

Questions from the June 27, 2011 – EPSDT Seminar

Referrals

What if the referral is for a problem not addressed at the annual EPSDT screen; does an EP visit have to be done?

Yes, an Interperiodic Screening must be done and the new problem noted in order to make valid EPSDT referrals.

Does this cause the referral to become PMP only? The Patient 1st/EPSDT referral is only valid for the diagnosis specified on the referral form, unless the box that indicates the consultant may treat the patient for additional diagnoses is checked.

When the consultant identifies a new condition and makes further referral(s), the PMP should be notified. The physician that received the initial referral should report back to the PMP as required and the findings should be documented in the patient's medical record.

If the PMP refers a patient to a GI specialist for GERD and the GI specialist hears a murmur and refers the patient to a cardiologist, is the cascading referral valid? The diagnosis wouldn't match or relate.

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If a doctor's office is asking for a PMP change referral, shouldn't they fill out their part of the referral first with their name and address, phone number and fax number, and then fax to the PMP to sign and send back to them?

As long as the correct information and signatures are on the form, Medicaid does not dictate who fills out the form. For example, if the doctor seeing the patient is not the PMP, but plans to become the patient's PMP, a referral form will be needed from the current PMP until the change is made. In this case, the patient's PMP may fill out the referral form and send to the doctor that is seeing the patient, or the doctor's office that desires the referral may fill out their part and send to PMP for signature.

If a practitioner in your office sees the patient, does a referral still have to be made? Imagine a patient comes for a screening and it's billed out as a V20.2 (well child check), then (the patient) later comes in and needs a specialty referral for a different issue. Even though the current screening was billed as routine, is it OK to give that screening date to the referral clinic (some clinics will not see a patient without a screening), or should we bring the patient back in for an interperiodic screening and code for the diagnosis needing the referral?

The patient must come back in for an Interperiodic Screening and the problem must be identified for the referral to be considered a valid EPSDT referral.

What do we do about providers who don't want to give cascading referrals?

All referrals are at the discretion of the PMP/screening provider. The patient must return to PMP/screening provider to obtain additional referrals.

Say the patient is assigned to one doctor in the office, but is screened by another doctor in that office. Do both doctors need to be on the referral if they are in the same practice?

It depends on whether the Patient 1st assignment is to the group or the individual.

- If the assignment is to the group (and the group has a specialty of being an EPSDT screener), then any doctor in the group may see the patient and refer them. In that case, only the doctor that screened the patient should be on the referral form.
- However, if the Patient 1st assignment is to the individual practitioner, and another provider performed the EPSDT screening, then both names and numbers should appear on the referral form.

Can you clarify group-enrolled vs. individual-enrolled regarding the referral form for Patient 1st and the EPSDT screener?

Upon enrolling in Patient 1st, a PMP chooses whether to enroll Patient 1st recipients under a group number or under individual providers' numbers. If the group number is chosen, then anyone in the group may see the recipient without a Patient 1st referral.

Forms

Who fills out the form? Is this going to be added to the provider manual? We have offices telling us we have to fill the form out and fax it to them to sign if we want a referral.

If a provider wishes to refer a patient to a specialist, the referring provider should fill out the referral form. However, Medicaid allows coordination between the providers as long as the information is completed accurately and the appropriate signatures are obtained.

Does Medicaid expect to accept other forms of electronic referrals besides efileshare.com (Now known as Order Facilitator), such as referrals through a PMP's EHR program?

The Agency is currently working to develop a state health information exchange and will update providers when changes are made.

With regard to signature on file: What is the difference between signature on file with agency and the signature on file agreement with EFile Share

Currently, “signature on file” pertains to claims submissions only. HP (the Agency’s fiscal agent) maintains the signature on file for claims submissions. Signature on file is not acceptable for referrals at any time.

The referral form currently requires a signature, or stamped/initialed, or designee signature on the form.

If a PMP is going to have a (designated) person sign the referral form, does the PMP need to send documentation of this to Medicaid, or keep any specific documentation on file within the office?

It is not necessary to send this to Medicaid. However, PMP should keep this documentation on file within the office.

Hearing

You stated that a complete audiogram is indicated for a child age five and over who fails a hearing screen. If we feel that there are distractions that may have caused him to fail the screen that day, is it acceptable to bring him back to your office for a repeat screen and then refer for a complete audiogram if he fails the second screen?

Medicaid limits only allow for Procedure Code 92551-EP to be billed once per year with an EPSDT screening.

We do auditory evoked testing for hearing screening, which is more accurate for screening than the pure tone audiometry, but it will not give results in decibels. Is that acceptable?

No. At this time, the Provider Manual specifies it must be recorded in decibels. However, the Agency will look into any modifications that may be appropriate and present it to our policy meeting for consideration.

Comment: If your requirement for hearing screening is decibels, then you are behind the current technology, you need to research and reconsider.

Can you provide recommendations and fact based information on the current technology? We will be happy to present at our policy meeting.

Can the screening codes for hearing and vision be billed for subjective screening?

No, subjective screenings are included in the reimbursement for the EPSDT Periodic screenings.

How should the two-week old check-up be coded?

From Chapter 28 in the Provider Manual:

“When the 2 week well-baby check up is done, the physician should bill procedure code 99461.” The 99461 is billable only once in the first 8 weeks of life.

Can a PMP see the patient at two weeks as most pediatricians do and then see the patient again at the two-month? Won't these count as one- and two-month periodic screenings?

If the 2-week well baby check up is billed with Procedure Code 99461, this code does not count as an EPSDT screening.

We see a newborn for initial hospital visit (99460) and then see the newborn in the office for initial care which is other than hospital (99461); are we not paid for both visits?

If you are billing 99460 (hospital) and 99461 (other than hospital or birthing center) on the same date of service, you will not be paid for both. If the physician is seeing the baby in the hospital for normal newborn care and discharges the baby on the same day, there is another code available for billing (99463).

If the physician sees the baby in the hospital for normal newborn care, the first day may be billed with 99460, and subsequent days of hospital care with a 99462 for normal newborn care. Then, if the baby is seen 2 weeks after discharge from the hospital, then 99461 may be billed in the office setting.

We have reviewed Chapter 28 of the Provider Manual and cannot find specifics about billing for the two-week visit. Can you please email us more information?

It is listed as newborn care in Chapter 28, page 16.

We see children who are in temporary custody of a girls' home. A physical exam is required for these girls to be at the home. Many of these girls are covered by Medicaid. How should we bill Medicaid for an office exam? EPSDT is difficult because a parent is not present, only the temporary guardian.

It should be billed as a Periodic screening, if the child has not had their scheduled periodic screening. If the child has already had their scheduled screening by another provider, and DHR is requiring another physical exam, then DHR should pay for this additional physical exam.

Are there any suggestions for holding the parents responsible for all screening no-shows that occur?

No, there are regulations that prohibit the billing of Medicaid recipients for no show appointments. I encourage you to speak or send letters to the parents outlining the importance of the screening and/or visits. The PMP's has the discretion to dismiss the recipient after a pattern of no shows. See Chapter 39 for guidance on dismissing recipients with notification.

General

If there is a language barrier (Spanish speaking), and a history cannot be obtained, what do we do?

Document that the history was unable to be obtained due to language barrier. You may request that family member, friend, or church member come back to translate, or have someone write down history in English for the medical record.

What visits count against the annual limit?

Office visit, consultation codes, intermediate eye exam codes, nursing home visits, and psychotherapy codes billed without an EP modifier are counted as office visits. When EPSDT referrals are made and the consultant does not indicate "EPSDT referred" on the claim form also count against the office visit limit.

What do we do if a patient has more diagnoses than can be transmitted on the claim but are listed in the chart?

List as many as possible on the claim, but make sure all diagnoses are in medical record.

How far down the road do you anticipate electronic referral for EHR users to be available?

The Agency (and the State of Alabama) is in the process of developing a state health information exchange. Providers will be notified as changes are made.

What are reimbursement rates for screening, interperiodic and sick visits?

Periodic screenings are \$70.00, interperiodic are \$27.00. Any other office visit codes are based on the level of care for the office visit.

Why do diaper agencies have to have doctor signature only on referral form? They say you cannot use a stamp

This is not a requirement of Medicaid.

PCP/PMP

Sometimes the patient is assigned to another PCP and they give us permission to see them for three months to get PCP changed. When we have to refer that patient to a specialist during that time we have to fill out a new referral form with current PCP and screening PCP, how do we get the person's signature on that referral, because that doctor does not work in our office? So we usually write signature on file. It would be hard to get those PCPs to sign every referral when we have to refer a patient to a specialist.

This should be treated as a cascading referral:

Have the PMP check the following box "Referral by consultant to other provider for additional conditions diagnosed by consultant (cascading referral)"

Copy this referral to send to consultant and copy the assigned Patient 1st Physician.

What if a patient moves out of the PMP's area, or exceeds the age limit of the PMP's panel. Does Medicaid automatically remove these patients or does the PMP have to request Medicaid to remove them?

The recipient should report the move to her eligibility case worker. The system would then identify the address/county change and assign the recipient to a new PMP based on the information on file. The recipient also can call the 1-800-362-1504 number and change his/her PMP assignment.

The Medicaid system does not automatically remove a recipient from a PMP panel when the recipient reaches or exceeds the age limit. In many cases, eligibility is lost due to the recipient aging out of the SOBRA program. Some PMPs may choose to continue to see the recipient.

The PMP may also request that the recipient may be removed from the Patient 1st panel. Please refer to Chapter 39 of the Provider Manual for guidelines.

We have PMP offices that say that it is not their responsibility to have patients taken off their lists when they haven't been seen. Is this correct?

It is the PMP's responsibility to dismiss recipients that are:

1. Non-compliant with appointments, referrals, medical care, etc. or
2. No longer meet their age criteria established by the pediatrician

Interperiodic Screenings

The patient is seen in the ED and told to see a specialist the next day. The specialist calls the PMP for a referral. Does the patient need to come to the PMP for an Interperiodic Screening?

All referrals are at the discretion of the PMP/screening provider. In the absence of an EPSDT referral, the PMP can give a Patient 1st referral. In that case, the specialist can bill the claim with a Patient 1st ONLY referral and no EPSDT diagnosis-related referral. The specialist visit will not be based on an EPSDT diagnosis-related screening and therefore will be subject to the 14-day office visit limit. If an Interperiodic Screening is completed by an EPSDT screener or if the PMP performs an Interperiodic Screening, visits to the specialist and other treatments will not be subject to annual visit limits bucket.

Patient 1st referrals are at the discretion of the PMP and the PMP may choose to provide a billing referral to the specialist. The PMP may wish for the child to come in for an interperiodic screening from which an EPSDT referral may be made as well as a Patient 1st screening. There is an advantage for the recipient to have an EPSDT screening as the service rendered as an EPSDT referral does not count against the benefit limits.

If the patient goes to the ED and has an emergency, such as a fracture of the arm, does the child need to come to the PMP for interperiodic screening?

Yes the child should come back to the PMP for an interperiodic screening and referral, in order for the visits to the specialists not to count against the yearly limit.

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Regarding the ortho question: Even if the patient has a fracture, they have to go back to the PMP for a referral?

Yes, in order for their EPSDT referred visits not to count against their yearly benefit limits.

When is a sick visit not an interperiodic screening? Can you please provide an example?

It is at the physician's discretion as to whether they bill a regular office visit, or an interperiodic screening. If the problem is something that they are expecting a follow-up visit, they should bill an interperiodic screening to allow for a self referral, so that future visits may be billed with the appropriate office visit code as referred, and not count against the yearly limit.

There are four documentation requirements for an Interperiodic EPSDT Screening.

1. Consent,
2. Medical-surgical history update,
3. Problem-focused physical examination, and
4. Anticipatory guidance/counseling related to the diagnosis made.

NOTE: If the patient is seen at a Children's Hospital Clinic or a USA clinic, a hospital-based screener (if enrolled with the hospital) can be given permission to perform a screening without the patient having to return to the Patient 1st PMP for an Interperiodic Screening. In this case, non PMP referral would be required because inpatient hospital services are exempt from Pt. 1st referral requirements. (see Chapter 39 of Provider Manual).

Self-Referrals

What is the proper documentation needed for a self-referral?

Self-referred written in the medical record for other visit is not in the Medicaid Manual. Please clarify if this is a new request.

Medicaid has updated and clarified its policy on self referrals as below:

The current rules are in Chapter 28:

Providers are not required to complete written referrals (Patient 1st or EPSDT) to the other providers in the same group, provided that all documentation by all physicians in that group for a specific recipient is included in **one common record** (electronic or paper). The medical record documentation shall clearly indicate that the PMP did a screening, identified the problem, and the referral was made to self or specialist within that group. Examples: Referral to self may be documented as “return for follow up prn.” or return to office in 2 weeks.”

Providers are required to complete written referrals to other specialists in the same group **if a common medical record is not used**. Referrals to specialists and other physicians outside of the group are required to have a written Patient 1st and/or EPSDT referral.