
04/2024	Appendix C-1	**RSV updates**: Beyfortus - Added 96380 & 96381, vaccine admin codes for Beyfortus, *(eff. 10/6/2023)* which replaces the previously instructed generic		

		CPT code 96372.		
04/2024	Appendix C-2	96372 should no longer be reported for the administration of Beyfortus *(eff. 3/1/2024)* Abrysvo - Added vaccine product Abrysvo (90678) *(eff. 01/01/2024)*	D A	DCH DCH/CMS
04/2024	Appendix J	Reimbursement allowed for the application of topical fluoride varnish.	A	DCH
01/2024	905	2024 CDC Immunization Schedules posted	M	CDC/ACIP
01/2024	1003, #6 p. X-3	Developmental screenings when performed outside of the Bright Futures requirements can also be reported for members ages 3 years through 6 years of age.	A	DCH
01/2024	Appendix C-2 p. C-3, C-5	Respiratory syncytial virus, monoclonal antibody: 90380 Beyfortus, 50 mg 90381 Beyfortus, 100 mg 96372 vaccine administration code *(eff. 10/1/2023)*	A	DPH/ DCH

[1] The revisions outlined in this Table are from 2024 to current. For revisions prior to 2024, please see prior versions of the policy.

601. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Benefit

601.1. Introduction

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit includes a comprehensive array of preventive, diagnostic, and treatment services for Medicaid eligible infants, children and adolescents under age 21, as specified in Section 1905(r) of the Social Security Act (the Act). The EPSDT benefit is also available to PeachCare for Kids® members up to 19 years of age. The EPSDT benefit is designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible. The goal of the EPSDT benefit is to assure that individual children get the health care they need when they need it. The EPSDT benefit also covers medically necessary diagnostic services. When a screening examination indicates the need for further evaluation of a child's health, the child should be appropriately referred for diagnosis without delay. States are required to arrange for and cover under the EPSDT benefit any Medicaid covered service listed in Section 1905(a) of the Act if that treatment or service is determined to be medically necessary to correct or ameliorate defects and physical and mental illnesses or conditions. This includes physician, nurse practitioner and hospital services; physical, speech/language, and occupational therapies; home health services, including medical equipment, supplies, and appliances; treatment for mental health and substance use disorders; treatment for vision, hearing and dental diseases and disorders, and much more. This broad coverage requirement results in a comprehensive, high-quality health benefit for children under age 21 enrolled in Medicaid.

Reference: EPSDT – A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents available at https://www.medicaid.gov/medicaid/benefits/downloads/epsdt-coverage-guide.pdf

The Health Check Program provides reimbursement for preventive health services, interperiodic visits, developmental screenings, brief emotional/behavioral assessments (Rev. 04/16), hearing and vision screenings, and immunizations under the EPSDT benefit. This manual provides information pertaining to the required screening components of the EPSDT program which should be performed in accordance with the American Academy of Pediatrics (AAP) Bright Futures recommendations for preventive health/well-child check-ups. Diagnostic and Treatment (DT) services available under the EPSDT benefit are reimbursed under other program areas within the Georgia Medicaid and PeachCare for Kids® programs.

601.2. The Early and Periodic Screening (EPS) Components of EPSDT

All screening components for the preventive exam should be provided as outlined in this manual. The required screening components include: a comprehensive unclothed physical examination (unclothed means to the extent necessary to conduct a full, age-appropriate examination); a comprehensive health and developmental history; developmental appraisal (including mental, emotional and behavioral health components); anticipatory guidance and health education; measurements; dental/oral health assessment; vision and hearing tests; certain laboratory procedures; lead risk assessments, and immunizations. Immunizations as needed should be given at the time

of the preventive health visit as appropriate. All the age-appropriate components per the periodicity schedule and this manual must be completed and documented for each screening as appropriate. All preventive/well-child services must be provided under the EPSDT benefit following the policies and procedures as outlined in this manual.

601.3. The Diagnostic and Treatment (DT) Components of EPSDT

The Diagnostic and Treatment policies, procedures, and billing for the EPSDT benefit are found under other Georgia Medicaid programs. However, the Health Check provider may address a medical condition at the time of the preventive health visit or during an interperiodic visit. Under these circumstances, the Health Check provider bills for the office visit associated with the medical condition.

601.4. Relevant Provider Manuals

Provider Manuals relevant to the EPSDT benefit include, but may not be limited to:

601.4.1. Advanced Nurse Practitioner Services

601.4.2. Autism Spectrum Disorders (ASD) Services (rev 01/22)

601.4.3. Children's Intervention Services (CIS)

601.4.4. Children's Intervention School Services (CISS)

601.4.5. Dental Services

601.4.6. Diagnostic Screening and Preventive Services (DSPS)

601.4.7. Durable Medical Equipment (DME) Services

601.4.8. Federally Qualified Health Center (FQHC) Services

601.4.9. Georgia Pediatric Program (GAPP)

601.4.10. Hospice Services

601.4.11. Hospital Services

601.4.12. Medicaid/PeachCare for Kids® Provider Billing Manuals

601.4.13. Nurse Midwifery Services

601.4.14. Orthotic and Prosthetic Services

601.4.15. Pharmacy Services

601.4.16. Physician Assistant Services

601.4.17. Physician Services

601.4.18. Rural Health Clinic (RHC) Services

601.4.19. Vision Care Services

Provider Manuals are available for downloading. Contact Gainwell Technologies (rev 01/21) at 1-800-766-4456 or visit the website at www.mmis.georgia.gov for more information.

601.5. The Medically Fragile Child

Many medically fragile children are under the care of medical specialists. The child's primary care provider may request Diagnostic and Treatment services for the child by documenting the medical necessity for the proposed medical service. The practitioner must state the medical reason for the requested service as it relates to the child's medical condition or diagnosis. These providers should refer to their applicable Medicaid programs' policies and procedures manual for policy guidelines. See Appendix J for resources available to children in Georgia and Appendix D for an explanation of services provided under the *Children's Intervention Services* program.

602. Enrollment

602.1. Provider Types

Physicians (pediatricians, family practitioners, general practitioners, internists, and OB/GYN specialists), Advanced Nurse Practitioners (pediatric, OB/GYN, family medicine or adult medicine), Certified Nurse Midwives, Local Education Agencies (LEAs) [*school districts*], hospitals, Local Boards of Health (county health departments), Rural Health Centers (RHCs) or Federally Qualified Health Centers (FQHCs) may enroll in the Health Check Program to provide EPSDT services. Physician sponsored advanced nurse practitioners (pediatric, OB/GYN, family medicine or adult medicine) and physician's assistants may also enroll in the Health Check program but must maintain current written protocols and physician sponsorship. These non-physician providers must submit an official letter from their physician sponsor as proof of physician sponsorship at the time of enrollment and at the time their physician sponsorship changes. Providers who wish to provide Diagnostic and Treatment services should enroll in their respective Medicaid program, such as Physician Services, Advanced Nurse Practitioner Services, etc. Physicians, nurse practitioners and nurse midwives may enroll in the Health Check Program to provide EPSDT services and their respective programs to provide diagnostic and treatment services by completing only one provider data form.

Local Education Agencies, hospitals, Local Boards of Health, RHCs or FQHCs must enroll as an entity, as opposed to each provider that will be providing services enrolling individually. The enrolling entity must ensure that only staff members who meet the qualifications listed in Section 603 of this manual are providing services.

602.2. Application Process

Providers who wish to enroll in the Health Check program are required to:

602.2.1. Meet the Conditions of Participation in Medicaid's Part I Policies and Procedures for Medicaid and PeachCare for Kids® Manual (Part I Manual) and the special conditions listed in Section 603.

602.2.2. Read the EPSDT Benefit Policy Manual prior to signing enrollment forms and

602.2.3. Complete and sign the Health Check Required Equipment form in Appendix F

602.2.4. In addition, it is strongly encouraged that providers submit an application for enrollment into the Vaccines For Children (VFC) Program – see Section 905.3 for more information.

602.2.5. The Department of Community Health contracts with Gainwell Technologies to provide an electronic health care administration system for its contracted providers. The Gainwell Technologies field representatives are responsible for assisting Medicaid and PeachCare for Kids® providers with claims adjudication, the web portal and technical support. Contact Gainwell Technologies (rev 01/21) at 1-800-766-4456 for more information.

603. Special Conditions of Participation

603.1. In addition to the general Conditions of Participation contained in Part I Policies and Procedures for Medicaid and PeachCare for Kids®, providers in the Health Check program must meet the following requirements:

603.1.1. Physicians, including those employed or contracted by an LEA, must be currently licensed to practice medicine. (Refer to the Physician Services Manual)

603.1.2. Nurse Practitioners, including those employed or contracted by an LEA, must maintain a current registered nurse license for the State of Georgia and current specialty certification by the appropriate certifying agent of the American Nurses Association. (Refer to the Advanced Nurse Practitioners Manual)

603.1.3. Nurse Midwives, including those employed or contracted by an LEA, must maintain a current registered nurse license and current certification as a nurse-midwife by the American College of Nurse-Midwives (ACNW). A copy of the national certification must be on file with the Division of Medicaid. (Refer to the Nurse Midwifery Manual)

603.1.3.1. Physician-sponsored providers, including those employed or contracted by an LEA, must be currently licensed to practice and must submit a copy of their license with the application. They must also maintain current written protocols, physician sponsorship and submit an official letter from their physician sponsor as proof of physician sponsorship. These providers include:

603.1.3.2. Certified pediatric, OB/GYN, family, general or adult nurse practitioners. A recent graduate of a Nurse Practitioner Program may enroll as a Nurse Practitioner once he/she passes the Specialty Certification exam.

603.1.3.3. Physician assistants must be licensed by the Georgia Board of Medical Examiners and be associated with one

or more sponsoring physician(s) on file with the Composite State Board of Medical Examiners. (Refer to the Physician Assistant Services Manual)

603.1.3.4. Public Health registered nurses, affiliated with a Georgia local board of health, who have successfully completed the required training for expanded role nurses.

603.2. Health Check providers **must** provide immunizations. It is recommended the provider enroll in the VFC program and submit a VFC Provider Enrollment Letter with their Health Check Provider Enrollment Application. This is encouraged because the vaccine administration fee is the only reimbursement a provider will receive for administering vaccines otherwise available through the VFC program. (The VFC vaccines may only be used by certain populations. See Section 905.3.) For members nineteen (19) years of age through twenty (20) years of age, VFC stock is not available. Providers must use their own stock of vaccines for these Medicaid eligible members and the Division will reimburse for the vaccine product and for vaccine administration.

603.3. Health Check providers must submit documentation verifying they possess the necessary equipment to perform all components of the periodic screening (See Section 903 for the equipment list.)

603.4. Health Check providers must determine whether members requesting a preventive health visit have already received that periodic screening. Periodic screenings for foster children in state custody are an exception to this requirement.

603.5. Health Check providers must perform, at the time of the member's preventive health visit, all of the EPSDT required components for that visit as listed below, along with those identified in the Bright Futures Periodicity Schedule (see Section 902). The EPSDT required components include:

603.5.1. A comprehensive health and developmental history, developmental appraisal (including mental, emotional and behavioral)

603.5.2. A comprehensive unclothed physical examination (unclothed means to the extent necessary to conduct a full, age-appropriate examination) including measurements

603.5.3. Health education and anticipatory guidance for both the child and caregiver

603.5.4. Dental/oral health assessment

603.5.5. Vision and hearing assessments

603.5.6. Laboratory testing (including blood lead screening appropriate for age and risk factors)

603.5.7. Appropriate immunizations, in accordance with the pediatric and adult schedules for vaccines established by the Advisory Committee on Immunization Practices

603.6. The Health Check provider must:

603.6.1. Provide all of the required EPSDT preventive health services, as identified by the periodicity schedule and this manual, during the preventive visit in order to be reimbursed at the Health Check visit rate. If additional service needs are identified, through the screening process, that are outside the scope of practice of the EPSDT primary care provider (PCP), the member must be referred to a provider who can address those needs.

603.6.2. Notify the member's PCP of the preventive health/interperiodic visit and any additional service needs identified during that visit, if the provider is not the member's EPSDT PCP. The member's PCP must make the appropriate referral(s).

603.6.3. Use Place of Service (POS) code 99 for all preventive health services and interperiodic visits. Public Health providers – see Section 1003 for additional information;

603.6.4. Document, in the member's health record, all services provided during the preventive health visit;

603.6.5. Send documentation of care rendered outside of the PCP or the medical home (such as medical records and immunization charting) to the PCP or the medical home as identified by the member within five (5) business days of the provision of those services;

603.6.6. Make available for on-site audits by the Division or its agents all records related to EPSDT services. Providers must submit plans for corrective action when requested;

603.6.7. Refer the member to other ancillary service providers for services that are not covered under the Medicaid or PeachCare for Kids® programs;

603.6.8. Provide services in a manner consistent with the policies, procedures and requirements outlined in this manual;

603.6.9. If performing the required laboratory testing, be in compliance with the Clinical Laboratory Improvement Amendment. Providers seeking information concerning laboratory services should contact the Healthcare Facility Regulation Division (HRFD) at (404) 657-5700;

603.6.10. Maintain an office, clinic, or other similar physical facility, which complies with local business and building license ordinances;

603.6.11. Provide immunizations as needed at the time of the preventive health visit. Providers not enrolled in the VFC program will not be reimbursed for the cost of the vaccine they administer to Medicaid members if those vaccines can be provided under the VFC program. They will only be reimbursed the vaccine administration fee. To enroll in the Vaccines For Children Program, please call 1-800-848-3868. For members nineteen (19) years of age through twenty (20) years of age,

VFC stock is not available. Providers must use their own stock of vaccines for these Medicaid eligible members and the Division will reimburse for the vaccine product and for vaccine administration.

603.6.12. Maintain legible, accurate, and complete medical records to support and justify the services provided. A Medical record is a summary of essential medical information on an individual patient including dated reports supporting claims submitted to the Division for services provided in an office, hospital, outpatient, or other place of service. Records of service shall be entered in chronological order by the practitioner who rendered the service.

603.7. All documentation in the medical record shall be legible and shall include but not be limited to:

603.7.1. Date(s) of service

603.7.2. Patient's name and date of birth

603.7.3. Name and title of person performing the service

603.7.4. Pertinent medical history; immunizations

603.7.5. Pertinent findings on examination

603.7.6. Medications, equipment or supplies prescribed/provided

603.7.7. Recommendations for additional treatment, procedures, or consultations

603.7.8. Tests and results

603.7.9. Plan of treatment/care and outcomes

603.7.10. Refusal of care documented with signed form by responsible person for member

603.7.11. The signature of the person performing the service. The original handwritten personal signature (electronic or fax signatures are acceptable only if these documents are legible) of the person performing the service must be on each document contained in the patient's medical record. When a fax document or signature is included in the medical record, the document with the original signature must be retrievable from the original source. This includes but is not limited to progress notes and lab reports for each date of service billed.

603.7.11.1. Electronic signature is defined as "an electronic or digital method executed or adopted by a party with the intent to be bound by or to authenticate a record, which is unique to the person using it, is capable of verification, is under the sole control of the person using it, and is linked to the data in such a manner that if the data are changed the signature is invalidated."

603.7.12. All documents contained in the medical record must be written in Standard English Language. Records must be available to the Georgia Division of Medicaid or its agents and to the U.S. Department of Health and Human Services upon request. Documentation must be timely, complete, and consistent with the by-laws and medical policies of the office or facility where the services are provided.

CHAPTER 700: Special Eligibility Conditions

701. Special Eligibility Conditions

All persons eligible for Medicaid who are less than twenty-one (21) years of age are eligible for the EPSDT benefit with the exception of women aged eighteen to twenty-one (18 to 21) who are enrolled in the Planning for Healthy Babies Program (P4HB®). P4HB participants are not eligible for the EPSDT benefit. All persons eligible for the PeachCare for Kids® program are eligible for the EPSDT benefit.

CHAPTER 800: Prior Approval/Authorization

801. Prior Approval/Authorization

801.1. Health Check Services do not require Prior Approval/Authorization.

801.2. Some EPSDT services provided to Medicaid and PeachCare for Kids® members may require prior authorization and/or a referral if the member has a PCP/medical home and the member's PCP/medical home does not perform those additional services.

801.3. Prior authorization may be required for services rendered by Diagnostic and Treatment providers. These providers should refer to their applicable Medicaid policy and procedure manuals for a listing of the services that require prior approval.

901. General

The Health Check Program provides reimbursement for preventive health and interperiodic visits and other services provided during those visits.

The Diagnostic and Treatment components of the EPSDT benefit are covered under other Georgia Medicaid programs as described previously in this manual. Those programmatic policies and procedures should be followed as specified in the appropriate related manuals (i.e., Physician Services program, etc.). Diagnostic and Treatment services are provided for identified suspicious or abnormal conditions by either the Health Check provider, if qualified to perform those services, or upon referral to an appropriate service provider of the member's choice.

902. AAP Periodicity Schedule and GA Minimum Standards for Screening Components

902.1. Periodicity Schedule

Effective April 1, 2025, the Georgia Division of Medical Assistance Plans adopted the AAP 2025 Bright Futures "Recommendations for Pediatric Health Care" Periodicity Schedule as the periodicity schedule for EPSDT visits and services. The schedule is available at https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf.

The updated 2025 Periodicity Schedule will be used for all EPSDT preventive health visits completed on or after April 1, 2025. Exception: the prenatal visit and over 21 years of age visit as listed on the schedule are not covered under the Health Check Category of Service (COS)600.

902.2. Screening Sequence

The periodic intervals for screening for all Medicaid and PeachCare for Kids® Health Check providers, as shown on the following page, are based on the American Academy of Pediatrics' recommendations.

902.3. Minimum Standards for Screening Components during the Preventive Health Visits

Required Components are specified here and in the chart and footnotes of the American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care (AAP Periodicity Schedule).

902.3.1. Visit Components: Every periodic health supervision (well-child) visit must include:

902.3.1.1. A comprehensive health, psycho-social and developmental history;

902.3.1.2. Documentation of vital signs

902.3.1.3. An unclothed comprehensive physical examination (unclothed means to the extent necessary to conduct a full, age-appropriate examination);

902.3.1.4. Assessment of growth and nutritional status;

902.3.1.5. Assessment of immunization status and provision of appropriate immunizations. (Use the Advisory Committee on Immunization Practices (ACIP) schedules);

902.3.1.6. Screening for vision, hearing, and development, as per AAP guidance;

902.3.1.7. Laboratory testing where appropriate to age and exam findings, and in line with AAP guidance. (Some testing, if not bundled, may be covered under other programs i.e. Physician Services, DSPS, etc. Please follow those programs' guidelines for reimbursement.);

902.3.1.8. Oral health screening, preventive counseling, and referral to a dentist for ongoing dental care;

902.3.1.9. Screening for and if suspected, reporting of child abuse and neglect;

902.3.1.10. Anticipatory guidance (Health Education); and

902.3.1.11. Referrals /follow-ups where appropriate based on history and exam findings.

902.3.2. Helpful materials:

902.3.2.1. https://brightfutures.aap.org

902.3.2.2. CDC Positive Parenting Tips at: http://www.cdc.gov/child-development/positive-parenting-tips/

902.3.2.3. Immunization schedule (Recommended Immunization Schedule, 0-18 years) Red Book (2024-2027): Report of the Committee on Infectious Diseases | AAP Books | American Academy of Pediatrics

902.4. Recommendations for Preventive Pediatric Health Care (Bright Futures/AAP)

902.4.1. Age

Calculate the child's age. If a child comes under care for the first time at any point on the schedule, or if any items were not accomplished at the suggested age, the member's visit should be brought up to date at the earliest possible time.

902.4.2. History

902.4.2.1. **Initial history**: All ages: The history may be obtained at the time of the visit from the parent/guardian or it may be obtained through a form or checklist sent to the

parent/guardian prior to the visit for completion. Initial history must contain, but is not limited to:

902.4.2.1.1. Present health status and past health history of member;

902.4.2.1.2. Developmental information;

902.4.2.1.3. Allergies and immunization history - allergies must be clearly and easily found in records;

902.4.2.1.4. Family history;

902.4.2.1.5. Dietary (nutrition) history;

902.4.2.1.6. Risk assessment of lead exposure; and

902.4.2.1.7. Refusal of Care documenta-tion form (as necessary).

902.4.2.1.8. Documentation: Initial health history is recorded in the medical record.

902.4.2.2. **Interval history:** All ages: For known patients, the age-specific history may be confined to the interval since the previous evaluation. The provider must review and supplement these histories at the time of the patient's examination. Include nutrition history.

Documentation: Evidence of review.

902.4.3. Measurements

902.4.3.1. Assessment of Growth:

For all ages, growth (length/height and weight) must be measured, plotted on a graph, and recorded as outlined below.

902.4.3.1.1. **Children younger than 2 years:** Age, weight, length, and head circumference are required. Measurements should be plotted on the appropriate World Health Organization (WHO) growth chart(s).

902.4.3.1.2. **Children 2 years of age and older:** Age, weight, height, and BMI are required. Measurements must be plotted on the appropriate Centers for Disease Control and Prevention (CDC) growth chart(s). The Body Mass Index (BMI) number must be plotted on the BMI-for-

age growth chart to obtain a BMI percentile ranking.

902.4.3.1.3. The CDC and WHO growth charts are available at the following website: http://www.cdc.gov/growthcharts/

902.4.3.1.4. Documentation: All measurements in numerical values must be recorded and plotted as indicated. All measurements outside of normal range must have an intervention. Interventions following assessments, as suggested by the CDC, are also acceptable. Please refer to Appendix E for the correct BMI diagnosis codes to be recorded on the claim. The diagnosis code must align with the BMI percentile plotted on the growth chart.

902.4.3.1.5. Fee For Service (FFS) EPSDT providers should not link the preventive health visit code to the BMI percentile diagnosis code on the claim.

902.4.3.2. Blood Pressure Assessment:

902.4.3.2.1. **Ch**ildren younger than 3 years: Infants and children with specific risk conditions need a blood pressure assessment. See the Bright Futures Guidance (BFG).

902.4.3.2.2. Children 3 years and older: Blood pressure assessment is performed at every visit.

902.4.3.2.3. Documentation: All measurements in numerical values must be recorded. All measurements outside of the normal range must have an intervention.

902.4.3.3. Vision Procedure:

902.4.3.3.1. **Children from birth to 3 years of age:** A Vision Risk Assessment is needed at every visit. This risk assessment includes: ocular history, vision assessment, external inspection of the eyes and lids, ocular motility assessment, pupil and red reflex examination.

If the risk assessment is positive, refer to an ophthalmologist.

902.4.3.4. **Children 3 years and older:** A Vision Screening is required at the 3, 4, 5, 6, 8, 10, 12, and 15 year old visits. (The routine screening at age 18 has been changed to a risk assessment). A Vision Risk Assessment should be performed at all other visits. Patients uncooperative with screening and with no history, nor signs/symptoms of problems, should be re-screened within 6 months. To test visual acuity, use age appropriate tests. BFG suggests the Snellen letter or Symbol E charts. The use of alternative tests (HOTV or Matching Symbol, Faye Symbol, Allen Pictures) should be considered for preschoolers.

If the risk assessment is positive, conduct a vision screening. If the vision screening is positive, refer to an ophthalmologist.

Reminder: If a child wears eyeglasses, assessment regarding the need for referral for optometric re-evaluation must be made based on screening with eyeglasses and the length of time since the last evaluation.

902.4.3.4.1. Documentation: Sensory Screening documentation consists of an age-appropriate assessment, assessment results (normal or abnormal) and examinations performed and results (pass/fail) data. Appropriate follow up or referral is needed for results outside of the normal range.

902.4.3.5. Hearing Procedure (rev 07/24):

902.4.3.5.1. **Newborns:** All newborns should receive a newborn hearing screening per the AAP "Year 2019 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs"

(DOI: https://doi.org/10.15142/fptk-b748)

If the newborn does not pass the hearing screening, refer for a follow-up outpatient rescreening within one month. For newborns who do not pass the rescreening, refer to an audiologist for a

hearing evaluation before 3 months.

Georgia's Early Hearing Detection and Intervention (EHDI) Program is housed in the Georgia Department of Public Health along with the Newborn Screening Program and the Children 1st Program. These three programs maintain and support a comprehensive, coordinated, statewide public health screening and referral system. EHDI includes:

902.4.3.5.1.1. Screening for hearing loss in the birthing hospital;

902.4.3.5.1.2. Rescreen hearing for infants that do not pass for both ears before one month of age

902.4.3.5.1.3. Refer to a licensed audiologist for a diagnostic hearing evaluation before three months of age

902.4.3.5.1.4. Enrollment in early intervention and support services before six months of age

902.4.3.5.1.5. Refer to the Georgia EHDI Program (http://dph.georgia.gov/EHDI) for further guidance.

902.4.3.5.2. **Infants and toddlers under age 2 years:** These children should be monitored for auditory skills, language development, middle ear status, and developmental milestones (surveillance).

902.4.3.5.3. **Infancy and Early Childhood visits:** Conduct a risk assessment at each preventive visit during the Infancy and Early Childhood years (from the three to five days visit through the 3-year-old visit). If the risk assessment is positive, refer to an audiologist.

902.4.3.5.4. **Middle Childhood and Adolescent**

visits: Conduct a risk assessment during the preventive visit at ages 7 years and 9 years. If the risk assessment is positive, refer to an audiologist.

902.4.3.5.5. **At the 4, 5-, 6-, 8- and 10-year visits:** Appropriate universal hearing screening (objective) is required.

902.4.3.5.6. **At the 11 years through 20 years visits:** Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 20 years. See *"The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies"*

902.4.3.5.7. The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies - Journal of Adolescent Health (jahonline.org)

902.4.3.5.8. Additional Guidance for Hearing Assessment Visits

Concerns identified during surveillance for children less than 2 years of age should be followed by performance of screening using a validated global screening tool (ASQ, PEDS, etc.). Those who do not pass the speech-language portion of the global screen or who have a caregiver concern should be referred immediately for further evaluation. Children with persistent middle ear effusions should be referred for otologic evaluation.

Older children who fail the risk assessment tool or screening should have appropriate intervention. Older children with persistent middle ear effusions should be referred for otologic evaluation.

902.4.3.5.9. **Documentation***:* Sensory Screening documentation consists of an age-appropriate assessment, assessment results (normal or abnormal) and examinations performed and results

(pass/fail) data. Appropriate follow up or referral is needed for results outside of the normal range.

Patients uncooperative with screening and with no history, nor signs/symptoms of problems, should be re-screened within 6 months. This time frame is not appropriate for newborns.

902.4.4. Developmental/Social/Behavioral/Mental Health Surveillance

902.4.4.1. Surveillance:

Required for all ages: This assessment should occur with each clinical encounter with the child or adolescent. Comprehensive childhood surveillance of development includes activities that will document *social, emotional*, *communication*, *cognitive*, and *physical development* concerns (this content is listed at each health supervision visit in BFG under *Surveillance of Development*). Psychosocial/ behavioral surveillance will encourage activities and interventions to promote mental health and emotional well-being. See BFG Chapter 3.

Documentation: Evidence of surveillance.

902.4.4.2. Maternal Depression Screening:

902.4.4.2.1. Required at the 1-, 2-, 4- and 6-month visits: At all visits (1, 2, 4, and 6 months), the mothers of newborn children should be asked about depression.

902.4.4.2.2. The relevant AAP guidance, in concert with Bright Futures recommendations (http://brightfutures.aap.org), references screening mothers with one of the following tools the Edinburgh Postnatal Depression Scale (EPDS), the Patient Health Questionnaire-9 (PHQ-9) or the Patient Health Questionnaire-2 (PHQ-2), administered at 1, 2, 4 and 6 months postpartum, with follow up referral for resources and treatment.

NOTE: Per the BF guidance, "Screening should occur per "Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice"

http://pediatrics.aappublications.org/content/early/2010/10/25/peds.2010-2348

902.4.4.2.3. **Documentation**: Evidence of assessment. Screening tool must be standardized and scorable. Document the screening tool used and the screening results in the medical record. If indicated, document the follow-up assessment, therapeutic intervention used, referrals made, and treatments received.

If evidence of depression is documented, EPSDT providers may refer the mother to the Georgia Crisis and Access Line (GCAL). GCAL, a statewide toll-free crisis hotline, provides access to resources and services to individuals in need of crisis management for mental health, addictive disease, and crisis services. GCAL can be reached 24 hours a day, 7 days per week at 1-800-715-4225 (GCAL) or accessed on the web at www.mygcal.com.

902.4.4.3. Developmental Screening:

Required at ages 9 months, 18 months, and 30 months:

Tools must meet the following criteria:

902.4.4.3.1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor (fine and gross), language, cognitive, and social-emotional.

902.4.4.3.2. Established Reliability: Reliability scores of approximately 0.70 or above.

902.4.4.3.3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s).

902.4.4.3.4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.

902.4.4.3.5. The following tools meet the above criteria and are included in the Bright Futures Recommendations for Preventive Care, which reference the updated January 2020 American Academy of Pediatrics (AAP) Statement (rev 07/21).

902.4.4.3.5.1. Ages and Stages Questionnaire - 3rd Edition (ASQ-3) - 1-60 months

902.4.4.3.5.2. Parents' Evaluation of Developmental Status (PEDS) – Birth to 8 years

902.4.4.3.5.3. Parents' Evaluation of Developmental Status - Developmental Milestones (PEDS-DM)

902.4.4.3.5.4. Survey of Well-Being in Young Children (SWYC) – 1-65 months

902.4.4.3.6. Tools included in the 2006 Statement that meet the above criteria but were not listed in the 2020 Statement (as they often are not used by primary care providers in the context of routine well-childcare) include the following:

902.4.4.3.6.1. Battelle Developmental Inventory Screening Tool (BDI-ST) – Birth to 95 months

902.4.4.3.6.2. Bayley Infant Neuro-developmental Screen (BINS) - 3 months to 2 yrs

902.4.4.3.6.3. Brigance Screens-II – Birth to 90 months

902.4.4.3.6.4. Child Development Inventory (CDI) - 18 months to 6 years

902.4.4.3.6.5. Infant Development Inventory – Birth to 18 months

The tools listed above are not specific recommendations but are examples of tools cited in Bright Futures that meet the above criteria. Tools that do NOT meet the criteria: It is important to note that standardized tools specifically focused on one domain of development (e.g. child's socio-emotional development [ASQ-SE] or autism [M-CHAT]) are not included in the list above as this measure is anchored to recommendations related to global developmental screening using tools that identify risk for developmental, behavioral, and social delays. **NOTE:** More information about the developmental screening tools that meet the measure criteria is available at Bright Futures Toolkit: Links to Commonly Used Screening Instruments and Tools | AAP Toolkits | American Academy of Pediatrics

902.4.4.3.7. **REFERENCE:** Center for Medicaid and CHIP Services, Centers for Medicare & Medicaid Services - Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) Technical Specifications and Resource Manual for Federal Fiscal Year 2024 (rev 01/24)

902.4.4.3.8. Documentation: Evidence of the screening. Documentation in the medical record must include all of the following: a note indicating the date on which the screening was performed; a copy of the completed standardized tool used; and documented evidence of a screening

result or screening score. If indicated, document the follow-up assessment, therapeutic interventions used, referrals made, and treatments received.

902.4.4.4. Autism Spectrum Disorder Screening:

902.4.4.4.1. **Required at ages 18 months and 24 months or any time parents raise a concern:** The screening should be performed with an autism-specific screening tool. The Modified Checklist For Autism in Toddlers, Revised (MCHAT-R) (rev 07/24) is the recommended tool and downloadable at https://www.mchatscreen.com

The MCHAT-R is a validated developmental screening tool for toddlers between 16 and 30 months of age and should not be used for children younger than 16 months of age. The MCHAT-R is designed to identify children who may benefit from a more thorough developmental and autism evaluation. The MCHAT-R can be administered and scored as part of the preventive health visit and can be used by specialists or other professionals to screen for developmental delay and autism. The MCHAT-R on-line version features the latest scoring system, Modified Checklist for Autism in Toddlers, Revised with Follow-Up (MCHAT-R/F), making the results more sensitive in detecting developmental concerns.

902.4.4.4.2. ***Documentation:*** Evidence of the screening. Documentation in the medical record must include a note indicating the date on which the screening was performed; a copy of the screening tool used; and documented evidence of a screening result or screening score. If indicated, document the follow-up assessment, therapeutic interventions used, referrals made, and treatments received.

902.4.4.4.3. For guidelines related to autism spectrum disorder, including a list of acceptable Autism Spectrum Disorder

Assessment Tools, refer to the Autism Spectrum Disorder Policy Manual (01/22).

902.4.4.5. Tobacco, Alcohol, or Drug Use Assessment:

Required at 11 years through 20 years of age: At all adolescent (11-20 years) visits, pre-teens and teens should be asked about substance use.

The screening should be performed and documented or the child referred for care at any encounter when a parent raises a concern. AAP recommends using the CRAFFT screening tool (rev 10/19) (available at http://www.crafft.org) for this assessment.

Documentation: Evidence of assessment. Screening tool must be standardized and scorable (rev 10/18). Document the screening tool used and the screening results (i.e., CRAFFT score). If indicated, document the follow-up assessment, therapeutic intervention used, referrals made, and treatments received.

902.4.4.6. Depression and Suicide Risk Screening:

Required at 12 years through 20 years of age: At all adolescent (12-20 years) visits, pre-teens and teens should be asked about depression.

AAP recommends using the Patient Health Questionnaire (PHQ)-9 (rev 04/23) Modified for Teens (PHQ-A) and Patient Health Questionnaire (PHQ)-2) or other tools available in the GLAD-PC toolkit. (Guidelines for Adolescent Depression in Primary Care - The Reach Institute)

The Bright Futures Materials and Tools are available at https://brightfutures.aap.org (rev 04/25)

Documentation: Evidence of assessment. Document the screening tool used and the screening results in the medical record. If indicated, document the follow-up assessment, therapeutic intervention used, referrals made, and treatments received.

Fee For Service EPSDT providers should link the depression screening procedure code (96127) to the applicable preventive health visit ICD-10 diagnosis code. The providers should not link a depression screening diagnosis code to the preventive health visit procedure code (rev 04/16).

902.4.5. Physical Exam

902.4.5.1. Physical Exam and Nutrition:

All children: A comprehensive physical exam is required for periodic and catch-up visits. The physical examination is the cornerstone of pediatric evaluation. Per the Federal EPSDT policy guidelines, the physical examination must be an unclothed physical inspection (unclothed means to the extent necessary to conduct a full, age-appropriate examination) that checks the general appearance of the child to determine overall health status. This process can pick up obvious physical defects, including orthopedic disorders, hernias, skin diseases, genital abnormalities and oral health needs. Physical inspection includes an examination of all organ systems such as pulmonary, cardiac, and gastrointestinal.

Documentation: Findings on all organ systems must be documented in the medical record. A checklist type form allowing documentation of normal/ abnormal findings may be utilized for recording the different organ systems. Abnormal findings require further evaluation, follow-up or parental counseling.

902.4.5.2. Nutrition:

The Federal EPSDT policy guidelines mandate assessment of nutritional status but state it can be accomplished during many different parts of the exam. "Accurate measurements of height and weight...are among the most important indices of nutritional status." "If information suggests dietary inadequacy, obesity or other nutritional problems, further assessment is indicated."

Documentation: Evidence of the assessment.

902.4.6. Procedures

902.4.6.1. Newborn Screenings (rev 07/24)

According to Georgia's Health Code Rule 511-5-5.03, "It is the goal of the Department that every baby born alive in Georgia shall be tested for the following conditions, unless their parents or legal guardians object in writing on the ground that such tests and treatment conflict with their religious beliefs".

902.4.6.1.1. Newborn Blood Screening (rev 07/24)

All infants 3 months and under:
Georgia law requires that every live born infant receive a blood screening for selective inherited disorders.

The Georgia Newborn Screening (NBS) Program ensures that every newborn in Georgia is screened for 35 inheritable conditions for prompt identification and treatment through the newborn dried blood spot card.

A sample of each infant's blood should be collected 24 to 48 hours after the first feeding or prior to the infant's discharge from the birthing facility if the infant is discharged before 24 hours of age. In this case, a second specimen shall be collected within 5 days of birth.

Refer to the Georgia Newborn Screening Policy and Procedure Manual for further guidance.

The Newborn Blood Screening process may not be complete with results available before the first scheduled preventive health visit; however, these results should be actively tracked to completion and documented as soon as possible. If the results are outside the normal limits for a newborn screening condition, the provider should ensure that the child receives prompt appropriate retesting and/or make a referral to an appropriate specialist.

Providers may access newborn screening results online through the State Electronic Notification Surveillance System (SendSS). Results are also available through the Georgia Public Health Laboratory's Newborn Screening eReports web portal.

Information regarding the SendSS registration process is available at: https://sendss.state.ga.us/newsendss/index.html

Providers may register as a user of the Georgia Department of Public Health Laboratory's Newborn Screening eReports electronic portal by completing the DPH Newborn Screening eReports Web Portal Access Request Form. The form is available at www.dph.ga.gov/NBS, or the direct link

is:
https://dph.georgia.gov/document/document/registration-form/download

902.4.6.1.2. Critical Congenital Heart Disease (CCHD) Screening (rev 07/24)

Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital.

https://publications.aap.org/pediatrics/article/146/1/e20191650/77026/Updated-Strategies-for-Pulse-Oximetry-Screening

CCHD was added to the Georgia newborn screening panel in 2014. In accordance with the Georgia Newborn Screening Program's Policy and Procedure Manual, hospitals and birthing centers shall be equipped to conduct a critical congenital heart disease (CCHD) screening test on newborns using pulse oximetry. This screening can detect 12 core CCHD conditions and 6 non-CCHD, secondary conditions in newborns which could result in disability or death.

Documentation: Refer to the Georgia Newborn Screening Policy and Procedure Manual for further guidance and documentation requirements.

902.4.6.1.3. Newborn Hearing Screening (rev 07/24)

Hearing screening is conducted by delivering soft sounds to each ear to measure response to sounds prior to hospital discharge.

See page IX-10 Hearing Procedure and the Georgia Newborn Screening Policy and Procedure Manual for more information.

Contact the Georgia Newborn Screening Program with questions at DPH-NBS@dph.ga.gov or visit www.dph.ga.gov/NBS.

902.4.6.1.4. Hearing-Targeted Congenital Cytomegalovirus (cCMV) Testing (04/2025)

If an infant does not pass the initial or final inpatient newborn hearing screening, in cases where a second screening is performed, the hospital or birthing center shall conduct cCMV testing before discharge or 21 days of age, whichever comes first.

See the Congenital Cytomegalovirus (cCMV) Policy and Procedure Manual and https://dph.georgia.gov/EHDI/ccmv for more information. (4/2025)

902.4.6.2. Immunizations

All children: An immunization assessment is required for all children. This is a key element of preventive health services. Immunizations, if needed and appropriate, shall be given at the time of the preventive health visit. The Federal EPSDT policy guidelines mandate the use of the current ACIP schedule at http://www.cdc.gov/vaccines

Documentation: All immunizations (historic and current) must be documented in the medical record and recorded in the Georgia Registry of Immunization Transactions and Services (GRITS). Refusals must be documented with a signed document.

902.4.6.3. Anemia Screening (Hematocrit and Hemoglobin)

Anemia Screening Procedure:

902.4.6.3.1. At 12 months: Screening must be performed on all members with documentation of a hemoglobin or hematocrit measurement.

902.4.6.3.2. At 4 months: Selective screening may be performed on all preterm, low birth weight infants and those not on iron fortified formula.

902.4.6.3.3. Anemia Risk Assessme**nt:** An anemia risk assessment is required at the 4-, 15-, 18-, 24-, and 30-months visits, and annually starting at 3 years.

Documentation: Evidence of screening, if required, and/or test results as well as any further evaluation, treatment or counseling for results outside of the normal limits. Evidence of a risk assessment performed at the 4-, 15-, 18-, 24-, and 30-months visits, and annually thereafter starting at 3 years. This can be part of the nutrition assessment.

902.4.6.4. Lead Screening

902.4.6.4.1. Blood Lead Risk Assessment:
The Blood Lead Risk Assessment *is* required at 6, 9 and 18 months and 3 to 6 years per the BFG periodicity schedule. A questionnaire, based on currently accepted public health guidelines, should be administered to determine if the child is at risk for lead poisoning. A recommended tool is the Georgia Healthy Homes and Lead Poisoning Prevention Program (GHHLPPP) Blood Lead Risk Assessment Questionnaire which can be found at
Healthy Homes and Lead Poisoning Prevention | Georgia Department of Public Health
EnvHealthLeadRiskQuestionaire (1).pdf
When using the questionnaire, a blood lead test should be done immediately if the child is at high risk (one or more "yes" or "I don't know" answers on the lead risk assessment questionnaire) for lead exposure. Completing this questionnaire does not count as a blood lead screening.

Note: Assessment questions are not needed if a Blood Lead Level (BLL) screening (test) will be done at the visit.

Documentation: Risk assessment findings per the Bright Futures periodicity schedule with selective BLL screening (test) if there is a positive response or a change in risk.

902.4.6.4.2. Blood Lead Level (BLL) Screen:

902.4.6.4.2.1. A BLL screening (test) is required at 12 and 24

months.

902.4.6.4.2.2. Children between the ages of 36 months and 72 months*:* All children in this age range must receive one BLL screening IF they have not previously been tested for lead exposure.

902.4.6.4.2.3. ALL **venous** sample lead screening tests conducted using any Magellan Diagnostic lead testing system should be laboratory analyzed by a properly accredited laboratory (rev 07/17).

Documentation*Error! Bookmark not defined.****:*** Test results as well as any further evaluation, treatment or counseling for results outside of the normal limits must be documented in the medical record.

Note: Completing a lead risk assessment questionnaire **DOES NOT** count as a blood lead level screening and does not meet Medicaid requirements.

The Georgia Healthy Homes and Lead Poisoning Prevention Program (GHHLPPP) at 404-657-6534 has a Lead Risk Assessment Questionnaire that the provider may choose to us. The questionnaire can be accessed at Healthy Homes and Lead Poisoning Prevention | Georgia Department of Public Health

Resource: See Appendix A: Guidelines for Elevated BLL. These must be used if a child has results outside normal limits.

902.4.6.5. Tuberculin Risk Assessment and Test:

902.4.6.5.1. **Tuberculin Risk Assessment:** Required at the 1-, 6-, 12-, and 24-month visits then annually beginning at age 3 years. An assessment is given using a risk assessment questionnaire. The questionnaire should assess at least four (4) major risk factors:

902.4.6.5.1.1. Contact with TB disease

902.4.6.5.1.2. Foreign birth

902.4.6.5.1.3. Foreign travel to TB endemic countries; and

902.4.6.5.1.4. Household contact with TB

902.4.6.5.2. The AAP Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents recommends asking the following questions:

902.4.6.5.2.1. Was your child born in a country at high risk for tuberculosis?

902.4.6.5.2.2. Has your child traveled (had contact with resident populations) for longer than 1 week to a country a high risk for tuberculosis?

902.4.6.5.2.3. Has a family member or contact had tuberculosis or a positive tuberculin skin test?

Documentation:
Validated risk assessment and responses. If positive on initial risk assessment questions, there should be

a TB test recorded.

Resources: https://brightfutures.aap.org/materials-and-tools/Pages/default.aspx

902.4.6.5.3. Tuberculin Test
TB testing is not required at any age. The TB test is only administered to a child when questions are positive on the TB risk assessment or as the practitioner designates.

***Documentation**:* If administered, a recorded Tuberculin skin test. If the practitioner needs to defer testing for reasons that cannot be validated with professionally written guidelines, consult with state TB experts. If a child cannot be given the screening test on this day, a follow-up visit is necessary. Document risk appropriate attempts to contact and re-schedule the appointment if the parent fails to keep the follow up appointment.

If the TB skin test result for a high-risk child less than six (6) months is negative, please retest the child at six (6) months of age.

For more information visit the Georgia Department of Public Health Tuberculosis (TB) Prevention and Control Program.

902.4.6.6. Dyslipidemia

902.4.6.6.1. Risk Assessment and selective screening when indicated: At the 2, 4, 6, 8 year and adolescence (12 through 16 year) visits.

902.4.6.6.2. **Screening:** Once between 9 and 11 years and once between 17 and 20 years: Universal screening is needed if not done previously in late adolescence (see periodicity schedule).

902.4.6.6.3. **Documentation:** Results of risk assessment and screening. Abnormal findings during assessment or screening

require further evaluation, follow-up or parental counseling.
Resource: See AAP-endorsed 2011 guidelines from the National Heart Blood and Lung Institute, "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).

902.4.6.7. Sexually Transmitted Infections (STIs):

902.4.6.7.1. **Risk Assessment:** At the 11 through 20-year visits.

902.4.6.7.2. **Screening:** Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*."

902.4.6.7.3. **Documentation:** Results of risk assessment and screening. Abnormal findings during assessment or screening require further evaluation, treatment, follow-up, referral or parental counseling.

902.4.6.8. Human Immunodeficiency Virus (HIV):

902.4.6.8.1. **Risk Assessment:** At the 11 through 14 year and 19 through 20-year visits.

902.4.6.8.2. **Screening:** Adolescents should be screened for HIV once between the ages of 15 and 18 years, according to the USPSTF recommendations, Recommendation: Human Immunodeficiency Virus (HIV) Infection: Screening | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org) making every effort to preserve confidentiality of the adolescent. 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.

902.4.6.8.3. **Documentation**: Results of risk assessment and screening. Abnormal findings during assessment or screening require further evaluation, treatment, follow-up, referral or parental counseling.

Refer to the Part II Policies and Procedures For Independent Lab Services Program Manual for in-office procedure codes are available for reimbursement for the routine HIV screening.

902.4.6.9. Cervical Dysplasia (Pap Test)

902.4.6.9.1. Adolescents should not be routinely screened for cervical dysplasia prior to age 21 years.

Indications for pelvic exams prior to age 21 are noted in the "Gynecologic Examination for Adolescents in the Pediatric Office Setting" (http://pediatrics.aappublications.org/content/126/3/583.full)

902.4.7. Oral Health

Every child should begin to receive oral health risk assessments by 6 months of age. The AAP recommends both the establishment of a dental home and the first dental exam no later than 12 months of age. Assessing for a dental home should occur at the 12-month and 18-month through 6-year visits.

902.4.7.1. Oral Health Visits

902.4.7.1.1. **Risk Assessment:** At the 6 and 9 month visits, conduct an oral health risk assessment.
Encourage the parent to select a dental home.

902.4.7.1.2. For the 12-, 18-, 24-, and 30-month visits, assess whether the child has a dental home. If no dental home is identified, perform a risk assessment and refer to a dental home. Recommend brushing with fluoride toothpaste in the proper dosage for age. See Maintaining and Improving the Oral Health of Young Children." For those at high risk, consider application of fluoride varnish

for caries prevention.

902.4.7.1.3. At 3 and 6 years: Determine if the patient has a dental home. If not, a referral must be made. If a dental home has not been established, perform a risk assessment. For those at high risk, consider application of fluoride varnish for caries prevention.

902.4.7.1.4. ***Documentation:*** Document a referral or inability to refer to a dental home if one has not been established. Document the risk assessment if less than 6 years and dental home not established. Document dental appointment for older children and care per AAPD periodicity schedule. Any abnormal findings must have an appropriate intervention for all children.
An oral health risk assessment tool has been developed by the AAP/Bright Futures. This tool can be accessed at oralhealth_RiskAssessmentTool.pdf (aap.org)
(www.aap.org/oralhealth)
(rev 07/17)

902.4.7.2. Fluoride Varnish

902.4.7.2.1. Once teeth are present, the application of fluoride varnish is required and may be applied every 3-6 months in the primary care or dental office for children between the ages of 6 months and 5 years. Indications for fluoride use are noted in the 2014 AAP clinical report "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/cgi/doi/10.1542/peds.2014-1699)

902.4.7.2.2. **Documentation***:* Evidence that fluoride varnish was applied once between the ages of 6 months and 5 years OR evidence that the provider addressed the fluoride varnish requirement and/or its importance with the parent.

902.4.7.3. Fluoride Supplementation

Starting at tooth eruption, fluoridated toothpaste is

recommended.
AAP clarifies recommendations on fluoride use in primary care | AAP News | American Academy of Pediatrics (http://www.aapd.org/media/policies_guidelines/g_fluoridetherapy.pdf)

If primary water source is deficient in fluoride, consider oral fluoride supplementation. See "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626)

902.4.7.3.1. **Risk Assessment:** Required at the 6 through 12-month visits, 18 month through 30 month visits, and then annually beginning at 3 years through 16 years.

902.4.7.3.2. **Documentation***:* Evidence that the provider addressed the fluoride supplementation requirement and/or its importance with the parent.

902.4.8. Anticipatory Guidance Procedure

902.4.8.1. **For all ages:** Anticipatory guidance and health education must be offered. It is a federally required component of the EPSDT preventive health visit. Age-appropriate topics/information must be presented during each visit. Providers may use oral and written information. Providers may refer to the specific guidance by age as listed in the Bright Futures Guidelines.

Providers must document discussion or provision of guidance for all children on Injury and Violence Prevention. Bright Futures Guidelines recommend and DCH requires sleep positioning counseling and documentation of such at every visit for members aged birth to six (6) months. DCH encourages sleep positioning counseling through the nine (9) month visit.

902.4.8.2. ***Documentation:*** Topics or name of handout given.

902.4.9. Referral/Treatment noted between the PCP and Specialist *or* Follow-Up for Abnormal Values

902.4.9.1. All suspicious or abnormal findings identified during an EPSDT visit must be treated or be further evaluated. The provider must either treat (if qualified) or refer all members with abnormal findings.

902.4.9.2. Documentation: Evidence of appropriate plan of care, treatment or referral for all components, results, and

overriding concerns.

903. Required Equipment and Required Location Where Services Are To Be Provided

In addition to an examination table and routine supplies, providers **must** have appropriate equipment in order to complete the EPSDT preventive health exam, such as:

903.1. Scale for weighing infants and other children;

903.2. Measuring board or appropriate device for measuring length or height in the recumbent position for infants and children up to the age of two (2) years;

903.3. Measuring board or accurate device for measuring height in the vertical position for children who are over two (2) years old;

903.4. Blood pressure apparatus with infant, child and adult cuffs;

903.5. Screening audiometer;

903.6. Eye charts appropriate for age of the child;

903.7. Ophthalmoscope and otoscope;

903.8. Developmental/Behavioral Health screening tools and supplies for the following:

903.8.1. Developmental Screening - The required developmental screenings at ages 9 months, 18 months, and 30 months must be accomplished using one or more of the recommended standardized developmental screening tools specified in Section 902.2.

903.8.2. Autism Screening

903.8.3. Depression Screening

903.8.4. Maternal Depression Screening

903.8.5. Tobacco, Alcohol, or Drug Use Assessment

903.9. Vaccines and immunization administration supplies; and

903.10. Lab supplies for appropriate lab tests/screenings.

903.10.1. The provider may also have a Centrifuge or other device for measuring hematocrit or hemoglobin

904. Periodic, Catch-up and Interperiodic Visits

The Georgia Department of Community Health, Division of Medicaid adopted the updated Bright Futures Periodicity Schedule and the schedule's components as the guidelines for each EPSDT preventive health visit. Please use these guidelines, the following tables and the EPSDT HIPAA referral codes (See Section 911) when billing **for the EPSDT visit.**

904.1. On Time EPSDT Periodic Visit Procedure Codes (Table A)

904.1.1. Use Table A when billing for the EPSDT periodic visits of children who are on time for their visits according to the updated Bright Futures Periodicity schedule. One visit from each sequence may be billed.

Table A **On Time EPSDT Preventive Health Visits**	
CPT Codes (include modifier EP)	**ICD-10-CM Codes**
99381, 99391 Infant (birth to 28 days)	**Z00.110** Health supervision for newborn under 8 days old **OR** **Z00.111** Health supervision for newborn 8 to 28 days old **OR** **Z02-Z02.89** (age 0 through 20 years)
99381, 99391 Infant (29 days to 1 year)	**Z00.121** Routine child health exam *with abnormal findings* **OR** **Z00.129** Routine child health exam *without abnormal findings* **OR** **Z02-Z02.89**
99382, 99392 Early childhood (age 1-4 years) **99383, 99393** Late childhood (age 5-11 years) **99384, 99394** Adolescent (age 12-14 years)	**Z00.121 or Z00.129 or Z02-Z02.89**
99384, 99394 Adolescent (age 15-17 years)	**Z00.121 or Z00.129 or Z02-Z02.89 or** **Z00.00** General adult medical exam *without abnormal findings* **OR** **Z00.01** General adult medical exam *with abnormal findings*
99385, 99395 (age 18-20 years)	**Z00.00 or Z00.01 or Z02-Z02.89**

904.1.2. Use the preventive visit codes (99381-99385, 99391-99395) for Medicaid-eligible and PeachCare for Kids® (PCK)-eligible children. All preventive visits must be coded with the EP modifier (Refer to Table A) and appropriate diagnosis code. The 25 modifier must be included when a vaccine is administered during the preventive visit. A preventive visit that is not performed as specified in the periodicity schedule should be coded as a catch-up visit (Refer to Table B.) Catch-up visits are only available for children younger than three (3) years of age.

904.1.3. If an abnormality/ies is encountered or a preexisting problem is addressed during the EPSDT Periodic visit, and if the problem/abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M (evaluation and management) service, then the appropriate Office/Outpatient code (99202-99205, 99211-99215) should also be reported. If the member is a new patient, defined as one who has not received any EPSDT services (face-to-face services reported with a CPT code) from a practitioner or any practitioner within the same group practice of the exact same specialty or subspecialty within the past 3 years, code the EPSDT preventive visit using the 9938x codes. If the member is an established patient, defined as one who has received an EPSDT service from a practitioner or any practitioner within the same group practice of the

same specialty or subspecialty within the past 3 years, code the EPSDT preventive visit using the 9939x codes. Use the appropriate E/M code (99202-99205, 99211-99215) for the office visit component.

904.1.4. Modifier EP and 25 should be added to the Office/Outpatient code to indicate that a significant, separately identifiable Evaluation and Management service was provided by the same EPSDT provider on the same day as the EPSDT Periodic visit. The appropriate EPSDT Periodic visit code is additionally reported. If an abnormality/ies is encountered use the appropriate HIPAA diagnosis code which relates to the medical service(s) provided.

904.2. Catch-Up EPSDT Visit Procedure Codes (Table B)

<table>
<tr><th colspan="3">Table B
Catch-Up Preventive Health Visits</th></tr>
<tr><th>Age of Child</th><th>HIPAA Proc Code
(include modifiers EP HA)</th><th>ICD-10-CM Codes</th></tr>
<tr><td rowspan="2">0 days through
11 months</td><td>99381</td><td rowspan="3"><u>Z00.110</u>
Health supervision for newborn under 8 days old

<u>Z00.111</u>
Health supervision for newborn 8 to 28 days old

<u>Z00.121</u>
Routine child health exam with abnormal findings

<u>Z00.129</u>
Routine child health exam without abnormal findings

Z02 – Z02.89 (age 0-3 years)</td></tr>
<tr><td>99391</td></tr>
<tr><td rowspan="2">12 months up to
3 years</td><td>99382</td></tr>
<tr><td>99392</td><td></td></tr>
</table>

904.2.1. Use Table B when billing for the EPSDT periodic visits of children who have missed one or more of their EPSDT periodic visits according to the updated Bright Futures Periodicity schedule and need to get caught up with the Periodicity schedule.

904.2.2. Use Table B for Medicaid-eligible and PeachCare for Kids®-eligible children who have missed their EPSDT periodic visit(s). Catch-up preventive visits are only available for children younger than three (3) years of age. All catch-up preventive visits must be coded with the EP and HA modifiers and appropriate diagnosis code (see Table B). The 25 modifier must be included when a vaccine is administered during the catch-up preventive visit.

904.2.3. The Health Check provider must complete all missed components during this catch-up visit but may only bill for one catch-up visit (*Example - Child presents to the Health Check provider at eight (8) months of age and has missed the four- and six-month periodic visits.*

All components of the four- and six-month periodic visits must be included during the present catch-up visit and documentation must be provided for all periodic visit components included during this catch-up visit.) The appropriate EPSDT Catch-Up visit procedure code along with the EP and HA modifiers and appropriate diagnosis code (see Table B) must be included on the claim.

904.2.4. If abnormalities are encountered or a preexisting problem is addressed during the EPSDT Catch- Up visit, and if the problem/abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then the appropriate Office/Outpatient code (99202-99205, 99211-99215) should also be reported. The provider should use the appropriate HIPAA diagnosis code that relates to the medical service(s) provided and include modifiers EP and 25.

904.2.5. If the member is a new patient, one who has not received any EPSDT services (defined as face-to-face services reported with a CPT code) from a practitioner or any practitioner within the same group practice of the exact same specialty or subspecialty within the past 3 years, code the EPSDT preventive visit using the 9938x codes. If the member is an established patient, defined as one who has received an EPSDT service from a practitioner or any practitioner within the same group practice of the same specialty or subspecialty within the past 3 years, code the EPSDT preventive visit using the 9939x codes. Use the appropriate E/M code (99202-99205, 99211-99215) for the office visit component.

904.3. Interperiodic EPSDT Visits Procedure Codes (Table C)

904.3.1. Use Table C when billing interperiodic visits for the EPSDT Medicaid-eligible and PeachCare for Kids®-eligib**le** children who are up to date on their periodic visits but have been referred because of a suspected problem to a qualified health provider or have a medical necessity for another visit: i.e. referred to the EPSDT provider because of a suspected problem by a health, developmental, or educational professional who comes into contact with the child outside of the formal health care system or a need identified by the provider or parent. The complete set of EPSDT preventive health visit components does not have to be performed. EPSDT providers must document the correct level of care when using office visit codes.

Table C
Interperiodic EPSDT Visit Procedure Codes

Include modifier EP and use appropriate HIPAA diagnosis code that relates to the medical service(s) provided.

New Patient	Established Patient
	99211
99202	99212
99203	99213
99204	99214

99205	99215

904.3.2. Code the EPSDT interperiodic visit (99202-99205, 99211-99215) with the EP modifier. When vaccines are administered during the interperiodic visit, code the EPSDT interperiodic visit (99202-99205, 99212-99215) with the EP and 25 modifiers. The National Correct Coding Initiative (NCCI) does not allow reimbursement of the 99211 code when it is billed together with any of the vaccine administration codes (90460, 90471-90474).

904.4. Interperiodic Vision and Hearing Screening (Table D)

Table D **Interperiodic Vision and Hearing Screening** (include modifier EP)			
HIPAA Procedure Code	**Interperiodic Screening**	**ICD-10 Diagnosis Code**	**PCK and FFS Rate**
99173	Interperiodic Vision	Z01.00 or Z01.01 Or appropriate abnormal results code	$5.62
V5008, 92551–92553, 92555-92556	Interperiodic Hearing	Z01.10 or Z01.110 Or Z01.118 Or appropriate abnormal results code	$5.62

904.4.1. Per the Federal EPSDT policy guidelines, interperiodic screening, vision, hearing, and dental services which are medically necessary to determine the existence of suspected physical or mental illnesses or conditions are to be provided.

904.4.2. An enrolled provider may use the codes as indicated in Table D when billing for vision and/or hearing screening only. For example, a recheck of a failed hearing screening or a child who needs Form 3300 (Certificate of Vision, Hearing, Dental and Nutrition Screening) completed. Separate reimbursement is not allowed when these screenings are performed during the periodic preventive visit.

Note: The Georgia Department of Public Health's Form 3300 has been revised to document a nutrition screening. More information and a copy of the form can be found at: https://georgia.gov/get-required-health-records-attend-school (04/25)

904.4.3. The determination of whether an interperiodic screen is medically necessary may be made by a health, developmental, or educational professional who encounters the child outside of the formal health care system [e.g., State early intervention or special education programs, Head Start and day care programs, the Special Supplemental Food Program for Women, Infants and Children (WIC), and other nutritional assistance programs].

904.5. Other helpful information

904.5.1. The blood lead level screening is due at the 12- and 24-month preventive visits and the preventive visit will not be reimbursed without documentation that the blood lead level screening occurred.

904.5.2. FFS providers must submit the CPT code 83655 with modifier EP and 90 or 91 along with the CPT code 36415 or 36416 modifier EP and appropriate ICD-10 diagnosis code (i.e., Z13.88, Z00.121, Z00.129, Z77.011) to signify blood lead level screening.

904.5.3. Reimbursement for immunization administration will be provided when vaccines are administered and properly coded on the claim by the provider.

904.5.4. The appropriate EPSDT Referral Code should be documented on the EPSDT claim when an EPSDT preventive visit has occurred. (See Section 911 – EPSDT HIPAA Referral Codes and Appendix H – EPSDT HIPAA Referral Code Examples.)

905. Immunizations

905.1. Recommended Immunization Schedules:

Current immunization schedules from the Advisory Committee on Immunization Practices (ACIP) should be used as the guidelines for administering immunizations.

ACIP recommendations must be read along with the footnotes of each schedule.

Refer to the following ACIP immunization schedules:

905.1.1. Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger

905.1.2. Catch-up Immunization Schedule for Children and Adolescents who start late or who are more than 1-month behind

905.1.3. Recommended Child and Adolescent Immunization Schedule by Medical Indication

905.1.4. Recommended Adult Immunization Schedule by Age Group

905.1.5. Recommended Adult Immunization Schedule by Medical Condition and Other Indications

905.2. Delayed Immunizations

Practitioners who begin the immunization process on children who are late or at times other than the recommended optimal immunization schedule may use recommendations from the ACIP Catch-up Immunization Schedule for Children and Adolescents who start late or who are more than 1-month behind.

905.3. Vaccines for Children (VFC) Program

It is recommended that all Health Check providers enroll in the VFC Program to provide immunizations to Medicaid eligible children whose ages are birth through

eighteen (18) years of age. If the Health Check provider giving the EPSDT preventive health exam does not wish to participate in the VFC Program, it is expected that they administer vaccines at the time of service and understand that only the administration fee will be reimbursed. The VFC Program is a federally funded and state operated vaccine supply program that began October 1, 1994. The program supplies, at no cost to all public health and private health care providers, federally purchased vaccines to be administered to children in certain groups. Children eligible to receive VFC-provided vaccines include the following:

905.3.1. children enrolled in Medicaid;

905.3.2. children who do not have health insurance

905.3.3. children who are American Indian or Alaskan native; and

905.3.4. children who have health insurance but for whom vaccines are not a covered benefit.

905.3.5. PeachCare for Kids® members may receive state purchased vaccines. Questions regarding enrollment and vaccine orders should be directed to the appropriate VFC program (1-800-848-3868).

905.3.6. Since vaccines are provided at no cost to the Health Check provider for children eighteen (18) years and younger, only administration costs are allowed to be submitted for reimbursement for vaccines administered to this age group.

905.4. Tdap and Meningococcal Requirements

905.4.1. 7th Grade Immunization Requirements

Beginning in the 2014-2015 academic school year (effective July 1, 2014), the Georgia Department of Public Health (DPH) Rule (511-2-2) requires all students born on or after January 1, 2002 entering or transferring into seventh (7th) grade and any "new entrant" entering into 8th-12th grades in Georgia must provide proof that the student has received one dose of Tdap (tetanus, diphtheria, pertussis) vaccine and one dose of meningococcal conjugate (MCV4) vaccine. DPH guidelines state that the student must have received the meningococcal vaccine on or after their 10th birthday for entry into the 7th grade. A student that received the meningococcal vaccine before their 10th birthday will need to be revaccinated on or after his/her 10th birthday. There is a minimum time interval of 8 weeks between the previous dose of the MCV4 vaccine and the newly required dose.

This law affects all public and private schools including, but not limited to, charter schools, community schools, juvenile court schools and other alternative school settings (excluding homeschool). "New Entrant" means any child entering any school in Georgia for the first time or entering after having been absent from a Georgia school for more than twelve months or one school year.

905.4.2. 11th Grade Immunization Requirements

Georgia's immunization requirements for students entering or transferring into the eleventh grade have been revised to align with the current recommendations of the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).

Beginning in the 2020-2021 academic school year (effective July 1, 2020), all students who are new entrants or transfers into a Georgia school in the eleventh grade, will require proof of a booster dose of the meningococcal conjugate vaccine, unless their first dose was received on or after their sixteenth birthday. Georgia law requires students be vaccinated against this disease, unless the child has an exemption.

School Vaccines and Updates | Georgia Department of Public Health (04/2025)

906. Diagnostic, Treatment and Referral Services

906.1. All suspicious or abnormal findings identified during an EPSDT preventive health visit must be treated or be further evaluated.

906.2. When an EPSDT service is needed but not performed during the EPSDT preventive health visit, the child provider should be appropriately referred for diagnosis.

906.3. For non-CMO (care management organization) Medicaid and PeachCare for Kids® Fee-For Service (FFS) members, the screening provider must either treat (if qualified) or refer all members with abnormal findings. Members needing referrals must be appropriately referred to Medicaid or PeachCare for Kids® enrolled providers. For information on billing levels allowed for treatment during the EPSDT periodic and interperiodic visits, see section 1003. Billing Tips.

906.4. If the provider is not the member's EPSDT PCP, the provider must notify the member's PCP of the preventive health/interperiodic visit to discuss any clinical findings which require prompt medical attention.

906.5. Referral and prior authorization may be required for children who are assigned a PCP.

906.6. The level of treatment required should determine whether additional services are billed or provided during the EPSDT scheduled visit.

907. Lead Screening

The purpose of screening for lead absorption is to identify children who have either symptomatic or asymptomatic lead poisoning and to intervene as quickly as possible to reduce their blood lead levels.

907.1. Since 1989, Federal law has required that children enrolled in Medicaid must have their blood lead level measured at 12 and 24 months of age.

907.2. A blood lead test, capillary or venous, must be used when screening Medicaid-eligible

children. A capillary Blood Lead Test that is elevated (≥ 3.5ug/dL reported by a certified lab) must be confirmed with a repeat Blood Lead Test (confirmatory venous specimen is preferred) at a certified laboratory.

907.3. ALL venous sample lead screening tests conducted using any Magellan Diagnostic lead testing system should be laboratory analyzed by a properly accredited laboratory.

907.4. Lead Health Education and Anticipatory Guidance

Health education is a required component of screening services **(**EPSDT benefit in accordance with section 1905(r) of the Act) and includes anticipatory guidance.

907.4.1. Anticipatory Guidance regarding Lead Exposure should be provided to families when children are:

907.4.1.1. 3-6 months of age and again at 12 months.

907.4.1.2. Between the ages of 24 and 72 months at well-child visits and when a lead risk assessment questionnaire is administered.

907.4.2. The following topics should be covered with anticipatory guidance:

907.4.2.1. Effects of lead poisoning on children

907.4.2.2. Sources of lead poisoning

907.4.2.3. Pathways of exposure (including placental exposure)

907.4.2.4. How to prevent a child's exposure to lead hazards

907.4.2.5. Appropriate schedule for testing children for lead poisoning

907.5. Lead Case Management

All children whose initial screening test shows an elevated blood lead level should follow the Georgia Healthy Homes and Lead Poisoning Prevention Program's (GHHLPPP) Case Management Guidelines. Georgia Department of Public Health (DPH) Lead Hazard Risk Assessors, under the guidance of the GHHLPPP, will perform an environmental lead risk assessment for all children with a confirmed blood lead level of ≥3.5 ug/dL, as well as provide education about low-cost methods to reduce identified lead hazards. As a primary care provider, you will be notified by a DPH Lead Hazard Risk Assessor of the results of the environmental lead risk assessment and remediation recommendations.

Refer to the GHHLPPP Case Management Guidelines located in Appendix A, Guidelines in Screening and Reporting Elevated Blood Lead Levels.

908. Oral Health and Dental Services

Per the Federal EPSDT policy guidelines, dental services must be provided to eligible members under twenty-one years of age. Dental services required under the EPSDT benefit include:

908.1. Dental care needed for relief of pain, infection, restoration of teeth, and maintenance of dental health (provided at as early an age as necessary); and

908.2. Emergency, preventive, and therapeutic services for dental disease that, if left untreated, may become acute dental problems or cause irreversible damage to the teeth or supporting structures.

908.3. In addition, medically necessary oral health and dental services, including those identified during an oral screening or a dental exam, are covered under the EPSDT benefit.

908.4. Refer to the Dental Services Program Policy and Procedures Manual.

908.5. In accordance with the American Academy of Pediatric Dentistry (AAPD) – Oral Health Policies & Recommendations (The Reference Manual of Pediatric Dentistry), dental providers should refer to the Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents for best practice recommendations about anticipatory guidance and timing of other clinical modalities which promote oral health during infancy, childhood, and adolescence. The AAPD intends these recommendations to help practitioners make clinical decisions concerning preventive oral health interventions, including anticipatory guidance and preventive counseling, for infants, children, and adolescents. The Recommended Dental Periodicity Schedule for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling may be assessed at https://www.aapd.org/globalassets/media/policies_guidelines/bp_recdentperiodschedule.pdf

909. Other Related Medicaid Programs (This is not an inclusive list)

See the policies and procedures manual of the related programs for complete information. Provider Manuals relevant to EPSDT providers include, but may not be limited to:

909.1. Advanced Nurse Practitioner Services

909.2. Autism Spectrum Disorder (ASD) Services

909.3. Children's Intervention Services (CIS)

909.4. Children's Intervention School Services (CISS)

909.5. Dental Services

909.6. Diagnostic Screening and Preventive Services (DSPS)

909.7. Durable Medical Equipment (DME) Services

909.8. Federally Qualified Health Center (FQHC) Services

909.9. Georgia Pediatric Program (GAPP)

909.10. Hospice Services

909.11. Hospital Services

909.12. Medicaid Medicaid/PeachCare for Kids® Provider Billing Manuals

909.13. Nurse Midwifery Services

909.14. Orthotic and Prosthetic Services

909.15. Pharmacy Services

909.16. Physician Assistant Services

909.17. Physician Services

909.18. Rural Health Clinic (RHC) Services

909.19. Vision Care Services

Provider Manuals are available for downloading. Contact Gainwell Technologies (rev 01/21) at 1-800-766-4456 or visit the website at www.mmis.georgia.gov for more information.

910. Summary of Non-covered Services

Non-Covered Services include services provided in a manner inconsistent with the provisions of this manual.

911. EPSDT Profile (Appointment Tracking System)

911.1. The purpose of the EPSDT Appointment Tracking System is to track enrolled Fee-For-Service children eligible for services and to assist providers in conducting and documenting outreach and follow-up activities to EPSDT families and children.

911.2. The EPSDT Appointment Tracking System fully supports the State's goals of providing appropriate and continuing screening and treatment services to Georgia's children and of preventing more costly health problems by encouraging regular health care.

911.3. This system provides immediate access to medical and dental information on EPSDT members through online inquiry and provides a reminder call system at no cost to the EPSDT provider. These capabilities enhance the control and operation of the EPSDT program and allow information gathering to support research and program development.

911.4. In collaboration with the monthly EPSDT roster (Periodic Screenings Due Report), the EPSDT Profile (Appointment Tracking System) provides:

911.4.1. Member's demographic information in addition to the last dates for Hearing (Interperiodic Hearing), Vision (Interperiodic Vision), EPSDT Medical and Dental screenings.

911.4.2. Detailed information on the member's entire EPSDT history. This allows the provider to view the member's entire EPSDT history and document outreach attempts as a result of letters/rosters distributed. Based on the notice type distributed by Gainwell Technologies (rev 01/21), all the provider has to do is document the member's response

and a response date. For example, if the provider arranges a future appointment with the member, he/she will select scheduled appointment under the drop down box for response type and enter the date of the appointment under response date.

911.5. The Response Type options on the drop-down box are:

911.5.1. Set Appointment (EPSDT preventive health screening visit)

911.5.2. Set Appointment (Dental)

911.5.3. Set Appointment (Blood Lead).

911.5.4. Screen Completed

911.6. The last section of the EPSDT Profile is the critical health information. EPSDT medical and dental providers are encouraged to enter information determined to be useful to another Health Care professional in the delivery of care to the member (For example, allergic to Penicillin).

911.7. If you need further instructions, feel free to click on the help link.

912. EPSDT HIPAA Referral Codes

The Centers for Medicare and Medicaid Services (CMS) defines an EPSDT referral as a member scheduled for another appointment with the EPSDT Provider or a referral to another provider for further needed diagnostic and treatment services as a result of at least one health problem identified during the EPSDT preventive health visit. Effective with HIPAA implementation, CMS and DCH require documentation of EPSDT Referral Codes when submitting EPSDT Screening Code Claims (See Appendix H for examples). When completing the Health Insurance Claim Form [*CMS-1500*], the EPSDT Referral Codes must be entered in the shaded area of box 24H. (See Appendix I)

912.1. Example 1: If the EPSDT screening is normal, the referral code is NU (No follow up visit needed)

912.2. Example **2**: If the EPSDT screening indicates the need for further diagnostic and treatment services and a follow-up visit is necessary, use the applicable referral code(s):

912.2.1. AV Available, Not Used: Patient refused referral

912.2.2. S2 Under Treatment: Patient is currently under treatment for health problem and has a return appointment

912.2.3. ST New Services Requested: Referral to another provider for diagnostic or corrective treatment scheduled

913. Access to Mental Health Services

Health Link operates the Georgia Crisis and Access Line (GCAL) through a contract with the Department of Behavioral Health and Developmental Disabilities (DBHDD). To access mental health, addictive disease, and crisis services 24 hours a day, 7 days per week call 1-

800-715-4225 (GCAL) or go to www.mygcal.com

914. Services for Foster Care Children

As of March 3, 2014, children, youth, and young adults in state custody, children receiving adoption assistance and a select group of children under the Juvenile Justice system, were transitioned to Medicaid managed care under the Georgia Families 360º Program. Amerigroup Community Care is the single Care Management Organization (CMO) managing this population (see Appendix M). Children in state custody under the Kenny A. Consent Decree are required to have an EPSDT preventive health visit and a dental visit within 10 days of official transition to state custody. Unless otherwise noted, EPSDT services for all other children enrolled in the Georgia Families 360º Program should follow the Bright Futures Periodicity Schedule.

CHAPTER 1000: Basis for Reimbursement

1001. Fee for Service

The Division will pay the lower of the lowest price regularly and routinely offered to any segment of the general public for the same service or items on the same date(s) of service, the lowest price charged to other third party payers, or effective with dates of service July 1, 2003, the statewide maximum allowable reimbursement which is 84.645% of Medicare's Resource Based Relative Value Scale (RBRVS) for 2000 for Region IV (Atlanta). All procedure codes recognized and adopted after the 2000 RBRVS are subject to the statewide maximum allowable reimbursement – 84.645% of the Region IV Medicare RBRVS in effect at the time the procedure code was adopted

1002. Vaccines for Children

Since the Vaccines For Children (VFC) program supplies vaccines to providers at no cost to the provider for children birth through eighteen (18) years who have Medicaid, the Division will reimburse an administration fee only for immunizations given to Medicaid enrolled children of this age group. These fees cover the cost of administering the immunizations as well as any paperwork involved (including an immunization or health certificate). Refer to Appendix C for the reimbursement rates for the administration of vaccines provided by the VFC program for the Medicaid-eligible children birth through eighteen (18) years. Appendix C also includes the reimbursement rate for the administration of state-purchased vaccines for the PeachCare for Kids® Fee for Service population, for children birth through age eighteen (18) years.

For members nineteen (19) years of age through twenty (20) years of age, VFC stock is not available. Providers must use their own stock of vaccines for these Medicaid eligible members. Health Check providers may include a vaccine administration code on their EPSDT claims when vaccines are administered to members nineteen (19) years of age through twenty (20) years of age. The Division will reimburse for the vaccine product and for vaccine administration. Billing tips for vaccine administration and the effective date for this change are in Appendix C of this manual and providers are strongly encouraged to follow those tips.

1003. Billing Tips

The following are tips to assist with billing for EPSDT screening services and interperiodic visits.

1003.1. The EPSDT preventive health visit is reimbursed as a package of services. All of the age appropriate EPSDT preventive health visit components (as identified in the Bright Futures periodicity schedule) must be completed for each screening visit and billed under one procedure code except where indicated. All preventive or well-child services, except normal newborn care in the hospital, must be billed under the EPSDT Program following the policies and procedures as outlined in this manual.

1003.2. EPSDT preventive health visits must be referred by or performed by the child's primary care practitioner for those services to be reimbursed. Only one (1) periodic preventive or well-child visit will be reimbursed per member at each age-appropriate interval, as specified in the periodicity schedule (excluding foster care members).

1003.3. Providers must perform the age-appropriate hearing and vision screening in order to be reimbursed for the complete EPSDT preventive health exam. Providers may not refer the child to another provider for hearing and vision screening which is required at the time of the EPSDT

preventive health visit.

1003.4. When a visit is found to be medically necessary between periodic visit sequences, the EPSDT provider may be reimbursed by billing the appropriate interperiodic visit procedure code. An interperiodic visit cannot be billed on the same date of service as a complete EPSDT preventive health visit.

1003.5. The Georgia Medicaid program reimburses for many of the Diagnostic and Treatment services under other Medicaid programs.

1003.6. Office Visit Codes

1003.6.1. Providers must use place of service (POS) code 99 when billing office visits for EPSDT preventive health screening services. All diagnostic x-ray, laboratory testing (except hematocrit, hemoglobin) and/or treatment services provided to the EPSDT member at the time of the preventive health visit, can be billed on the same CMS 1500 claim form as the EPSDT preventive health visit if the EPSDT provider uses a CMS 1500 form to bill Diagnostic and Treatment Services (i.e., Physician Services, Nurse Practitioner Services, etc.).

Effective May 1, 2015, paper claims are no longer accepted by Gainwell Technologies (rev 01/21). As part of the Georgia Paperless Initiative, providers are required to submit CMS 1500 claims electronically over the GAMMIS web portal. For more information regarding the Paperless Initiative, please access the web portal and review all related Banner Messages.

If an EPSDT provider uses a UB 04 to bill Diagnostic and Treatment services (i.e., Hospitals, Rural Health Clinics, etc.), they may also bill the EPSDT preventive health visit services on the UB 04.

1003.7. Developmental Screenings

1003.7.1. Periodic Screening Visits

A developmental screening should be performed at the following periodic visits: 9, 18, and 30 months. Providers must bill code 96110 with the EP modifier and the appropriate preventive ICD-10 diagnosis code in order to receive reimbursement for this screening.

Only one (1) developmental screening will be reimbursed at each of these intervals. If the child is not seen at the 9-, 18-, or 30-month visit, a developmental screening should be performed during the catch-up visit for the missed periodic visit. This catch-up developmental screening should be billed, using the EP and HA modifiers with code 96110 and the appropriate preventive ICD-10 code. The provider can only bill one (1) catch-up developmental screening during any one (1) catch-up interval

1003.7.2. Non-Periodic Screening Visits (Sick Visits)

Developmental screenings when performed outside of the Bright Futures requirements can also be reported. A developmental screening may be performed, as needed, for members ages 3 years through 6 years of age. Providers must bill code 96110 with the EP,U1 modifiers and the appropriate ICD-10 diagnosis code in order to receive reimbursement for this screening.

1003.8. Autism Spectrum Disorder Screenings

1003.8.1. Periodic Screening Visits

Autism screenings should be performed at the 18- and 24-month periodic visits (or catch-up visits). Providers must bill code 96110 with the EP,UA or EP,UA,HA modifiers and the appropriate ICD-10 diagnosis code in order to receive reimbursement for this screening.

1003.8.2. Non-Periodic Screening Visits (Sick Visits)

Autism screenings when performed outside of the Bright Futures requirements can also be reported. Providers must bill code 96110 with the EP,UA modifiers and Z13.41 or the applicable ICD-10 diagnosis code to receive reimbursement for the screening.

For guidelines related to Autism Spectrum Disorder, including a list of acceptable Autism Spectrum Disorder Assessment Tools, refer to the Autism Spectrum Disorder policy manual.

1003.9. Behavioral/Social/Emotional Screening

Providers should bill procedure code 96127 with the EP modifier, POS 99 and the appropriate ICD-10 diagnosis code to receive reimbursement. Procedure code 96127 is reimbursed at the current default rate. Procedure code 96127 should be listed only once per claim for multiple units. The units submitted should not exceed acceptable medically unlikely edit (MUE) maximum established by CMS

1003.9.1. Periodic Screening Visits

Brief Emotional/Behavioral health risk assessments performed during the EPSDT periodic screening visit in accordance with the Bright Futures requirements may be reported (i.e., tobacco, alcohol, or drug use assessment; anemia risk assessment; lead risk assessment).

An annual depression screening should be performed for members ages 12 years through 20 years during the EPSDT periodic screening visit. When completed during the periodic visit, the depression screening can be reported as a brief emotional/behavioral assessment. Providers should bill code 96127 with the EP modifier, POS 99 and the appropriate ICD-10 diagnosis code to receive reimbursement.

1003.9.2. Non-Periodic Screening Visits (Sick Visits)

Brief emotional /behavioral assessments, when performed during non-periodic screening visits, can also be reported for the following:

1003.9.2.1. depression screenings (outside of the BF requirements); AND

1003.9.2.2. emotional/behavioral assessments conducted for other conditions, such as ADHD, suicidal risk, anxiety, eating disorders, etc.

Brief emotional /behavioral assessments performed during non-

periodic visits should be billed with the E/M office visit code (992xx) and reported with procedure code 96127, the appropriate ICD-10 diagnosis code, along with the EP modifier and POS 99.

1003.10. Patient-Focused Health Risk Assessments

Providers should bill procedure code 96160 with the EP modifier, POS 99 and the appropriate ICD-10 diagnosis code to receive reimbursement. Procedure code 96160 is reimbursed at the current default rate. Procedure code 96160 should be listed only once per claim for multiple units. The units submitted should not exceed acceptable medically unlikely edit (MUE) maximum established by CMS.

1003.10.1. Periodic Screening Visits

Patient Focused health risk assessments performed during the EPSDT periodic screening visit in accordance with the Bright Futures requirements may be reported (i.e., tobacco, alcohol, or drug use assessment; anemia risk assessment; lead risk assessment).

Providers should bill procedure code 96160 with the EP modifier, POS 99 and the appropriate ICD-10 diagnosis code to receive reimbursement. Code the health risk assessment (96160) with the EP, 59 modifiers when reporting the health risk assessment(s) and vaccine administration codes for the same visit.

1003.10.2. Non-Periodic Screening Visits (Sick Visits)

Health risk assessments when performed outside of the Bright Futures requirements can also be reported. Health risk assessments performed during non-periodic visits should be reported with procedure code 96160, the appropriate ICD-10 diagnosis code, along with the EP modifier and POS 99. Code the health risk assessment (96160) with the EP, 59 modifiers when reporting the health risk assessment(s) and vaccine administration codes for the same visit.

1003.11. Caregiver-Focused Health Risk Assessments

Providers should bill procedure code 96161 with the EP modifier, POS 99 and the appropriate ICD-10 diagnosis code to receive reimbursement. Procedure code 96161 is reimbursed at the current default rate. Procedure code 96161 should be listed only once per claim for multiple units. The units submitted should not exceed acceptable medically unlikely edit (MUE) maximum established by CMS

1003.11.1. Periodic Screening Visits

Caregiver focused health risk assessments performed during the EPSDT periodic screening visit in accordance with the Bright Futures requirements may be reported, (i.e., maternal depression screening).

A maternal depression screening should be performed during the following EPSDT periodic screening visits:

By 1 month

2 months

4 months

6 months

Providers should bill procedure code 96161 with the EP modifier, POS 99 and the appropriate ICD-10 diagnosis code to receive reimbursement. Code the caregiver focused health risk assessment (96161) with the EP, 59 modifiers when reporting the health risk assessment(s) and vaccine administration codes for the same visit.

1003.11.2. Non-Periodic Screening Visits (Sick Visits)

Caregiver focused health risk assessments when performed outside of the Bright Futures requirements can also be reported. Health risk assessments performed during non-periodic visits should be reported with procedure code 96161, the appropriate ICD-10 diagnosis code, along with the EP modifier and POS 99. Code the health risk assessment (96161) with the EP, 59 modifiers when reporting the health risk assessment(s) and vaccine administration codes (90460, 90471-74) for the same visit.

1003.12. Hematocrit and Hemoglobin Level

The laboratory tests due at the twelve (12) months visit for hematocrit and hemoglobin levels may be performed as in office tests at the time of the EPSDT preventive health visit by the PCP; or the blood sample may be obtained by the PCP and submitted to a Medicaid contracted lab; or the member may be sent to a Medicaid contracted lab for the blood draw and laboratory analysis. The PCP must document in the medical record which option was selected. These tests cannot be sent to a non-participating laboratory for analysis.

1003.13. Federally required Blood Lead Level (BLL) screening

If FFS EPSDT providers use private laboratories for BLL screening or perform BLL screening using an in-office Lead Analyzer, the EPSDT provider cannot file a claim for reimbursement of the BLL test.

The Georgia Public Health Laboratory provides analysis of blood lead specimen and charges a laboratory fee. Fee for Service providers may submit claims to DCH for this fee if the blood sample is obtained by them during the visit and sent to the GPHL for analysis. To ensure accurate reimbursement, FFS providers must submit the CPT code 83655 with modifier EP and 90 or 91 along with the CPT code 36415 or 36416 modifier EP and appropriate ICD-10 diagnosis code (i.e., Z13.88, Z00.121, Z00.129, Z77.011).

Additional details regarding this process are contained in Appendix A.

1003.14. Vaccine Administration

In order to receive the administration fee from the Division for administering federally or state purchased vaccines for children 0 – 18 years of age, the child must be a Medicaid or PeachCare for Kids® member. Since the federally or state purchased vaccines are provided at no cost to the provider, the Division will only reimburse an administration fee based upon the Division's maximum allowable rate. The vaccine's National Drug Code

(NDC) is not required to be included on the EPSDT claim for reimbursement for the administration of federally or state purchased vaccines for children 0-18 years of age.

Beginning April 1, 2013, providers should bill any of the following appropriate vaccine administration codes, when administering VFC vaccines, as they apply: 90460, 90471, 90472, 90473, 90474. Additional details regarding the use of the vaccine administration codes are contained in Appendix C.

EPSDT providers may bill the EPSDT Program for vaccines administered to members nineteen (19) years of age through twenty (20) years of age. Include the vaccine CPT code, diagnosis code, and NDC, along with the appropriate vaccine administration code**(s)** [90471, 90472, 90473, 90474] on the EPSDT claim. The Division will reimburse for the vaccine product (providers must use their own stock of vaccines) and for vaccine administration. Additional details regarding the use of the vaccine administration codes and the effective date for this change are contained in Appendix C.

1003.15. School-Based Vaccine Clinics

Public Health providers must use place of service (POS) code 03 when billing the vaccine administration fee for vaccines administered during school-based clinics held within their county of jurisdiction.

1003.16. School-Based Telemedicine Services

1003.16.1. LEAs enrolled as Health Check providers to serve as telemedicine originating sites only will be allowed to bill the telemedicine originating site facility fee (procedure code Q3014). The LEA provider should report procedure code Q3014 along with the EP and GT modifiers, POS 03, and the appropriate ICD-10 diagnosis code(s). The diagnosis code(s) should be the same diagnosis code(s) listed on the distant site (rendering) provider's claim.

1003.16.2. The rendering provider serving as the telemedicine distant site should report the E/M office visit code (992xx) along with the GT modifier (including any other applicable modifiers), the appropriate POS, and the ICD-10 diagnosis code(s).

1003.16.3. For the originating site (LEA) provider to receive reimbursement for procedure code Q3014, a corresponding paid history claim from the distant site provider must be found in GAMMIS. The distant site provider's claim billed for the same member, same date of service, with an E/M office visit code (992xx), the same ICD-10 diagnosis code(s) and the GT modifier, will confirm that a telemedicine service was rendered. If no record of the E/M claim is found that aligns with the LEA provider's originating site claim, the originating site claim will suspend up to 30 days after submission in search of the E/M claim. If no record of an E/M claim is found within 30 days after submission of the LEA provider's originating site claim, reimbursement to the LEA provider will be denied. It is the responsibility of the LEA provider to contact the provider who rendered the distant site service to determine if the E/M visit was billed.
The telemedicine originating facility fee is reimbursed at the current DEFAULT rate.

1003.17. Consultation Services

Effective July 1, 2014, providers enrolled in the EPSDT Program, may bill for reimbursement of the following office/outpatient consultation codes: 99242, 99243, 99244, 99245. The EP modifier must be added to the applicable code along any other applicable modifiers. A consultation service can be rendered once every three years.

1003.18. Tobacco Cessation Counseling Services

Effective January 1, 2014, the Division began coverage of tobacco cessation counseling services to all Medicaid members. Providers enrolled in the EPSDT Program may bill 99406 and 99407 for the reimbursement of tobacco cessation counseling. The EP modifier must be added to the applicable code.

The tobacco cessation counseling must be rendered in a face-to-face setting with the member. Only two 12-week tobacco cessation treatment periods will be allowed per member per year. The provider must document the services in the member's medical record every 30 days during the 12-week treatment period.

1003.19. Incontinence Supplies

Incontinence supplies are covered for children ages 2 through 20 years who have an underlying medical condition that prevents control of the bowels or bladder. Incontinence supplies are not covered for convenience. Children under the age of 2 years will be considered for coverage on a case-by-case basis. Since incontinence supplies are not covered for members over 20 years of age, or on a general basis for members under 21 years, providers must ensure the following for services to be considered for coverage:

1003.19.1. the item is considered durable medical equipment (DME);

1003.19.2. there is a current order prescribed by a physician; and

1003.19.3. a prior authorization (PA) must be submitted which includes documentation of medical necessity.

Refer to the DME Manual for further guidance.

1003.20. Fluoride Varnish

Once teeth are present, the application of fluoride varnish is required and may be applied every 3-6 months in the primary care or dental office for children between the ages of 6 months and 5 years.

1003.21. Other Procedure Codes

When billing for EPSDT screening services and interperiodic visits, only the procedure codes for those services found in this manual may be reimbursed under the EPSDT Program. Reimbursement for other services billable to Medicaid is covered under the program areas overseeing the delivery of those services.

1003.22. National Correct Coding Initiative (NCCI) Medically Unlikely Edits (MUEs) Limits

Providers are reminded to bill in compliance with the NCCI MUE limit for procedure codes and to check the MUE file, at minimum, on a quarterly basis for updates. Procedure codes submitted with frequencies greater than the allowed MUE will be denied according to the NCCI MUE regulations set by CMS.

1003.23. NCCI Procedure-To-Procedure (PTP) Edits

Providers are reminded to bill in compliance with the NCCI PTP edits. The NCCI PTP edits define pairs of Healthcare Common Procedure Coding System (HCPCS)/ Current Procedural Terminology (CPT) codes that should not be reported together. The purpose of the PTP edits is to prevent improper payments when incorrect code combinations are reported. Procedure codes that should not be reported together will be denied according to the NCCI PTP edits defined by CMS.

1003.24. Other Reimbursement Rates

Procedure Code & Description	**Modifier(s)**	**Rate** (*Enhanced Rate)
96110 – Developmental Screening	EP or EP HA or EP U1	$11.77
96110 – Autism Screening	EP UA or EP UA HA	$11.77
96127 – Brief Emotional/ Behavioral Assessment (depression screening)	EP	$4.55
96160 – Patient-Focused Health Risk Assessment (i.e., tobacco, alcohol, drug use risk assessment)	EP	$3.95
96161 – Caregiver-Focused Health Risk Assessment (i.e., maternal depression screening)	EP	$3.95
Q3014 – Telehealth Originating Site Facility Fee	EP	$20.52
99401 – Preventive Medicine Counseling	EP	$28.29
99242 – Patient Office Consultation, typically 30 minutes	EP	$89.66* $78.78
99243 – Patient Office Consultation, typically 40 minutes	EP	$122.60* $100.50
99244 – Patient Office Consultation, typically 60 minutes	EP	$182.06* $139.12

99245 – Patient Office Consultation, typically 80 minutes	EP	$223.01* $180.61
99406 – Smoking and Tobacco Use Intermediate Counseling, Greater than 3 minutes up to 10 minutes	EP	$13.73* $10.51
99407 – Smoking and Tobacco Use Intensive Counseling, Greater than 10 minutes	EP	$27.18* $20.71

Revised 02/19/25

Questions regarding Medicaid billing should be directed to Georgia Health Partnership (GHP) at 1-800-766-4456 or 'Contact Us' at www.mmis.georgia.gov

APPENDIX A
Guidelines in Screening and Reporting Elevated Blood Lead Levels

A. Mission

The mission of the Georgia Healthy Homes and Lead Poisoning Prevention Program (GHHLPPP) is to eliminate childhood lead poisoning in Georgia.

B. Screening Guidelines: Children

Screening for lead poisoning helps identify children who need interventions to reduce their blood lead levels. Many children who may have been exposed to lead or who are at risk for lead poisoning go without being screened. This makes their chances of being harmed by lead greater. Parents and providers should know when a child should be tested for lead poisoning.

C. Guidelines in Screening and Reporting Elevated Blood Lead Levels

i. Lead Screening Requirements and Medical Management Recommendations for children ages 6 to 72 months

1. GHHLPPP RISK FACTORS ASSESSMENT QUESTIONNAIRE - ask these questions at the 6, 9, 18 months and 3, 4, 5, 6 years of age preventive visits.

   (a) Is your child living in or regularly visiting, or has your child lived in or regularly visited, a house or childcare center built before 1978?

   (b) Does your child have a sibling or playmate who has or has had lead poisoning?

   (c) Does your child come in contact with an adult who works in an industry or has a hobby that uses lead (battery factory, steel smelter, stained glass, fishing or hunting)?

   (d) Has your child spent more than 1 week in South or Central American, Africa or Asia since their last blood test?

   (e) Does anyone in your family use ethnic or folk remedies, cosmetics or eat candies or use pottery imported from South or Central America, Africa or Asia?

   (f) If the answer is YES or UNKNOWN to any of the questions, a blood lead test is necessary!

https://dph.georgia.gov/environmental-health/healthy-homes-and-lead-poisoning-prevention

2. Test the blood of ALL Medicaid children for lead poisoning at 12 and 24 months of age AND children 3 to 6 years of age if never tested *regardless* of their risk factors.

ii. Recommended Medical and Case Management Actions

Lead Screening Requirements and Medical Management Recommendations for Children

Test all Medicaid children at 12 and 24 months of age, and children 3 to 6 years of age if never tested *regardless of their risk factors*!

IT IS A FEDERAL REQUIREMENT

Recommended Medical and Case Management Actions

Blood Lead Levels (BLL)	Recommended Medical and Case Management Actions							
	Confirmatory Blood Lead Test	**Hospitalization**	**Chelation Therapy (A)**	**Blood Lead Level Retest**	**Referrals (B)**	**History and Physical (C)**	**Lead Poisoning Education (D)**	**Reducing Exposure and Absorption(E)**
< 3.5 µg/dL	No	No	No	No	No	No	No	No
3.5 - 9 µg/dL	Within [2] day to 3 months, venous or capillary	No	No	See ***Retest Chart*** below	Yes	Yes	YES	YES
10-19 µg/dL	within 1 day to 3 months, venous or capillary	No	No	see ***Retest Chart*** below	YES	YES	YES	YES
20-44 µg/dL	within 1 day to 1 Month, venous or capillary	No	No	see ***Retest Chart*** below	YES	YES	YES	YES
45-69 µg/dL	within 24- 48 hours, venous preferred	No, if home is lead-safe	YES	see ***Retest Chart*** below	YES	YES	YES	YES
70 µg/dL or higher	within 24 hours, venous only	YES **MEDICAL EMERGENCY**	YES	see ***Retest Chart*** below	YES	YES	YES	YES

THERE IS NO SAFE LEVEL OF LEAD IN THE BODY – DAMAGE CAUSED BY LEAD POISONING IS *PERMANENT* AND *IRREVERSIBLE*!

[1] If the child's blood lead level persists between 10-19 ug/dL (2 blood lead tests 3 months apart) proceed according to the level of care for 20-44 µg/dL**.**

iii. Explanation of Recommended Medical and Case Management Actions

Guidelines in Screening and Reporting Elevated Blood Lead Levels:
Lead Screening Requirements and Medical Management Recommendations

For children ages 6 to 72 months

Explanation of Recommended Medical and Case Management Actions

1. **Chelation Therapy**: if chelation therapy is indicated, the child should be immediately removed from the hazardous environment until the child's environment is made lead-safe; however, if the home is already lead-safe, the child may remain in the home unless hospitalization is indicated.

2. **Referrals**: contact local health department and/or **GHHLPPP** to assist in case management and environmental investigations.

3. **History and Physical**: take medical, environmental, and nutritional history, test for anemia and iron deficiency, assess neurological, psychosocial, and language development, screen all siblings under age 6, and evaluate risk of other family members, especially pregnant women.

4. **Lead Poisoning Education**: discuss sources of lead, effects of lead, lead-based paint hazards associated with living in a pre-1978 and/or renovating a pre-1978 home. Discuss how lead affects prenatal care and well childcare at ages 3, 6, and 12 months and explain what blood lead levels mean and their significance. Lastly, contact **GHHLPPP** for information.

5. **Reducing Exposure and Absorption**: discuss damp cleaning to remove lead dust on surfaces, eliminating access to deteriorating lead paint surfaces, and ensuring regular meals which are low in fat and rich in calcium and iron; contact **GHHLPPP** for materials.

D. Elevated Blood Lead Re-Test Chart

Use this chart to determine when to retest children who are *confirmed as lead-poisoned.*
Venous testing is **strongly preferred**, but capillary testing is acceptable

If the child's last confirmed BLL was…	**and…**	
	if the child's blood lead level HAS NOT DROPPED at least 3 µg/dl over a span of at least 3 months…	if the child's blood lead level HAS DROPPED at least 3 µg/dl over a span of at least 3 months…
	then test the child again in…	
3.5-9 µg/dL	3 months	6 months
10-19 µg/dL	3 months	3 months
20-24 µg/dL	1 month	2 months
25-44 µg/dL	1 month	1 month
45-69 µg/dL	1 month after chelation	1 month after chelation
≥70 µg/dL	1 month after chelation	1 month after chelation
Retesting should occur until the blood lead level is less than 3.5 µg/dL for six months, all lead hazards have been removed, housing is made lead-safe, and no new exposure exists.		

Department of Public Health, 200 Piedmont Avenue, SE, Atlanta, GA, 30334,
Phone (404) 463-3754 | Fax (404) 463-4039

E. Lead Screening Guidelines for Children

i. Screening for lead poisoning helps identify children who need interventions to reduce their blood lead levels. Many children who may have been exposed to lead or who are at risk for lead poisoning go without being screened. This makes their chances of being harmed by lead greater. Parents and providers should know when a child should be tested for lead poisoning.

ii. Medicaid and PeachCare for Kids

All children enrolled in Medicaid and PeachCare for Kids® should be tested for lead poisoning and offered certain services based on the following schedule:

Age	Lead Blood Test	Lead Risk Assessment Questionnaire	Anticipatory Guidance
6 months		X	X
9 months		X	X
12 months	X (risk assessment if not enrolled in Medicaid)		X
24 months	X (risk assessment if not enrolled in Medicaid)		X
36-72 months	X – If there's no record of previous test at 12 and 24 months	X - Complete annually unless blood lead test performed	X

Source: Healthy Homes and Lead Poisoning Prevention | Georgia Department of Public Health

F. Lead Risk Assessment Questionnaire

The GHHLPPP Childhood Lead Risk Questionnaire can be found at:

Healthy Homes and Lead Poisoning Prevention | Georgia Department of Public Health in English, Spanish and Vietnamese.

When using the questionnaire, blood lead tests should be done right away if the child is at high risk (one or more "yes" or “I don't know" answers on the lead risk assessment questionnaire) for lead exposure. Completing this questionnaire does not count as a lead screening.

G. Blood Lead Test

i. A blood test is the preferred method for lead screening. There are two tests used to obtain blood lead specimens: capillary blood test or venous blood test. Finger stick capillary blood tests (the Lead Care II Analyzer uses capillary blood) can be done as the initial screening. However, a lab analyzed sample is necessary for confirmation. Safety measures should be taken to reduce the risk of contamination of the capillary blood sample. These measures include:

   1. Rinsing powder from the examination gloves

   2. Thoroughly washing patient’s hands with soap and water, then drying them before taking a sample.

ii. A venous blood test can be done as the initial screening as well. This method should always be used to confirm elevated blood lead test results when a capillary test was used as the initial screening. Alternatively, a second lab analyzed capillary test can be used to confirm an initial capillary test when the test is conducted according to the schedule in Table 1 - Lead Screening Requirements and Medical Management Recommendations for Children ages 6 to 72 months.

iii. All venous sample lead screening tests conducted using any Magellan Diagnostic lead testing system should be laboratory analyzed by a properly accredited laboratory.

H. Lab Submission

The Decatur Regional Laboratory provides an analysis of blood lead specimens to Georgia children less than 72 months of age. The provider’s office should contact the laboratory to use this service. GHHLPPP does not recommend or endorse the use of another lab.

Decatur Public Health Laboratory
1749 Clairmont Road
Decatur, Georgia 30033

I. Reporting Guidelines

i. Laboratories attempt to test each lead specimen on the day it arrives. The reports are mailed back to providers on the same day. All laboratory data is sent monthly in electronic format to GHHLPPP.

ii. Providers should report the results of all screening and follow-up blood lead level (BLL) tests to GHLPPP. Because data from laboratories often do not include demographic information, complete reports from providers' offices are very important. If reports are not complete, GHHLPPP may contact providers' offices for missing information.

iii. Results must be reported by State Electronic Notification Disease Surveillance System (SendSS)

1. SendSS is a web-based reporting system designed to collect information about notifiable diseases in Georgia.

2. Click here for reporting instructions.

iv. Providers who utilize the Lead Care II Analyzer to perform blood lead tests should report the Lead Care II Analyzer generated results to the GHHLPPP. On a weekly basis, providers should upload their test results to the State Electronic Notification Disease Surveillance System (SendSS). SendSS recommends providers keep track of their Lead Care II Analyzer test results by documenting those results in a Blood Lead Test Reporting Log provided by GHHLPPP (link above). If reports are not complete, GHHLPPP may contact providers' offices for missing information. Complete a new Blood Lead Reporting each week. Upload the Blood Lead Test Reporting Log and submit weekly to the GHHLPPP via SendSS. For uploading instructions, refer to the *SendSS Registration and Login Manual for Uploading Lead Report Files*.

J. State Electronic Notification Disease Surveillance System (SendSS)

i. Registration and Login Manual for Uploading Lead Report Files may be accessed at:

https://dph.georgia.gov/sites/dph.georgia.gov/files/related_files/site_page/EnvHealthLeadReportingInstructions.pdf

ii. Before you can enter the system, you must accept the Privacy Statement [1]. Selecting "I disagree with this statement" will terminate your login and return you to the login page.

iii. The home page can be accessed with the following URL and is best viewed using Microsoft Internet Explorer Version 6.x.x. https://sendss.state.ga.us

iv. In order to gain access to SENDSS, you will first need to fill in a registration form and create a login.

K. Georgia Comprehensive Childhood Lead Poisoning Prevention Program Case Management Guidelines

Georgia Comprehensive Childhood Lead Poisoning Prevention Program Case Management Guidelines	
Blood Lead Level	**Recommendations**
< 3.5 ug/dl	• No safe threshold above "0" has been identified. Medical provider should provide anticipatory guidance for any blood lead level (BLL) above "0".
3.5 – 9µg/dL	Per GHHLPPP recommendations, the **medical provider** will: • Conduct diagnostic (confirmatory) test (venous preferred) within 3 months. If child is < 12 months old or it is believed the BLL may be increasing rapidly, the test should be done earlier. • Test other children in the home <72 months of age who have not been tested in the last 6 months. • Conduct nutritional assessment • Continue testing at 3 month intervals until all the following conditions are met: o BLL has remained <3.5µg/dL for at least 6 months (two tests at least 3 months apart) o Lead hazards have been controlled. o There are no new sources of lead exposure **GHHLPPP** or the Case Management Provider will send, by mail, email or deliver the following information to the caregiver: • Child should receive a diagnostic (confirmatory) test (venous preferred) within 3 months. • Recommendation to have other children in the home <72 months of age who have not been tested in the last 6 months, tested. **GHHLPPP** will refer the case to a DPH Regional Healthy Homes Coordinator (RHHC) **Regional Healthy Homes Coordinator** or Case Management Provider will give in-person (or in some cases by phone or mail, or email) to caregiver: • Information on lead poisoning cause and effect, environmental lead hazard reduction, and nutrition. • Information on WIC services available. • Information on Children 1st Program information (newborns to 5 years old) • Information on Children's Medical Services (CMS) if child =>5 years old **Regional Healthy Homes Coordinator** will also: • Conduct or arrange an environmental risk assessment by a certified risk assessor. Risk assessment should occur within 2 weeks of receiving referral from GHHLPPP.

10 – 44µg/dL	Per GHHLPPP recommendations, the **medical provider** will: • Conduct diagnostic (confirmatory) test (venous preferred) within 1 week-1 month. • Test other children in the home <72 months of age who have not been tested in the last 6 months. • Conduct comprehensive medical evaluation including nutritional assessment. • Continue testing at 1-3 month intervals until all the following conditions are met: - BLL has remained <3.5µg/dL for at least 6 months (two tests at least 3 months apart) - Lead hazards have been controlled - There are no new sources of lead exposure. **GHHLPPP** or the Case Management Provider will send, by mail, the following information to the caregiver: • Child should receive a diagnostic (confirmatory) test (venous preferred) within 1 week to 1 month, • Recommendation to have other children in the home <72 months of age who have not been tested in the last 6 months, tested. **GHHLPPP** will refer the case to a DPH Regional Healthy Homes Coordinator (RHHC) **Regional Healthy Homes Coordinator** or the Case Management Provider will give in-person (or in some cases by phone, email or mail) to caregiver: • Information on lead poisoning cause and effect, environmental lead hazard reduction, and nutrition. • Information on WIC services available. • Information on Children 1st Program information (newborns to 5 years old) • Information on Children's Medical Services (CMS) if child =>5 years old **Regional Healthy Homes Coordinator** will also: • Conduct or arrange an environmental risk assessment by a certified risk assessor. Risk assessment should occur within 1-2 weeks of receiving referral from GHHLPPP. • Send by mail or email (or in some cases call) a summary of risk assessment and recommendations to the caregiver, property owner and medical provider. • Provide a copy of the risk assessment in approved format to GHHLPPP.

45 – 69µg/dL	**URGENT** Per GHHLPPP recommendations, the **medical provider** will: o Conduct diagnostic (confirmatory) test (venous preferred) within 24-48 hours. o Test other children in the home <72 months of age who have not been tested in the last 6 months. o Conduct comprehensive medical evaluation, including nutrition assessment and consider pharmacologic treatment. Contact the Georgia Poison Center for consultation. o Continue testing at 1–2-month intervals until all the following conditions are met: - BLL has remained <45µg/dL for at least 4 months (two tests at least 2 months apart) then start follow up blood lead testing at 3-month intervals until BLL has remained <3.5µg/dL for at least 6 months (two tests at least 3 months apart) - All identified lead hazards have been controlled Note: A child receiving chelation therapy MAY NOT return to the home until all lead hazards have been controlled. - There are no new sources of lead exposure**.** **GHHLPPP** or the Case Management Provider will give, by phone, the following recommendation to the caregiver: o Child should receive a diagnostic (confirmatory) test (venous preferred) within 24-48 hours, o Recommendation to have other children in the home <72 months of age who have not been tested in the last 6 months, tested. **GHHLPPP** will refer the case to a Regional Healthy Homes Coordinator (RHHC) **Regional Healthy Homes Coordinator** or the Case Management Provider will give in-person (or in some cases by phone) to caregiver: o Information on lead poisoning cause and effect, environmental lead hazard reduction, and nutrition. o Information on WIC services available. o Information on Children 1st Program information (newborns to 5 years old) o Information on Children's Medical Services (CMS) if child =>5 years old **Regional Healthy Homes Coordinator** will also: o Conduct or arrange an environmental risk assessment by a certified risk assessor. Risk assessment should occur within 48 hours of receiving referral from GHHLPPP. o Call-in a summary of risk assessment and recommendations to the caregiver, property owner and medical provider. o Provide a copy of the risk assessment in approved format to GHHLPPP.

≥ 70µg/dL	**MEDICAL EMERGENCY**. **DO NOT DELAY MEDICAL TREATMENT**. Per GHHLPPP recommendations, the **medical provider** will: • Conduct diagnostic (confirmatory) test (venous preferred) as emergency lab test. • Conduct immediate medical evaluation and pharmacologic treatment. Contact the Georgia Poison Center for consultation. • Test other children in the home <72 months of age who have not been tested in the last 6 months. • Continue testing at 1–2-month intervals until all the following conditions are met: o BLL remains <45µg/dL for at least 4 months (two tests at least 2 months apart) then start follow up blood lead testing at 3-month intervals until BLL has remained <3.5µg/dL for at least 6 months (two tests at least 3 months apart) o All identified lead hazards have been controlled Note: A child receiving chelation therapy MAY NOT return to the home until all lead hazards have been controlled. o There are no new sources of lead exposure**.** **GHHLPPP** or the Case Management Provider will give, by phone, the following recommendation to the caregiver: • Child should receive a diagnostic (confirmatory) test (venous preferred) immediately. • Recommendation to have other children in the home <72 months of age who have not been tested in the last 6 months, tested. **GHHLPPP** will refer the case to a Regional Healthy Homes Coordinator (RHHC) **Regional Healthy Homes Coordinator** or the Case Management Provider will give in-person (or in some cases by phone) to caregiver: • Information on lead poisoning cause and effect, environmental lead hazard reduction, and nutrition. • Information on WIC services available. • Information on Children 1st Program information (newborns to 5 years old) • Information on Children's Medical Services (CMS) if child =>5 years old **Regional Healthy Homes Coordinator** will also: • Conduct or arrange an environmental risk assessment by a certified risk assessor. Risk assessment should occur within 24 hours of receiving referral from GHHLPPP. • Call-in a summary of risk assessment and recommendations to the caregiver, property owner and medical provider • Provide a copy of the risk assessment in approved format to GHHLPPP. • If child must go to different housing unit post chelation, RHHC will inspect the new unit for lead hazards and inform medical provider that home is lead safe prior to child's release from hospital.

i. Access guidelines at: ***Healthy Homes and Lead Poisoning Prevention | Georgia Department of Public Health***

ii. GA-AAP recommends a follow-up blood test within 3 months if the initial test is 5-9 µg/dL

iii. For questions on the GHHLPPP guidelines, please contact:

Georgia Healthy Homes and Lead Poisoning Prevention Program
200 Piedmont Avenue, SE| East Tower | Atlanta, GA 30334
Phone: 404-657-6534 Fax: 404-463-4039

Healthy Homes and Lead Poisoning Prevention | Georgia Department of Public Health
https://dph.georgia.gov/environmental-health/healthy-homes-and-lead-poisoning-prevention

L. ENVIRONMENTAL LEAD RISK ASSESSMENTS

i. Certified Lead Risk Assessors who conduct the initial environmental lead risk assessment should bill Medicaid using code T1028 and the appropriate diagnosis code. For follow up clearance inspections following removal of the lead hazards, the certified lead risk assessor should bill Medicaid using code T1028 with the U-1 modifier. For additional information, please consult the Diagnostic Screening and Preventive Services (DSPS) Manual.

ii. Procedure Code

T1028	Initial lead investigation
T1028 - (Modifier U-1)	Post hazard abatement

M. Georgia and other Lead Resources

i. Lead Information for Professionals and Parents

For information on lead poisoning and prevention, professionals and parents can call GHHLPPP (Georgia Healthy Homes and Lead Poisoning Prevention Program) at 404-657-6534 or the National Lead Information Center at
1-800-424-lead (5323).

ii. Georgia Public Health Laboratory (GPHL)

The Georgia Public Health Laboratory, which has locations in Decatur and Waycross performs blood lead testing on children for the Georgia Healthy Homes and Lead Poisoning Prevention Program (GHHLPPP). Contact information:

GPHL
1749 Clairmont Road
Decatur, GA 30033
Phone 1-800-GEORGIA

iii. Emergency Information on Lead:

Call the Georgia Poison Center at 1-800-222-1222

N. Sources of Lead

i. Common Sources of Lead

1. Lead-based paint

2. Lead dust, which is produced by aging lead-based paint

3. Soil, which is contaminated by lead emissions from gasoline (prior to 1978), lead-based paint chips, storage of old batteries, etc.

4. Water which flows through lead pipes or copper pipes soldered with lead (prior to 1986)

5. Improperly glazed ceramic pottery and cooking utensils

ii. Industries

1. Battery manufacturers or reclamation

2. Window replacement

3. Bronze manufacture

4. Firing range instructors

5. Gas station attendants

6. lass manufacturers

7. Lead pigment manufacture

8. Lead smelters and refiners

9. Plumbers, pipe fitters

10. Policemen who work in automobile tunnels

11. Printers

12. Radiator manufacture or repair

13. Shipbuilders

14. Welders or Cutters – Steel burning or cutting (dismantling bridges, ships, etc.)

15. Bridge or ship workers (including airports and boats)

16. Construction workers, particularly those doing:

(a) Department of Transportation (DOT) Sign Makers

(b) Painting

(c) Remodeling

(d) Renovation

(e) Road work (specifically painters)

iii. Hobbies, Sports, Other

1. Moonshine whiskey

2. Car or boat repair

3. Fishing

4. Glazed pottery making

5. Home remodeling

6. Lead soldering

7. Making lead shot or bullet

8. Shooting at firing range

9. Stained glass manufacture

10. Additives to some "health foods" and imported candies

11. Substance Use

12. Toy soldiers (leaded)

iv. Folk Remedies – Most commonly found in Mexican, Asian Indian, and Middle Eastern groups. Names include: *Alarcon, Alkohl, Azarcon, Bali Goli, Coral, Ghasard, Greta, Liga, Pay-loo-ah, Rueda*. Cosmetics, used commonly by those from the Middle East and India

O. Blood Lead Level (BLL) Testing Procedure Codes

i. Blood Lead Screenings should be performed at the 12 and 24 month periodic visits (or catch-up visits). There are two tests used to obtain blood lead level (BLL) specimens: capillary blood test or venous blood test. Finger stick capillary blood tests can be done as the initial screening; however, a lab analyzed sample is necessary for confirmation. The specimen may be sent to a private laboratory for analysis, the analysis may be performed using an in-office blood lead level analyzer (the Lead Care II Analyzer uses capillary blood) or sent to the Georgia Public Health Laboratory (GPHL).

ii. Providers should bill code 83655 with the EP modifier and appropriate ICD-10 diagnosis code which indicates the child is receiving a screening blood lead test *(i.e., Z13.88, Z00.121, Z00.129, Z77.011)* on the same claim with the appropriate blood test code 36415 (blood lead venous) or 36416 (blood lead capillary).

iii. Providers who send BLL specimen to the Georgia Public Health Laboratory (GPHL) will be billed $10.00 lab handling fee assessed by the GPHL. Therefore, Fee For Service (FFS) providers should bill code 83655 with modifiers EP, 90 or EP, 91 and appropriate ICD-10 diagnosis code *(i.e., Z13.88, Z00.121, Z00.129, Z77.011)* on the same claim with the appropriate codes (36415 or 36416). This billing will result in a FFS reimbursement of $10.00 for the lab handling fee assessed by the GPHL. This reimbursement is only available when documentation supports that the BLL specimen was sent to the GPHL.

APPENDIX B
Guidelines in Screening and Reporting for TB Disease and Infection

A. Tuberculin Skin Testing

i. Mantoux tuberculin skin testing is the standard method of identifying persons infected with M. tuberculosis. Multiple puncture tests should NOT be used to determine whether a person is infected.

ii. The reaction to the Mantoux test should be read by a trained health care worker 48 to 72 hours after the injection. If a patient fails to show up for the scheduled reading, a positive reaction may still be measurable up to 1 week after testing. However, if a patient who fails to return within 72 hours has a negative reaction, tuberculin testing should be repeated.

iii. Reporting Requirements

In Georgia, all tuberculosis must be reported immediately to the local county health department. Physicians, hospitals, laboratories and other health care providers are required to report any of the following:

1. Any child less than 5 years discovered with Latent TB Infection
2. Any confirmed case of TB
3. Any suspected case of TB
4. Any person being treated with two (2) or more anti-tuberculosis drugs
5. Any positive culture for Mycobacterium tuberculosis
6. Any positive smear for AFB (Acid Fast Bacilli)

B. How to report

i. Report cases electronically through the State Electronic Notifiable Disease Surveillance System (SENDSS)

ii. Call or fax to the Reporting Contacts at the District Health Office

iii. Call 1-866-PUB-HLTH (1-866-782-4584)

C. Childhood TB Risk Assessment Questionnaires

The AAP Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents (3rd edition) recommends asking the following questions:

i. Was your child born in a country at high risk for tuberculosis?

ii. Has your child traveled (had contact with resident populations) for longer than 1 week to a country a high risk for tuberculosis?

iii. Has a family member or contact had tuberculosis or a positive tuberculin skin test?

D. Resource

i. Resource: https://brightfutures.aap.org/materials-and-tools/Pages/default.aspx

ii. For more information about tuberculosis in Georgia: contact

Georgia Tuberculosis (TB) Section
2 Peachtree St. NW
12th Floor
Atlanta, GA 30303
(Phone) 404-657-2634
(Fax) 404-463-3460

iii. The Georgia TB Program has the legal responsibility for all TB clients in Georgia regardless of who provides the direct services. TB services are available to all who fall within the service criteria without regard to the client's ability to pay.

iv. Information also available at

Tuberculosis (TB) Prevention and Control | Georgia Department of Public Health

E. Tuberculin (TB) Skin Test Procedure Codes

i. The maximum reimbursement rate for the skin test provided by private providers is $8.13 and $3.00 for public health providers.

ii. Use the following procedure and diagnosis codes to document the Tuberculin Skin Test.

HIPAA Procedure Code	ICD-10 Diagnosis Code	HIPAA Modifier	Procedure Code Description	Fee For Service Reimbursement
86580	Z11.1	EP	TB Skin Test	$3.00 (public) $8.13 (private)

APPENDIX C
Vaccine Administration Codes and Vaccine Product Codes

A. Vaccine Administration Codes

Vaccine Administration Codes		
HIPAA Procedure Code	**HIPAA Modifier**	**Procedure Code Description**
90460	EP	**Pediatric Immunization Administration Code**. Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional.
90471	EP	**Non-Age Specific Immunization Administration Code.** Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid)
90472	EP	**Non-Age Specific Immunization Administration Code.** Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/ toxoid)
90473	EP	**Non-Age Specific Immunization Administration Code.** Immunization administration (includes intranasal or oral administration); one vaccine (single or combination vaccine/toxoid)
90474	EP	**Non-Age Specific Immunization Administration Code.** Immunization administration (includes intranasal or oral administration); each additional vaccine (single or combination vaccine/toxoid)

i. Vaccine Administration Code for Face-to-Face Counseling

1. 90460 - Vaccine administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional.

2. 90460 is reported when both of the following requirements are met: (1) The patient must be 18 years of age or younger. (2) The physician or other qualified health care professional must perform face-to-face vaccine counseling associated with the administration. *(Any clinical staff can do the actual administration of the vaccine per the physician's or the qualified health care professional's orders.)*

3. If both of these requirements are not met, report a non-age specific vaccine administration code(s) (90471-90474) instead.

4. 90460 may be reported for more than one (1) unit of vaccine administered during a single office visit.

5. Note*:* Local Public Health Departments May use vaccine administration code 90460 only if a physician or other qualified health care professional performs face-to-face vaccine counseling associated with administration of the vaccine

6. A 'qualified health care professional' is an individual who by education, training, licensure/ regulation, facility credentialing (when applicable), and payer policy is able to perform a professional service within their scope of practice and independently report a professional service. These professionals are distinct from 'clinical staff.' A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation, facility, and payer policy to perform or assist in the performance of specified professional services, but who does not individually report any professional services. (CPT 2012)

ii. Non-Age Specific Vaccine Administration Codes

1. These codes must be used when there is no face-to-face physician counseling associated with vaccine administration. The add-on codes (90472, 90474) may also be used in conjunction with the 90460 code.

2. Codes 90471 and 90473 are used to code for the first vaccine given during a single office visit. Codes 90472 and 90474 are considered add-on codes *(hence the + symbol next to them)* to 90471 and 90473, respectively. This means that the provider will use 90472 and 90474 in addition to 90471 or 90473 if more than one vaccine is administered during a visit. Providers may use 90460 for the first (i.e., counseled) vaccine and 90472 or 90474 for the second (i.e., non-counseled) vaccine. Note that there can only be one first administration during a given visit.

3. **90471 -** Vaccine administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid)

   (a) Do not report 90471 in conjunction with 90473 or 90460

4. **+90472 -** Vaccine administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure.)

   (a) May use 90472 in conjunction with 90471 or 90473 or 90460

5. **90473 -** Vaccine administration (includes intranasal or oral administration); one vaccine (single or combination vaccine/toxoid)

   (a) Do not report 90473 in conjunction with 90471 or 90460

6. **+90474 -** Vaccine administration (includes intranasal or oral administration); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure.)

   (a) May use 90474 in conjunction with 90471 or 90473 or 90460

iii. Vaccine Administration Codes for 19 – 20-year-olds

EPSDT providers may bill the EPSDT benefit for vaccines administered to members nineteen (19) years of age through twenty (20) years of age. Providers must include the vaccine's CPT, NDC, and diagnosis code, along with the appropriate vaccine administration code(s) [90471, 90472, 90473, 90474] on the EPSDT claim. The Division will reimburse for the vaccine product (providers must use their own stock of vaccines) and for vaccine administration.

iv. Billing Tips (excludes Beyfortus)

1. Code the vaccine administration with the appropriate vaccine administration code and the EP modifier.

2. For the vaccine, code the vaccine product code, the associated diagnosis code and the EP modifier.

3. The primary vaccine administration code (90460, 90471, or 90473) must <u>precede</u> the add-on vaccine administration code(s) (90472 or 90474), if <u>applicable</u>.

4. The vaccine product code must <u>immediately follow</u> the corresponding vaccine administration code.

5. Code the vaccine administration code(s), the vaccine product code(s), and the preventive or interperiodic visit on the same claim when vaccines are administered during a preventive or interperiodic visit. Each vaccine administration code should be listed only once per claim. If multiple vaccine product codes correspond to the same vaccine administration code, the vaccine administration code is listed once with the appropriate number of units indicated.

6. 90460 may be reported for more than one (1) unit of vaccine administered during a single office visit.

7. May report diagnosis code Z00.121 or Z00.129 or Z23 with each of the vaccine administration codes ONLY when vaccines are administered during EPSDT preventive health visits for members through age 17 years.

8. May report diagnosis code Z00.00 or Z00.01 or Z23 with the applicable vaccine administration code ONLY when vaccines are administered during EPSDT preventive health visits for members aged 15 years through 20 years.

9. Use the appropriate vaccine diagnosis code with the vaccine administration code when the vaccine is administered outside of the EPSDT preventive health visit.

10. Code the EPSDT preventive visit (9938x or 9939x) with the EP and the 25 modifiers when vaccines are administered during the preventive health visit.

11. Code the EPSDT interperiodic visits (99202-99205 or 99212-99215) with the EP and the 25 modifiers when vaccines are administered during the interperiodic health visit.

12. Code both the preventive visit (993xx) and interperiodic visit (992xx) with EP 25 modifiers when vaccines are administered during a preventive visit along with the E/M visit.

    (a) Example:

993xx EP 25	(preventive visits: 99381-99385, 99391-99395)
992xx EP 25	(E/M visits: 99202-99205, 99212-99215)
904xx EP	(vaccine administration codes: 90460, 90471-90474)
90xxx EP	(vaccine product codes)

13. The National Correct Coding Initiative (NCCI) does not allow reimbursement of the 99211 code when it is billed together with any of the vaccine administration codes regardless of whether the 25 modifier is appended to the 99211 code.

v. Billing Tips for Beyfortus vaccine administration

1. Code the administration of Beyfortus with vaccine administration code 96380 or 96381 and the EP modifier. The Beyfortus product code should immediately follow the vaccine administration code. Codes 96380 and 96381 replaces the previously instructed generic cpt code 96372. For claims beginning with effective date 3/1/2024, 96372 should no longer be reported for the administration of Beyfortus.

2. Code the preventive visit (9938x or 9939x) **OR** interperiodic visit (99202-99205 or 99212-99215) with the EP modifier when Beyfortus only is administered during the visit.
    (a) Example:

99xxx EP	(preventive visits: 99381-99385, 99391-99395) OR (E/M visits: 99202-99205, 99212-99215)

9638x EP	(Beyfortus vaccine administration codes: 96380, 96381)
9038x EP	(Beyfortus vaccine product codes: 90380, 90381)

3. Code the EPSDT preventive visit (9938x or 9939x) with the EP 25 modifiers and the interperiodic visit (99202-99205 or 99212-99215) with the EP modifier when Beyfortus only is administered during the visit.
   (a) Example:

993xx EP	(preventive visits: 99381-99385, 99391-99395)
992xx EP 25	(E/M visits: 99202-99205, 99212-99215)
9638x EP	(Beyfortus vaccine administration codes: 96380, 96381)
9038x EP	(Beyfortus vaccine product codes: 90380, 90381)

4. Reimbursement Rates

RSV administration codes	**Reimbursement Rates**
96380 96381	$10.00 $18.50 (PCK)

vi. Examples (excludes Beyfortus)

1. Code the preventive visit (993xx) with EP 25 modifiers when vaccines are administered during a preventive visit

993xx EP 25	(preventive visits: 99381-99385, 99391-99395)
904xx EP	(vaccine administration codes: 90460, 90471-90474)
90xxx EP	(vaccine product codes)

2. Code the interperiodic visit (992xx) with EP 25 modifiers when vaccines are administered during a E/M visit.

992xx EP 25	(E/M visits: 99202-99205, 99212-99215)
904xx EP	(vaccine administration codes: 90460, 90471-90474)
90xxx EP	(vaccine product codes)

3. Code both the preventive visit (993xx) and interperiodic visit (992xx) with EP 25 modifiers when vaccines are administered during a preventive visit along with the E/M visit.

993xx EP 25	(preventive visits: 99381-99385, 99391-99395)
992xx EP 25	(E/M visits: 99202-99205, 99212-99215)
904xx EP	(vaccine administration codes: 90460, 90471-90474)
90xxx EP	(vaccine product codes)

vii. Examples for Beyfortus

1. Code the preventive visit (993xx) with EP modifier when Beyfortus is administered during a preventive visit

993xx EP	(preventive visits: 99381-99385, 99391-99395)
9638x EP	(Beyfortus vaccine administration codes: 96380, 96381)
9038x EP	(Beyfortus vaccine product codes: 90380, 90381)

2. Code the interperiodic visit (992xx) with EP modifier when Beyfortus is administered during a E/M visit.

992xx EP	(E/M visits: 99202-99205, 99212-99215)
9638x EP	(Beyfortus vaccine administration codes: 96380, 96381)
9038x EP	(Beyfortus vaccine product codes: 90380, 90381)

3. Code the preventive visit (993xx) with the EP modifier and interperiodic visit (992xx) with EP 25 modifiers when Beyfortus is administered during a preventive visit along with the E/M visit.

993xx EP	(preventive visits: 99381-99385, 99391-99395)
992xx EP 25	(E/M visits: 99202-99205, 99212-99215)
9638x EP	(Beyfortus vaccine administration codes: 96380, 96381)
9038x EP	(Beyfortus vaccine product codes: 90380, 90381)

viii. Examples for Beyfortus, along with other vaccines

1. Code the preventive visit (993xx) with EP 25 modifiers when Beyfortus, along with other vaccines, are administered during a preventive visit

993xx EP 25	(preventive visits: 99381-99385, 99391-99395)
904xx EP	(vaccine administration codes: 90460, 90471-90474)
90xxx EP	(vaccine product codes)
9638x EP	(Beyfortus vaccine administration codes: 96380, 96381)
9038x EP	(Beyfortus vaccine product codes: 90380, 90381)

2. Code the interperiodic visit (992xx) with EP 25 modifiers when Beyfortus, along with other vaccines, are administered during a E/M visit.

992xx EP 25	(E/M visits: 99202-99205, 99212-99215)
904xx EP	(vaccine administration codes: 90460, 90471-90474)
90xxx EP	(vaccine product codes)
9638x EP	(Beyfortus vaccine administration codes: 96380, 96381)
9038x EP	(Beyfortus vaccine product codes: 90380, 90381)

3. Code both the preventive visit (993xx) and interperiodic visit (992xx) with EP 25 modifiers when Beyfortus, along with other vaccines, are administered during a preventive visit along with the E/M visit.

993xx EP 25	(preventive visits: 99381-99385, 99391-99395)
992xx EP 25	(E/M visits: 99202-99205, 99212-99215)

904xx EP	(vaccine administration codes: 90460, 90471-90474)
90xxx EP	(vaccine product codes)
9638x EP	(Beyfortus vaccine administration codes: 96380, 96381)
9038x EP	(Beyfortus vaccine product codes: 90380, 90381)

B. Vaccine Product Codes and Diagnosis Codes (Ages Birth through 18 years)

The following vaccine procedure and diagnosis codes must be included on the claim, following the vaccine administration code, when billing for vaccine administration. HIPAA Modifier = EP

HIPAA Procedure Code + EP Modifier	Vaccine Procedure Code Description (Ages Birth through 18 years)
90380	Respiratory Syncytial Virus (RSV) monoclonal antibody, recombinant, 50 mg (0.5 ml) dosage, for intramuscular use (Beyfortus) (birth up to 24 months)
90381	Respiratory Syncytial Virus (RSV) monoclonal antibody, recombinant, 100 mg (1.0 ml) dosage, for intramuscular use (Beyfortus) (birth up to 24 months)
90678	Respiratory Syncytial Virus (RSV) vaccine, pref, subunit, bivalent, for intramuscular use (Abrysvo)
90619	Meningococcal conjugate vaccine, serogroups A, C, W, Y, quadrivalent, tetanus toxoid carrier (MENACWY-TT), for intramuscular use (2-18 years) [MenQuadfi]
90620	Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B (MenB-4C), 2 dose schedule, for intramuscular use (10-18 years) [Bexsero]
90621	Meningococcal recombinant lipoprotein vaccine, serogroup B (MenB-FHbp), 2 or 3 dose schedule, for intramuscular use (10-18 years) [Trumenba]
90623	Meningococcal conjugate vaccine serogroups A, C, W, Y, B-FHBP, pentavalent, tetanus toxoid carrier (MENACWY-TT), for intramuscular use [Penbraya]
90633	Hepatitis A vaccine (HepA), pediatric/adolescent dosage-2 dose schedule, for intramuscular use
90636	Combination Hepatitis A/Hepatitis B vaccine, adult dosage, 3 dose, for intramuscular use (18 years)
90647	Haemophilus influenzae type B vaccine (Hib), PRP-OMP conjugate, 3 dose schedule, for intramuscular use
90648	Haemophilus influenzae type b vaccine (Hib), PRP-T conjugate, 4 dose schedule, for intramuscular use

HIPAA Procedure Code + EP Modifier	Vaccine Procedure Code Description (Ages Birth through 18 years)
90651	Human Papillomavirus (HPV) vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58 nonvalent (9vHPV), 2 or 3-dose schedule, for intramuscular use (females and males 9 years and older) [Gardasil 9]
90656	Influenza vaccine, trivalent, split virus, preservative-free, for intramuscular use
90657	Influenza vaccine, trivalent, 0.25 mL dosage, for intramuscular use
90658	Influenza vaccine, trivalent, 0.5 mL dosage, for intramuscular use
90660	Influenza vaccine, trivalent for nasal administration
90661	Influenza vaccine, trivalent derived from cell cultures
90674	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit preservative and antibiotic free, 0.5mL dosage, for intramuscular use
90685	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.25 mL dosage, for intramuscular use
90686	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.5 mL dosage, for intramuscular use
90687	Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.25 mL dosage, for intramuscular use
90688	Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.5 mL dosage, for intramuscular use
90672	Influenza virus vaccine (FluMist), quadrivalent, live (LAIV4), for intranasal use (2 years and older)
90673	Influenza vaccine, trivalent derived from recombinant DNA, for intramuscular use
90756	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use
90670	Pneumococcal conjugate vaccine, 13 valent (PCV13), for intramuscular use
90671	Pneumococcal conjugate vaccine, 15 valent (PCV15), for intramuscular use
90677	Pneumococcal conjugate vaccine, 20 valent (PCV20), for intramuscular use
90684	Pneumococcal conjugate vaccine, 21 valent (PCV21), for intramuscular use
90680	Rotavirus vaccine, pentavalent (RV5), 3 dose schedule, live, for oral use (RotaTeq)
90681	Rotavirus vaccine, human, attenuated (RV1), 2 dose schedule, live, for oral use (Rotarix)

HIPAA Procedure Code + EP Modifier	Vaccine Procedure Code Description (Ages Birth through 18 years)
90696	Diphtheria, tetanus toxoids, and acellular pertussis vaccine and inactivated poliovirus vaccine, (DTaP-IPV), for intramuscular use (ages 4-6 years)
90697	Diphtheria, tetanus toxoids, acellular pertussis (whooping cough), haemophilus influenzae type B, hepatitis B and polio vaccine, (DTaP-IPV-Hib-HepB), for intramuscular use (ages 6 weeks to 5 years) [Vaxelis]
90698	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Haemophilus influenza type B, and inactivated poliovirus vaccine (DTaP-IPV/Hib), for intramuscular use
90700	Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), for intramuscular use (ages younger than 7 years)
90707	Measles, mumps, and rubella virus vaccine (MMR), live, for subcutaneous use
90710	Measles, mumps, rubella, and varicella vaccine (MMRV), live, for subcutaneous use
90713	Poliovirus vaccine (IPV), inactivated, for subcutaneous or intramuscular use
90714	Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, for intramuscular use (7 years to 18 years, 11 months)
90715	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), for intramuscular use (7 years to 18 years, 11months)
90716	Varicella virus vaccine (VAR), live, for subcutaneous use
90723	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B and inactivated poliovirus vaccine (DTaP-Hep B-IPV), for intramuscular use
90732	Pneumococcal polysaccharide vaccine, 23-valent (PPSV23), adult or immunosuppressed patient dosage, when administered to 2 years or older, for subcutaneous or intramuscular use
90734	Meningococcal conjugate vaccine, serogroups A, C, W, Y, quadrivalent, diptheria toxoid carrier, (MenACWY-D) or CRM197 carrier (MenACWY-CRM), for intramuscular use
90739	Hepatitis B vaccine (HepB), CPG-Adjuvanted, adult dosage, 2 or 4 dose schedule, for intramuscular use
90744	Hepatitis B vaccine (HepB), pediatric/adolescent dosage, 3 dose schedule, for intramuscular use
90747	Hepatitis B vaccine (HepB), dialysis or immunosuppressed patient dosage, 4 dose schedule, for intramuscular use

C. Vaccine Procedure and Diagnosis Codes (Ages 19 through 20 years)

The Division will reimburse for the vaccine product (providers must use their own stock of vaccines) and for vaccine administration for vaccines administered to Medicaid-eligible members nineteen (19) years of age through twenty (20) years of age. Providers who administer any one of the vaccines listed below will receive reimbursement for administering each vaccine PLUS reimbursement for the vaccine product. The reimbursement rates for the vaccine products may be found in the Providers' Administered Drug List, published under the Fee Schedule on GAMMIS: www.mmis.georgia.gov and identified as "PADL – Appendix A – Schedule of Maximum Allowable". Providers must include the vaccine's procedure and diagnosis codes on the claim.

HIPAA Procedure Code + EP Modifier	**Vaccine Procedure Code Description (Ages 19 through 20 years)**
90619	Meningococcal conjugate vaccine, serogroups A, C, W, Y, quadrivalent, tetanus toxoid carrier (MENACWY-TT), for intramuscular use (MenQuadfi)
90620	Meningococcal recombinant protein and outer member vesicle vaccine, serogroup B (MenB-4C), 2 dose schedule, for intramuscular use (Bexsero)
90621	Meningococcal recombinant lipoprotein vaccine, serogroup B (MenB-FHbp), 2 or 3 dose schedule, for intramuscular use (Trumenba)
90623	Meningococcal conjugate vaccine serogroups A, C, W, Y, B-FHBP, pentavalent, tetanus toxoid carrier (MENACWY-TT), for intramuscular use [Penbraya]
90632	Hepatitis A vaccine (HepA), adult dosage, for intramuscular use
90636	Combination Hepatitis A/Hepatitis B vaccine, adult dosage, 3 dose, for intramuscular use
90739	Hepatitis B vaccine (HepB), CPG-Adjuvanted, adult dosage, 2 dose or 4 dose schedule, for intramuscular use
90746	Hepatitis B vaccine (HepB), adult dosage 3 dose schedule, for intramuscular use
90747	Hepatitis B vaccine (HepB), dialysis or immunosuppressed patient dosage 4 dose, for intramuscular use
90759	Hepatitis B vaccine (HepB), 3AG 10 mcg, 3 dose schedule, for intramuscular use (Hevbrio)
90651	Human Papillomavirus HP vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonvalent (9vHPV), 2 or 3-dose schedule, for intramuscular use (females & males) [Gardasil 9]

HIPAA Procedure Code + EP Modifier	**Vaccine Procedure Code Description (Ages 19 through 20 years)**
90656	Influenza vaccine, trivalent, split virus, preservative-free, 0.5 mL dosage, for intramuscular use
90658	Influenza vaccine, trivalent, split virus, preservative-free, 0.5 mL dosage, for intramuscular use
90660	Influenza vaccine, trivalent for nasal administration
90661	Influenza vaccine, trivalent derived from cell cultures
90673	Influenza vaccine, trivalent derived from recombinant DNA
90674	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5mL dosage, for intramuscular use
90682	Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use
90686	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.5 mL dosage, for intramuscular use
90688	Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.5 mL dosage, for intramuscular use
90672	Influenza virus vaccine (FluMist), quadrivalent, live (LAIV4), for intranasal use (2 years and older)
90756	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use
90707	Measles, mumps, and rubella virus vaccine (MMR), live, for subcutaneous use
90713	Poliovirus vaccine (IPV), inactivated, for adults at high risk, for subcutaneous or intramuscular use
90714	Tetanus and diphtheria toxoids (Td) absorbed, preservative free, for intramuscular use
90715	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), for intramuscular use
90716	Varicella virus vaccine (VAR), live, for subcutaneous use

HIPAA Procedure Code + EP Modifier	**Vaccine Procedure Code Description (Ages 19 through 20 years)**
90670	Pneumococcal conjugate vaccine, 13 valent (PCV13), for intramuscular use
90671	Pneumococcal conjugate vaccine, 15 valent (PCV15), for intramuscular use
90677	Pneumococcal conjugate vaccine, 20 valent (PCV20), for intramuscular use
90684	Pneumococcal conjugate vaccine, 21 valent (PCV21), for intramuscular use
90732	Pneumococcal polysaccharide vaccine, 23-valent (PPSV23), adult or immunosuppressed patient dosage, for subcutaneous or intramuscular use
90734	Meningococcal conjugate vaccine, serogroups A, C, W, Y, quadrivalent, diptheria toxoid carrier, (MenACWY-D) or CRM197 carrier (MenACWY-CRM), for intramuscular use
90678	Respiratory Syncytial Virus (RSV) vaccine, pref, subunit, bivalent, for intramuscular use (Abrysvo)

D. Covid-19 Vaccines & Administration Codes

i. Covid-19 vaccines are not reimbursed under the Health Check Program.

ii. For listing of Covid-19 Vaccines & Administration Codes, see the '*Provider's Administered Drug List – Covid-19 Monoclonal Antibodies'* Fee Schedule located on GAMMIS.

APPENDIX D
Children's Intervention Services

A. Children's Intervention Services (CIS) program

The Children's Intervention Services (CIS) program offers coverage for restorative and/or rehabilitative services to eligible members in non-institutional settings. Services must be determined medically necessary and be recommended and documented as appropriate interventions by a physician or other licensed practitioner of the healing arts, within their scope of practice under state law, for the maximum reduction of physical disability or developmental delay and restoration of the member to the best possible functional level.

B. CIS services

The CIS program is comprised of seven intervention services that must be provided by licensed practitioners of the healing arts. The seven services are:

i. Audiology

ii. Nursing

iii. Nutrition provided by licensed dieticians

iv. Occupational Therapy

v. Physical Therapy

vi. Counseling provided by licensed clinical Social Workers

vii. Speech-language Pathology

C. CIS providers

Qualified providers must be currently licensed as:

i. audiologists

ii. registered nurses

iii. dietitians

iv. occupational therapists

v. physical therapists

vi. clinical social workers

vii. speech-language pathologists.

APPENDIX E
Childhood Obesity –
Weight Assessment, Counseling for Nutrition & Physical Activity for Children/Adolescents

A. Body Mass Index (BMI)

i. **What is BMI?** Body Mass Index (BMI) is used as a screening tool to identify possible weight problems for children and adolescents. The Centers for Disease Control and Prevention (CDC) and the American Academy of Pediatrics (AAP) recommend the use of BMI to screen for overweight and obesity in children and adolescents aged 2 through 19 years.

BMI is a number calculated from a child's weight and height. BMI does not measure body fat directly, but it is a reliable indicator of body fatness for most children and adolescents.

For children and adolescents, BMI is age- and sex-specific and is often referred to as BMI-for-age. A child's weight status is determined using an age- and sex-specific percentile for BMI rather than the BMI categories used for adults because children's body composition varies as they age and varies between boys and girls.

ii. **What is a BMI percentile?** After the BMI is calculated for children and adolescents, the BMI number is plotted on the BMI-for-age growth charts (for either girls or boys) to obtain a percentile ranking. Percentiles are the most commonly used indicator to assess the size and growth patterns of individual children in the United States. The percentile indicates the relative position of the child's BMI number among children of the same sex and age. The CDC's growth charts show the weight status categories used with children and adolescents.

iii. Weight Status Category & Percentile Range

These percentiles are based on the CDC's growth charts which are available at http://www.cdc.gov/growthcharts/

WEIGHT STATUS CATEGORY	PERCENTILE RANGE
Underweight	Less than the 5th percentile
Healthy Weight	5th percentile to less than the 85th percentile
Overweight	85th to less than the 95th percentile
Obese	Equal to or greater than the 95th percentile

iv. How to interpret BMI?

Calculating the BMI-for-age for children of different ages and sexes may yield the same numeric result, but the result may fall at a different percentile for each child for one or both of the following reasons:

1. The normal BMI-related changes that take place as children age and as growth occurs (ex. The amount of body fat changes with age).

2. The normal BMI-related differences between sexes (ex. The amount of body fat differs between girls and boys).

B. Documentation for HEDIS Compliance – Weight Assessment

i. Documentation in the medical record for BMI must include the following:

1. Height

2. Weight

3. BMI percentile

ii. Documentation must include height, weight and BMI percentile during the measurement year. The height, weight and BMI percentile must be from the same data source. Either of the following meets criteria for BMI percentile: BMI percentile documented as a value (e.g., 85th percentile) OR BMI percentile plotted on an age-growth chart. Only evidence of the BMI percentile or BMI percentile plotted on an age-growth chart meets HEDIS criteria.

C. ICD-10 Codes to Identify BMI

Body Mass Index (BMI) – Pediatrics		
BMI Code	**BMI Percentile**	**Range**
Z68.51	< 5th percentile for age	Underweight
Z68.52	5th to < 85th percentile for age	Normal/ Healthy Weight Range
Z68.53	85th to < 95th percentile for age	Overweight
Z68.54	≥ 95th percentile for age	Obese

i. FFS EPSDT providers are encouraged to report BMI diagnosis codes with the EPSDT preventive health codes. Do not point the preventive health visit code to the BMI diagnosis code because this will cause the FFS claim to deny payment.

D. Counseling for Nutrition

i. Guidelines

The *Dietary Guidelines for Americans, 2020-2025 and Online Materials (https://www.dietaryguidelines.gov/resources/2020-2025-dietary-guidelines-online-materials)* comprise core principles to help people, ages 2 years and older, develop healthy lifestyles based on individual needs, likes, and dislikes related to both eating and physical activity.
The Dietary Guidelines recommend that children and adolescents consume a healthy eating pattern that accounts for all foods and beverages within an appropriate calorie level.
A healthy eating pattern includes a variety of vegetables from all of the subgroups, fruits, grains, fat-free or low-fat dairy, a variety of protein foods and oils. A healthy eating pattern limits saturated fats and *trans* fats, added sugars, and sodium.

ii. Documentation for HEDIS compliance – Counseling for Nutrition

Documentation (in the medical record) of counseling for nutrition must include a statement indicating the date and at least one of the following:

1. Discussion of current nutrition behaviors (e.g., eating habits, dieting behaviors).

2. Checklist indicating nutrition was addressed.

3. Counseling or referral for nutrition education.

4. Member received educational materials on nutrition during a face-to-face visit.

5. Anticipatory guidance for nutrition.

6. Weight or obesity counseling.

E. ICD-10 Code to Identify Counseling for Nutrition

i. Z71.3 – nutritional counseling

ii. FFS EPSDT providers are encouraged to report the nutrition diagnosis code with the EPSDT preventive health codes. Do not point the preventive health visit code to the nutrition and physical activity counseling diagnosis code because this will cause the FFS claim to deny payment.

F. Counseling for Physical Activity

i. Guidelines

The *Physical Activity Guidelines for Americans* (*https://health.gov/sites/default/files/2019-09/Physical_Activity_Guidelines_2nd_edition.pdf*) describe the types and amounts of physical activity that offer substantial health benefits for children and adolescents (ages 6 to 17) and adults. The *Physical Activity Guidelines for Americans* complement the *Dietary Guidelines for Americans*, and together the documents provide guidance on the importance of being physically active and eating healthy foods to promote health and reduce the risk of chronic diseases. The Physical Activity Guidelines recommend that children and adolescents have 60 minutes (1 hour) or more of physical activity each day. Physical activity includes aerobic/endurance activities (to increase cardiorespiratory fitness), muscle-strengthening (resistance training which builds strong muscles), and bone-strengthening (weight-bearing or weight-loading activities which promote bone growth and strength).

G. Documentation for HEDIS Compliance – Counseling for Physical Activity

i. Documentation (in the medical record) of counseling for physical activity must include a statement indicating the date and at least one of the following:

1. Discussion of current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation).

2. Checklist indicating physical activity was addressed.

3. Counseling or referral for physical activity.

4. Member received educational materials on physical activity during a face-to-face visit.

5. Anticipatory guidance specific to the child's physical activity.

6. Weight or obesity counseling.

ii. The following notations or examples of documentation are not compliant with HEDIS requirements:

1. BMI

(a) No BMI percentile documented in medical record or plotted on age-growth chart.

(b) Notation of BMI value only.

Notation of height and weight only.

2. Nutrition

(a) No counseling/education on nutrition and diet.

(b) Counseling/education before or after the HEDIS measurement year

(c) Notation of "health education" or "anticipatory guidance" without specific mention of nutrition.

(d) A physical exam finding or observation alone (e.g., well-nourished) is not compliant because it does not indicate counseling for nutrition.

(e) Documentation related to a member's "appetite" does not meet criteria

3. Physical Activity

(a) No counseling/education on physical activity.

(b) Notation of "cleared for gym class" along without documentation of a discussion.

(c) Counseling/education before or after the HEDIS measurement year.

(d) Notation of "health education" or "anticipatory guidance" without specific mention of physical activity.

(e) Notation of anticipatory guidance related solely to safety (e.g., wears helmet or water safety) without specific mention of physical activity recommendations.

(f) Notation solely related to screen time (computer or television) without specific mention of physical activity.

iii. Services may be rendered during a visit other than a well-child visit. These services count if the specified documentation is present, regardless of the primary intent of the visit. Services specific to the assessment or treatment of an acute or chronic condition do not count toward the "Counseling for Nutrition" and "Counseling for Physical Activity" measures.

APPENDIX F
EPSDT Program Required Equipment Form

- ☐ Scale for Weighing Infants **present**
- ☐ Scale for Weighing Children and Adolescents **present**
- ☐ Measuring Board or Device for measuring Length or Height in the recumbent position for Infants and Children up to the age of two (2) **present**
- ☐ Measuring Board or Device for measuring Height in the vertical position for children who are over two (2) years old **present**
- ☐ Blood Pressure apparatus with infant, child, and adult cuffs **present**
- ☐ Screening audiometer **present**
- ☐ Centrifuge or other device for measuring hematocrit or hemoglobin may be **present**
- ☐ Eye charts appropriate for age of the child **present**
- ☐ Developmental/Behavioral, Alcohol/Substance Abuse and Depression screening tools and supplies **present** (*The required developmental screenings at ages 9 months, 18 months, and 30 months **must** be accomplished using one or more of the recommended standardized developmental screening tools specified in Section 902.2)*
- ☐ Vaccines and immunization administration supplies **present**
- ☐ Lab supplies for appropriate lab tests/screenings **present**
- ☐ Ophthalmoscope and Otoscope **present**

The information supplied in this document is true, accurate and complete and is hereby released to the Georgia Department of Community Health, Division of Medicaid, for purpose of enrolling in the EPSDT Program. I understand that falsification, omission or misrepresentation of any information in this enrollment document will result in a denial of enrollment, the closure of current enrollment, and the denial of future enrollment request, and may be punishable by criminal, civil or other administrative actions. I understand that my completion of this form certifies that I have the necessary equipment as listed in Part II- Policies and Procedures Manual for the EPSDT Program.

_____ _____

Provider Name *Date*

_____

Provider Title

_____

Provider/Confirmation Number

APPENDIX G
Preventive Oral Health: Fluoride Varnish

A. Purpose

Fluoride varnish acts to retard, arrest, and reverse the caries process. The teeth absorb the fluoride varnish, strengthening the enamel and helping prevent cavities. It is not a substitute for fluoridated water or toothpaste.

B. Application

Once teeth are present, the application of fluoride varnish is required and may be applied every 3-6 months in the primary care or dental office for children between the ages of 6 months and 5 years. Recommendation: Prevention of Dental Caries in Children Younger Than 5 Years: Screening and Interventions | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org)

C. Indications

Indications for fluoride use are noted in the 2020 AAP Clinical Report "Fluoride Use in Caries Prevention in the Primary Care Setting | Pediatrics | American Academy of Pediatrics (aap.org) https://publications.aap.org/pediatrics/article/146/6/e2020034637/33536/fluoride-use-in-caries-prevention-in-the-primary

D. Documentation:

Evidence that fluoride varnish was applied once between the ages of 6 months and 5 years OR evidence that the provider addressed the fluoride varnish requirement and/or its importance with the parent.

i. CPT Codes

1. 99188

2. D1206

ii. Effective April 1, 2024, Health Check providers are allowed reimbursement for the application of topical fluoride varnish. Providers should report cpt code 99188 with the EP modifier and POS 99.

iii. Effective January 1, 2015, the application of topical fluoride varnish by a physician or other qualified health care professional may be billed with the new CPT code 99188. This applies to providers enrolled in and filing claims under GA Medicaid programs 430, 431, and 740.

iv. Only providers enrolled in and filing claims under GA Medicaid programs 430, 431, 450, and 740 may bill Code D1206 Fluoride Varnish (eff. 1/1/2010).

v. Providers may not bill for an Evaluation and Management (E/M) visit in addition to billing for the application of fluoride varnish, if the sole purpose of the visit was to apply the fluoride varnish. In this instance, the provider may bill for the fluoride varnish code only.

E. Category of Service

i. Dentists: under category of service 450

ii. Physicians: under category of service 430

iii. Physician Assistants (PA): under category of service 431

iv. Nurse Practitioners: under category of service 740

For more information including the payment rate for this service, please see the Part II Policies and Procedures Manual for Dental Services.

F. Resources (not mandatory to use)

i. Smiles for Life Oral Health Risk Assessment Tool:

ii. ADA Caries Risk Assessments Forms**:**

ADA Caries Risk Assessment Form (Age 0-6)
ADA Caries Risk Assessment Form (Age >6)

iii. Smiles for Life Online trainings:

Child Oral Health (Course 2)
Caries Risk Assessment, Fluoride Varnish and Counseling (Course 6) (Course 6)

iv. Oral Health Professional Websites: American Dental Association (ADA): http://www.ada.org

American Academy of Pediatric Dentistry (AAPD): http://www.aapd.org

v. Patients at risk for caries include those with: insufficient sources of dietary fluoride; high carbohydrate diets; caretakers who transmit decay-causing bacteria to children via their saliva; areas of tooth decalcification; reduced salivary flow; and poor oral hygiene. AAP training course also includes “children from low socioeconomic and ethnocultural groups.”

APPENDIX H

EPSDT HIPAA Referral Code Examples

A. HIPAA Referral Codes Examples

i. Child has come in for an EPSDT Interperiodic Hearing Screen and the provider finds that the child has an ear infection. The provider treats the child for the ear infection at the time of the interperiodic visit and requests a follow up appointment with him in two weeks. What EPSDT referral code should be documented?

EPSDT Referral Code: **S2**

ii. Child has come in for an EPSDT Screen and has experienced complications with diabetes since birth. The provider treats the child for the diabetes complications at the time of the preventive health visit and does not request a follow up appointment. What EPSDT referral code should be documented?

EPSDT Referral Code: **NU**

iii. Child has come in for an EPSDT Screen and during the screen, the mother informs the provider that the child has behavior problems. The provider refers the child for further diagnostic testing within two weeks with a Diagnostic and Behavioral Center. What EPSDT referral code should be documented?

EPSDT Referral Code: **ST**

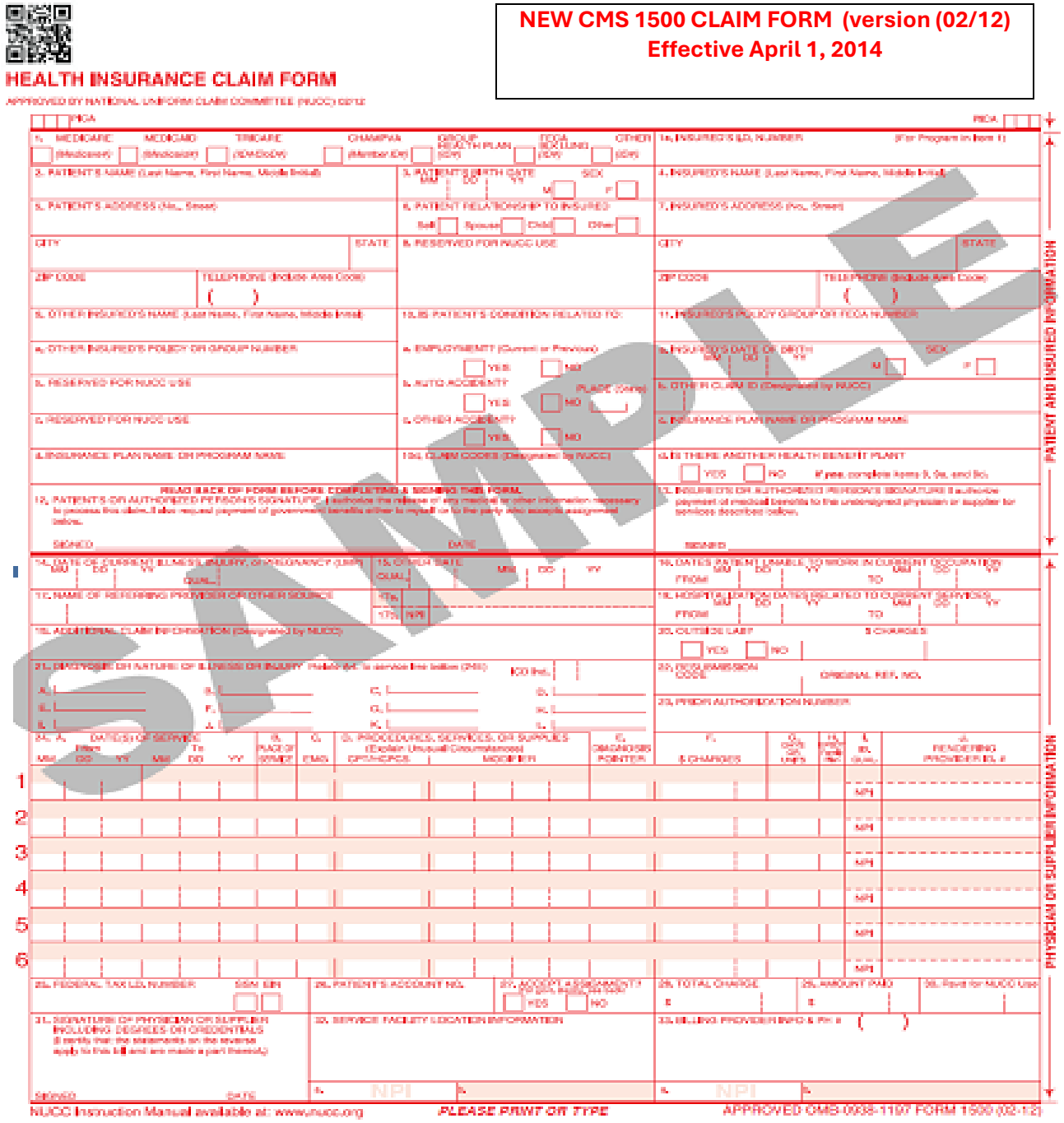
iv. Child has come in for EPSDT Screen and the provider finds that the child has some developmental problems. The provider refers the child for further diagnostic testing with a Developmental and Behavioral Center. Mom refuses the Developmental and Behavioral appointment. What EPSDT referral code should be documented?

EPSDT Referral Code: **AV**

APPENDIX I

NEW CMS 1500 CLAIM FORM (version 02/12) - SAMPLE

Effective May 1, 2015, paper claims are no longer accepted by Gainwell Technologies. As part of the Georgia Paperless Initiative, providers are required to submit CMS 1500 claims electronically over the GAMMIS web portal. For more information regarding the Paperless Initiative, please access the web portal and review all related Banner Messages.



New CMS 1500 Field Locator Instructions

The following table outlines the **revised changes** on the above CMS 1500 claim form version 02/12:

FLD Location	NEW Change
Header	Replaced 1500 rectangular symbol with black and white two-dimensional QR Code (Quick Response Code)
Header	Added "(NUCC)" after "APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE."
Header	Replaced "08/05" with "02/12"
Item Number 1	Changed "TRICARE CHAMPUS" to "TRICARE" and changed" (Sponsor's SSN)" to "(ID#/DoD#)."
Item Number 1	Changed "(SSN or ID)" to "(ID#)" under "GROUP HEALTH PLAN"
Item Number 1	Changed "(SSN)" to "(ID#)" under "FECA BLK LUNG."
Item Number 1	Changed "(ID)" to "(ID#)" under "OTHER.'
Item Number 8	Deleted "PATIENT STATUS" and content of field. Changed title to "**RESERVED FOR NUCC USE**."
Item Number 9b	Deleted "OTHER INSURED's DATE OF BIRTH, SEX." Changed title to "**RESERVED FOR NUCC USE**."
Item Number 9c	Deleted "EMPLOYER'S NAME OR SCHOOL." Changed title to "**RESERVED FOR NUCC USE**."
Item Number 10d	Changed title from "RESERVED FOR LOCAL USE" to "CLAIM CODES (Designated by NUCC)." **Field 10d is being changed to receive Worker's Compensation codes or Condition codes approved by NUCC.** **FOR DCH/Gainwell Technologies:** FLD 10d on the OLD Form CMS 1500 Claim (08/05) will no longer support receiving the Medicare provider ID.
Item Number 11b	Deleted "EMPLOYER'S NAME OR SCHOOL." **Changed title to "OTHER CLAIM ID** (Designated by NUCC)". Added dotted line in the left-hand side of the field to accommodate a 2-byte qualifier
Item Number 11d	Changed "If yes, return to and complete Item 9 a-d" to "If yes, complete items 9, 9a, and 9d." (Is there another Health Benefit Plan?)
Item Number 14	Changed title to "DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)." Removed the arrow and text in the right-hand side of the field. Added "QUAL." with a dotted line to accommodate a 3-byte qualifier." **FOR DCH/Gainwell Technologies: Use Qualifiers: 431 (onset of current illness); 484 (LMP); or 453 (Estimated Delivery Date)**.
Item Number 15	Changed title from 'IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE" to "OTHER

FLD Location	NEW Change
	DATE." Added "QUALIFIER." with two dotted lines to accommodate a 3-byte qualifier: 454 (Initial Treatment); 304 (Latest Visit or Consultation); 453 (Acute Manifestation of a Chronic Condition); 439 (Accident); 455 (Last X-ray); 471 (Prescription); 090 (Report Start [Assumed Care Date); 091 (Report End [Relinquished Care Date); 444 (First Visit or Consultation).
Item Number 17	Added a dotted line in the left-hand side of the field to accommodate a 2-byte qualifier – **Used by Medicare** for identifiers for provider roles: Ordering, Referring and Supervising. **FOR DCH/Gainwell Technologies:** Use the following Ordering Provider, Referring, Supervising Qualifiers (**effective 4/01/2014**): **Ordering = DK; Referring = DN or Supervising = DQ.**
Item Number 19	Changed title from "RESERVED FOR LOCAL USE" to "ADDITIONAL CLAIM INFORMATION (Designated by NUCC)." **FOR DCH/Gainwell Technologies:** Remove the Health Check logic from field 19 and add it in **field 24H.**
Item Number 21	Changed instruction after title (Diagnosis or Nature of Illness or Injury) from "(Relate Items 1, 2, 3 or 4 to Item 24E by Line)" to "Relate A-L to service line below (24E)."
Item Number 21	Removed arrow pointing to 24E (Diagnosis Pointer).
Item Number 21	Added "ICD Indicator." and two dotted lines in the upper right-hand corner of the field to accommodate a 1-byte indicator. Use the highest level of code specificity in FLD Locator 21. **Diagnosis Code ICD Indicator** - new logic to validate acceptable values (0, 9). ICD-9 diagnoses (CM) codes = value 9; or ICD -10 diagnoses (CM) codes = value 0. **(Do not bill ICD 10 code sets before October 1, 2015.)**
Item Number 21	Added 8 additional lines for diagnosis codes. Evenly space the diagnosis code lines within the field.
Item Number 21	Changed labels of the diagnosis code lines to alpha characters (A-L).
Item Number 21	Removed the period within the diagnosis code lines
Item Number 22	Changed title from "MEDICAID RESUBMISSION" to "RESUBMISSION." The submission codes are: 7 (Replacement of prior claim) 8 (Void/cancel of prior claim)
Item Numbers	The supplemental information is to be placed in the shaded section of 24A through 24G as defined in each Item Number.

FLD Location	NEW Change
24A – 24 G (Supplemental Information)	**FOR DCH/Gainwell Technologies**: Item numbers **24A** & **24G** are used to capture Hemophilia drug units. **24H** (EPSDT/Family Planning).
Item Number 30	Deleted "BALANCED DUE." Changed title to "**RESERVED FOR NUCC USE**."
Footer	Changed "APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)" to "APPROVED OMB-0938-1197 FORM 1500 (02/12)."

Completion of the Health Insurance Claim Form for EPSDT Services
Billed by Fee-for-Service Providers

Review these helpful tips for completing the Health Insurance Claim Form (CMS-1500) for EPSDT Services. See Appendix H for EPSDT HIPAA Referral Code Examples.

Item 9 Other Insured's Name
Leave blank. EPSDT preventive health screenings are exempt from third party liability. Even if the member has other insurance, you may file Medicaid first for preventive health services.

Item 21 Diagnosis
Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field.

Enter the codes to identify the patient's diagnosis and /or condition. List no more than **twelve (12)** diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line.

Item 24A Dates of Service (DOS)
The "From" and "To" DOS will always be the same. Since there is only one DOS, enter the date under "From." Leave "To" blank or re-enter "From" date.

Item 24B Place of Service (POS)
Enter POS code 99 for all preventive health services and interperiodic visits.

Item 24C EMG (emergency)
Leave blank for "No".

Item 24D HCPCS Code and Modifier
Enter procedure code and the EP modifier, plus any additional modifiers as applicable.

Item 24E Diagnosis Pointer
Enter the diagnosis code reference letter (pointer) to relate to the DOS 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. Do not use commas between letters.

Item 24H HIPAA EPSDT Referral Codes

- If EPSDT screening resulted in an EPSDT referral, enter the appropriate referral code:
  - ✓ Document AV, S2, or ST in the shaded area of box 24H
- If EPSDT screening did not result in an EPSDT referral:
  - ✓ Document NU in the shaded area of box 24H
- A "Y" for Yes or "N" for No is **not** entered with the referral code in the shaded area or in the unshaded area of box 24H.

APPENDIX J
Resources for Children in Georgia

Georgia Public Health Programs

Programs for Children with Disabilities or Special Health Care Needs:

Babies Can't Wait Program (Birth – 3 years)
200 Piedmont Avenue, SE
Atlanta, GA 30334
http://dph.georgia.gov/Babies-Cant-Wait
404-657-2850
888-651-8224

Children's Medical Services (Birth – 21 years)
200 Piedmont Avenue, SE
Atlanta, GA 30334
http://dph.georgia.gov/CMS
404-657-2850

Children 1st Program
200 Piedmont Avenue, SE
Atlanta, GA 30334
http://dph.georgia.gov/children1st
404-657-2850

Women, Infants, and Children (WIC)
200 Piedmont Avenue, SE
Atlanta, GA 30334
https://dph.georgia.gov/WIC
1-800-228-9173

Georgia Families
For members in Medicaid or PeachCare for Kids®
Most Medicaid and PeachCare for Kids members must enroll in the Georgia Families managed care program and choose a health plan and a provider.
https://www.georgia-families.com/GASelfService/en_US/home.htm
1-888-GA-ENROLL (1-888-423-6765)

PeachCare for Kids®
CHIP Program
(PeachCare for Kids offers free to low cost health insurance, inclusive of the EPSDT benefit, to uninsured, eligible children living in Georgia)
P.O. Box 786
Alma, GA 31510
www.PeachCare.org
1-877-GA-PEACH (1-877-427-3224)

Vaccines for Children (VFC) Program
GA Department of Public Health Immunization Program
200 Piedmont Avenue, SE
Atlanta, GA 30334
https://dph.georgia.gov/vaccines-children-program
(800) 848-3868
(404) 657-5013/ 5015
DPH-gavfc@dph.ga.gov

Georgia Department of Education (GaDOE)

Ask DOE Manager
2054 Twin Towers East
205 Jesse Hill Jr. Drive SE
Atlanta, GA 30334
(404) 656-2800
(800) 311-3627 (GA)
(404) 651-8737 (fax)
askdoe@gadoe.org

Special Education
Division for Special Education Services and Supports
Georgia Department of Education
1754 Twin Towers East
205 Jessie Hill Jr. Drive, SE
Atlanta, GA 30334-9048
(404) 656-3963
Web: www.doe.k12.ga.us/

Programs for Children with Disabilities: Ages 3 through 7

Young Children/619 Coordinator
Division for Special Education Services and Supports
Georgia Department of Education
1870 Twin Towers East
Atlanta, GA 30334-5060
(404) 657-9965
Web: www.doe.k12.ga.us

Division of Family & Children Services (DFCS)
http://dfcs.dhs.georgia.gov
1.800.georgia (1.800.436.7442)
678.georgia (678.436.7442) – Atlanta area

DFCS Office of Constituent Services
(404) 657-3433
- Child Welfare Online Contact Form

complete online contact form for issues related to Adoptions, Child Protective Services, Foster Care or any other Child Welfare issue.

Child Protective Services / Child Abuse & Neglect
1-855-GACHILD / 1-855-422-4453
(404) 657-3400

Medicaid
(877) 423-4746

Food Stamps
(877) 423-4746

Energy Assistance
(877) 423-4746

Temporary Assistance for Needy Families
(877) 423-4746

Department of Behavioral Health and Developmental Disabilities (DBHDD)
200 Piedmont Avenue, SE
Atlanta, GA 30334
404-657-2252
http://dbhdd.georgia.gov

Other Resources:

Parent-To-Parent of Georgia
Parent to Parent of Georgia offers a variety of services to Georgia residents ages birth to 26 years and their families impacted by disabilities or special healthcare needs.

3070 Presidential Parkway, Suite 130
Atlanta, GA 30340
(770) 451-5484
(800) 229-2038
Web: http://p2pga.org

Healthy Mothers, Healthy Babies Powerline
Source for healthcare referrals and information
2300 Henderson Mill Road
Suite 410
Atlanta, GA 30345
(770) 451-0020
(770) 451-2466
(800) 300-9003
(800) 822-2539
thecoalition@hmhbga.org
www.hmhbga.org

APPENDIX K

General Claims Submission Policy for Ordering, Prescribing, or Referring (OPR) Providers

The Affordable Care Act (ACA) requires physicians and other eligible practitioners who order, prescribe and refer items or services for Medicaid beneficiaries to be enrolled in the GA Medicaid Program. As a result, CMS expanded the claim editing requirements in Section 1833(q) of the Social Security Act and the providers' definitions in sections 1861-r and 1842(b)(18)C. Therefore, claims for services that are ordered, prescribed or referred must indicate who the ordering, prescribing or referring (OPR) practitioner is. The Department will utilize an enrolled OPR provider identification number for this purpose. Any OPR physicians or other eligible practitioners who are NOT already enrolled in Medicaid as participating (i.e. billing) must enroll separately as OPR. The National Provider Identifier (NPI) of the OPR provider must be included on the claim submitted by the participating, i.e. rendering provider. If the NPI of the OPR provider noted on the Georgia Medicaid claim is associated with a provider who is not enrolled in the Georgia Medicaid program, the claim will not be paid.

Effective 4/1/2014, DCH will begin editing claims submitted through the web, EDI, and on CMS 1500 forms for the presence of an ordering, prescribing or referring provider as required by program policy. The edit will be informational until 6/1/2014. Effective 6/1/2014, the ordering, prescribing or referring provider will become a mandatory field and claims that do not contain the information as required by policy will begin to deny.

For the New CMS-1500 claim form:
Enter qualifiers to indicate if the claim has an ordering, prescribing or referring to the left of the dotted line in box 17 (Ordering = DK; Referring = DN or Supervising = DQ.

For claims entered via the web:
Claims headers were updated to accept ordering or referring Provider ID and name for Dental and Institutional claims and the referring provider's name for Professional claims. The claim detail was updated to accept an ordering or referring provider ID and name. Utilize the "ordering" provider field for claims that require a prescribing physician.

For claims transmitted via EDI:
The 837 D, I and P companion guides were updated to specifically point out the provider loops that capture the rendering, ordering, prescribing, referring and service facility provider information that is now used to transmit OPR information.

APPENDIX L

Reimbursement Rates

Reimbursement Rates for the Health Check Program (COS 600) for Medicaid-Eligible Members & PeachCare for Kids

A. Reimbursement

i. When billing Health Check Services, the following HIPPA modifier(s) are allowed:

1. EP
2. EP 25
3. EP HA
4. EP HA 25

ii. Physicians and physician extenders (physician assistants, nurse practitioners) are reimbursed at 100% of the established rates when billing the specified codes and modifiers for Health Check services rendered to Medicaid-eligible members and PCK-eligible members.

iii. Physicians and physician extenders who are eligible for the House Bill (HB) Primary Care Providers (PCP) rate increases are reimbursed 100% of the established rates, when billing the specified codes and modifiers for Health Check services rendered to Medicaid-eligible and PCK-eligible members.

(Rev. 4/2025)

B. **Rates for Preventive Services**

Preventive Visit Codes	Enhanced Rates	Non-Enhanced Rates
99381	$107.75	$67.38
99391	$99.99	
99382	$112.38	
99392	$106.92	
99383 (age 5-7 years)	$117.35	$67.38
99393 (age 5-7 years)	$106.58	
99383 (age 8-11 years)	$117.35	$55.38
99393 (age 8-11 years)	$106.58	
99384	$132.94	$55.38
99394	$116.82	
99385	$129.03	$55.38
99395	$115.86	
Rates apply to Medicaid-eligible members and PeachCare for Kids®-eligible members**.**		

(rev. 04/2025)

C. Rates for E/M Services

Interperiodic Visit Codes	Enhanced Rates	Non-Enhanced Rates	
		Medicaid-eligible members	PCK-eligible members
99202	$72.04	$54.57	$71.16
99203	$109.35	$76.53	$103.01
99204[1]	$167.09	$110.51	$158.37
99205[1]	$202.13	$137.12	$197.18
99211	$19.16 $19.99 (PCK)	$17.46	$17.46
99212	$46.19	$29.67	$41.54
99213	$82.05	$82.05	$69.11
99214	$115.71	$115.71	$102.49
99215[1]	$148.33	$93.46	$137.88
Rates apply to Medicaid-eligible members and PeachCare for Kids®-eligible members.			

(rev. 04/2025)

D. Rates for Vaccine Administration

Vaccine Product Codes	Enhanced Rates	Non-Enhanced Rates	
		Medicaid-eligible members	**PCK-eligible members**
90460	$22.15	$10.00	$18.50
90471	$23.78		
90472	$12.99		
90473	$23.78		
90474	$12.10 $18.69 (PCK)		
Rates apply to Medicaid-eligible members and PeachCare for Kids®-eligible members.			

(rev. 04/2025)

APPENDIX M

Georgia Families, Georgia Families 360, and Non-Emergency Medical Transportation

For information on the Georgia Families, Georgia Families 360, or Non-Emergency Medical Transportation program, please access the overview document at the following link:

i. Policy Fee Schedule(s):
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Fee%20Schedules/tabId/20/Default.aspx

ii. Georgia Families Overview:
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx

iii. Georga Families 360 Overview:
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx

iv. Non-Emergency Medical Transportation Overview:
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx