



## EPSDT SCREENING BILLING GUIDE CMS-1500 & UB-04 Format (Effective March 1, 2010)



### EPSDT BILLING GUIDELINES

- All EPSDT screening services including vaccine administration fees should be submitted to Gateway either on a CMS-1500, UB-04 or the corresponding 837P or 837I format for EDI claims within 60 days from the date of service.
- An EPSDT screen is complete when codes from each service area required for that age, including the appropriate evaluation and management codes, are documented. Consult the current Pennsylvania Children's Checkup (EPSDT) Program Periodicity Schedule and Coding Matrix as well as the Recommended Childhood Immunization Schedule for screening eligibility information and the services required to bill for a complete EPSDT screen.
- Claims will be paid at the provider's EPSDT rate only if the appropriate evaluation and management code and EP modifier are submitted.
- With the exception of the dental component for clinics that do not offer dental services, FQHCs/RHCs may not bill for partial screens.
- Gateway uses a fully automated coding review software. The software programmatically evaluates claim payments in accordance with CPT-4, HCPCS, ICD-9, AMA and CMS guidelines as well as industry standards, medical policy and literature and academic affiliations.

### CMS-1500 and UB-92 PAPER FORMAT REQUIREMENTS

- Beginning March 1, 2010 EPSDT screening services must be reported with the age-appropriate evaluation and management code (99381-99385, 99391-99395, 99431 and 99435) along with the EP modifier. (Discontinue billing S0302.) **Both** an appropriate procedure code **and** revenue code must be used on the UB-04.
- The EP modifier must follow the evaluation and management code in the first position on the claim form. Use CPT modifiers (52 or 90) plus CPT code when applicable.
- Diagnosis code V20.2 must be noted as the primary diagnosis in Box 21. You may enter up to three additional diagnosis codes.
- Report visit code '03' in box 24(h) of the CMS-1500 when providing EPSDT screening service.
- Report Condition Code "A1" in block 24 on the UB-04.
- Report 2-character EPSDT referral code for referrals made or needed as a result of the screen in box 10(d) on the CMS-1500 or in block 57 on the UB-04. Codes for referrals made or needed as a result of the screen are:

YO – Other	YV – Vision	YH – Hearing
YB – Behavioral	YM – Medical	YD – Dental



**EPSDT SCREENING BILLING GUIDE**  
**Electronic 837 P & 837I Format**  
(Effective March 1, 2010)

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**CMS-1500 and UB-04 EDI FORMAT REQUIRMENTS**

- Beginning March 1, 2010 EPSDT screening services must be reported with the age-appropriate evaluation and management code (99381-99385, 99391-99395, 99431 and 99435) along with the EP modifier. (Discontinue billing S0302.) **Both** an appropriate procedure code **and** revenue code must be used on the UB-04.
- The EP modifier must follow the evaluation and management code in the first position on the claim form. Use CPT modifiers (52 or 90) plus CPT code when applicable.
- Diagnosis code V20.2 must be noted as the primary diagnosis in Box 21. You may enter up to three additional diagnosis codes.
- Populate the SV111 of the 2400 loop with a “yes” for an EPSDT claim (this is a mandatory federal requirement).
- Populate the Data Element CLM12 in the 2300 Claim Information Loop with “01” (meaning EPSDT).
- Populate NTE01 of the NTE segment with “ADD”. This means that additional information is available in ‘field’ NTE02 (see below).
- Populate NTE02 of the NTE segment of the 2300 Claim Information Loop with appropriate referral codes:  
YO – Other                      YV – Vision                      YH – Hearing  
YB – Behavioral                YM – Medical                      YD – Dental