

Chapter 33-000 HEALTH CHECKS and Treatment Services for Conditions Disclosed During HEALTH CHECKS (EPSDT)

33-001 Introduction

33-001.01 Legal Basis: HEALTH CHECKS are covered under the Early and Periodic Screening, Diagnosis, and Treatment Program which was established by Title XIX of the Social Security Act. Section 1905(r) of the Social Security Act was added by the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239).

33-001.01A Annual Participation Goals: Section 1905(r) of the Social Security Act also mandates setting annual participation goals for screening services.

33-001.02 Purpose and Scope: HEALTH CHECK, the Nebraska Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program is a service available to all individuals age 20 and younger eligible for medical assistance. The goal is to provide each eligible individual the opportunity for achieving and maintaining optimal health status. This can be facilitated by early detection of illness or defects through regular and periodic screening examinations, by providing follow-up care of the conditions detected during the screening, by providing continuity of care, and by promoting healthy lifestyles. It is intended to encourage and ensure that treatment is available and received by those eligible and in need of treatment by the application of medical knowledge and technology to cure, correct, or alleviate health problems. Preventive health care provides the following benefits:

1. Early detection and treatment of health problems to prevent serious impairment and to increase the chance of successful treatment;
2. Protection from certain preventable diseases by immunization for children at an early age;
3. Maintenance of good health and assurance of normal development through periodic check-ups and the establishment of a "medical home." In most cases, this will be a continuing relationship with a primary care physician; and
4. Savings of future medical costs.

The EPSDT program's objectives are ensuring the availability and accessibility of required health care resources and helping Medicaid-eligible children and their parents or caretakers effectively use them. This may be accomplished through care coordination. Care coordination includes:

1. Provision of effective outreach/education activities which inform parents of the benefits of having their children receive HEALTH CHECK screening , diagnosis, and treatment services;
2. Provision of consumer education to parents which assists in making responsible decisions about participation in preventive health care and appropriate utilization of health care resources;
3. Assurance of continuing and comprehensive health care beginning with the screening through diagnosis and treatment for conditions identified during screening;

4. Provision of assistance to families in making medical and dental appointments and in obtaining needed transportation; and
5. Establishment of case management of screening services to monitor and document that all HEALTH CHECK (EPSDT) services are delivered within established time frames.

This may be accomplished through interagency agreement, managed care contract, or fee for service with qualified Medicaid-enrolled providers as determined by the NMAP. Examples of EPSDT participants in particular need of care coordination may be pregnant adolescents, children with special health care needs, medically fragile children, foster care children, and children with significantly environmental risk.

33-001.03 Services Provided for Clients Enrolled in the Nebraska Health Connection (NHC): Certain NMAP clients are required to participate in the Nebraska Medicaid Managed Care Program known as the Nebraska Health Connection (NHC). See 471-000-122 for a listing of the NHC plans.

33-001.03A HMO Plans: The NHC HMO plans are required to provide, at a minimum, coverage of services as described in this chapter. The prior authorization requirements, payment limitations, and billing instructions outlined in this Chapter do not apply to services provided to clients enrolled in an NHC HMO plan. Services provided to clients enrolled in an NHC HMO plan are not billed to NMAP. The provider shall provide services only under arrangement with the HMO.

33-001.03B Primary Care Case Management (PCCM) Plans: All NMAP policies apply to services provided to NHC clients enrolled in a PCCM plan. All services provided to clients enrolled in NHC PCCM plans are billed to NMAP.

33-001.03C HEALTH CHECK Under NHC: HEALTH CHECK services are covered services under the Nebraska Health Connection (NHC). EPSDT participants enrolled with capitated (HMO) plans or PCCM network should receive HEALTH CHECK health screening services from their primary care physician (PCP). Plans are to meet the annual participation goals as required under contract.

When vision, hearing, and dental screening examinations are included in the HMO capitated plan in which the EPSDT participant is enrolled, the vision, hearing, and dental screening provider must work with the Plan for payment. These screening services must be available according to the established periodicity schedules in 471 NAC 33-002.03 and under the guidelines for interperiodic examinations in 471 NAC 33-002.04.

Vision, hearing, and dental screening examinations for HMO enrollees whose plan does not include these in the capitated rate do not require PCP referral and can be obtained from any qualified Medicaid-enrolled provider. Independent hearing screening exams require referral management from the PCCM plan. Providers should contact the plan before providing services. Vision and dental screening for PCCM enrollees will not require PCP referral. Prior authorization is prohibited for HEALTH CHECK screening exams.

Services that are identified as a result of a HEALTH CHECK screen that are not covered under the Nebraska Medicaid Assistance Program are not included in the NMMCP. These services require prior authorization per 33-001.03, Treatment Services.

33-001.04 Definition of Terms: The following terms are defined in relation to HEALTH CHECK and treatment services under the EPSDT program.

Early: As soon as an individual's or a family's eligibility for assistance has been established; or, in the case of a family already receiving assistance, as early as possible in the individual's life. This includes informing Medicaid-eligible pregnant women so that prevention begins prenatally.

Periodic: Intervals established for examination or screening to ensure continued health and to detect conditions requiring treatment. Dental screening examinations are recommended for children following eruption of their first tooth, but no later than age one according to the American Dental Association. Medical, visual, and hearing exams are to begin with a neonatal exam and follow, at a minimum, the periodicity schedule based on the American Academy of Pediatrics schedule for health supervision visits (see 471 NAC 33-002.03). The physician may establish an alternate periodicity schedule based on medical necessity. The initial examination of a newborn is considered an initial HEALTH CHECK (EPSDT) examination and the child is considered participating in the program. All well-baby and well-child examinations are to be reported as HEALTH CHECK examinations through the HEALTH CHECK (EPSDT) program.

Screening Services: Periodic child health assessments which are regularly scheduled to examine and evaluate the general physical and mental health, growth, development and nutritional status of eligible children. The screenings are performed to identify individuals who may require diagnosis, further examination, and/or treatment. Prior authorization approval of health, dental, vision, and hearing screening examinations for EPSDT participants is prohibited. The following screening services are included in the EPSDT benefit:

1. Health Screening Services:
 - a. Comprehensive health and developmental history (including assessment of both physical and mental health development);
 - b. Comprehensive unclothed physical examination;
 - c. Appropriate immunizations for age and for health history;

- d. Appropriate laboratory procedures, including blood lead testing for age and populations groups; and
- e. Health education (including anticipatory guidance);
2. Dental Screening Services: For children age one and older, dental screening services are furnished by direct referral to a dentist. Medically necessary and reasonable diagnosis and treatment including, at a minimum, relief of pain and infections, restoration of teeth, and maintenance of health are covered;
3. Vision Screening Services: An age-appropriate visual assessment. Medically necessary and reasonable diagnosis and treatment for defects in vision are covered; and
4. Hearing Screening Services: An age-appropriate hearing assessment. Medically necessary and reasonable diagnosis and treatment for defects in hearing are covered.

Diagnosis: The determination of the nature or cause of a physical or mental disease or abnormality. A diagnosis enables a physician to make a plan for treatment specific to the EPSDT participant's problems. Under certain circumstances, diagnosis may be provided at the same time as screening. In other circumstances, diagnosis may be provided during a second appointment. The diagnosis may or may not require further follow-up. It may result in referral for treatment.

Treatment Services: HEALTH CHECK (EPSDT) follow-up services necessary to diagnose or to treat a condition identified during a HEALTH CHECK (EPSDT) health, visual, hearing, or dental screening examination are covered under the following conditions:

1. The service is required to treat the condition (i.e., to correct or ameliorate defects and physical or mental illnesses or conditions) identified during a periodic or interperiodic HEALTH CHECK (EPSDT) screening examination and documented;
2. The provider of services is a Medicaid-enrolled provider;
3. The service is consistent with applicable federal and state laws that govern the provision of health care;
4. The service must be medically necessary, safe and effective, not considered experimental/investigational (see 471 NAC 10-004.05), and must be generally employed by the medical profession;
5. Supplies, items, or equipment that is determined to be not medical in nature will not be covered;
6. Where alternative and medically appropriate modes of treatment exist and are available the NMAP may choose among the alternatives which services are available based on cost-effectiveness;

7. Services currently covered under the Nebraska Medical Assistance Program will be governed by the guidelines of NMAP;
8. Services not covered under the Nebraska Medical Assistance Program but defined in Section 1905(a) of the Social Security Act must meet the conditions of items 1 through 6 (above). Criteria and requirements for certain services are outlined in this Chapter. Unless otherwise outlined, all services not covered under NMAP must be prior authorized by the Medicaid Division, Department of Health and Human Services Finance and Support. Requests for prior authorization must be submitted to: Nebraska Department of Health and Human Services Finance and Support, Medicaid Division. The provider shall submit requests for NMAP prior authorization using the standard electronic Health Care Services Review – Request for Review and Response transaction (ASC X12N 278) or by completing and submitting a written request. The request must include -
 - a. A copy of the screening exam form or the name of the screening practitioner and the date of the screening exam which identified the condition; and
 - b. A plan of care which includes -
 - (1) History of the condition;
 - (2) Physical findings and other signs and symptoms, including appropriate laboratory data;
 - (3) Recommended service/procedure, including (if known) the potential provider of service (e.g., equipment, supplies) or where the services will be obtained;
 - (4) Estimated cost, if available; and
 - (5) Expected outcome(s).

The plan of care may be submitted on Form EPSDT-5, "Plan of Care," (see 471-000-38) or as a statement by the screening practitioner. The Medical Director or designee shall make a decision on each request in an expeditious manner. Appropriate health care professionals may be consulted during the decision-making process. A response will be sent to the screening practitioner, managed care plan if an enrollee, and the client's worker in the local HHS office. For wards of the Department, a response is sent to the client's case manager in the local office. If the initial request is denied, additional information may be sent for reconsideration.

33-002 HEALTH CHECKS (EPSDT Screening Evaluations): The screening examination is performed to identify those health problems which require further examination and/or treatment. Form CMS-1500 for HEALTH CHECK health screening services (see 471-000-62) or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) is designed to -

1. Report the screening findings during the screening examination;
2. Report services associated with the screening exam as defined in 471 NAC 33-003, HEALTH CHECK (EPSDT) Special Services; and
3. Claim charges for these services.

The Recommendations for Preventive Pediatric Health Care published by the American Academy of Pediatrics (see 471 NAC 33-002.03) are recommended as guidelines for content and minimum frequency for HEALTH CHECK (EPSDT) examinations. The initial newborn assessment in the hospital is considered a HEALTH CHECK screening. Total obstetrical care fulfills the requirement of a HEALTH CHECK examination for EPSDT participants.

Screening physicians using the appropriate professional claim form or electronic format (see Claim Submission Table at 471-000-49) will be subject to random selection of medical chart review to assure the minimum components of the screening examination are performed.

33-002.01 Screening Providers: Screening services are to be performed by or under the supervision of a physician, dentist, or other provider qualified under State and Federal law to furnish primary medical and health services. Periodic and interperiodic examinations shall, at a minimum, include the health screening services defined in 471 NAC 33-001.03 (see item 1 of the definition of Screening Services). Vision and hearing screening examinations cannot be limited to the screening physician but may be obtained directly from an ophthalmologist or optometrist for vision services and licensed audiologist for the hearing service. In an effort to support the "medical home" concept or a permanent primary care relationship and to avoid fragmentation or duplication of services, the provision of vision and hearing screening provided within the context of the health screening is encouraged. If not performed with the health screening, care coordination with the primary physician is recommended (see 471 NAC 33-001.03).

33-002.02 Components of Health Screening: Each health screening must at a minimum include the components A-E (defined in 471 NAC 33-002.02A through 33-002.02E), and at the screening physician's judgment components F-H (defined in 471 NAC 33-002.02F through 33-002.02H). Component F, vision screening and component G, hearing screening, may be obtained directly from a qualified provider of these screening services. See 471 NAC 24-000 for policy relating to coverage of vision services and 471 NAC 23-000 for policy relating to coverage of hearing services.

Note: If a component is not performed based on the physician's judgment, the physician documents the reason in the medical record.

33-002.02A Health and Developmental History: This information may be obtained from the parent or responsible adult familiar with the child at the time of the screening or prior to the screening through interview and by use of the physician's history form. The history is to include contact information, a description of the family, and medical, developmental and behavioral information on the child and the family. A comprehensive history is to be obtained on the initial examination and updated at subsequent periodic examinations. Developmental surveillance may include a review of gross and fine motor development, language development, self-help skills, social-emotional development, and cognitive skills. It is a review of developmental progress within the context of overall health and well-being, given the child's age and culture. If a formal development test is given to assess development, it may be billed separately from the full screening package by the screening physician if that is the physician's customary practice. The health and developmental history component also includes the assessment of nutritional status to determine whether the child has any symptoms related to nutritional status. The history should also include a risk assessment of children/adolescents for early identification of mental health or substance abuse concerns.

33-002.02B Comprehensive Unclothed Physical Examination: This component is to be performed during each initial and periodic examination. The exam includes a physical growth evaluation and a check of the general appearance of the child to determine overall health status. Physical inspection includes a check of the organ systems.

33-002.02C Immunizations: This is to be an assessment of the immunization status determined at each screening examination and updated according to the most current immunization schedule of the Advisory Committee on Immunization Practices (ACIP) and/or American Academy of Pediatrics. Immunizations must be given at the time of the screening examination unless medically contraindicated at the time; these may be rescheduled at an appropriate time.

The Vaccine for Children Program (VFC) provides federally-purchased vaccine for most childhood immunizations for Medicaid-eligible children and adolescents 18 years old and younger. NMAP will not reimburse for a physician's private stock vaccine when the vaccine is available through the VFC program.

Adolescents age 19 and 20 are also covered for routine preventative immunizations under the EPSDT program. Medicaid reimbursement is available for the physician's private stock vaccine plus an administration fee for immunization of these individuals.

When a physician uses federal-purchased vaccine for immunizations, the physician must bill NMAP only for the administration. The physician must use the modifier "SL" with the vaccine code when billing for the administration. Billed charges for the administration of VFC vaccines cannot exceed the state maximum as determined by the federal VFC program. Contact the Nebraska VFC program with questions regarding the Nebraska maximum. NMAP reimburses for the administration of VFC vaccine according to the Nebraska Medicaid Practitioner Fee Schedule.

Vaccine For Children (VFC) participation is a requirement of the NHC primary care providers (PCP) providing childhood immunizations to children enrolled in an NHC health plan. Public health immunization clinics are an accessible and cost effective resource for immunizations. Contractual agreements are encouraged between managed care plans and local health departments and immunization clinics operating under the supervision of the Department of Health and Human Services, Division of Public Health. Immunization clinics must - (1) Follow the Division of Public Health protocol manual, (2) Receive vaccine, supplies, and materials from the Division of Public Health, (3) Be formally evaluated annually by the Division of Public Health, and (4) Be sponsored by a physician enrolled in the Nebraska Medicaid program. Such agreements may include provisions relating to the administration of immunizations, the administration fee reimbursement, immunization reporting requirements, and procedures for outreach and coordination of HEALTH CHECK exams and immunizations with the clinics to the plan and/or the PCP.

33-002.02D Laboratory Tests: The laboratory tests listed below are performed as appropriate for the child's age and population group as determined by the screening physician. Recommended tests are:

1. Hemoglobin/Hematocrit: A microhematocrit determination or hemoglobin concentration test from venous blood or a fingerstick according to the American Academy of Pediatrics Recommendations for Pediatric Preventive Health Care.
2. Sickle Cell: If indicated by population group. This is done with a sickle cell preparation or hemoglobin solubility test.
3. Tuberculin testing (PPD): Tuberculin testing is recommended annually for children with risk factors such as:
 - a. low socioeconomic status;
 - b. reside in areas where tuberculosis is prevalent;
 - c. exposed to tuberculosis;
 - d. immigrant status; or
 - e. children with immunosuppressive conditions;The Mantoux test is the recommended test for screening of tuberculosis.
4. Lead toxicity screening: An assessment of risk of high-dose lead exposure and blood lead testing by either capillary or venipuncture collection method. All children ages 6-72 months of age are considered at risk for lead poisoning and must be assessed at the screening exam. Beginning at six months of age and at each visit thereafter the screening provider must assess the child's risk for exposure. The risk assessment questions to be asked are:
 - (a) Does your child live in or regularly visit a house built before 1978? Does the house have peeling or chipping paint?
 - (b) Does your children live in a house built before 1978 with recent, ongoing, or planned renovation or remodeling:
 - (c) Have any of your children or their playmates had lead poisoning;
 - (d) Does your child frequently come in contact with an adult who works with lead (e.g. construction, welding, pottery)
 - (e) Does your child live near a lead smelter, battery-recycling plant, or other industry likely to release lead?
 - (f) Do you use any home or folk remedies that may contain lead?
 - (g) Does your child live near a heavily traveled major highway where soil and dust may be contaminated with lead?
 - (h) Does your home's plumbing have lead pipes or copper with lead solder joints?
 - (j) Has your child had a blood lead test in the last 12 months?

If the answers to all questions are negative, a child is considered at low risk for high doses of lead exposure but is to receive a blood lead test at 12 months and, if possible, at 24 months.

If the answer to any of the questions is positive, a child is considered at high risk and a blood lead test must be obtained immediately and at subsequent screening examinations. Physicians are to reference CDC guidelines for patient management and treatment.

Environmental Investigation: Locating the source of lead contamination is considered an integral part of the management and treatment of a Medicaid eligible child diagnosed with an elevated blood lead level.

Trigger: Patient specific environment investigations will be covered if the child's blood lead level is above 20 micrograms per deciliter confirmed by blood lead testing by venipuncture method and a physician must have diagnosed lead toxicity.

Site: An environmental lead investigation is an assessment of the child's home or primary residence by a health professional certified as a lead inspector using a portable x-ray fluorescence (XRF) analyzer. The investigation must also include:

1. An interview with the family to gather basic information about the habits of the child and provide information about source of lead exposure, nutritional guidelines, prevention, and clean-up advice.
2. Written recommendations to the owner of the house/apartment for the immediate and permanent removal or reduction for the lead sources.

Non-medical activities such as removal of lead sources, providing alternate housing, or analysis of samples which are sent to laboratories are not covered.

Payment: Payment will be made under an interagency contract with local or state health departments utilizing certified lead inspector at a negotiated rate that includes the initial environmental investigation and a follow-up visit, if needed.

5. Urinalysis: A rapid screening or dip test on children to detect the presence of sugar and albumin.
6. Serum Cholesterol Determination: If indicated.
7. Others: There are other tests that may be determined appropriate based on individual's age, sex, health history, clinical symptoms, and exposure to disease.

Note: When the above criteria are not met, NMAP does not cover mass screening.

33-002.02E Health Education/Anticipatory Guidance: This includes anticipatory guidance or assistance in understanding what to expect in terms of the child's development and to provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention to parent(s) or caretaker and child. Health education is to be part of the initial and subsequent periodic examinations. Note: Suggested guidelines are found in the most recent edition of the American Academy of Pediatrics "Guidelines for Health Supervision" or "Bright Futures, Guidelines for Health Supervision of Infants, Children, and Adolescents" published by the National Center for Education in Maternal and Child Health.

33-002.02F Vision Screen: Screening is to be appropriate for the child's age. Vision screening must be performed to detect problems in acuity, color blindness, and ocular alignment.

33-002.02F1 Vision Screen Within the Context of the Health Screen: Screening for visual problems for children from birth to age three may be subjective through history taking and observation. Beginning approximately age three, if the child is testable, testing is recommended at each periodic health screening according to the Recommendations for Preventive Pediatric Health Care or more often when medically indicated. Examples of appropriate testing include:

1. Examination of the external eye, and performing ophthalmoscopy on the inner eye, to assure good ocular health.
2. Visual acuity of each eye at 20 feet using a Snellen Chart, Allen Figures, Tumbling E, HOTV, Picture tests, or the equivalent.
3. Assessment of ocular alignment, which should include range of motion testing and alternate cover testing at distance and near, or the equivalent.
4. Color discrimination testing.

Referral Criteria Guidelines: Children with any ocular signs or symptoms such as blurred vision; squinting; wandering eye; crossed eye; excessive blinking; itchy, burning, or scratchy eyes; red eye or eyelid; swollen or crusted eyelid; headache if associated with reading or other demanding visual task should be referred to an optometrist or ophthalmologist. Children who fail the vision screen as listed below should also be referred to an optometrist or ophthalmologist:

1. Any abnormality of the external eye, or of internal eye as detected with the ophthalmoscope.
2. Visual acuity with a two line difference between eyes; visual acuity of 20/50 or worse in either eye for children 3-5 years old; visual acuity of 20/40 or worse in either eye for children 6 and older. (Visual acuity of 20/50 means the child cannot identify half the 20/40 figures. Visual acuity of 20/40 means the child cannot identify half the 20/30 figures. 20/40 figures are twice as big as 20/20 figures, or they are 20/20 figures just perceived at one half the distance. 20/30 figures are 1 1/2 times as big as 20/20 figures, or they are 20/20 figures just perceived at 2/3 the distance.)
3. Inability of either eye to follow a penlight through a full range of motion. Wandering, turning, or jumping of the eyes when the eyes are alternately covered while the child is carefully watching a small distant object. Wandering, turning, or jumping of the eyes when repeated while the child focuses on a small object at reading distance.
4. Failure to discriminate color is not necessarily a basis for referral, but the child and family should be counseled concerning any deficit.

33-002.02F2 Vision Screen Performed By Ophthalmologist/Optometrist: NMAP covers annual eye examinations for EPSDT participants beginning at approximately age 3. More frequent exams will also be covered if needed to determine the existence of suspected conditions. For coverage of vision services for diagnosis and treatment, see Chapter 24-000 Visual Care Services.

33-002.02G Hearing Screen: Screening is to be appropriate for the child's age. Hearing screening must be performed to detect problems in hearing loss and speech development.

33-002.02G1 Hearing Screen Within the Context of the Health Screen: Screening for hearing problems for children from birth to age three may be subjective through history-taking, observation, and use of clinical voice screening such as clapping, talking, or other noise to determine if there is a hearing problem that needs formal testing. The American Speech-Language-Hearing Association (ASHA) Guidelines for Identification Audiometry (1985, reconfirmed 1990) recommend the individualized, manual, pure tone screening at 20 decibels be conducted for each ear at test frequencies to include 1000, 2000, and 4000 Hz when in conjunction with acoustic immittance screening. If acoustic immittance is not part of the screening, 500 Hz should be added

Referral Criteria Guidelines: ASHA states a failure to respond at the screening level to one or more frequencies in either ear is criteria for referral for further evaluation. Appropriate overall criteria for referral may be based on a failed response of 30 dB or greater in any frequency in either ear. Beginning approximately at age three, if the child is testable, audiometric screening is recommended through the use of an audiometer. Audiometric testing is recommended at health screening visits according to the Recommendations for Preventive Pediatric Health Care or more often when medically indicated.

33-002.02G2 Hearing Screen When Performed By a Licensed Audiologist: Hearing screening examinations or "routine" hearing examinations are those performed with no connection to treatment or diagnosis for a specific illness, symptoms, complaint, or injury. The examination is to follow the standards outlined by the ASHA for pure-tone screening. The hearing periodicity schedule outlines the recommended and appropriate minimum frequency for hearing screening examination (see 471 NAC 33-002.03B). More frequent exams will be covered if needed to determine the existence of suspected problems. Hearing screening examinations or "routine" hearing examinations for EPSDT participants do not require prior authorization for payment. For coverage of hearing services for diagnosis and treatment, see Chapter 23-000, Speech Pathology and Audiology Services.

33-002.02H Dental Screening: The dental screening examination is to be performed to detect deterioration of hard tissues and inflammation or swelling of soft tissues. For very young children, this may be performed by a visual inspection of the palate and dental ridge as part of the health screening examination. A direct referral to a dentist is required beginning at age one as indicated on the health screening periodicity schedule (see 471 NAC 33-002.03A) or earlier if determined medically necessary. Thereafter, dental screening examinations at six-month intervals are recommended. More frequent dental examinations will also be considered appropriate to determine the existence of suspected conditions. Dental screening examinations for EPSDT participants do not require prior authorization for payment. For coverage of dental services for diagnosis and treatment, see 6-000, Dental Services.

33-002.03 Periodicity Schedules: The following schedules provide a minimum basis for follow-up assessments after the initial examination to ensure continued health and well-being and to detect conditions requiring treatment. Wards of the Department may be screened each time they are placed in a foster home or facility. Physical examinations may be performed when necessary for school, camp, or similar activity.

33-002.03A Health Screening Periodicity Schedule: "Recommendations For Preventive Pediatric Health Care" published by the American Academy of Pediatrics (most recent version) is considered the minimum guidelines for health screening examinations.

33-002.03B Hearing Screening Periodicity Schedule:

Birth to 3 years Screening through history taking, observation, and clinical voice screening at intervals that follow the Health Screening periodicity schedule.

Age 3 years to
21 years Screening by standard testing method yearly or according to the Health Screening periodicity schedule. (Others allowed - see 471 NAC 33-002.04, Interperiodic Screening.)

33-002.03C Dental Screening Periodicity Schedule:

Birth to 21 years At six month intervals, dental screening is to be obtained from a dentist beginning at age one or earlier if medically necessary. Visual inspection of the mouth for very young children is recommended as part of each Health Screening examination. (Others allowed - see 471 NAC 33-002.04, Interperiodic Screening.)

33-002.03D Vision Screening Periodicity Schedule:

Birth to 3 years Screening through history taking and observation at intervals that follow Health Screening periodicity schedule.

Age 3 years to
21 years Screening by standard testing method yearly or more frequently if medically necessary. (Others allowed - see 471 NAC 33-002.04, Interperiodic Screening.)

33-002.04 Interperiodic Screening: Interperiodic screening examinations, performed outside of the periodicity schedule, will be covered when medically necessary to determine the existence of suspected physical or mental illnesses or conditions or if the severity of an illness or condition has changed. The determination of whether an interperiodic screening is medically necessary may be made by a health, developmental, or educational professional who comes into contact with the child outside of the formal health care system. Note: If the minimum components of a periodic health screening as defined in 471 NAC 33-002.02 are not performed, and only illness care is provided, the service should be reported and claimed on the appropriate professional claim form or electronic format (see Claim Submission Table at 471-000-49) as an acute care service. These visits require that a complete HEALTH CHECK screen be done (components A-E).

33-002.05 Interagency Agreements: The HEALTH CHECK (EPSDT) program shall coordinate with other programs that provide health services to children as provided in 42 CFR 441.61 and State Medicaid Manual, Part 5, Section 5230. Interagency collaborative activities address several goals simultaneously:

1. Containing costs and improving services by reducing service overlaps or duplications, and closing gaps in the availability of services;
2. Focusing services on specific population groups or geographic areas in need of special attention; and
3. Defining the scope of the programs in relation to each other.

Examples of agencies for which interagency agreements would be appropriate are public health programs, Head Start, and school districts. The interagency agreement may include HEALTH CHECK (EPSDT) services, such as outreach and referral, notification, support services, health care services, and/or follow-up services.

33-002.06 Continuing Care Providers: Continuing care is the provision of HEALTH CHECK (EPSDT) preventive, acute, and chronic care services by a single provider, who coordinates care, maintains a consolidated medical record of the child, and is the child's regular source of health care. A continuing care provider is one who -

1. Agrees to provide to formally enrolled children screening, diagnosis, and treatment for conditions identified during screening or referral to a provider capable of providing the appropriate services;
2. Maintains a complete health history, including information received from other providers;
3. Is responsible for providing needed physician services for acute, episodic, and/or chronic illnesses and conditions;
4. Ensures accountability by submitting reports reasonably required by NMAP; and
5. Works with the EPSDT case manager, if one is assigned.

As appropriate, the formal enrollment means that the EPSDT-eligible child or family has agreed to use one provider as a regular source of continuing care services for a stated period of time, and that mutual obligations of both client and provider are recognized by signed enrollment agreement.

The continuing care agreement must specify what options the provider will use to provide the following HEALTH CHECK (EPSDT) services:

1. Provision of dental services, or direct referral to a dentist or referral to the local HHS Office to obtain dental services;
2. Provision of all or part of the required transportation and scheduling assistance, or referral to local HHS Office to obtain such assistance; and
3. Referral assistance for treatment not covered by the plan but needed, or referral to local HHS Office to obtain assistance as well as other provisions outlined in the agreement.

Managed care plans will be considered continuing care providers if these provisions are met.

33-002.07 Payment for HEALTH CHECK (EPSDT) Services: Nebraska Medicaid pays for covered HEALTH CHECK services, except for clinical laboratory services or when provided under capitated contract for EPSDT participants enrolled in capitated plans, at the lower of -

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule for that date of service. The allowable amount is indicated in the fee schedule as -
 - a. The unit value multiplied by the conversion factor;
 - b. The invoice cost;
 - c. The maximum allowable dollar amount; or
 - d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

Payment for clinical laboratory services is at the amount allowed for each procedure code in the fee schedule for clinical laboratory services as established by Medicare.

The Department reserves the right to adjust the fee schedule to -

1. Comply with changes in state or federal requirements;
2. Comply with changes in national standard code sets such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is -
 - a. Not appropriate for the service provided; or
 - b. Based on errors in data or calculation;

Providers will be notified of the revisions and their effective dates.

33-002.08 Billing Requirements: Providers shall bill Medicaid on Form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837) for HEALTH CHECK (EPSDT) exams, HEALTH CHECK-associated services, and other comparable exams. See Claim Submission Table at 471-000-49.

Note: Providers are to bill all well-baby, well-child exams, and comparable examinations as HEALTH CHECK examinations.

The physician or the physician's authorized agent submit the physician's usual and customary charge for each procedure code listed on or in the claim.

33-002.08A Procedure Codes: Physicians shall use HCPCS procedure codes when submitting claims or encounter data to the Department for Medicaid services. These codes are defined by the Health Care Common Procedure Coding System (HCPCS). These five-digit codes and two-digit modifiers are divided into two levels:

1. Level 1: The codes contained in the most recently published edition of the American Medical Association's Current Procedural Terminology (CPT); and
2. Level 2: Federally-defined alpha-numeric codes.

HCPCS/CPT procedure codes used by NMAP are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-518 and 533.)

33-003 HEALTH CHECK (EPSDT) Special Services: The following services are covered to prevent, correct, or ameliorate a disease or condition identified during a screening examination and reported on the HEALTH CHECK claim form or electronic format. These services are considered part of the EPSDT benefit and are available to Medicaid-eligible individuals under 21.

All special service providers must be licensed Medicaid-enrolled providers who have submitted written required documentation and received written approval from the Medicaid Division. All providers requesting to provide HEALTH CHECK special services must submit a request in writing. All written information pertaining to provider requests or approval should be submitted to the Medicaid HEALTH CHECK program specialist at P.O. Box 95026, Lincoln, NE 68509. Any additional provider requirements for approval to provide special services and receive reimbursement are detailed in the following service sections. All approved providers must complete and submit a "Medical Assistance Provider Agreement," Form MC-19. Payment for services is according to NMAP Practitioner Fee Schedule unless included as part of a capitated plan. For HMO enrollees, providers of these services must obtain a referral or authorization from the PCP to receive payment. See the Claim Submission Table at 471-000-49 for billing instructions.

Approval to provide special services for Medicaid reimbursement is granted in writing by the Medicaid Division. Payment for special services is made according to the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-533) unless included as part of a capitation plan. Instructions for billing will be included with the written approval. The Medicaid Division may also withdraw a provider's approval by written notification to the provider if the provider no longer meets the following identified requirements.

33-003.01 Nutritional Counseling: This service involves short term (one to four sessions per medical home referral) one-on-one nutritional counseling sessions. This does not include group sessions, which may be covered through weight management services (see 471 NAC 33-006). The child's condition must indicate that a nutritional problem or a condition of such severity exists that nutritional counseling beyond that normally expected as part of the standard medical management is warranted.

Nutritional problems or conditions that are considered appropriate for nutritional counseling are -

1. Chronic gastrointestinal tract problems, such as chronic constipation, colitis, liver dysfunctioning, ulcers, tumors, gastroesophageal reflux, malabsorption disorders or chronic diarrhea associated with nutrient loss, short bowel syndrome, or celiac disease;
2. Chronic cardiovascular problems, blood and renal, such as kidney failure, heart disease, or renal failure hypertension;
3. Metabolic disorders, such as diabetes, electrolyte imbalance, cystic fibrosis, disorders of lipid metabolism, or in-born errors of metabolism, such as phenylketonuria (PKU);
4. Malnutrition problems, such as protein, mineral, vitamin, and energy deficiencies, failure to thrive, anorexia nervosa, or bulimia; and
5. Other problems and conditions, such as food allergy and/or intolerance, anemias, pregnancy, drug-induced dietary problems, nursing bottle mouth syndrome, obesity, inadequate or inappropriate techniques of feeding, inadequate or excessive weight gain, neoplasms, or cleft palate or cleft lip.

This is not an all inclusive list. Other conditions may be appropriate for this service and approved upon review by the Medicaid Division. This service does not include long term nutritional counseling for eating disorders (see 471 NAC 32).

For ongoing nutritional information for individuals meeting certain criteria (children under five lactating, postpartum, or pregnant women), a referral must be made to the Special Supplemental Food Program for Women, Infants, and Children (WIC).

33-003.01A Provider Requirements and Requests for Approval: Physicians providing HEALTH CHECK (EPSDT) services or licensed medical nutrition therapists may be approved to provide nutritional counseling. Those who are interested in providing this service shall submit a written request and include (1) person(s) providing services and their credentials, (2) general content of nutritional counseling session, (3) conditions most frequently expected to be encountered. (4) usual length and frequency of sessions, and (5) customary charge. NMAP may request periodic review of the services. Requests for reapproval must be submitted when a change in approved content occurs.

For ongoing nutritional counseling for individuals meeting certain criteria (children under five; lactating, postpartum, or pregnant women), a referral must be made to the Special Supplemental Food Program for Women, Infants, and Children (WIC).

33-003.02 Risk Reduction Services for EPSDT Participants: An EPSDT participant is an individual who has had a HEALTH CHECK screening examination and therefore considered a program participant.

33-003.02A Prepared Childbirth Sessions: The basic six to eight week series of childbirth sessions, early pregnancy sessions, refresher sessions, cesarean birth sessions, breast-feeding session, and infant care sessions are covered when provided by licensed and Medicaid-enrolled practitioners approved by the Medicaid Division. The services are covered when a comparable community service is not readily available at no cost.

Childbirth educators who are licensed practitioners interested in providing this service for Medicaid-eligible individuals age 20 and younger shall complete Form MC-19, "Medical Assistance Provider Agreement," and return the form with a letter stating the class type, general description, class outline, or statement of content, and length of sessions for initial approval. Childbirth educators must include proof of certification or course completion by a recognized childbirth education association. Requests for reapproval must be submitted when a change in the initial proposal occurs. NMAP may request periodic review of the services. Requests to approve changes to approved services must be submitted to the Medicaid Division. Approval is based on guidelines from recognized childbirth education associations and demonstrate appropriateness.

Risk reduction services are:

- Family home visitation for risk assessment and risk reduction services
- Health education and infant-child care/parenting session or breast-feeding instruction session
- Early pregnancy session
- Prepared childbirth session (six-eight week series) or comparable cesarean birth session
- Prepared childbirth refresher series

33-003.02B Pediatric Prenatal Visit: The pediatric prenatal visit is a scheduled visit to initiate and set the tone for a working relationship between the expectant parent(s) and the prospective primary care provider of the infant's health care. This is usually scheduled in the last trimester of the pregnancy. The purpose is to gather medical information, give information, answer questions, and initiate a continuing relationship in the best interest of the child. It provides the opportunity to establish a supportive, positive relationship based on mutual respect. Other benefits include the chance to discuss the benefits of early and regular health care, of appointment-keeping, and utilizing the most appropriate place of service. A prenatal visit usually includes a maternal and family health history and related data gathering, preparation of parent(s) for hospital birth information on breast-feeding vs. bottle feeding, information on infant care, information on parenting classes, preparation for potential changes in family and sibling relationships with birth, information on effects of drugs and medications on pregnancy and nursing infants, discussion on preparation for home care and home safety, information on well baby care, information on choosing child care, and office philosophy and practices.

33-003.03 Well Child Cluster Visit: The cluster visit is a well child visit in a group setting with parent-child pairs of similar age offering the opportunity for the provision of extended physician-parent/child time with a focus on psychosocial aspects as well as physical aspects of well child care. Cluster visits are covered for infants and children, according to the American Academy of Pediatric schedule for examinations. The cluster visit must include a complete HEALTH CHECK (EPSDT) examination. The parent may opt for this service instead of the individual visit for the parent(s).

Providers interested in providing this service shall submit a description of the cluster visit, including format, group size, scheduling, and content to the Medicaid Division to request initial prior approval. Requests to approve any changes to the approved service must be submitted to the Medicaid Division.

33-004 Dental Services for Conditions Identified During a HEALTH CHECK

33-004.01 Orthodontic Treatment: NMAP covers orthodontic treatment for individuals age 20 and younger for treatment of handicapping malocclusions. NMAP requires prior authorization of orthodontic treatment except diagnostic evaluation procedures. NMAP regulation regarding orthodontic treatment is in Chapter 6-000.

33-005 (Reserved)

REV. MARCH 2, 2008
MANUAL LETTER # 25-2008

NEBRASKA DEPARTMENT OF
HEALTH AND HUMAN SERVICES

NMAP SERVICES
471 NAC 33-006

33-006 (Reserved)