Washington State Health Care Authority

Washington Apple Health (Medicaid)

EPSDT Well-Child Program Billing Guide

(Formerly referenced as the EPSDT Program Billing Guide)

October 1, 2024

Washington State Health Care Authority

Disclaimer

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict arises between this document and a governing statute or Health Care Authority (HCA) rule, the governing statute or HCA rule applies.

Billing guides are updated on a regular basis. Due to the nature of content change on the internet, we do not fix broken links in past guides. If you find a broken link, check the most recent version of the guide. If the broken link is in the most recent guide, notify us at askmedicaid@hca.wa.gov.

About this guide[1]

This publication takes effect **October 1, 2024,** and supersedes earlier guides to this program. Unless otherwise specified, the program in this guide is governed by the rules found in chapter 182-534 WAC.

HCA is committed to providing equal access to our services. If you need an accommodation or require documents in another format, call 1-800-562-3022. People who have hearing or speech disabilities, call 711 for relay services.

> Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by HCA.

Refer also to the ProviderOne Billing and Resource Guide for valuable information to help you conduct business with HCA.

How can I get HCA Apple Health provider documents?

To access provider alerts, go to HCA's Provider Alerts webpage.

To access provider documents, go to HCA's provider billing guides and fee schedules webpage.

Confidentiality toolkit for providers

The Washington State Confidentiality Toolkit for Providers is a resource for providers required to comply with health care privacy laws.

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[1] This publication is a billing instruction.

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Where can I download HCA forms?

To download an HCA form, see HCA's Billers and provider's webpage, and select Forms & Publications webpage. Type the HCA form number into the Search box as shown below (Example 13-835).

Copyright disclosure

What has changed?

The table below briefly outlines how this publication differs from the previous one. This table is organized by subject matter. Each item in the *Subject* column is a hyperlink that, when clicked, will take you to the specific change summarized in that row of the table.

Subject	Change	Reason for Change
Immunizations in an outpatient hospital or hospital-based clinic setting	Relocated section	To improve useability
Immunizations in an outpatient hospital or hospital-based clinic setting	Added CPT® codes for RSV and COVID-19 Relocated bullet regarding CPT® codes not allowed with VFC vaccines	Billing clarification
How do I bill for stand-alone vaccine counseling?	Removed bullet with a link to the *Apple Health COVID-19 Vaccine Policy*	COVID-19 vaccine information is now located in this billing guide.
Provider Reimbursement for COVID-19 Vaccine Counseling COVIC-19 Vaccination in the Home	New sections regarding COVID-19 vaccinations	The agency is sunsetting the *Apple Health COVID-19 Vaccine Policy* publication

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Resources Available

Topic	Resource
Where can I find information on becoming an HCA provider	See HCA's ProviderOne Billing and Resource Guide.
Questions on payments, denials, general questions regarding claims processing, or HCA-contracted managed care organization (MCO)	See HCA's ProviderOne Billing and Resource Guide.
Submitting claims for payment	See HCA's ProviderOne Billing and Resource Guide.
Billing questions	**See the** Apple Health (Medicaid) clinical policy and billing contact information
Questions on private insurance or third-party liability, other than HCA-contracted managed care plans	See HCA's ProviderOne Billing and Resource Guide.
Questions about prior authorization, limitation extensions, or exception to rule	See HCA's ProviderOne Billing and Resource Guide.
Referral for Mental Health	Contact the client's managed care organization
Referral for Substance Use Assessment	Washington Recovery Help Line
Where is the EPSDT Fee Schedule?	See HCA's EPSDT Fee Schedule

Topic	Resource
Obtaining prior authorization or a limitation extension	For prior authorization or limitation extension, providers may submit prior authorization requests online through direct data entry into ProviderOne. See HCA's **prior authorization webpage** for details. Providers may also fax requests to 866-668-1214 along with the following: • A completed, typed *General Information for Authorization form*, HCA 13-835. This request form must be the initial page when you submit your request. • A completed *Fax/Written Request Basic Information* form, HCA 13-756, all documentation listed on this form, and any other medical justification. See **Where can I download HCA forms?**

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Program Overview

Early Periodic Screening, Diagnosis, and Treatment (EPSDT) is a federally mandated, comprehensive, and preventive health care benefit. The purpose of this program is to ensure children and adolescents age 20 and younger receive appropriate preventive, dental, mental health, developmental, and specialty services. Medically necessary treatment identified in the EPSDT well-child checkup is covered under the EPSDT benefit.

The EPSDT benefit requires periodic screening services, often referred to as well-child checkups, as one of the mandatory components to monitor healthy development and identify issues as early as possible. This billing guide describes the required EPSDT well-child checkup elements and referrals to medically necessary services administered through HCA.

Learn more about EPSDT at Medicaid.gov and access resources at HCA's Early Periodic Screening, Diagnosis, and Treatment webpage.

What are the components of the EPSDT benefit?

Early: Monitor healthy development to identify problems early

Periodic: Provide well-child checkups at established, age-appropriate intervals

Screening: Conduct physical, dental, mental, developmental, hearing, vision, and other screening or laboratory tests to detect potential issues

Diagnosis: Diagnostic assessment and testing to follow-up when a risk is identified during checkups and screening

Treatment: Medically necessary health care services to control, correct, or ameliorate any identified issues regardless of whether the service is covered in the state Medicaid plan

> **Note:** HCA evaluates the request for medical necessity based on the definition in WAC 182-500-0070 and the process in WAC 182-501-0165.

Who should use this billing guide?

This guide contains instruction for qualified providers offering EPSDT well-child checkups, including:

- Physicians and resident physicians
- Naturopathic physicians
- Advanced Registered Nurse Practitioners (ARNPs)
- Physician Assistants (PAs)

- Registered nurses working under the guidance of a physician or ARNP who may also perform EPSDT well-child checkups. (Only physicians, PAs, and ARNPs can diagnose and treat problems found in a screening.)

This guide may also be helpful to health care professionals who want to assist clients and their families in accessing preventive health care services and navigating the pathway to evaluation and treatment services.

What are the time limits for scheduling requests for EPSDT well-child checkups?

Requests for EPSDT well-child checkups must be scheduled within the following time limits:

For EPSDT well-child checkup requested through:	Client:	Schedule within:
• HCA's managed care organizations (MCOs), • Primary care case management (PCCM) organization, or • Primary care providers (PCPs)	Infants under age two	21 days of request
• HCA's managed care organizations (MCOs), • Primary care case management (PCCM) organization, or • Primary care providers (PCPs)	Children age two and older	Six weeks of request
• HCA's managed care organizations (MCOs), • Primary care case management (PCCM) organization, or • Primary care providers (PCPs)	Children receiving foster care (upon placement)	30 days of the original placement or as soon as possible
• A community mental health center • Head Start • A substance use provider • An early childhood education and assistance program (ECEAP)	People age 20 and younger	14 days of the request

Note: Children and youth entering foster care (i.e., out-of-home placement) and for whom there is a known illness or health concern may have an initial health screen (IHS) within five days of entering foster care. For more information, see EPSDT Well-Child Checkups and Foster Care.

Is transportation to and from EPSDT well-child checkups available?

Yes. Apple Health covers non-emergency medical transportation for eligible clients to and from covered services, including well-child checkups, through contracted brokers when eligibility requirements are met. For more information, see HCA's Transportation services (non-emergency) webpage.

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Client Eligibility

Most Apple Health clients are enrolled in an HCA-contracted managed care organization (MCO). This means that Apple Health pays a monthly premium to an MCO for providing preventive, primary, specialty, and other health services to Apple Health clients. Clients in managed care must see only providers who are in their MCO's provider network, unless prior authorized or to treat urgent or emergent care. See the HCA's Apple Health managed care page for further details.

It is important to always check a client's eligibility prior to providing any services because it affects who will pay for the services.

Who is eligible for EPSDT well-child checkups?

HCA pays Washington Apple Health providers to perform EPSDT well-child checkups for all children age 20 and younger who are enrolled in Apple Health.

> **Note**: Refer clients to the Health Benefit Exchange (HBE) if they are age 20 and younger and their benefit package does not cover EPSDT. This application process will evaluate these clients for a possible change in their benefit package to include EPSDT. Family Planning Only is an example of a benefit package that does not cover EPSDT services.

How do I verify a client's eligibility?

Check the client's Services Card or follow the two-step process below to verify that a client has Apple Health coverage for the date of service and that the client's benefit package covers the applicable service. This helps prevent delivering a service HCA will not pay for.

Verifying eligibility is a two-step process:

Step 1. **Verify the patient's eligibility for Apple Health**. For detailed instructions on verifying a patient's eligibility for Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in HCA's ProviderOne Billing and Resource Guide.

If the patient is eligible for Apple Health, proceed to **Step 2**. If the patient is **not** eligible, see the note box below.

Step 2. **Verify service coverage under the Apple Health client's benefit package.** To determine if the requested service is a covered benefit under the Apple Health client's benefit package, see HCA's Program Benefit Packages and Scope of Services webpage.

Note: Patients who are not Apple Health clients may apply for health care coverage in one of the following ways:

- **Online**: Go to **Washington Healthplanfinder** - select the "Apply Now" button. For patients age 65 and older or on Medicare, go to **Washington Connections** – select the "Apply Now" button.
- **Mobile app:** Download the **WAPlanfinder app** – select "sign in" or "create an account".
- **Phone**: Call the Washington Healthplanfinder Customer Support Center at 1-855-923-4633 or 855-627-9604 (TTY).
- **Paper**: By completing an *Application for Health Care Coverage (HCA 18-001P)* form.
  To download an HCA form, see HCA's Free or Low Cost Health Care, **Forms & Publications** webpage. Type only the form number into the Search box (Example: **18-001P**). For patients age 65 and older or on Medicare, complete the *Washington Apple Health Application for Aged, Blind, Disabled/Long-Term Services and Supports (HCA 18-005)* form.
- **In-person**: Local resources who, at no additional cost, can help you apply for health coverage. See the **Health Benefit Exchange Navigator**.

What if an infant has not yet been assigned a ProviderOne Client ID?

Newborns: If a child is younger than age 60 days and has not been issued a ProviderOne Client ID, use the birthing parent's ProviderOne Client ID and put **SCI=B** in the claim notes field. Put the child's name, gender, and birth date in the client information fields.

Twins/Triplets: When using mom's ProviderOne Client ID for twins, triplets, etc., identify each infant separately using a separate claim for each. For example, the first infant would be "SCI=BA," the second infant would be "SCI=BB," and the third infant would be "SCI=BC."

Note: For parents enrolled in an HCA-contracted MCO, the MCO is responsible for providing medical coverage for the clients' newborns.

Are clients enrolled in an HCA-contracted managed care organization (MCO) eligible?

Yes. Most Apple Health clients are enrolled in an HCA-contracted managed care organization (MCO). For these clients, managed care enrollment will be displayed on the client benefit inquiry screen in ProviderOne. All services must be requested directly through the client's Primary Care Provider (PCP). Clients can contact their MCO by calling the telephone number provided to them or use the information provided under "Contact your Apple Health plan" listed on HCA's Apple Health managed care webpage.

All medical services covered under an HCA-contracted MCO must be obtained by the client through the client's MCO provider network. The MCO is responsible for the:

- Payment of covered services.
- Payment of services referred by a participating provider to an outside provider.

> **Note:** To prevent denied claims, check the client's eligibility both before scheduling services and at the time of the service. Also make sure proper authorization or referral is obtained from the MCO. See HCA's ProviderOne Billing and Resource Guide for instructions on how to verify a client's eligibility.

Managed care enrollment

Most Apple Health clients are enrolled in an HCA-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. Some clients may start their first month of eligibility in the fee-for-service (FFS) program because their qualification for MC enrollment is not established until the month following their Apple Health eligibility determination. **Exception:** Apple Health Expansion clients are enrolled in managed care and will not start their first month of eligibility in the FFS program. For more information, visit Apple Health Expansion. Providers must check eligibility to determine enrollment for the month of service.

New clients are those initially applying for benefits or those with changes in their existing eligibility program that consequently make them eligible for Apple Health managed care. Renewing clients are those who have been enrolled with an MCO but have had a break in enrollment and have subsequently renewed their eligibility.

Checking eligibility

Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to Washington Healthplanfinder's Get Help Enrolling page.

Clients' options to change plans

Clients have a variety of options to change their plan:

- **Available to clients with a Washington Healthplanfinder account:** Go to Washington HealthPlanFinder website.
- **Available to all Apple Health clients**:
  - Visit the ProviderOne Client Portal website.
  - Call Apple Health Customer Service at 1-800-562-3022. The automated system is available 24/7.
  - Request a change online at ProviderOne Contact Us (this will generate an email to Apple Health Customer Service). Select the topic "Enroll/Change Health Plans."

  For online information, direct clients to HCA's Apple Health managed care webpage.

Clients who are not enrolled in an HCA-contracted managed care plan for physical health services

Some Apple Health clients do not meet the qualifications for managed care enrollment. These clients are eligible for services under the fee-for-service (FFS) program.

In this situation, each managed care organization (MCO) will have a Behavioral Health Services Only (BHSO) benefit available for Apple Health clients who are not in integrated managed care. The BHSO covers only behavioral health treatment for those clients. Eligible clients who are not enrolled in an integrated HCA-contracted managed care plan are automatically enrolled in a BHSO, except for American Indian/Alaska Native clients. If the client receives Medicaid-covered services before being automatically enrolled in a BHSO, the fee-for-service program will reimburse providers for the covered services. Examples of populations that may be exempt from enrolling into a managed care plan are Medicare dual-eligible, American Indian/Alaska Native, Adoption Support and Foster Care alumni.

Integrated managed care

Clients qualified for enrollment in an integrated managed care plan receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contracted MCO.

Apple Health Expansion

Individuals age 19 and older who do not meet the citizenship or immigration requirements to receive benefits under federally funded programs and who receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contracted health plan. For more information, visit Apple Health Expansion.

EPSDT services do not apply to 19- and 20-year-olds who are on Apple Health Expansion. For information on well exam services that are covered under Apple Health Expansion for 19- and 20-year-olds, see the Physician's Related Services/Health Care Professional Services Guide.

American Indian/Alaska Native (AI/AN) Clients

American Indian/Alaska Native (AI/AN) clients have two options for Apple Health coverage:

- Apple Health Managed Care
- Apple Health coverage without a managed care plan (also referred to as fee-for-service [FFS])

If an AI/AN client does not choose a managed care plan, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the Health Care Authority's (HCA) **American Indian/Alaska Native webpage**.

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EPSDT Well-Child Checkups and Foster Care

Apple Health includes more extensive EPSDT benefits for children in foster care to ensure medical, dental, and mental health needs are promptly addressed. HCA covers an enhanced rate for providing well-child checkups for children in foster care, and these children have access to more frequent checkups.

The elements of an EPSDT well-child checkup are the same for all children. Learn more by reviewing the **Documentation of a well-child checkup**.

Integrated Apple Health Foster Care (AHFC)

Children and young adults in the Foster Care, Adoption Support and Alumni programs who are enrolled in Coordinated Care's (CC) Apple Health Core Connections Foster Care program receive both medical and behavioral health services from CC.

Clients under this program are:

- Under the age of 18 who are in foster care (out of home placement)
- Under the age of 21 who are receiving adoption support
- Age 18-21 years old in extended foster care
- Age 18 to 26 years old who aged out of foster care on or after their 18th birthday (alumni)

> **Note:** These clients are identified in ProviderOne as "Coordinated Care Healthy Options Foster Care."

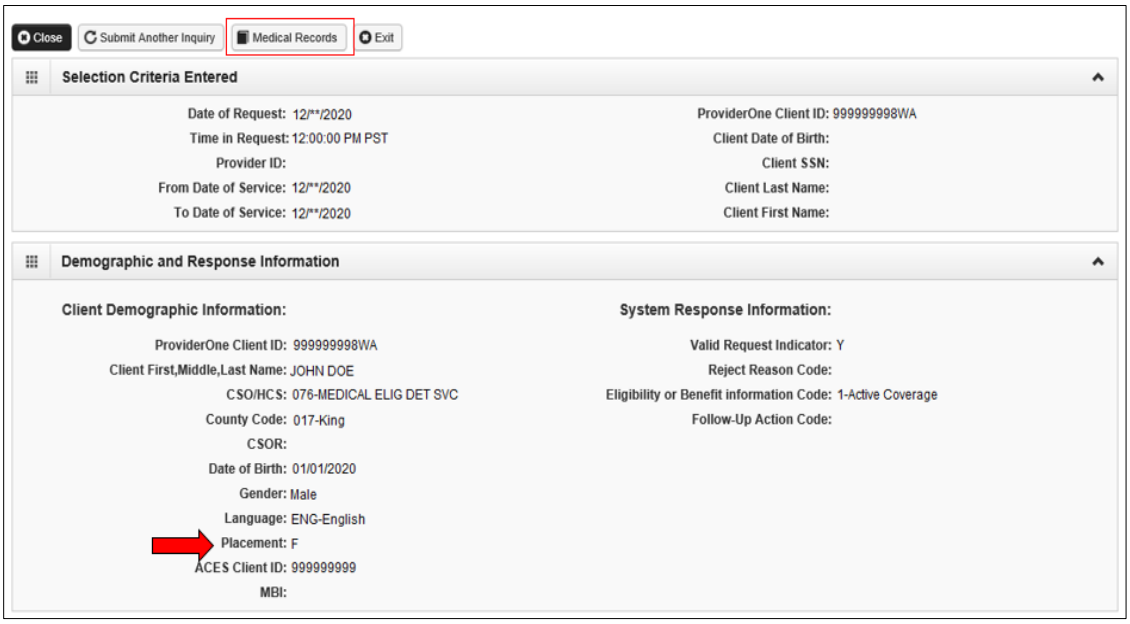
The Apple Health Customer Services team can answer general questions about this program. For specific questions about Adoption Support, Foster Care or Alumni clients, contact HCA's Foster Care and Adoption Support (FCAS) team at 1-800-562-3022, Ext. 15480.

Fee-for-Service Apple Health Foster Care

Children and young adults in the fee-for-service (FFS) Apple Health Foster Care, Adoption Support and Alumni programs receive behavioral health services through the regional Behavioral Health Services Organization (BHSO). For details, see HCA's **Mental Health Services Billing Guide**, under *How do providers identify the correct payer*?

How can I identify a child in foster care placement?

The following is a screenshot from ProviderOne. The placement code (indicated by the red arrow) may allow a provider who is billing certain evaluation and management (E&M) codes to receive an enhanced rate for the service.



If the client's ProviderOne eligibility inquiry screen indicates a child is associated with one of the foster care placement codes listed in the table below, the provider must use the TJ modifier along with the appropriate procedure code(s) to be paid an enhanced rate for EPSDT well-child checkups.

Foster Care Placement Codes

Placement Code	Description
A	Adoption Support Services
F	Foster Care Placement
H	Foster Care HB2530
P	Interstate Compact in Placement of Children's Service
R	Relative Foster Care Placement
T	Tribal Foster Care Placement

How often can a child in foster care have an EPSDT well-child checkup?

EPSDT well-child checkups for children in foster care are not limited. HCA allows EPSDT well-child checkups for foster care clients **without regard to the** Periodicity Schedule by billing CPT® codes 99381-99385 and 99391-99395 with a TJ modifier.

How do I bill EPSDT well-child checkups to receive the enhanced foster care rate?

Bill EPSDT well-child checkups for children in foster care by billing CPT® codes 99381-99385 and 99391-99395 with a TJ modifier.

What is an initial health screen (IHS) and how is it billed?

Children and youth who are entering foster care and for whom there is a known illness or health concern may have an initial health screen (IHS) within 5 days of entering foster care (i.e., out-of-home placement). The IHS aims to identify:

- Immediate medical, mental health, or dental needs of the child.
- Additional health conditions that the foster parent and social worker need to know.

If a child or youth is taken to an urgent care or emergency department, a treating provider must provide follow-up medical appointments, treatment, or medication as recommended.

> **Note:** The IHS is not intended to be as comprehensive as an EPSDT well-child checkup. All children in out-of-home care must have an EPSDT well-child checkup within 30 days of placement.

If the IHS is provided:

- Bill the appropriate evaluation and management (E&M) code (new patient CPT® codes 99201 – 99205 or established patient CPT® codes 99211–99215).
- Use ICD diagnosis code Z01.89 (encounter for other specified special examinations) as the primary diagnosis.
- Use modifier TJ.

See the Foster Care Initial Health Screen form, HCA 13-843 (see **Where can I download HCA forms**) and **the AAP Healthy Foster Care America Health Information Form** for information on the IHE components.

Can I bill for both an EPSDT well-child checkup and an IHS?

HCA does not pay for an IHS with the same date of service as an EPSDT well-child checkup. The child will not require an IHS if an EPSDT well-child checkup is performed.

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EPSDT Well-Child Checkups

EPSDT requires a periodic well-child checkup with the client's primary care provider (PCP). HCA's expectations for the recommended frequency of checkups align with the American Academy for Pediatrics (AAP) Bright Futures **Periodicity Schedule, including:**

Infancy					
1st week	1 month	2 months	4 months	6 months	9 months

Early Childhood						
12 months	15months	18 months	24 months	30 months	3 years	4 years

Middle Childhood and Adolescence
One checkup every calendar year for ages 5 through 20 years

Note: Children in foster care may receive additional EPSDT well-child checkups. See **EPSDT Well-Child Checkups and Foster Care** for more information.

Documentation for a well-child checkup

Providers must document in the client's medical record that each required element of the well-child checkup was done at the visit and what the findings were.

Each well-child checkup consists of the following elements, though how the element is completed depends on the age of the child:

1. **Initial/interval health history and a family health history**
2. **Measurements** – age-appropriate growth including length/height and weight and blood pressure
3. **Sensory screening – vision and hearing***
4. **Developmental/behavioral health screening***
5. **Physical exam**
6. **Procedures, including immunizations and laboratory tests***
7. **Oral health and fluoride varnish***
8. **Anticipatory guidance**

* These elements have add-on codes that may be billed in addition to evaluation and management (E&M) codes. See descriptions about each element and the available add-on codes listed below this section. For more information about billing EPSDT E&M codes, see **What are the billing requirements specific to EPSDT?**

> **Note:** Children in foster care may receive additional EPSDT well-child checkups. See **EPSDT Well-Child Checkups and Foster Care** for more information.

Elements of an EPSDT well-child checkup

1. **Initial/Interval health history and a family health history**

   It is each provider's responsibility to obtain both a comprehensive client and family medical history as part of the initial well-child checkup and update the history with relevant information at each subsequent well-child checkup.

2. **Measurements**

   - **Height/length must be measured at every well-child checkup**

     Measure infants and small children (at least up to age two) in the recumbent position, and older children standing erect. Record and chart height on a Centers for Disease Control and Prevention (CDC) growth chart or other standard growth chart in the child's medical record.

> **Note**: Further study or referral is indicated for a child who has deviated from the usual percentile rank (determined by comparison with graphed previous measurements), or for a child whose single measurement exceeds two standard deviations from the norm for that age (beyond the 97th or below the 3rd percentile).

   - **Weight must be measured at every well-child checkup**

     Weigh infants with no clothes on, small children with just underwear and older children and adolescents with ordinary house clothes (no jackets or sweaters) and no shoes. Record and chart weight, including the child's weight percentile, on a CDC growth chart or other standard growth chart in the child's medical record.

> **Note:** Further investigation or referral is indicated for a child who has deviated from the usual percentile rank (determined by comparison with graphed previous measurements), or in a child whose single measurement exceeds two standard deviations from the norm for that age (beyond the 97th percentile or below the 3rd percentile).

   - **Measure head circumference at every well-child checkup on infants and children up to age two**

Measure infants and children head circumference up to age two at every well-child checkup. Record the findings in the child's medical record. Growth in head circumference in infants is closely related to nutritional status.

Note: Record indications of further investigation or referral for the same situations described in height and weight, and record findings in the child's medical record. Microcephaly and macrocephaly in newborns are abnormalities not related to nutrition and need investigation or referral for evaluation.

- **Blood pressure must be measured at every well-child checkup for children age three and older**

Blood pressure must be measured at every well-child checkup for all children age three and older, using an appropriate-sized cuff. Record findings in the medical record. For younger children, measure blood pressure if risk factors are identified.

3. Sensory Screening

- **Vision Testing**

For children from birth to age three, eye evaluations include:

- Ocular history
- Vision assessment
- External inspection of the eyes and lids
- Ocular motility
- Pupil examination
- Red reflex examination

For children age three and older, eye evaluations include:

- Criteria listed above for children birth to age 3 years
- Age-appropriate visual acuity measurement (use of Snellen chart or similar can be billed in addition to the EPSDT E&M codes)

- **Hearing Screening**

Hearing screenings must be administered to every child age four and older. Audiometric testing may be billed in addition to the EPSDT E&M codes using CPT® codes 92551 and 92552.

4. Developmental/Behavioral health surveillance and screening

- **Developmental surveillance**

According to the American Academy of Pediatrics, developmental surveillance is a flexible, longitudinal, continuous, and cumulative process whereby health care

professionals identify children who may have developmental problems. Developmental surveillance includes information provided by the caregiver about how the child is growing and reaching developmental milestones and any concerns about their child's development. Health care professionals also maintain a developmental history, including observations of the child during the visit. Children with health issues or who miss developmental milestones must be identified as early as possible. Health care professionals must include questions related to behavior, social activity, and development in the initial and interval history.

- **Developmental/behavioral health screening**

  A developmental screening is the process of using a validated tool to identify risk factors, potential delays, and the need for further assessment. If a developmental screening indicates a potential delay or identified need, health care professionals must make the appropriate referrals for further evaluation or services. Complete the developmental screening according to the **Bright Futures schedule**.

  Required screening includes:

  - Structured developmental screening for ages 9, 18, and 30 months.
  - Parental and caregiver depression screening for caregivers and parents of infants ages 1 month, 2 months, 4 months, 6 months, 9 months, and 12 months.
  - Structured autism screening for ages 18 months and 24 months.
  - Structured behavioral/social/emotional screening for all ages at every well-child checkup.

Structured depression and suicide risk screening for children ages 12 and older. (See **Developmental and Behavioral Health Screening** section for more information on recommended screening timeframes and screening tools.)

> **Note:** When a developmental delay or disability is identified for children ages birth to three years, refer the child to **Early Support for Infants & Toddlers (ESIT)** for early intervention services. When a developmental delay or disability is identified for a child age three and older, refer to the **Washington Office of Superintendent of Public Instruction website**.

5. Physical Exam

At each visit, an age-appropriate physical examination is required with infants totally unclothed and older children undressed and appropriately draped. All findings must be documented in the medical record.

6. Procedures

- **Anemia Screening**

  Measure hemoglobin or hematocrit between age 9 and 12 months with additional screening between age 1 and age 5 for children at risk, as recommended by the

American Academy of Pediatrics (AAP). After this, perform a hematocrit only if indicated by a risk assessment and/or symptoms.

Complete hemoglobin or hematocrit during the first well-child checkup for all premature or low-birth weight infants and repeat according to the Periodicity Schedule. Record test results in the child's medical record.

- **Blood Lead Screening Test (Federal Medicaid Testing Requirement)**

Blood lead screening tests are required for all children enrolled in Apple Health Medicaid as follows:

- At ages 12 and 24 months
- At ages 24 to 72 months if no record of a previous blood lead screening test exists

Providers must perform a risk assessment at every checkup as appropriate. Providers may refer to the Department of Health's webpage for more information on recommended lead risk assessment tools, blood lead testing methodologies, requirements for reporting blood lead screening test results, and lead exposure risk mapping.

Note: Completion of a risk assessment does not meet the federal Medicaid requirement for blood lead screening tests. The requirement is met only when the blood lead screening tests (or a catch-up blood lead screening test) are conducted.

- **Tuberculin (TB) Test**

The American Academy of Pediatrics (AAP) does not recommend universal testing for TB. APP recommends assessment of risk at the first visit and annually thereafter for TB risk factors and testing of children with defined risk factors. The following list includes indicators that a child is at high risk for TB exposure:

a. Has a family member or close contact with active TB disease
b. Has a family member with a positive TB skin test
c. Was born in a high-risk country (all except US, Canada, Western European countries, Australia, and New Zealand)
d. Has traveled to a high-risk country and had contact with resident population for more than one week

For further guidance regarding TB testing for specific populations and comorbidity with other conditions, reference current AAP TB testing recommendations.

- **Dyslipidemia Screening**

Dyslipidemia (cholesterol) screening is a required component once between ages 9 and 11 years and again between ages 17 and 20 years. Refer to guidelines of the National Heart, Lung and Blood Institute found on their Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents webpage.

- **Sexually transmitted infections**

  According to current Centers for Disease Control and Prevention (CDC) recommendations, screening for sexually transmitted infections (STIs) is indicated for sexually active adolescents.

- **HIV**

  The U.S. Preventive Services Task Force (USPSTF) recommends screening for HIV at least once between ages 15 and 18 years. USPSTF recommends testing youth younger than age 15 who are at increased risk of HIV infection, including those who are sexually active, use injection drugs, or are being tested for other STIs, and screening annually.

- **Hepatitis C Virus Infection (HCV)**

  USPSTC and the CDC recommend screening for HCV infection at least once between ages 18 and 79.

  For persons under age 18 at increased risk of HCV exposure, USPSTF and CDC recommend one-time testing.

- **Immunizations**

  Administer immunizations according to the CDC Advisory Committee on Immunization Practices (ACIP) Recommended Immunization Schedule, including "catch-up" schedules for clients who are missing any routine vaccinations for their age. Bring immunizations up to date at well-child checkups and during any other visits the child makes to the health care provider.

  (See Immunizations for more information on Apple Health immunization coverage.)

7. Oral Health

Oral health requires ongoing supervision from health care providers. At each well-child checkup, do an oral assessment noting the number and location of teeth erupted, visible cavities and other symptoms. If the child does not have a dental home, provide a referral. If the child is enrolled with managed care and does not have an established dental home, refer the client to the MCO.

Oral health assessment and education includes:

- How to clean teeth as they erupt.
- How to prevent early childhood caries.
- How to recognize dental disease.
- How dental disease is contracted.
- Importance of preventive sealant.
- Application of fluoride varnish, when appropriate.

(See Oral Health section for more information on Apple Health dental and oral health coverage.)

8. Anticipatory Guidance

Anticipatory guidance is the process of offering timely, appropriate, and relevant information on general and age-specific child and adolescent health and development. It provides children, adolescents, parents, and caregivers with specific advice, tailored guidance, and what to expect as children grow and mature. At each visit, discuss pertinent information and make that information available in written form to clients and their families. Allow sufficient time for discussion and answering questions. Topics may include, but are not limited to:

- Benefits of healthy lifestyles
- Practices that promote well-being
- Physical, emotional, and developmental changes
- Common parenting concerns
- General health questions

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Developmental and Behavioral Health Screening

Standardized screenings play a critical role in early identification and intervention for conditions impacting children and youth in the present, as well as in their long-term development. Health care providers and early childhood professionals use screening tools to help detect concerns early and determine appropriate referral for services and intervention.

Screenings are done using standardized screening tools, which may include client and caregiver interview and observation. If a screening indicates a possible problem, the child is referred for an assessment where a diagnosis and plan of care are developed. Document the need for the service in the client's records. A screening that indicates a possible problem, without a follow up determination by a health care provider or early childhood professional, is not sufficient to determine a diagnosis.

Note: Review the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Screening Frequently Asked Questions (FAQ) for more information on common questions.

Note: When child abuse or neglect is suspected, a report to Child Protective Services 1-866-363-4276 must be made, even if the child is also referred for a mental health assessment.

Recommended screening tools

To align with American Academy of Pediatrics best practice recommendations, providers must reference the Bright Futures Toolkit for Commonly Used Screening Instruments for examples of available standardized tools. To be reimbursed, providers must document the name of the screening tool, the score, and any referrals made, or treatment intervention provided.

Providers must indicate the screening outcome for all covered screenings. See What modifier do I use to indicate a screening outcome? for more information.

Note: Providers must have adequate training to administer and interpret screening tools, including training to determine the screening outcome.

Covered screenings

Apple Health covers all medically necessary screenings, including required screenings in alignment with Bright Futures recommendations. All covered screenings align with National Correct Coding Initiative (NCCI) Medically Unlikely Edits (MUEs) maximum units of service.

CPT® Code	Condition	Required screening at routine checkups	Additional information
96110	Developmental Screening	9 months 18 months 30 months	
96110	Autism Screening	18 months 24 months	
96127 and 96160	Depression Screening	Every well-child checkup	
96127 and 96160	General Behavioral Health Screening	12 years and older	
96127 and 96160	Tobacco, Alcohol, and Drug Screening	11 years and older	
96161	Caregiver Depression Screening	1 month 2 months 4 months 6 months 9 months 12 months	HCA pays for up to two caregiver depression screenings per checkup Submit claims using the infant's ProviderOne client ID

How do I bill for screening?

When billing, providers must indicate the screening outcome by including either modifier U1 or U2. See **What modifier do I use to indicate a screening outcome**? When a screening indicates a possible problem, the screening provider must refer the child to an appropriate provider for an assessment to determine a diagnosis and develop a plan of care. To be paid, the provider must document in the client's record the name of the screening tool, the score, and the referrals made, or treatment intervention provided.

See **What if a problem is identified during an EPSDT well-child checkup?** for more information.

> **Note**: Eligible clients may receive a mental health or substance use assessment without an EPSDT well-child checkup or referral.
>
> **Note**: When a developmental delay or disability is identified for children ages birth through age three, refer to **Early Support for Infants & Toddlers (ESIT)** for early intervention services. When a developmental delay or disability is identified for a child age three and older, refer to **Special Education through Washington Office of Superintendent of Public Instruction**.

What modifier do I use to indicate a screening outcome?

Temporary suspension of modifier usage

Until July 1, 2025, HCA will allow providers to submit claims for reimbursement without a modifier. This will allow time for workflow changes and system updates.

Effective July 1, 2025, to receive reimbursement, providers must submit the appropriate CPT® code accompanied by one of the following modifiers to indicate whether a need was identified.

Modifier	Description
U1	No need identified (negative screen). Indicates screening score within a normal range.
U2	Need identified (positive screen). Indicates risk, concern, impairment, or identification of a developmental and/or behavioral disorder.

Note: Learn more about HCA's screening modifier requirement by reviewing the **Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Screening Frequently Asked Questions (FAQ)**

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Immunizations

Apple Health covers **all** vaccines according to recommendations and guidelines of the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) Recommended Immunization Schedule.

Immunizations covered by the EPSDT program are listed in the Professional Administered Drug Fee Schedule.

How do I bill for vaccines for clients ages 19 and 20?

For clients ages 19 and 20 who are eligible for EPSDT vaccines:

- Bill HCA for the cost of the vaccine itself by reporting the administration code and the procedure code for the vaccine administered. DO NOT use modifier SL.
- HCA covers the vaccine using the Professional Administered Drug Fee Schedule.

In an outpatient hospital or hospital-based clinic setting

- Bill for the vaccine by reporting the appropriate procedure code for the vaccine given using:
  - An electronic institutional claim
  - The hospital's outpatient provider NPI number
- Bill the appropriate administration procedure code for the vaccine given (CPT® codes 90471-90474) using:
  - An electronic institutional claim
  - The hospital's outpatient provider NPI number
- For RSV (CPT® codes 90380 and 90381), bill administration CPT® code 96380 or 96381.
- For COVID-19 vaccines, bill administration CPT® code 90480.

> **Note:** For administered vaccines for clients age 18 and younger that are **not free** from DOH, please follow the billing instructions for clients ages 19 and 20.

How do I bill for free vaccines for clients age 18 and younger?

For vaccines that are available at no cost from the Department of Health (DOH) through the Childhood Vaccine Program and the federal Vaccines for Children (VFC) Program for children age 18 and younger, HCA pays only for the administrative cost of the vaccine and not for the vaccines themselves. These vaccines are identified in the Comments column of the Professional Administered Drug Fee Schedule as free from DOH.

In a nonfacility setting

- Bill for the vaccine by reporting the procedure code for the vaccine given with modifier SL (e.g., CPT® 90707 SL). HCA pays an administrative fee for those vaccines that are free from DOH and are billed with modifier SL (e.g., CPT® 90707 SL).
- Bill the appropriate administration procedure code for the vaccine given (CPT® codes 90471-90474).
- For RSV (CPT® codes 90380 and 90381), bill administration CPT® code 96380 or 96381.
- For COVID-19 vaccines, bill administration CPT® code 90480.
- Administration CPT® codes 90460-90461 are not allowed with VFC vaccines. See **How do I bill for stand-alone vaccine counseling?** for vaccine counseling billing instructions.

In an outpatient hospital or hospital-based clinic setting

If a vaccine is available free from DOH (see the **Professional Administered Drug Fee Schedule**), then HCA will:

- Deny the vaccine claim line.
- Combine vaccine payment with the payment for the administration of the vaccine.

For RSV (CPT® codes 90380 and 90381), bill administration CPT® code 96380 or 96381.

For COVID-19 vaccines, bill administration CPT® code 90480.

Administration codes CPT® codes 90460-90461 are not allowed with VFC vaccines. See **How do I bill for stand-alone vaccine counseling?** for vaccine counseling billing instructions.

How do I bill for stand-alone vaccine counseling?

Providers may bill for stand-alone vaccine counseling.

- Stand-alone vaccine counseling refers to when a patient or caregiver, or both, receives counseling about a vaccine from a health care practitioner, but the patient does not actually receive the vaccine dose at the same time as the counseling (i.e., no vaccine delivery or injection occurs during the practitioner visit).
- To receive reimbursement, providers must bill using CPT® code 99401 with diagnosis code Z71.85 (encounter for immunization safety) in the primary position on the claim.

> **Note**: Do not bill stand-alone vaccine counseling on the same date of service as an EPSDT well-child checkup.

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Provider Reimbursement for COVID-19 Vaccine Counseling

Vaccine counseling visits

A vaccine counseling visit is a conversation between a qualified health professional and a client about the COVID-19 vaccine. Conversations may include, but are not limited to:

- The client's or caregiver's reasons for not being vaccinated
- Addressing concerns identified by the client or caregiver
- Providing tailored and individualized medical advice regarding the COVID-19 vaccine for the client and caregiver
- Providing resources about how to get a COVID-19 vaccine, if applicable

Document counseling visits in the client's medical record according to standard documentation guidelines.

Vaccination status

The provider must check a client's vaccination status in the provider's medical records and the Department of Health (DOH) Washington Immunization Information System (WAIIS) database. If there is no indication that the client is vaccinated or that the client is only partially vaccinated, the provider may contact the client for a counseling visit. If immunization registry checks are not feasible, client attestation to vaccination status is acceptable.

Billing information

Qualified health providers

Providers who counsel clients about COVID-19 vaccine information and availability can bill in the following ways (review CPT® guidelines for code guidance):

- If the provider is already seeing the client for a prescheduled visit and counseling for COVID-19 vaccination increases the complexity of the visit or the time spent with the client, the provider may account for this by choosing the appropriate evaluation and management (E/M) level.
- The provider may bill CPT® code 99401 using modifier 25 in addition to billing an E/M visit. The E/M visit in this case does not include the time spent on COVID counseling.
- The provider may bill CPT® code 99401 individually if no E/M visit occurred and COVID vaccine counseling was provided.

Nurses/Medical Assistants

Nurses and medical assistants who counsel clients about COVID-19 vaccine information and availability may bill using CPT® code 99211. Usually, the presenting problem(s) are minimal.

Indian Health Service (IHS) providers

For information about reimbursement for Indian Health Service providers, see the **Tribal Health Billing Guide.**

Federally qualified health centers (FQHCs) and Rural health clinics (RHCs)

For information about reimbursement in FQHC and RHC settings, see the **Federally Qualified Health Centers Billing Guide** and the **Rural Health Clinics Billing Guide**.

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COVID-19 Vaccination in the Home

HCA pays an additional fee for administering the COVID-19 vaccine in the home (HCPCS code M0201) when the client:

- Is generally unable to leave the home. If they do leave home, it requires a considerable and taxing effort.
- Has a disability or faces clinical, socioeconomic, or geographical barriers to getting a COVID-19 vaccine in settings other than their home.
- Faces challenges that significantly reduce their ability to get vaccinated outside the home, such as challenges with transportation, communication, or caregiving.

Oral Health

Oral health is critically important to overall health and well-being. All Apple Health clients should have a dental home or primary dental provider. Eligible clients may go to a dental provider for routine preventive care or for restorative care without a referral from the PCP. See HCA's **Dental-Related Services Billing Guide.**

Eligible clients may also go to an orthodontic provider without an EPSDT screen or referral. HCA covers orthodontics for children with cleft lip or palates or severe handicapping malocclusions. HCA reviews all requests for orthodontic treatment or orthodontic-related services for clients who are eligible for services under the EPSDT program (**WAC 182-534-0100**). See HCA's **Orthodontic Services Billing Guide.**

Fluoride varnish

Once teeth are present, fluoride varnish may be applied by a qualified health care professional to all children. See the limits for fluoride varnish application in the Topical fluoride treatment section of HCA's **Dental-Related Services Billing Guide.** When fluoride varnish is applied during an EPSDT well-child checkup, additional payment is available by billing CPT® code 99188 with modifier DA for eligible ABCD clients.

Clients who are enrolled in an HCA-contracted MCO, but not eligible for ABCD services, may receive fluoride varnish. Effective for dates of service January 1, 2020, through June 30, 2021, do not bill the client's MCO. Bill HCA directly for this service using CPT® code 99188 with modifier KZ.

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What if a problem is identified during an EPSDT well-child checkup?

When a health, developmental, or behavioral health issue is identified during a well-child checkup, the health care provider must make every effort to provide access to all medically necessary services (see WAC 182-500-0070) within the categories of mandatory and optional services (as defined under those listed in Medicaid law section 1905(a)) by requesting noncovered service(s), treating the identified issue, or referring to other providers and services.

Requesting a noncovered service

To request a noncovered service, send a completed Fax/Written Request Basic Information form HCA 13-756 to the address or fax listed on the form. (See Where can I download HCA forms?) HCA evaluates the request for medical necessity based on the definition in WAC 182-500-0070 and the process in WAC 182-501-0165.

Treating an identified issue

Health care professionals may provide services for clients when services are within their scope of practice. Providers are not limited to the procedure codes listed within this billing guide. They may also use HCA's Physician-Related Services/Health Care Professional Services Billing Guide, as necessary.

When a provider treats the identified condition on the same day as the well-child checkup, the provider must bill the treatment or appropriate level E&M code with modifier 25 to receive additional reimbursement for the office visit. Providers must bill using the appropriate ICD diagnosis code that describes the condition found.

To ensure accurate payment, bill the treatment procedure codes and the EPSDT well-child checkup procedure codes on separate claim forms.

For more information regarding billing guidance for additional services, access HCA's provider billing guides and fee schedules.

Referring to other providers and services for additional evaluation or treatment services

Providers may refer the client or caregiver to other providers and services to obtain necessary evaluation and/or treatment services.

Common referrals include all the following:

- Early Supports for Infants & Toddlers (Early Intervention)
- Special education for children age three and older
- Mental and behavioral health services
- Washington's Mental Health Referral Service for Children and Teens
- **Home Visiting**—Many of the home visiting programs for infants and young children in Washington are administered by the Department of Children Youth and Families.

Referral guidelines for mental health or substance use concerns

The referring provider must follow-up to ensure a mental health/substance use disorder assessment was completed. The diagnosing or treating mental health or substance use provider must communicate the results of the referral back to the primary care provider.

Referral Type	Schedule within:
Urgent referral*	Immediately
Non-urgent referral	Within two weeks from the date the problem is identified

Note: Children may also be referred for a behavioral health assessment at a parent's request. Make a referral if the child or parent sees the behavior or symptom as problematic, even if the issues seem minor or within normal range to you. Parents' and teachers' perceptions have shown to be the best predictors of behavioral health problems.

*What types of referrals are considered urgent?

Some behaviors, symptoms, and risk factors may signal that a child is in crisis. In these cases, the referral process must be accelerated so that the child may be assessed and treated promptly. An immediate referral must be made by telephone to the behavioral health agency whenever the child exhibits any of the following:

- Fire-setting
- Suicidal behavior or suicidal ideation
- Self-destructive behavior
- Torturing animals
- Destroying property
- Substance use, either in conjunction with other mental health concerns or if the child is age 11 and younger.
- Moderate or severe substance use with or without co-occurring mental health concerns
- Sexual acting out
- Witnessing a death or other substantial physical violence
- Experiencing sexual or physical abuse
- Out of touch with reality, delusional (psychotic decompensation)
- Imminent risk of placement in a more restrictive setting

The crisis response system should be used only if the child is a danger to himself/herself or others.

Mental health/substance use assessment referral indicators

Category	Indicators for a Mental Health Assessment
Family	• problems separating • physical abuse or neglect • psychological abuse • sexual abuse • domestic violence • divorce/separation • chronic physical or mental illness of parent • parent experiencing substance use disorder • parental discord • few social ties • problems with siblings • death of parent/sibling • parent in criminal justice system
Peer activity	• no confidence • social isolation • fighting and bullying

Category	Indicators for a Mental Health Assessment
Behaviors	• temper tantrums • fire setting • stealing • tics • sexually acting out • lying • substance use • destroys property • aggressive • over activity • in trouble with law • impulsive • attachment problems in infants • overly compliant to passive • defiant • running away • truancy
Schools	• school failure • school refusal • absenteeism and truancy
Feelings	• anxiety or nervousness • feeling depressed • low self-esteem • fearful • suicidal
Thoughts	• delusions • hallucinations • incoherence • self-destructive thoughts

Category	Indicators for a Mental Health Assessment
Somatic symptoms	• trouble sleeping • sleepwalking • night terrors • enuresis • encopresis • eating disorder
Social	• lack of housing • frequent moves • financial problems • sexual abuse • foster care • history of detention
Growth and Developments	• slow weight gain • nonorganic failure to thrive • mentally retarded • learning disabilities • language delay • attention problems • speech problems

Derived from a World Health Organization, primary care child-oriented classification system. Haeres, S.M., Leaf, P.J., Leventhal, J.M., Forsyth, B., and Speechley, K.N. (1992), Identification and management of psychosocial and developmental problems in community-based primary care pediatric practices. Pediatrics, 89(3), 480 – 485.

The indicators listed above may be elicited from caregivers and children through interviews described in professional references (e.g., American Academy of Pediatrics: Guidelines for Child Health Supervision; and the Region X Nursing Network: Prenatal and Child Health Screening and Assessment Manual). It may be appropriate to interview the child separate from the caregiver beginning at age eight years.

Screening infants and toddlers for mental health problems is an emerging science. Based on professional judgment, referral is appropriate when there are concerns that a family and social environment do not support the infant's mental wellness.

Children with behaviors not listed on the checklist should also be referred for mental health services if the parent desires. It is important to remember that if the child or parent

sees the behavior or symptom as problematic, make a referral, even if the issues seem minor or within normal range to you.

How are substance use screening and treatment provided?

Screening and brief intervention may be provided in the following ways:

- **Screening, Brief Intervention, and Referral to Treatment (SBIRT)**

  A comprehensive, evidence-based, public health practice designed to identify people who are at risk for or have some level of substance use disorder which can lead to illness, injury, or other long-term morbidity or mortality. SBIRT services are provided in a wide variety of medical and community healthcare settings. Any provider who has completed the SBIRT training and provides a brief intervention or a brief intervention and referral may seek reimbursement for these services using CPT® code 99408 for intervention that is less than 30 minutes. See HCA's **Physician-Related Services/Health Care Professional Services Billing Guide** for more details.

- **Washington Recovery Help Line**

  The Washington Recovery Help Line is the consolidated help line for substance use, problem gambling, and mental health. The help line provides anonymous and confidential crisis intervention and referral services for Washington State residents. Professionally trained volunteers and staff are available to provide emotional support 24 hours a day and offer local substance use services. To refer people experiencing substance use disorder, call the 24-hour Washington Recovery Help Line at 800-789-1511.

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General Authorization

Authorization is HCA's approval for certain medical services, equipment, or supplies, before the services are provided to clients, as a precondition for provider reimbursement. **Prior Authorization (PA) and limitation extensions (LE) are forms of authorization.**

What is prior authorization (PA)?

Prior authorization (PA) is HCA's or its designee's approval for certain medical services, equipment, or supplies, before the services are provided to clients. When PA is applicable, it is a precondition for provider reimbursement.

What is a limitation extension (LE)?

HCA limits the amount, frequency, or duration of certain services and reimburses up to the stated limit without requiring PA. HCA requires a provider to request PA for a limitation extension (LE) to exceed the stated limits.

See **Resources Available** for the fax number and specific information (including forms) that must accompany the request for LE.

HCA evaluates requests for LE under the provisions of **WAC 182-501-0169**.

How do I obtain authorization?

Send your request to HCA's Authorization Services Office (see **Resources Available**). For more information on requesting authorization, see HCA's **ProviderOne Billing and Resource Guide.**

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Billing

All claims must be submitted electronically to HCA, except under limited circumstances. For more information about this policy change, see **Paperless Billing at HCA**. For providers approved to bill paper claims, see **HCA's Paper Claim Billing Resource.**

Providers must follow HCA's billing requirements in the **ProviderOne Billing and Resource Guide.** These billing requirements include, but are not limited to, all the following:

- Time limits for submitting and resubmitting claims and adjustments
- What fee to bill HCA for eligible clients
- When providers may bill a client
- How to bill for services provided to primary care case management (PCCM) clients
- Billing for clients eligible for both Medicare and Medicaid
- Third-party liability
- Record-keeping requirements

Note: See Resources Available for more information on billing.

How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on HCA's **Billers and Providers webpage**, under **Webinars.**

For information about billing Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) claims, see the ProviderOne 5010 companion guides on the **HIPAA Electronic Data Interchange (EDI) webpage.**

What are the billing requirements specific to EPSDT?

Use the appropriate evaluation and management code for the well-child checkup, CPT® codes 99381-99395. Use the appropriate diagnosis code when billing any EPSDT well-child checkup (e.g., Z00.129 - Encounter for routine child health examination without abnormal findings).

Bill for EPSDT services, including elements of the EPSDT well-child checkup, such as laboratory work, hearing tests, x-rays, or immunization administration using the appropriate procedure code(s)on the same claim as the EPSDT well-child checkup. Refer to guidance within **Documentation of a Well-Child Checkup** for information on appropriate procedure codes for each element.

Enhanced pediatric primary care rates

Enhanced primary care provider rates are available for vaccine administration and certain pediatric care services for clients age 20 and younger, including EPSDT well-child checkups. Physician and nonphysician practitioners are eligible for the increase.

To view the Enhanced pediatric fee schedule, see HCA's **Physician-Related/Professional Services Billing Guides and Fee Schedules webpage**.

Providers serving clients covered by an HCA-contracted managed care organization (MCO) should contact the individual MCO for rate information.