NC Medicaid

Health Check Program Guide

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NC Health Check Early Preventive Screening Program Guide

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Section I: Health Check Overview

Well-Child Preventive Services

Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit, as specified in **42 U.S.C.§ 1396d(r) [1905(r)] of the *Social Security Act*,** requires coverage of a comprehensive menu of preventive, diagnostic and treatment services for its eligible beneficiaries under age 21. Federal EPSDT law requires states to make health care services available to all Medicaid eligible children to "correct or ameliorate" defects, physical or mental illness, or health conditions identified through a screening assessment, when those services meet carefully applied and individualized standards of pediatric medical necessity.

EPSDT benefit guarantees contained in **§ 1905(r) of the *Social Security Act*** specifically require that eligible children have access to early and regular medical surveillance and preventive services, including but not limited to physical assessments, vision, hearing, recommended vaccines, developmental/mental health screenings, referral and follow-up care to promote good health and to ensure earliest possible diagnosis and treatment of health problems. In North Carolina, this preventive health services/periodic screening portion of Medicaid's package of healthcare benefits for children is known as *Health Check*. A comprehensive wellness exam is performed during periodic Early Periodic Screening visits and is reimbursed by the North Carolina Medicaid program.

All *Health Check* services are available without copay or other beneficiary expense, to Medicaid eligible children. When a screening discloses a need for further evaluation of an individual's health, diagnostic and treatment services must be provided. Referrals should be arranged without delay and there should be follow-up to ensure the enrollee receives a complete diagnostic evaluation.

For beneficiaries who are currently involved with the justice system, and receiving screening and diagnostic services under Consolidated Appropriations Act (CAA) 5121 (please see Health Check Guide Addendum: Consolidated Appropriations Act 5121 Requirements below) referrals for follow up treatment should be arranged without delay for a time after their release from incarceration, and there should be follow-up to ensure the enrollee receives a complete diagnostic evaluation.

Each provider rendering NC Medicaid *Health Check* Well-Child services shall:

- Deliver a comprehensive exam, inclusive of all *Health Check* required preventive health screening and assessments;
- Assist families with scheduling appointments for timely *Health Check* Early Periodic Screening visits, assessments, referrals and follow-up;
- Implement a system for follow-up with families whose children miss their *Health Check* Early Periodic Screening visits;

- Complete, document, and follow up on appropriate referrals for medically necessary services to treat conditions and health risks identified through a *Health Check* screening.

Each *Health Check* component that is required in the Early Periodic Screening visit is vital for measuring and monitoring a child's physical, mental and developmental growth over time. Families are encouraged to have their children receive *Health Check* visits with immunizations on a regular schedule.

All healthcare professionals who provide a *Health Check* Early Periodic Screening must complete all core components of the visit, including, but not limited to, vaccinations, blood lead screens, developmental screens, and 18/24 month screens for Autism Spectrum Disorders (ASD), and provide complete documentation of those assessments in the child's medical record, including history, current status, findings, results of clinical interventions and of brief screens, referrals and recommendations.

NC Health Check Preventive Health Services Periodicity Schedule

North Carolina's recommended schedule for *Health Check* Early Periodic Screens reflects the evidence-based principles of preventive care set forth by the **American Academy of Pediatrics (AAP)** in their most current landmark publication, *Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents*. Support for the elements and intervals of primary care services recommended in this schedule also comes from the **American Dental Association (ADA), the American Academy of Pediatric Dentistry (AAPD)** and other child health advocacy organizations.

The *Bright Futures Recommendations for Preventive Pediatric Health Care* **Periodicity Schedule** is located on the American Academy of Pediatrics Preventive Care/Periodicity Schedule webpage.

North Carolina's ***Health Check Periodicity Schedule*** is included in this section of the Guide and is available on the NC Medicaid Wellness Visits, and Diagnostic and Treatment Services.

The NC *Health Check* Program recommends regular Early Periodic Screening for beneficiaries as indicated in the following State Periodicity Schedule. NC Medicaid's Periodicity Schedule is only a guideline. Should a beneficiary need to have screening or assessment visits on a different schedule, the visits are still covered. While frequency of visits is not a required element of reimbursement by NC *Health Check*, this schedule of visits for eligible infants, children and adolescents is strongly recommended to parents and health care providers.

NC Periodicity Schedule Quick View

Components / Screening Services	Newborn	3-5 days	By 1 month	2 month	4 month	6 month	9 month	12 month	15 month	18 month	24 months	30 months
Length/Height and Weight	•	•	•	•	•	•	•	•	•	•	•	•
Head Circumference	•	•	•	•	•	•	•	•	•	•	•	
Weight for Length	•	•	•	•	•	•	•	•	•	•		
Body Mass Index											•	•
Blood Pressure	*	*	*	*	*	*	*	*	*	*	*	*
Vision Screening	*	*	*	*	*	*	*	*	*	*	*	*
Hearing Screening	•	•			*	*	*	*	*	*	*	*
Maternal Depression Screen (96161)			•	•	•	•						
Developmental Screening (96110)						•	•	•		•	•	•
Autism Screenings [2] (96110)										•	•	
Developmental Surveillance	•	•	•	•	•	•		•	•		•	
Behavioral/ Social/ Emotional Screening	•	•	•	•	•	•	•	•	•	•	•	•
Tobacco, Alcohol or Drug Use Assessment												
Depression and Suicide Risk Screening												
Physical Examination	•	•	•	•	•	•	•	•	•	•	•	•
Newborn Blood	•	•										
Newborn Bilirubin	•											
Critical Congenital Heart Defect	•											
Anemia					*			•	*	*	*	*
Lead						*	*	•		*	•	
Tuberculosis			*			*		*			*	
Dyslipidemia											*	

Components / Screening Services	Newborn	3-5 days	By 1 month	2 month	4 month	6 month	9 month	12 month	15 month	18 month	24 months	30 months
Sexually Transmitted Infections												
HIV												
Hepatitis B Virus Infection	*	←	●	●	●	●	●	●	●	●	●	→
Hepatitis C Virus Infection												
Sudden Cardiac Arrest/ Death												
Cervical Dysplasia												
Oral Health						•	•	*		*	*	*
Fluoride Varnish						←	●	●	●	•	→	
Fluoride Supplement						*	*	*		*	*	*
Anticipatory Guidance	•	•	•	•	•	•	•	•	•	•	•	•
Immunization	Follow Advisory Committee on Immunization Practices recommendations for age appropriate immunization guidelines and Centers for Disease Control and Prevention Child, Adolescent and Catch-Up Immunization Schedules found at: cdc.gov/vaccines/schedules/index.html Refer to the North Carolina Immunization Branch for additional information.											

Key: ● = to be performed * = risk assessment to be performed ←●→ = range during which a service may be provided

Components / Screening Services	3 yrs	4 yrs	5 yrs	6 yrs	7 yrs	8 yrs	9 yrs	10 yrs	11 yrs	12 yrs	13 yrs	14 yrs	15 yrs	16 yrs	17 yrs	18 yrs	19 yrs	20 yrs
Length/Height and Weight	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Head Circumference																		
Weight for Length																		
Body Mass Index	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Blood Pressure	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Vision Screening	•	•	•	•	*	•	*	•	*	•	*	*	•	*	*	*	*	*
Hearing Screening	*	•	•	•	*	•	*	•	•	•	•	→	←	•	→	←	←	•
Maternal Depression Screen (96161)																		
Developmental Screening (96110)																		
Autism Screenings [2] (96110)																		
Developmental Surveillance	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Behavioral/ Social/ Emotional Screening	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Tobacco, Alcohol or Drug Use Assessment									*	*	*	*	*	*	*	*	*	*
Depression and Suicide Risk Screening										•	•	•	•	•	•	•	•	•
Physical Examination	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Newborn Blood																		
Newborn Bilirubin																		
Critical Congenital Heart Defect																		
Anemia	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Lead	*	*	*	*														
Tuberculosis	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Dyslipidemia		*		*		*	←	•	→	*	*	*	*	*	→	→	→	•
HIV									*	*	*	*	•	→	→	→	→	→
Sexually Transmitted Infections									*	*	*	*	*	*	*	*	*	*

Components / Screening Services	3 yrs	4 yrs	5 yrs	6 yrs	7 yrs	8 yrs	9 yrs	10 yrs	11 yrs	12 yrs	13 yrs	14 yrs	15 yrs	16 yrs	17 yrs	18 yrs	19 yrs	20 yrs
Hepatitis B Virus Infection	←	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	→
Hepatitis C Virus Infection																•	←	→
Sudden Cardiac Arrest/ Death									*	←	—	—	—	—	—	—	—	→
Cervical Dysplasia																		
Oral Health	*	*	*	*														
Fluoride Varnish	←	—	→															
Fluoride Supplement	*	*	*	*	*	*	*	*	*	*	*	*	*	*				
Anticipatory Guidance	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Immunization	Follow Advisory Committee on Immunization Practices recommendations for age appropriate immunization guidelines and Centers for Disease Control and Prevention Child, Adolescent and Catch-Up Immunization Schedules found at: http://www.cdc.gov/vaccines/schedules/index.html Refer to the North Carolina Immunization Branch for additional information.																	

Key: ● = to be performed * = risk assessment to be performed ←●→ = range during which a service may be provided

Footnotes:	
1:	***EPSDT's covered screening services*** are medical, mental health, vision, hearing and dental. ***Per the Center for Medicare & Medicaid Services (CMS), the five required components of an Early and Periodic Screening encounter are***: • Comprehensive health and developmental history that assesses for both physical and mental health, as well as for substance use disorders; • Comprehensive, unclothed physical examination; • Appropriate immunizations, in accordance with the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices; • Laboratory testing (including blood lead screening appropriate for age and risk factors); and, • Health education and anticipatory guidance for both the child and caregiver. North Carolina follows an enhanced schedule for developmental screens. Developmental screens must be done at the 6-month, 12-month, 18- or 24-month, 36 months, 48 month and 60-month visits. Body Mass Index (BMI) Percentile (recording BMI begins at age 2 through 20); blood pressure (BP begins at age 3, continuing through age 20); anticipatory guidance and parent/caregiver education.
2:	***Scientifically validated screening tools*** must be used when administering brief screens. Providers must keep appropriate documentation of the screening tool in the child's medical records, must document results and referrals necessary, and are required to coordinate follow-up care if risk factors are identified. Required developmental screenings (e.g., developmental milestone survey, speech and language delay screen) and Autism screenings can be billed with CPT 96110/EP. Caregiver depression screens may be billed to the child's Medicaid insurance as CPT 96161/ EP/59. NC Medicaid will reimburse providers for up to 4 caregiver depression risk screens administered to the child's caregiver during the infant's first year postpartum.
3.	Psychosocial Assessment: Perform socio-emotional (S-E)/Mental Health screening and surveillance, including ACEs, social determinants, routines, relationships, functioning (school, home, peers) parenting, parental Mental H, trauma exposure, family disruptions, environmental risks. Explore positive findings. Observe child and parent, perform exam as indicated. Elicit and reinforce strengths throughout. Use scientifically validated screening tools as clinically indicated to identify risk for psychosocial/emotional/behavioral risks. ▪ 96127/ EP for Emotional/Behavioral screens, including ASQ-SE, PSC/SDQ/PSQ-A/Beck's, CRAFFT, Vanderbilt, Conners. ▪ When 96160/EP or 96161/EP are billed with CPT code 96127/EP, modifier 59 must be appended to 96160/96161. For beneficiaries **> 11** years old AAP recommends following screens (included EP modifier): ▪ 96160/EP mod for Adolescent Health Risk Assessment (Bright Futures Adolescent Questionnaire/GAPS/HEADSSS) ▪ 99406/99407/EP mod for Smoking/Tobacco Use Cessation; **for svc directly to beneficiary, add 25 mod** ▪ 99408/99409/EP mod for ETOH/SA Screening/Brief Intervention; for s**vc directly to beneficiary, add 25 mod**
4:	**Hearing Screens:** When performing hearing screens, providers indicate completion on claim with CPT 92551 or 92552+ EP, $0.00 billable amount.
5.	**Oral Health:** • **CMS** defines "dental services" as services provided by or under the supervision of a dentist, and "oral health services" as services ***not*** provided by, or under the supervision of a dentist. • Oral health screenings, services such as fluoride applications and referrals to a Dental Home, are performed by licensed physicians and Non-Physician practitioners (PA, NP, RN, LPN) who meet Medicaid's training requirements and are an integral component of preventive health visits. • **North Carolina requires an Oral Health Screening at every preventive health visit.** • **NC Medicaid** allows a total of six oral screening packages (examination, preventive oral health and dietary counseling (code D0145), and application of fluoride varnish (code D1206) on beneficiaries from the time of tooth eruption up to age 3 ½. Although dental varnishing is not a requirement of a Health Check screening assessment, it is strongly recommended. Qualified providers who perform a Health Check Well Child Checkup and dental varnishing may bill for both services. **For billing codes and guidelines**, refer to Clinical Coverage Policy # 1A-23, *Physician Fluoride Varnish Services,* on NC Medicaid's Program Specific Clinical Coverage Policies webpage.
6.	**Anemia**: Risk assessment to be performed at 4 months of age, Hbg or Hct **must** be measured at 12 months for all children. After 12 months of age, assess for risk factors at every preventive visit. See 'Diagnosis and Prevention of Iron Deficiency and Iron Deficiency Anemia in infants and young children (0-3 years of age)', at pediatrics.aappublications.org/content/126/5/1040.full
7:	**Lead Screening**: Required at 12- and 24-months. Children between 36 -72 months of age must be tested if they have not been previously tested. Children new to Medicaid that have never been tested for blood lead should be tested at any age, when risk factors are present. Providers may bill one unit CPT 83655 when using a Point of Care, CLIA approved Blood Lead Analyzer. Capillary blood draws are considered incidental to preventive service and should not be billed. Providers must follow all guidelines for reporting to State Blood Lead program/DPH. **A venous sample must be collected for *outside laboratory analysis* for a screen result > 5 ug.**
8.	**HIV/STI testing:** Providers are to follow the most current *CDC Sexually Transmitted Diseases Treatment Guidelines* for screening and treatment of adolescents cdc.gov/sti/hcp/clinical-guidance/?CDC_AAref_Val=https://www.cdc.gov/std/treatment/default.htm The 2017 Bright Futures recommends that adolescents should be screened for HIV once between the ages of 15 and 18, making every effort to preserve the confidentiality of the patients. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and then re-assessed annually.

Additional Billing Details:

Capillary blood draws are considered incidental to *Health Check* Early Periodic Screening and should not be billed. CPT Code for Blood Draws: Report 36415/EP for *Venous* blood draw when an external laboratory analysis is required.

Report CPT 96161/EP for Caregiver Depression Screens/First year of life, administered to caregiver for benefit of infant and CPT 96160/EP for Adolescent Risk Screens (*Bright Futures* Supplemental Questionnaire/GAPS/HEADSS).

For Health Check Required Components: Report all component services that were performed with appropriate CPT Codes.

When a focused complaint is treated same day as a preventive service visit: Report *only* the additional work required to evaluate/manage focused complaint and bill on same claim with preventive service, appended with '25' Modifier. Follow all documentation requirements supporting medical necessity.

Early Periodic Screening ICD-10-CM Codes

ICD-10- CM Code	Descriptor
	Well Child Exams
Z00.121	Encounter for routine child health examination ***with*** abnormal findings
Z00.129	Encounter for routine child health examination ***without*** abnormal findings
Z00.110	Newborn check under 8 days old
Z00.111	Newborn check 8 to 28 days old
Z00.00	Encounter for general adult medical exam (pt > 18 years) ***without*** abnormal findings
Z00.01	Encounter for general adult medical exam (pt > 18 years) ***with*** abnormal find
Routine Interperiodic Screening Encounters	
Z02.89	Encounter for other administrative exams
Interperiodic Visits Following a Failed Vision or Hearing Screen	
Z01.00	Encounter for examination of eyes and vision without abnormal findings
Z01.01	Encounter for examination of eyes and vision with abnormal findings
Z01.110	Encounter for hearing examination following failed hearing screening
Z01.10	Encounter for examination of ears and hearing without abnormal findings
Z01.118	Encounter for examination of ears and hearing with other abnormal findings
ACIP/VFC Immunizations	
Z23	Encounter for immunization
Z28.3	Under-immunized status
Lead Screens and follow Up of Positives	
Z13.88	Encounter for screening for disorder due to exposure to contaminants
Z77.011	Contact with and (suspected) exposure to lead.
Tuberculosis Screens	
Z11.1	Encounter for screening for respiratory tuberculosis

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Section II*:* Periodic NC Health Check Preventive Services Visit Components

A complete ***Health Check*** Early Periodic Screening visit must include all of the age-appropriate components identified below.

Comprehensive Health History

At the time of the initial evaluation, this will include a medical history, family history, social history, and review of systems. The provider must update this information in the beneficiary's medical record at each subsequent visit.

Unclothed Physical Assessment and Measurements

The provider shall perform a **complete physical appraisal** of the unclothed child or adolescent at each periodic NC *Health Check* Early Periodic Screening visit to distinguish any observable deviations from normal, expected findings. The complete physical assessment must be provided based on guidance from the most recent AAP Bright Futures Guidelines. The assessment will use techniques of inspection, palpation, percussion, and auscultation. Weight (for all ages) and height (for all ages) and head circumference (for infants and children up to and including age 24months) must be measured. Weight for length must be determined for all beneficiaries less than 24 months of age. BMI must also be calculated, and BMI percentile must be determined by plotting on a gender and age-appropriate growth chart (starting at age 24 months). Blood pressure and blood pressure percentile (starting at age 3) is required, but additional vital signs should be measured as appropriate. Providers should reference tables of age-normed vital signs as needed.

AAP Bright Futures Guidance for a comprehensive physical exam can be found at: *Bright Futures Evidence and Rationale, Health Supervision Visits* aap.org/en/practice-management/bright-futures/bright-futures-materials-and-tools/

BMI Percentile Coding

Childhood obesity is a serious national health concern, presenting documented risks to health and well-being during childhood and throughout the lifespan. A priority of the AAP is helping primary care clinicians and families prevent and treat childhood obesity and overweight conditions.

Measurement and follow-up of Body Mass Index (BMI) percentile is a core Healthcare Effectiveness Data and Information Set (HEDIS) measure for quality of care. In December of 2009, the **Agency for Healthcare Research and Quality** (AHRQ) included BMI measurement in its set of 24 child health indicators for state Medicaid and CHIP programs. North Carolina ***Health Check*** encourages all primary care providers to incorporate appropriate ICD-10-CM diagnosis codes on

claims billed for each wellness/preventive visit. Additionally, when recording and reporting BMI percentiles, providers are *strongly encouraged* to report one of the following ICD 10-CM codes in the Diagnosis Code Information section in the NCTracks Web Portal by adding new diagnosis line. (This entry crosswalks to block 21.2, 21.3 or 21.4 of the CMS-1500 Claim Form).

ICD 10 Code	BMI Percentile
Z68.51	< 5th percentile
Z68.52	5th to < 85th percentile
Z68.53	85th to < 95th percentile
Z68.54	≥ 95th percentile

ICD 10 Coding

Providers are *required* to report the primary ICD-10-CM codes in the NC Tracks Web Portal when creating a Professional claim under Service(s) Screen for Diagnosis Code Information (crosswalk to block 21.1 of the CMS-1500 Claim Form) for all NC *Health Check* Early Periodic Screening visits/Interperiodic Screening Visits. See page 10 for ICD-10-CM Code Descriptors.

Nutritional Assessment

This assessment may include a combination of physical, laboratory, health-risk assessment, and dietary determinations that yield information for assessing the nutritional status of the beneficiary. Further assessment or an appropriate management plan, with referral and follow-up, is indicated when dietary practices suggest risk factors for co-morbidities, dietary inadequacy, obesity, disordered eating practices (pica, eating disorders, or excessive supplementation) or other nutritional problems.

Best practice references include:

- The most recent (4th Edition) *Bright Futures Guidelines* and *Bright Futures Nutrition* pocket guides, found at: brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/Pages/default.aspx
- The *Eat Smart Move More North Carolina* Prescription Pads Promoting "5-3-2-1-Almost None" Prevention Message at: eatsmartmovemorenc.com/resource/pediatric- obesity-clinical-tools/
- The US Department of Agriculture, "ChooseMyPlate" food group recommendations at: choosemyplate.gov/

- The *Pediatric Obesity Clinical Tools* are available at: eatsmartmovemorenc.com/resource/pediatric-obesity-clinical-tools/
- Research about multivitamin supplementation for female adolescents of childbearing age is available at:

  jama.ama-assn.org/cgi/content/full/279/18/1430

  and at:

  everywomannc.com

Vision Screenings

Objective screenings must now be performed during **every** periodic screening assessment beginning at age three through age 6 years, and again at age 8 years, age 10 years, age 12 years, and age 15 years. This is per the 2024 Bright Futures schedule, which can be found at:

Preventive Care/Periodicity Schedule (aap.org)

Providers shall selectively screen vision at other ages based on the provider's assessment of risk, including any academic difficulties. For guidance on vision risk assessment/screening for children and youth, go to **AAP Policy Statement** on *"Eye Examination in Infants, Children and Young Adults by Pediatricians"* at:

publications.aap.org/pediatrics/article-abstract/111/4/902/63135/Eye-Examination-in-Infants-Children-and-Young?redirectedFrom=PDF

Vision CPT codes with the EP modifier **must** be listed on the claim form format in addition to the preventive medicine CPT codes for a periodic Health Check screening assessment. **No additional reimbursement is allowed for these codes**

For children who are uncooperative with vision screening, providers may ask the parent or legal guardian to bring the child back into the office within 1-2 weeks for a second attempt at the vision screening. Children who cannot be tested after repeated attempts must be referred to an *eye care professional* for a comprehensive vision examination. The repeated attempts and the referral to an eye care professional must be documented in the medical record.

For children who are blind or who are unable to be screened for any reason, providers shall:

- Document in the beneficiary's medical record the date of service and the reason(s) why the provider was unable to perform the vision screening; and
- Submit the claim to the NC Medicaid's billing contractor without the vision CPT code. Fiscal Agent will process the claim.

Instrument-Based Pediatric Vision Screening

Amblyopia, high refractive error, and strabismus are the most common conditions that cause visual impairment in children. Instrument-based screening devices used for vision screening in the pediatrician's office can detect these conditions. According to the AAP policy statement published in Jan. 2016, instrument-based screening devices can be used at any age but have better success after 18 months of age. The AAP *Bright Futures Guidelines* states that Instrument-based ocular screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 years through 5 years of age. CPT code 99177, Screening of Eye with Special Instrument Onsite Analysis is separately reimbursable effective Nov. 1, 2024.

Hearing Screenings

Objective screenings using an audiometer (auditory sweep) or otoacoustic auditory emission (OAE) tool must now be performed annually for children ages 4 through 6 years, at age 8 years, age 10 years, at one visit between the ages of 11 years and 14 years, one visit between the ages of 15 through 17 years, and one visit between the ages 18 through 21 years. This follows the 2024 Bright Futures schedule, which can be found at:

Preventive Care/Periodicity Schedule (aap.org)

Hearing CPT codes with the EP modifier **must** be listed on the claim form format in addition to the preventive medicine CPT codes for a periodic Health Check screening assessment. **No additional reimbursement is allowed for these codes.**

At all other ages, providers shall selectively screen based on the provider's assessment of risk.

Screening must occur if:

- the parent is concerned about the child's hearing, speech or language; or
- parent or child reports problems including academic difficulties; or
- the child is exposed to:
    - potentially damaging noise levels;
    - head trauma with loss of consciousness;
    - recurring ear infections;
    - acute or chronic disease that could contribute to hearing loss; or
    - ototoxic medications

For further guidance go to:

Medical Home (aap.org)

For children who are uncooperative with hearing screening, providers may ask the parent or legal guardian to bring the child back into the office within 1-2 weeks for a second attempt at the

hearing screening. Children who cannot be tested after repeated attempts *must be referred to an audiologist* for a hearing evaluation. The provider shall document repeated attempts and referral to an audiologist in the medical record.

For children who are deaf or who are unable to be screened for any reason, providers shall:

- Document in the patient's medical record the date of service and the reason(s) the provider was unable to perform the hearing screening, and;
- Submit the claim to NC Medicaid Fiscal Agent without the hearing CPT code, Fiscal Agent will process the claim.

Interperiodic Screening Visit

Interperiodic screenings, outside of the established periodicity schedule, must be made available when an illness or condition is suspected that was not present during the regular scheduled periodic screening, or to determine if there has been a change in a previously diagnosed illness or condition that requires additional services. The provider performs the necessary screening components and provides or refers for any additional diagnostic or treatment services. Referrals for an Interperiodic screen may be made by a physician, school nurse, or any health or developmental education personnel who comes in contact with the child. An Interperiodic screening can only be billed if the child has already received the expected, complete age-appropriate medical screening or screening visit. If a complete age-appropriate medical screening has not been performed, the provider should administer a complete, age-appropriate medical screening visit.

Per CMS's ***EPSDT- A Guide for States***, "EPSDT requires coverage of medically necessary 'Interperiodic' screening outside of the state's periodicity schedule. Coverage for such screenings is required based on an indication of a medical need to diagnose an illness or condition that was not present at the regularly scheduled screening or to determine if there has been a change in a previously diagnosed illness or condition that was not present at the regularly scheduled screening or to determine if there has been a change in a previously diagnosed illness or condition that requires additional services. The determination of whether a screening service outside of the periodicity schedule is necessary may be made by the child's physician or dentist, or by a health, developmental, or educational professional who comes into contact with a child outside of the formal health care system. This includes, for example, personnel working for state early intervention or special education programs, Head Start, and the Special Supplemental Nutrition Program for Women, Infants, and Children."

Example of Screenings Beyond Those Required by the Periodicity Schedule

A child receives a regularly scheduled periodic vision screening at age 5 at which no problem is detected. According to the state's periodicity schedule, his next vision screening is due at age 7. At age 6, the school nurse recommends to the child's parent that the child see an optometrist because a teacher suspects a vision problem. Even though the next scheduled vision screening is not due until the age of 7, the child would be entitled to receive a timely "Interperiodic' screening to determine if there is a vision problem for which treatment is needed. The screening should not be delayed if there is a concern the child may have a vision problem.

Source: NPRM, 58 Fed. Reg. 51288, 51290, 51291 (Oct. 1, 1993)

For more information, please see "EPSDT- A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents" at:
medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf

Dental Screenings

An oral screening must be performed at every *Health Check* well-child visit. In addition, assessing for a dental home should occur at the 12-month and 18-month through 6-year visits. If no dental home is identified, perform a risk assessment and refer to a dental home. Per the AAPD, a dental home should be established no later than 12 months of age. If no dental home is identified by age 3, the PCP/Pediatrician **must** refer the child to a dentist for future dental care. A referral must be done for any older child or adolescent that does not have a dental home. An oral screening performed during a physical assessment is *not a substitute for an examination by a dentist* that results from a direct referral. The initial dental referral must be provided unless it is known that the child already has a dental home. An oral health risk assessment is recommended for all young children at well-child visits up to age 3 ½ years. Oral risk screening tools include either the ***NC Priority Oral Risk and Referral Tool*** **(PORRT)** or the ***Bright Futures Oral Health Risk Tool*****.** When any screening indicates a need for dental services at an early age, referrals must be made for needed dental services and documented in the child's medical record. The NC Oral Health periodicity schedule for dental examinations, found in this section, *is a separate and independent schedule* for regular *dental care for children*.

Refer to the **Oral Health Periodicity Schedule** in this document and on NC Medicaid's website at: medicaid.ncdhhs.gov/providers/programs-and-services/medical/wellness-visits-and- diagnostic-and-treatment-services

For a list of North Carolina dental providers by county who accept Medicaid, go to:

medicaid.ncdhhs.gov/find-a-doctor/medicaid-dental-providers

For further guidance regarding dental benefits, see the **Medicaid Dental Coverage Policy** at: medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies

Note: Dental varnishing is strongly recommended once teeth are present. Providers who perform a Health Check screening assessment and dental varnishing may bill for both services. Per AAP recommendation, once teeth are present fluoride varnish may be applied to all children every 3-6 months in the primary care or dental office. For billing codes and guidelines, refer to Clinical Coverage Policy # 1A-23, **Physician Fluoride Varnish Services,** on NC Medicaid's website at:

medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies

North Carolina Oral Health Periodicity Schedule

The North Carolina Medicaid Oral Health Periodicity Schedule follows a modified version of the **American Academy of Pediatric Dentistry's (AAPD)** *Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance, and Oral Treatment for Children*. The periodicity schedule has been developed in consultation with local authorities in the field of pediatric oral health care. This schedule is designed for the care of children who have no contributing medical conditions and are developing normally. All services rendered under NC Medicaid Dental Services Clinical Coverage Policy guidelines must be medically necessary.

Promotion of oral health care is considered a joint responsibility between oral health professionals and other health care professionals. This periodicity schedule recommends appropriate intervals of care which correspond to reasonable standards of dental practice.

The schedule is not intended to prescribe by whom the services should be provided, particularly for Medicaid eligible infants and toddlers under age 3. This will be determined by other factors including local community capacity to provide care to preschool Medicaid children.

The NC Medicaid Oral Health Periodicity Schedule can be modified for children with special health care needs or if disease or trauma contributes to variations from the norm.

North Carolina's Oral Health Periodicity Schedule.

RECOMMENDATIONS	AGE				
	Birth through 12 months	12 through 24 months	2+ years through 6 years	6+ years through 12 years	12 + years
Clinical Oral Evaluation [1, 2]	*	*	*	*	*
Assess Oral Growth and Development [3]	*	*	*	*	*
Caries Risk Assessment [4, 5]	*	*	*	*	*
Radiographic Assessment [6]			*	*	*
Prophylaxis and Topical Fluoride [5, 6]	*	*	*	*	*
Fluoride Supplementation [7, 8]	*	*	*	*	*
Anticipatory Guidance / Counseling [9]	*	*	*	*	*
Oral Hygiene Counseling [10]	Parent/Caregiver	Parent/Caregiver	Patient and Parent/Caregiver	Patient and Parent/Caregiver	Patient
Dietary Counseling [11]	*	*	*	*	*
Injury Prevention Counseling[12]	*	*	*	*	*
Counseling for Non-nutritive Habits[13]	*	*	*	*	*
Assessment for Substance Abuse Counseling Referral				*	*
Periodontal Assessment [5, 6]				*	*
Assessment for Developing Malocclusion			*	*	*
Assessment for Pit and Fissure Sealants [14]			*	*	*
Assessment and/or Removal of 3rd Molars					*
Transition to Adult Dental Care					*
Referral to Primary Care Physician, as needed	*	*	*	*	*

North Carolina's Oral Health Periodicity Schedule.

1 The Primary Care Physician/Pediatrician/Dentist should perform the first/initial oral health screening following AAP/AAPD guidelines

2 An oral evaluation should be done by the Primary Care Physician/Pediatrician/Dentist up to age 3. Every infant should receive an oral health risk assessment from his/her primary health care provider or qualified health care professional at age 6 months and age 9 months: (1) assessing the patient's risk of developing oral disease using an accepted caries-risk assessment tool; (2) providing education on infant oral health; and (3) evaluating and optimizing fluoride exposure. The evaluation should include an assessment of pathology and injuries.

3 By clinical examination

4 All children should be referred to a dentist for the establishment of a dental home **by 12 months** of age if possible, and no later than age 3. Children determined by the PCP/Pediatrician to be at risk for early childhood caries (ECC) should be referred to a dentist as early as 6 months, after the first tooth erupts, or 12 months of age (whichever comes first) for establishment of a dental home. Children at risk for ECC are defined as:

- Children with special health care needs
- Children of mothers with a high caries rate
- Children with demonstrable caries, heavy plaque, and demineralization ("white spot lesions")
- Children who sleep with a bottle or breastfeed throughout the night

Once dental care is established with a dental professional, it is recommended that every child enrolled in Medicaid see the dentist for routine care every six months.

5 Must be repeated at regular intervals to maximize effectiveness.

6 Timing, selection and frequency determined by child's history, clinical findings, susceptibility to oral disease and the child's ability to cooperate with the procedure.

7 Consider when systemic fluoride exposure is suboptimal.

8 Up to at least age 16.

9 Appropriate oral health discussion and counseling should be an integral part of each visit for care.

10 Initially, responsibility of parent; as child develops, joint responsibility with parent; then when indicated, responsibility lies with child

11 At every appointment; initially discuss appropriate feeding practices, the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity

12 Initial discussions should include play objects, pacifiers, and car seats; when learning to walk, include injury prevention. For school-age children and adolescent patients, counsel regarding routine playing and sports, including the importance of mouth guards.

13 At first, discuss the need for additional sucking: digits vs. pacifiers; then the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school- aged children and adolescent patients, counsel regarding any existing parafunctional habits such as fingernail biting, clenching or bruxism.

14 For caries-susceptible primary and permanent molars; placed as soon as possible after eruption.

Note: Please refer to NC Medicaid Clinical Coverage Policy No. 4A -- Dental Services for covered services and limitations.

REFERENCES FOR ORAL HEALTH PERIODICITY SCHEDULE

1. American Academy of Pediatrics, "Policy Statement on Oral Health Risk Assessment Timing and Establishment of the Dental Home", Pediatrics, 111(5):1113-16 (2003).

2. *Guide to Children's Dental Care in Medicaid*, U.S. Department of Health & Human Services, Centers for Medicare and Medicaid Services (Oct. 2004), available at:medicaid.gov/medicaid/benefits/downloads/child-dental-guide.pdf

3. Cruz GG, Rozier RG, and Slade G, "Dental Screening and Referral of Young Children by Pediatric Primary Care Providers," Pediatrics, 114(5):642-52 (Nov. 2004)

4. Scale NS and Casamassimo PS, "Access to Dental Care for Children in the United States: A Survey of General Practitioners," JADA, 134:1630-1640 (Dec. 2003)

5. American Academy of Pediatric Dentistry, *Policy on Use of a Caries-risk Assessment Tool (CAT) for Infants, Children and Adolescents* Originating Council, Council on Clinical Affairs, adopted 2002, Revised 2013, available at: G_CariesRiskAssessment1.PDF (aapd.org)

6. American Academy of Pediatric Dentistry, *Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children and Adolescents* Originating Council, Council on Clinical Affairs, Revised 2022, available at: aapd.org/globalassets/media/policies_guidelines/bp_periodicity.pdf

7. Bright Futures/American Academy of Pediatrics, *Recommendations for Preventive Pediatric Health Care*, American Academy of Pediatrics (2024), available at: aap.org/en/practice-management/care-delivery-approaches/periodicity-schedule/

Immunizations

The most current recommended immunization schedules, approved by the **Advisory Committee on Immunization Practices** (ACIP), **American Academy of Pediatrics** (AAP), and the **American Academy of Family Physicians** (AAFP) may be found at:

cdc.gov/vaccines/schedules/index.html

Please Note:

When an immunization administration code appears on the same claim as CPT 9938x/9939x, the provider must append '25' modifier to CPT 9938x / 9939x.

Without modifier '25', these coding combinations will cause the claim to deny per CCI edit.

Laboratory Procedures

Certain laboratory procedures are required at designated ages, including screens for newborn metabolic/sickle cell disease, hemoglobin or hematocrit and blood lead.

Medicaid will not reimburse separately for routine laboratory tests (Hemoglobin/Hematocrit and Tuberculin skin test) when performed during a *Health Check* Early Periodic Screening visit. Other laboratory tests, including, but not limited to, blood lead screening, dyslipidemia screening, pregnancy testing and sexually transmitted disease screening for sexually active youth, may be performed and billed when medically necessary.

Newborn Metabolic/Sickle Cell Screening

North Carolina hospitals are required to screen all newborns *prior to discharge from the hospital* for sickle cell disease and a number of other genetic and metabolic conditions. **Those results from the State Laboratory of Public Health must be documented in the child's medical record as soon as possible**. This ideally should be a print-out of the results from the state lab's website for that child.

The *State Laboratory of Public Health* website may be found at:

slph.dph.ncdhhs.gov/

It is important to confirm **no later than one month of age** that the newborn metabolic/sickle cell screening has been done. Results are available online to healthcare providers by two weeks of age in most cases. Contact the hospital of birth if the results are not available online to confirm that the screening was done. An infant without documentation of screening at birth should have the screening test completed as soon as possible. A newborn metabolic screen cannot be done by the *State Laboratory of Public Health* after six months of age.

Resources available to you if a screening test is positive include the **NC Newborn Screening Follow-up Coordinator** at 919-707-5634 or the **Children with Special Health Care Needs Help Line** at 1-800-737-3028, and the **N.C. Sickle Cell Program** at:

ncsicklecellprogram.org/resources.asp

Tuberculin Tests

The national tuberculosis incidence rate (new cases per 100,000 population per year) rose from 2.2% in 2020 to 2.5% in 2022. In North Carolina, the incidence rate of tuberculosis has declined, however the global rate of tuberculosis has increased by 3.6% between 2020 and 2021, so vigilance by providers is essential. A full report of incidence/prevalence of tuberculosis in North Carolina may be found at:

epi.dph.ncdhhs.gov/cd/tb/figures.html#summary

The **North Carolina Tuberculosis Control Program** screening guidelines are as follows:

The following children and adults are legally required (10A NCAC 41A.0205) to receive a TST:

- Household and other close contacts of active cases of pulmonary and laryngeal tuberculosis
- Persons reasonably suspected of having tuberculosis disease
- Inmates in the custody of, and staff with direct inmate contact, in the Department of Corrections upon incarceration or employment, and annually thereafter
- Patients and staff in long term care facilities upon admission or employment, using the two-step skin test method
- Staff in adult day care centers providing care for persons with HIV infections or AIDS upon employment, using the two-step skin test method
- Persons with HIV infection or AIDS

The following children should receive a baseline TST or interferon gamma release assay when they initially present for healthcare:

- Foreign-born individuals from high incidence areas, such as Asia, Africa, Caribbean, Latin America, Mexico, South America, Pacific Islands or Eastern Europe. Low prevalence countries for TB disease are USA, Canada, Japan, Australia, Western Europe and New Zealand.
- Individuals who inject illicit drugs or use crack cocaine
- Migrants, seasonal farm workers, and the homeless (if unable to ensure completion of evaluation and TLTBI, screen for disease)
- Persons who have traveled outside the US and stayed with family and friends who live in high incidence areas, for greater than 1 month cumulatively

- Children and adolescents exposed to high-risk adults (homeless, substance abuse, incarcerated, HIV positive)
- Persons with conditions that increase the risk of progression to disease once infected
    - Current or planned use of immunosuppressive medication, particularly biologic agents (e.g. infliximab, adalimumab, etanercept)

A subsequent TST is not necessary unless there is a continuing risk of exposure to persons with tuberculosis disease.

Source: epi.dph.ncdhhs.gov/cd/lhds/manuals/tb/Chapter_II_2018_rev2.pdf

Routine TB screening (screening without the presence of at least one of the screening criteria listed by the North Carolina Tuberculosis Control Branch) is not recommended. When a risk factor is identified, the provider shall document it, along with the outcome of TB testing in the beneficiary's medical record.

TB testing should be performed for children and adolescents at increased risk of exposure to tuberculosis **via the Purified Protein Derivative (PPD) intradermal injection/Mantoux method** (not the Tine® Test). An interferon gamma release assay (blood test, either **QuantiFERON-TB Gold Plus®** test or **T-SPOT TB® test**) can be used in place of the tuberculin skin test. Subsequent TB skin testing (or blood testing) is not necessary unless there is a continuing risk of exposure to persons with tuberculosis disease.

The **North Carolina Tuberculosis Control Program** (919-733-7286) is responsible for oversight of testing of household and other close contacts of active cases of pulmonary and laryngeal tuberculosis. Questions related to policy interpretation or other questions related to TB skin testing should be directed to the local health departments.

For more information please visit:
epi.dph.ncdhhs.gov/cd/lhds/manuals/tb/Chapter_II_2018_rev2.pdf

Sexually Transmitted Infections/Diseases

Providers are to follow the most recent *CDC Sexually Transmitted Diseases Treatment Guidelines* for screening and treatment of adolescents:

cdc.gov/sti/hcp/clinical-guidance/?CDC_AAref_Val=https://www.cdc.gov/std/treatment/default.htm

Based on the 2024 Bright Futures recommendations, adolescents should be screened for HIV once between the ages of 15 and 18, making every effort to preserve the confidentiality of the patient. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STI's, should be tested for HIV and re-assessed annually.

The USPSTF recommendations for HIV testing are currently being updated and can be found at: uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/hum

Same Day Health Check Wellness Visits and Sick Child (E/M) Encounters

When Medicaid beneficiaries under 21 years of age receiving a preventive screen also *require* evaluation and management of a focused complaint, the provider may deliver all medically necessary care and submit a claim for both the preventive service (CPT 9938x / 9939x) and the appropriate level of focused, E/M service (CPT 9920x/9921x).

The provider's electronic signature on the claim is the attestation of the medical necessity of both services. All requirements in this section regarding documentation of the additional, focused service must be adhered to by the provider.

When providing evaluation and management of a focused complaint (CPT 9920x / 9921x) during an Early Preventive Screening visit, the provider may claim only the *additional* time required above and beyond the completion of the comprehensive Early and Preventive Screening exam (CPT 9938x / 9939x) to address the complaint.

Same Day Health Check and Wellness Visits and Sick (E/M) Child encounters are not applicable to "eligible juveniles" while incarcerated. CAA 5121 allows for the reimbursement of screening and diagnostic services while the "eligible juvenile" is incarcerated, it does not allow for the reimbursement of treatment services while the "eligible juvenile" is still incarcerated. In the event an "eligible juvenile" is in need of treatment services that do not require a referral for additional treatment to be received after their release, (i.e. sick visit, evaluation and management services), they should be referred back to the carceral facility to meet their care needs. After the "eligible juvenile" is released from the carceral facility, they are eligible to receive any treatment services found to be medically necessary.

Requirements for providing Preventive and Focused Problem (E/M) care same day:

- Provider documentation **must** support billing of both services. Providers may create separate notes for each service rendered in order to document medical necessity.
- The note documenting the focused (E/M) encounter should contain a separate history of present illness (HPI) paragraph that clearly describes the specific condition requiring evaluation and management.
- All elements supporting the additional E/M service must be apparent to an outside reader/reviewer.
- The documentation must clearly list in the assessment the acute/chronic condition(s) being managed at the time of the encounter.
- If the provider creates one document for both services, **he or she must clearly delineate the problem-oriented history, exam, and decision making from those of the preventive service.**
- In deciding on appropriate E/M level of service rendered, only activity performed "above and beyond" that already performed during the *Health Check* Early Periodic Screening visit is to be used to calculate the additional level of E/M service. **If any portion of the history or exam was performed to satisfy the preventive service, that same portion of work should not be used to calculate the additional level of E/M service.**

Modifier 25 must be appended to the appropriate E/M code. Modifier 25 indicates that 'the patient's condition required *a significant, separately identifiable E/M service* above and beyond the other service provided'.

Anticipatory Guidance and Health Education

Anticipatory guidance and health education that are age appropriate and targeted to address a number of topics and needs over time should be a part of every *Health Check* Early Preventive Screening visit. The *Bright Futures* Pocket Guide provides a quick reference tool for anticipatory guidance topics by age, and can be found by visiting brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/Pages/default.aspx

Follow-Up and Referral

In a family-centered medical home, the health care team works in partnership with a child and a child's family to assure that all of the medical and non-medical needs of the child are met. To assure continuity of care, if the *Health Check* visit is not performed in the child's medical home, then the results of the visit and recommendations for follow-up should be shared in a timely manner with the child's medical home.

For children and youth with suspected or identified problems that are not treated in-house by the provider of the *Health Check* visit, those children and youth must be referred to and receive consultation from an appropriate source. A requirement of *Health Check* /EPSDT is that children be referred for and receive medically necessary health care services to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening assessment.

If a communicable disease has been diagnosed, report the disease using the *Confidential Communicable Disease Report – Part 1* Form at: epi.publichealth.nc.gov/cd/docs/dhhs_2124.pdf

Providers must indicate referrals using Z00.121 *"Encounter for routine child health examination with abnormal findings,"* along with the diagnosis code attributed to the finding to ensure proper tracking of referrals.

Providers should assist with planning for the youth's transition from pediatric to adult health care, encouraging their involvement in health care decision making, and supporting the parent's role in promoting the development of the youth's self-management skills.

Finally, providers should discuss timing for the next *Health Check* Early Periodic Screening appointment and schedule a visit, if appropriate.

Transition resources for families who have youth with special health care needs are available at:

gottransition.org/

aafp.org/news/health-of-the-public/20181031caretransition.html

Section III: Blood Lead Testing

General Discussion:

Primary prevention of lead exposure/poisoning aims to minimize children's risks for its neurodevelopmental effects and behavioral disorders through source control and early detection. Screening of North Carolina's child Medicaid beneficiaries and early identification of those at risk for lead exposure should occur during Early Periodic Screening ("Health Check") visits.

Following recommendations of the **Center for Disease Control and Prevention** and *Bright Futures* guidelines of the **American Academy of Pediatrics,** Medicaid requires blood lead testing of all enrolled infants and young children as follows:

- Conduct a blood lead test at 12 months of age (or earlier, if indicated),
- Conduct a blood lead test at 24 months,
- Children ages 36-72 months should have a blood lead test if no record of prior lead testing is available.

Recent changes in the follow-up schedule for diagnostic/confirmed blood lead levels, updated June 2018, include:

- Referral to local health department to offer an environmental investigation with a confirmed blood lead level between 5-9 micrograms per deciliter (µg/dL).
- With a confirmed blood lead level greater than or equal to (≥) 10 µg/dL:
    - Referral to local health department for required environmental investigation and remediation enforcement if hazards are identified.
    - Referral to CDSA Early Intervention or CC4C as appropriate
    - Referral to Social Services as needed for housing or additional assistance.

Medical follow-up begins with a blood lead ≥ 3.5µg/dL. Capillary blood specimens are adequate for the initial testing. Children's hands should be washed thoroughly with soap and water before capillary testing to avoid environmental lead contamination from the skin. Use of an alcohol wipe is not sufficient. NC Medicaid supports the use of Point of Care (POC) blood lead analyzers (i.e. LeadCare) for conducting initial blood lead tests *only*. **If a POC blood lead analyzer is used, only a capillary sample may be used**. A venous diagnostic specimen should be collected for confirmation of all blood lead test results ≥ 3.5 µg/dL. The POC analyzer should NOT be used to conduct another test. **Diagnostic specimens must be sent to an outside reference laboratory for analysis.** Use of the POC analyzer is not acceptable for diagnostic testing. (Note: Capillary diagnostic specimens are accepted if a venous specimen cannot be obtained. However, all diagnostic specimens must be sent to an outside reference laboratory for analysis.)

State Laboratory of Public Health and Blood Lead Testing

The State Laboratory of Public Health will analyze blood lead specimens for all children less than six years of age, as well as refugee children less than 16 years of age, at no charge. Providers requesting analysis of specimens from children outside of this age group should contact the State Laboratory of Public Health at 919-807-8878. **Blood lead test results for specimens analyzed by the State Laboratory can be obtained at the *North Carolina State Laboratory of Public Health Clinical Lab Result Reporting*; at the following web address indicated below.**

celruser.dph.ncdhhs.gov/user/login;jsessionid=fNZWnH1aoMMll4dvRXP+ow**

Records are retained at the State Laboratory for two years and are filed by date of receipt in the Laboratory. **For additional information about lead testing and follow-up refer to the *North Carolina Childhood Lead Testing and Follow Up Manual,* found at:**

ehs.dph.ncdhhs.gov/hhccehb/cehu/lead/docs/2019ClinicalManualTextandAppendicesFINAL-092019v3-cleanFinal.pdf

NORTH CAROLINA DIVISION OF PUBLIC HEALTH FOLLOW-UP SCHEDULE FOR DIAGNOSTIC / CONFIRMED BLOOD LEAD LEVELS FOR CHILDREN UNDER THE AGE OF SIX

Blood Lead Level	Response
Clinical and environmental follow-up is based on the *truncated* test result. Example: Actual result= 4.79; Actions based on truncated value= 4	
All diagnostic (i.e., confirmation) tests should be performed as soon as possible within specified time periods. ➢ Diagnostic tests should be venous; however, capillary tests are accepted if a venous cannot be obtained. ➢ Follow-up testing can be capillary. ➢ CDC protocol for capillary sampling of blood lead should be followed. (See Resources) ➢ If diagnostic test result falls into a lower category - follow response for the lower risk category. ➢ If diagnostic or follow-up test result falls into a **higher category** – conduct another diagnostic test to confirm the higher risk category. Follow guidelines for higher risk category, after confirmation. ➢ Point of care (POC) lead analyzers (i.e., LeadCare) should **NOT** be used for diagnostic tests. ➢ Diagnostic tests must be sent to an outside reference laboratory.	
<3.5 µg/dL	• Report blood lead test result to parents and document notification • Educate family about lead sources and prevention of lead exposure ○ **Retest at age 2, earlier if risk of exposure increases**
3.5-5 µg/dL (Perform diagnostic test **within 3 months**)	**Take same actions as above -AND- if diagnostic test result is 3.5-5 µg/dL:** • Provide clinical management • Conduct nutritional assessment and refer child to the WIC Program • Take environmental history to identify lead sources (DHHS 3651 Form) • Refer to local health department to offer an environmental investigation • Test other children under the age of six in same household **Follow-up testing: Every 3 months until 2 consecutive tests are <3.5 µg/dL (based on the *truncated* test result)**
5-9 µg/dL (Perform diagnostic test **within 3 months**)	**Take same actions as above -AND- if diagnostic test result is 5-9 µg/dL:** • Complete form 3651: Exposure History of Child with Elevated Blood Lead Levels to identify possible lead sources and fax form to (919)841-4015 • Refer case to local health department to offer an environmental investigation • Conduct follow-up testing every 3 months until 2 consecutive tests are <3.5 µg/dL
10-44 µg/dL (Perform diagnostic test **within 1 month** at 10-19 µg/dL; **within 1 week** at 20-44 µg/dL)	**Take same actions as above -AND- if diagnostic test result is 10-44 µg/dL:** • Refer to local health department for required environmental investigation and remediation enforcement if hazards are identified • Refer child to CDSA* Early Intervention or CC4C** as appropriate • Refer to Social Services as needed for housing or additional assistance **Follow-up testing:** • **10-24 µg/dL: every 1-3 months until 2 consecutive tests are <5 µg/dL** • **25-44 µg/dL: every 2 weeks to 1 month until 2 consecutive tests are <5 µg/dL (based on the *truncated* test result)**
45-69 µg/dL (Perform diagnostic test **within 48 hours** at 45-59 µg/dL; **24 hours** at 60-69 µg/dL)	**Take same actions as above -AND- if diagnostic test result is 45-69 µg/dL:** • Consult with Carolinas Poison Center (1-800-222-1222) for advice on chelation and/or hospitalization • Consider an abdominal x-ray check for an ingested object • Alert NC CLPPP by calling 919-707-5950 **Follow-up testing: 45-69 µg/dL: every 2 weeks to 1 month until 2 consecutive tests are <5 µg/dL (based on the *truncated* test result)**
≥70 µg/dL (Perform emergency diagnostic test **immediately**)	**Take same actions as above -AND- if diagnostic test result is ≥70 µg/dL:** • Hospitalize child and begin medical treatment immediately **Follow-up testing: Same as 45-69 µg/dL category**

*Children's Developmental Service Agency **Care Coordination for Children

Resources:

- DHHS 3651 Form
- Agencies for Referrals by County
- Educational Materials for Families
- CDC Protocol for Capillary Sampling of Blood Lead
- CDC Protocol for Later Follow-up Testing after Blood Lead Level (BLL) Declining

Provider Payment when using Point of Care (POC) Lead Analyzer Laboratories

Summary:

- Providers using POC lead analyzers must enroll in and meet requirements of **CLIA**, must follow all **North Carolina Childhood Lead Poisoning Prevention Program** (NC CLPPP) / Testing and Follow-up Recommendations, and must comply with North Carolina blood lead test reporting requirements (G.S. § 130A-131.5 to 131.8).

- Providers who use, **CLIA** approved/waived point of care (POC) units may bill one unit CPT 83655 with EP modifier when the screen is administered during a Health Check Early Periodic Screening Visit.

- A Blood Lead screen may be conducted and billed in other encounters, per applicable billing instructions, when examination findings indicate risk for lead exposure, and when findings are documented in the medical record.

- NC Medicaid may conduct retrospective reviews to ensure that providers have met all mandatory requirements when conducting and billing for blood lead tests. Providers not complying with all enrollment and reporting requirements listed above are subject to recoupment and other actions as specified in state statute and in the provider's Medicaid agreement.

Use of Point of Care (POC) Lead Analyzers and Public Health Implications

North Carolina Medicaid supports the use of POC blood lead analyzers for conducting initial blood lead screens *only*. Current POC technologies do not support their use for definitive diagnostics. Definitive diagnostics require that a venous sample be evaluated by an appropriately licensed/certified diagnostic laboratory.

Only a **capillary blood sample** is to be used for a POC lead screen.

North Carolina state law requires two *consecutive* elevated blood lead test results prior to initiating follow-up services (see follow-up schedule for details). POC analyzers provide a rapid *screen* result for the initial testing by ***capillary*** puncture. A second (diagnostic) ***venous*** blood lead sample can usually be collected before the child leaves the provider's office when possible, expediting ordering of follow-up treatment and services.

When using a POC blood lead screening instrument, blood lead samples must be collected by capillary puncture only for the *initial* blood lead screen. Two samples should not be analyzed on the POC device for a patient on the same day. **Do not run a venous blood lead sample on a POC blood lead screening instrument. Following notice of a positive screen, a venous sample** should be collected **as soon as possible** for definitive diagnosis/confirmation of all initial blood lead screen results ≥ 3.5 micrograms per deciliter (µg/dL). The venous sample must be analyzed using a high complexity (CLIA non-waived) laboratory methodology, prior to referring a child for an environmental investigation or medical management.

A venous sample should also be drawn and analyzed using a high (CLIA non-waived) laboratory methodology when a diagnostic or follow-up test result falls in a higher risk category.

Federal and State Requirements for Childhood Blood Lead Testing

In 2021, the Lead Exposure Prevention and Advisory Committee revised the definition for elevated blood lead level (BLL) for children in the US. The revised definition emphasizes focus of the **CDC Advisory Committee on Childhood Lead Poisoning Prevention (ACCLPP)** on primary prevention of lead poisoning. In addition, the ACCLPP recommends that clinicians educate families about prevention of lead exposure and provide environmental assessments to identify sources of lead exposure before testing children for lead poisoning.

The revised reference value (3.5 µg/dL (0.24 micromole/L) is based on the 97.5th percentile of the BLL distribution among children one to five years of age. Any test result equal to or greater than 3.5 µg/dL obtained by capillary specimen should be confirmed using a *venous blood sample*. A clinical laboratory licensed by the **Clinical Laboratory Improvement Amendments** of 1988 **(CLIA)** must be used for diagnostic blood lead analysis.

POC Lead Analyzer Laboratory Requirements

Facilities using a POC lead analyzer need to be aware that **CLIA** designates them as a laboratory. Therefore, all POC laboratories must enroll in and meet requirements of **CLIA, *and must***:

- follow all **North Carolina Childhood Lead Poisoning Prevention Program (NC CLPPP**) testing, and follow-up recommendations,
- comply with North Carolina blood lead test **reporting requirements (G.S. § 130A-131.5 to 131.8)**.

Please note that our state requirements exceed the minimum requirements set forth by **CLIA or the **Commission on Office Laboratory Accreditation (COLA)**.*

Statutory Reporting Requirements for Blood Lead Testing

State law requires laboratories to electronically submit all blood lead test results for children within five working days after test completion to the **Division of Public Health**. File submission is mandatory, and providers using POC lead analyzer laboratories must comply. Violations of state statute may result in legal actions as defined by the statute and in recoupment of the claim.

Diagnostic Testing Following a Positive Screen

POC blood lead analyzers have a limit of detection of 3.3 µg/dL. Because of limitations at lower blood lead levels, both *the manufacturer and the **CDC** do not sanction POC analyzers for diagnostic testing*. Therefore, the state requires the immediate collection of a diagnostic specimen for analysis by an outside reference laboratory, *without any repeat analysis using the POC analyzer* before sending the diagnostic specimen out. **For diagnostic testing, CLIA certified laboratories must use a "high complexity" laboratory analysis.**

State Laboratory of Public Health (State Lab) will analyze blood lead specimens for all children less than six years of age (and refugee children through 16 years). Providers are encouraged to utilize the State Lab as it expedites test result reporting.

Provider Billing for POC Lead Analyzers and Follow-up Diagnostic Tests

Providers using a POC lead analyzer may bill the usual and customary charge for the blood lead analysis using CPT code 83655. When the screen is performed as part of an Early Periodic Screening ('Health Check") visit, an EP modifier is to be included on the appropriate claim line of the billing detail. Diagnostic (confirmation) tests may be analyzed by the State Laboratory or other **CLIA** certified laboratory only. Tests for purposes other than screening **may not** be performed by the POC Lead Analyzer.

North Carolina General Statute § 130A-131.8. Laboratory Reports

All laboratories doing business in this State shall report to the Department all environmental lead test results and blood lead test results for children less than six years of age and for individuals whose ages are unknown at the time of testing. Reports shall be made by electronic submission within five working days after test completion.

Reports of blood lead test results shall contain all of the following:

- The child's full name, date of birth, sex, race, ethnicity, address, and Medicaid number, if any.
- The name, address, and telephone number of the requesting health care provider.
- The name, address, and telephone number of the testing laboratory.
- The laboratory results, whether the specimen type is venous or capillary; the laboratory sample number, and the dates the sample was collected and analyzed.

Additionally, POC lead analyzer laboratories must maintain documentation of instrument calibration and quality control testing, dates blood lead test result files are submitted to the state, and outside reference laboratory used for analysis of diagnostic tests. Medicaid records must be retained according to the schedule laid out in the "North Carolina Department of Health and Human Services Records Retention and Disposition Schedule for Grants."

Additional Resources

For more information about blood lead testing guidelines and reporting requirements, providers can consult the following websites and documents:

NC General Statute for Lead Poisoning in Children G.S. § 130A-131.5 to 131.8 (See p.1-4)

NC Childhood Lead Testing and Follow-up Manual

NC Childhood Lead Poisoning Prevention Program Resources

NC State Laboratory of Public Health

Record Retention & Disposition Schedule | NCDHHS

Follow-Up Schedule Blood Lead Levels for Children Under the Age of Six (ncdhhs.gov)

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Section IV: Administration of Brief Screening Tools for Developmental, Emotional/Behavioral and Other Health Risks

This *Health Check* Program Guide section provides information on administration and billing of health risk, developmental, and emotional/behavioral screens consistent with current **Centers for Medicare & Medicaid Services (CMS)** guidance and CPT definitions.

Surveillance

The *Bright Futures Guidelines* of the **American Academy of Pediatrics** recommend that providers conduct routine surveillance of all children (including pre-teens and adolescents). Face-to-face surveillance activities include:

- Eliciting and attending to parents' concerns about their child's development,
- updating the child's developmental progress,
- making accurate and informed observations of the child in the areas appropriate to the child's age and developmental stage, including;
    - language and cognitive abilities,
    - physical, social and emotional health and,
    - growth and development,
- identifying both risk and protective factors, including environmental factors, and,
- documenting all surveillance activities and findings.

Surveillance of risks to normal and healthy growth and development in children is a required component of every Early Periodic Screening visit for Medicaid beneficiaries, per federal Medicaid and **Early and Periodic Screening, Diagnostic, and Treatment** (**EPSDT)** regulations found at **42 U.S.C.1396 et seq./ §1905(r) of the Social Security Act**.

The 2017 *Bright Futures "Recommendations for Preventive Pediatric Health Care"* references AAP's 2006 Policy Statement highlighting the central importance of surveillance:

"Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home and an appropriate responsibility of all pediatric health care professionals."

The authors recommend that developmental surveillance be incorporated at every Early Periodic Screening preventive care visit. ***Any concerns raised during surveillance should be promptly addressed with standardized developmental screening tests.***

The early identification of developmental problems should lead to further developmental and medical evaluation, diagnosis and treatment, including early developmental intervention.

The full AAP reference may be found at:
pediatrics.aappublications.org/content/pediatrics/118/1/405.full.pdf

This activity is considered incidental to performance of a wellness exam and is included in the fee for the office visit.

General Guidance on Use of Structured Screening Tools

Per the **AAP,** structured screening entails the use of standardized and scientifically validated tools designed to **identify risk** for developmental delay or for behavioral/emotional problems. Providers are responsible for ensuring the use of up-to-date, scientifically validated structured screens. The AAP has established the Screening Technical Assistance and Resource (STAR) Center for more information on screenings for the pediatric population.

The STAR Center can be found online at: Screening Technical Assistance and Resource (STAR) Center (aap.org)

Please Note:

Per CPT definitions and AAP and CMS guidance, brief screens should be used only to 'identify risk' for presence of a developmental or emotional/behavioral problem. **The use of a brief screen to change an already diagnosed health condition or illness is not best practice.**

N.C. Medicaid reimburses providers for services delivered directly* to an eligible beneficiary, including screening and counseling services.

*** Note:** Providers, please review guidance on "Maternal Depression Screening" for a general rule exception.

When billing NC Medicaid for any coverable brief screen, the child's medical record must include:

- documentation indicating the date on which the test was performed,
- standardized tool used,
- screening result/score,
- guidance given and,
- referrals made.

Specific Screens

Screening for Maternal Postpartum & Caregiver Depression

CPT 96161: Administration of caregiver-focused health risk assessment instrument (e.g., 'health hazard appraisal'), for benefit of the patient, with scoring and documentation per standardized instrument.

The **AAP**, in a policy statement through its *"Bright Futures"* publication, recommends screening for maternal depression as a standard of pediatric best practice. **CMS**, on May 11th, 2016 released their Informational Bulletin supporting coverage of Caregiver Depression Screens and referral of the dyad for mental health services by State Medicaid Agencies. North Carolina's ***Health Check*** Program supports both the early identification of risk for caregiver depression during Early Periodic Screening visits in the first year postpartum *and* the practitioner's referral of at-risk mothers and caregivers to appropriate resources for support and treatment. Treatment must address the mother-child or caregiver-child dyad relationship, and follow-up of the infant and caregiver by the PCP is necessary. For more information, please visit:

pediatrics.aappublications.org/content/126/5/1032

North Carolina Medicaid will reimburse providers for up to four depression risk screens administered to caregivers during the infant's first year postpartum. **AAP** recommends screening at the 1, 2, 4, and 6 month visits. **CMS** directs use of CPT code 96161 (Health Hazard Appraisal), one (1) unit per administration, with EP modifier when billing for this service. When conducted as part of a comprehensive ***Health Check*** Early Periodic Screening visit, this screen may be billed to the infant's Medicaid coverage. Providers should carefully review this Program Guide's section on ***"General Guidance on Use of Structured Screening Tools"*** and follow all documentation requirements.

Note: The AAP also recommends follow-up of the infant with a social-emotional screen when a caregiver depression screen has been positive.

Examples of Scientifically Validated Screening for Maternal & Caregiver Depression

The use of a particular scientifically validated tool is a provider's decision. **The American Academy of Pediatrics** has provided examples of scientifically validated tools which screen for risk of caregiver depression at:

Integrating Postpartum Depression Screening in Your Practice in 4 Steps (aap.org)

Instrument	**Abbreviation**
Edinburgh Postnatal Depression Scale	EPDS
Patient Health Questionnaire 2 / 9	PHQ 2 – PHQ 9

Required Screens for "Healthy Development" and Screening for Autism Spectrum Disorders (ASD)

CPT 96110

"Developmental screening (e.g., developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument."

Please Note: *This code definition was revised in 2015 to more clearly define its use. Please review current CPT and CMS guidance on this code.*

CMS has directed that **CPT Code 96110** be used to report screening for healthy physical development (speech and language development, gross and fine motor development, personal-social development). These screens may be administered during preventive service encounters (9938x/9939x), at "sick child" visits or during Evaluation and Management (E/M) visits. These screens may be billed to NC Medicaid using **CPT code 96110.** Medicaid will reimburse for **CPT 96110** to a maximum of two units of per visit for children 5 years of age and younger. In North Carolina, developmental screens must be done at the 6-month, 12-month, 18- or 24- months, and ages 3, 4, and 5-year visits.

Examples of Scientifically Validated Developmental Screening Tools

The AAP has provided the following examples of scientifically validated tools which screen for developmental risk. The use of a particular scientifically validated tool is a provider's decision. The inclusion of any set of AAP recommended screens in this guide does not constitute endorsement or preference of any screening tool.

Developmental Surveillance and Screening Patient Care (aap.org)

Instrument	Abbreviation:
Ages / Stages Questionnaire – 3rd Ed	ASQ 3
Parent's Evaluation of Developmental Status	PEDS
Parent's Evaluation of Developmental Status-Developmental Milestones	PEDS DM

Screening for Autism Spectrum Disorders

The Center for Disease Control and Prevention (CDC) estimates that an average of 1 in 48 children in the United States is challenged by an autism spectrum disorder. NC Medicaid follows **AAP** *Bright Futures* recommendations for conducting structured risk screens during *Health Check* Early Periodic Screening visits.

Providers must perform routine screening for ASD at 18 and 24 months of age.

- An ASD screen may be administered at a "catch-up" visit if the 18- or 24-month visit was missed.

Providers may screen for developmental risk for ASD at ages greater than 30 months when the provider or caregiver has concerns about the child. The structured screening tool should be validated for the child's chronological age.

Findings supporting use of a developmental screen for ASD may include:

- observed difficulties in responsiveness, age-appropriated interaction or communication,
- a report by parent or caregiver, or,
- diagnosis of an ASD in a sibling.

Examples of Scientifically Validated Screening Tools for Autism Spectrum Disorders

Instrument	Abbreviation
Modified Checklist for Autism in Toddlers	**M-CHAT (R/F)**
Screening Tool for Autism in Toddlers and Young Children	**STAT**

Modifiers Required on Claim Details When Entering CPT 96110

Providers must **always use CPT Code 96110 and EP modifier** when conducting a general developmental or an Autism Spectrum Disorder screen.

Screening for Emotional / Behavioral Health Risks

CPT 96127
Brief emotional/behavioral assessment, with scoring and documentation, per standardized instrument.

In Jan. 2015, **CMS** added a "brief emotional/behavioral assessment with scoring and documentation" in response to the Affordable Care Act's federal mandate to include mental health services as part of the essential benefits in all insurance plans offered in individual and small group markets.

CPT code 96127 should be used to report the administration of a structured screen for emotional and behavioral health risks, including social-emotional development in young children, attention-deficit/hyperactivity disorder (ADHD), depression, suicidal risk, anxiety, substance abuse and eating disorders, when their use is indicated by guidelines of clinical best practice and surveillance. Medicaid will reimburse providers for **CPT code 96127** to a maximum of two units per visit.

Modifiers Required on Claim Details When Entering CPT 96127

The **EP** modifier should always accompany the code when a **Medicaid beneficiary** under 21 years old receives an emotional/behavioral health screen in a preventive service, sick child or E/M encounter.

Examples of Scientifically Validated Screening Tools for Behavioral/Emotional Health Risks

The AAP lists the following screens for emotional/behavioral health risks. The use of a particular scientifically validated tool is a provider's decision. The inclusion of any set of AAP recommended screens in this guide does not constitute endorsement or preference of any screening tool.

Bright Futures Developmental, Behavioral, Psychosocial, Screening and Assessment Forms (aap.org)

Instrument	Abbreviation
Ages and Stages Questionnaire: Social Emotional 2	ASQ-SE-2
Alcohol Use Disorders Identification Test	AUDIT
Australian Scale for Asperger's Syndrome	ASAS
Beck Youth Inventories: Second Edition	BYI-II
Behavior Assessment Scale for Children: Second Edition	BASC-2
Brigance Screens	n/a
Behavior Rating Inventory of Executive Function	BRIEF
Brief Infant and Toddler Social Emotional Assessment	BITSEA
Columbia Suicide Severity Rating Scale	C-SSRS
Conner's Rating Scale	n/a
Drug Abuse Screening Tool	DAST-A
Instrument	**Abbreviation**
Early Childhood Screening Assessment	ECSA
Generalized Anxiety Disorder	GAD-7
Kutcher Adolescent Depression Scale	n/a
Life Event Checklist	LEC
Patient Health Questionnaire	PHQ-2/PHQ-9
Pediatric Symptom Checklist	PSC
Screen for Childhood Anxiety Related Disorders	SCARED
Social Communication Questionnaire	SCQ
Strength and Difficulties Questionnaire	SDQ
Substance Abuse and Alcohol Abuse Screening (brief screen only)	CRAFFT
Vanderbilt Rating Scales	n/a

The 2024 ***Bright Futures*** *"Recommendations for Preventive Pediatric Health Care"* recommends a psychosocial/behavioral assessment at every Early Periodic Screening *(Health Check)* visit. NC Medicaid will reimburse providers for administration of up to two units of psychosocial screening (CPT 96127) per visit. All documentation requirements for administration of screens apply.

Screening for Adolescent Health Risks

CPT 96160

Administration of patient-focused health risk assessment instrument (e.g. health hazard appraisal) with scoring and documentation, per standardized instrument

The AAP recommends use of an adolescent health risk assessment tool to screen for a variety of possible psychosocial and health risks and strengths in adolescents, ages 11 years and older.

Risks include, but are not limited to,

- alcohol and drug use,
- low self-esteem,
- tobacco use,
- sexually transmitted infections,
- pregnancy,
- violence,
- injury,
- poor nutrition and physical activity.

Strengths include, but are not limited to,

- good nutrition,
- positive relationships with peers,
- some mastery of a skill, talent or sport,
- family supports, school engagement / community involvement, and,
- delay of sexual activity.

For health risk screens in adolescents (youth aged 11 years or older) **CPT code 96160** (Health Risk Assessment) may be reported when conducting a health risk screen for an adolescent (a Medicaid beneficiary 11 years of age and older). **Beginning Jan. 1, 2017, CMS updated the Medically Unlikely Edit (MUE) for CPT code 96160 to a limit of 1 unit**.

Modifiers Required on Claim Details When Entering CPT 96160

- The **EP** modifier must append the code when a Medicaid beneficiary ages 11 through 20 years old receives a health risk screen in a preventive service, sick child, or E/M encounter.
- CPT 96160 may not be used to claim a stand-alone administration of a CRAFFT (CPT 96217) brief screen.

Examples of Scientifically Validated Screening Tools for Adolescent Health Risk

The AAP has provided the following examples of scientifically validated tools which screen for adolescent health risks. The use of a particular scientifically validated tool is a provider's decision. The inclusion of any set of AAP recommended screens in this guide does not constitute endorsement or preference of any screening tool.

Instrument	Abbreviation
Bright Futures Supplemental Adolescent Questionnaire	n/a
Guidelines for Adolescent Preventive Services	GAPS
HEADSS Adolescent Risk Assessment	HEADSS

Other Screening -Related Services for Adolescents

AAP Bright Futures, along with USPSTF, recommend screening all adolescents for depression at every well visit, beginning at age 12. This is done in addition to the general risks and strengths assessment. **CPT code 96127** should be used to report the administration of a structured screen for depression.

Smoking Cessation Screens/Intervention: Adolescents 11 through 20 Years of Age

CPT 99406: *Smoking and Tobacco Cessation Counseling Visit*: Intermediate, greater than 3 minutes, up to 10 minutes.

CPT 99407: *Smoking and Tobacco Cessation Counseling Visit*: Intensive, Greater than 10 Minutes.

This code indicates that **counseling** was provided for smoking cessation. **Providers may bill the above codes only when counseling is provided *directly* to the beneficiary**. The CPT code is only appropriate for use when **the patient** is receiving the counseling for tobacco use.

Modifiers Required on Claim Details When Entering CPT 99406-99407

For Medicaid beneficiaries 11 years through 20 years of age receiving counseling for smoking/tobacco cessation as part of a Health Check Wellness Visit, sick child or E/M visit, the code should be accompanied by **modifier 25** to indicate that a separate and identifiable service was delivered in addition to the visit. When the service is provided as part of a Health Check Early Periodic Screening visit, the **EP modifier** must be appended.

Providers should always include documentation in the beneficiary's medical record noting the intervention, patient response and current status, follow up plan and referrals.

Alcohol Structured Screens/Intervention: Adolescents 11 through 20 Years of Age

CPT 99408: *Alcohol and/or substance (other than tobacco) abuse structured screening and brief intervention services*; 15 to 30 minutes

CPT 99409: *Alcohol and/or substance (other than tobacco) abuse structured screening and brief intervention services*; greater than 30 minutes

Note: A brief screen alone (CRAFFT) is to be identified and billed using **CPT 96127**.

Providers may bill the above codes only when alcohol and/or substance abuse counseling is provided ***directly*** to the beneficiary. The CPT code definition indicates that the patient is receiving **both a screen and counseling** for alcohol use.

Modifiers Required on Claim Details When Entering CPT 99408-99409

For Medicaid beneficiaries 11 years through 20 years of age receiving alcohol and/or substance abuse counseling as part of a *Health Check* Early Periodic Screening visit, sick child or E/M visit, the code should be accompanied by **modifier 25** to indicate that a separate and identifiable service was delivered in addition to the visit. When the service is provided as part of a *Health Check* Early Periodic Screening visit, the **EP modifier** must be appended.

For any screen, the provider must document the screening tool used, the results of the screening tool, the discussion with parents, and any referrals made.

For more information:

- The Bright Futures Tool Kit/GAPS/HEADSSS is available at: brightfutures.aap.org/materials-and-tools/tool-and-resource-kit/Pages/default.aspx

- Find the AAP Mental Health Initiatives site and the AAP Mental Health Toolkit at: publications.aap.org/toolkits/pages/Mental-Health-Toolkit

- Find out more about scientifically validated emotional/behavioral brief screens at: aap.org/en/practice-management/bright-futures/bright-futures-materials-and-tools/bright-futures-tool-and-resource-kit/bright-futures-developmental-behavioral-psychosocial-screening-and-assessment-forms/

  aap.org/en/patient-care/mental-health-initiatives/

- Information from the Center for Disease Control may be accessed at: cdc.gov/child-development/?CDC_AAref_Val=https://www.cdc.gov/ncbddd/childdevelopment/screening.html

- For more information, about Alcohol and Substance Abuse Screening and Brief Intervention (CRAFFT) go to: crafft.org/about-the-crafft/

A Note on Modifiers and Early Periodic Screens

Modifier 25

Modifier 25 is used to describe a significant and separately identifiable E/M service above and beyond the other service provided. When a standardized screen or assessment is administered along with any E/M service (e.g., preventive medicine service), both services should be reported and modifier 25 (significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service) should be appended to the E/M code to show the E/M service was distinct and necessary at the same visit.

Modifier 59

A 59 modifier is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. For example, when a maternal depression screen and a health risk assessment are performed in the same visit, the 59 modifier should be appended to CPT 96161.

For more information on use of a '59' modifier, please click on the following link:
cms.gov/ncci-medicare/medicare-ncci-add-code-edits

EP Modifier

An EP modifier is used to identify Early and Periodic Screens, and services provided in association with an Early and Periodic Screen, therefore any service provided in an Early and Periodic Screen should have an EP modifier It is important to append an EP modifier to these services, as some of these CPT codes are also used for services provided to adults.

Examples of Claim Detail for an Early Periodic Screening Visit

The table below illustrates a few examples of the appropriate use of modifiers when billing components of an Early Periodic Screening Visit. Each claim line shows the CPT code, followed by the appropriate modifier(s) to include with that CPT code in the billing scenarios provided.

	CPT 1			**CPT 2**			**CPT 3**			**CPT 4**			**CPT 5**			**CPT 6**		
1	9939x-9938x	**EP**	**25**	90471	**EP**		90460	**EP**		96110	**EP**		96127	**EP**		96160	**EP**	**59**
2	9939x-9938x	**EP**	**25**	96110	**EP**		96127	**EP**		96160	**EP**	**59**						
3	9939x-9938x	**EP**	**25**	96110	**EP**		96127	**EP**		96161	**EP**	**59**						
4	9939x-9938x	**EP**	**25**	96127	**EP**													
5	9939x-9938x	**EP**	**25**	96127	**EP**		99406	**EP**										
6	9939x-9938x	**EP**	**25**	96127	**EP**		99408	**EP**										
7	9939x-9938x	**EP**	**25**	96161	**EP**	**59**	90471	**EP**		90474	**EP**							

Section V: Immunizations

The immunization administration codes currently covered are CPT procedure codes 90460, 90461 and 90471 through 90474:

Procedure Code	Description
90460	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered
90461	Each additional vaccine or toxoid component administered (List separately in addition to code for primary procedure) * Per the PPACA legislation, CPT code 90461 is NOT reimbursable for VFC services
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); **one vaccine** (single or combination vaccine/toxoid)
90472+ **(add-on-code)**	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid) **each additional vaccine** (single or combination vaccine/toxoid) List separately in addition to code for primary procedure
90473	Immunization administration by intranasal or oral route; **one vaccine** (single or combination vaccine/toxoid)
90474+* **(add-on-code)**	Immunization administration by intranasal or oral route; **each additional vaccine** (single or combination vaccine/toxoid) List separately in addition to code for primary procedure

Stand-Alone Vaccine Counseling Codes

As mentioned in State Health Official Letter #22-002 "Medicaid and CHIP Coverage of Standalone Vaccine Counseling", CMS created new HCPCS codes so that providers may use them to bill for stand-alone vaccine counseling. This includes COVID-19 stand-alone vaccine counseling codes for counseling provided to Medicaid beneficiaries who are eligible for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) provisions. These codes can be used for stand-alone vaccine counseling provided in-person and/or via telehealth. The codes and descriptors are included below

G0310	**Immunization counseling by a physician or other qualified health care professional when the vaccine(s) is not administered on the same date of service, 5 to 15 mins time**
G0312	**Immunization counseling by a physician or other qualified health care professional when the vaccine(s) is not administered on the same date of service for ages under 21, 5 to 15 mins time.**
G0315	**Immunization counseling by a physician or other qualified health care professional for COVID-19, ages under 21, 5-15 mins time.**

Please Note:

- Currently, 90474 cannot be billed with 90473 as there are no two oral and/or intranasal vaccines or combination of an oral and intranasal vaccine that would be given to a recipient. *Always append EP modifier to **all vaccine codes**, including 90460.*

- For all vaccines administered after October 1, 2015, providers should use ICD 10-CM code Z23.

- Per the PPACA legislation, CPT code 90461 is NOT reimbursable for VFC services

Coding for Vaccine Administration
General Coding Guidance

- **Per CCI: When claiming an immunization administration with a preventive service (Early and Periodic Screening) visit, the '25' modifier must accompany the E/M code.**
- Administration codes covered for Medicaid recipients in the Health Check age range, 0 through 20 years of age, are CPT codes 90471 through 90474.
- Administration code 90460 is only to be used for Medicaid recipients, age 0-18 years of age when vaccine counseling is provided before administration of the vaccine.
- Providers must bill the appropriate number of units on the detail along with the total charge of **all** units billed for that code.
- An immunization administration fee may be billed if it is the only service provided that day or if any immunizations are provided in addition to a Health Check assessment or an office or sick child visit. When billing in conjunction with an examination code or an office or sick visit code, an immunization diagnosis is **not required**. When billing an administration code for immunizations as the **only** service for that day, providers **are required** to use an immunization diagnosis code. Always list the CPT vaccine product codes when billing these administration codes with the **EP** modifier.
- When reporting or billing vaccine administration codes, providers must use the appropriate CPT code(s) with the **EP** modifier listed.
- Do NOT append the **EP** modifier to the CPT vaccine product codes.
- The National Drug Code (NDC) must be submitted along with the CPT vaccine product code.
- Providers must use ICD 10-CM coding for all immunizations given after Oct. 1, 2015. In all routine cases, that code is now Z23.
- Face-to-face counseling of the patient and family by the physician or qualified healthcare professional during the administration of a vaccine is billed with CPT 90460 with the **EP** modifier. One unit is billed for each vaccine for which counseling is provided.
- CPT code 90460 is an immunization administration code, which includes counseling. It is not an add-on "counseling" code. Therefore, 90460 cannot be mixed with other codes for the same vaccine product. If the physician or qualified health care professional

provides only a vaccine information statement (VIS), this does not constitute face-to-face counseling for the purposes of billing CPT code 90460EP.

- Administration of one injectable vaccine is billed with CPT code 90471 (without counseling) or 90460 (one unit) with the **EP** modifier.

- Additional injectable immunization administrations (without counseling) are billed with either CPT code 90461 or 90472 with the **EP** modifier. The appropriate number of units must be billed for each additional immunization administration CPT procedure code, with the total charge for all units reflected on the detail.

- Administration of **one** vaccine that is an **oral** immunization is billed with the administration CPT code 90473 with the **EP** modifier.

- All the units billed for CPT codes 90471EP, 90472EP, 90473EP, 90474EP, 90460EP and 90461EP must be billed on ONE detail to avoid duplicate audit denials.

- **SC Modifier:** Certain purchased vaccines require the SC modifier. See specific billing guidance posted in NCTracks for further information. Generally, vaccine-specific guidance is published in individual articles in the NC Medicaid provider bulletin.

- CPT code 90473 can only be billed if the oral vaccine is the only immunization provided on that date of service.
- CPT code 90473 cannot be billed with another immunization administration code on that date of service. See guidance in next bullet for further clarification. A *second* oral immunization (*Only Rotavirus Oral is currently supported by VFC/NCIP*) cannot be billed at this time.

- Administration of an oral vaccine provided **in addition to** one or more injectable vaccines is billed with CPT code 90474 with the **EP** modifier.

- CPT vaccine product codes for the vaccines administered must be reported or billed, as appropriate, even if administration codes are not being billed.

- Immunizations and therapeutic injections may be billed on the same date of service and on the same claim.

Federally Qualified Health Center or Rural Health Clinic Providers:

- An immunization administration fee code(s) may be billed if it is the only service provided that day, or if any immunizations are provided in addition to a Health Check assessment.
- An immunization administration fee code(s) cannot be billed in addition to a core visit code. Report the CPT vaccine code(s) without billing the administration fee.
- Providers may bill a core Behavioral Health visit (T1015 HI) and a Health Check screening assessment on the dame date of service, on separate claims.
- A preventive service visit (9938x-9939x) cannot be billed on the same day as a T1015 (all-inclusive clinic visit).

EPSDT PROVISION

EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions and without meeting the specific criteria in this section when such services are medically necessary health care services to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]. This includes EPSDT coverage of additional codes/procedures as it relates to immunization and immunization administration.

When a non-covered vaccine item is considered a medical necessity, or a limit on administration will be exceeded the provider should submit a request for prior authorization as a state non-covered service for a beneficiary under 21 years of age through the NCTracks Provider Portal. Documentation must show how the service, product or procedure will correct, improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

For more information on EPSDT and Medicaid's Children's benefit, see:
medicaid.ncdhhs.gov/providers/programs-and-services/medical/wellness-visits-and-diagnostic- and-treatment-services

Section VI: North Carolina Vaccines for Children Program

Disease prevention through immunization is a fundamental component to improving health and controlling rising healthcare costs worldwide. Immunization against polio, measles, diphtheria, pertussis (whooping cough), rubella (German measles), mumps, smallpox, tetanus, rotavirus and *Haemophilus influenza* type b continues to have significant public health impacts. When immunization rates decrease, individual and social health burdens increase. Vaccination is one of the best ways parents can protect infants, children, and teens from potentially harmful diseases. When Medicaid enrolled health care providers support parents by providing education, administering and appropriately documenting all routine and ACIP recommended vaccinations, they take an active and essential role in ensuring a healthy future for all North Carolinians.

The **North Carolina Immunization Program** (NCIP)/**Vaccines for Children** (VFC) Program provides, at no charge, all recommended vaccines for all VFC-eligible children birth through 18 years of age present in North Carolina, including Medicaid enrolled children. Medicaid recipients from birth through 18 years of age are automatically eligible for VFC vaccine, including those dually covered by Medicaid and another insurance plan.

Vaccines are provided in accordance with the recommendations of the **Advisory Committee on Immunization Practices** (ACIP) of the **Centers for Disease Control and Prevention** (CDC). Because of the availability of NCIP/VFC vaccines for Medicaid enrolled children 18 years of age and younger, Medicaid does not reimburse for vaccines available from the NCIP/ VFC program. Medicaid does, however, reimburse for the administration of these vaccines.

In **rare** instances, due to recalls or true shortages of vaccines, Medicaid may reimburse for purchased vaccine that is normally provided through the NCIP/VFC program. In those instances, specific billing instructions will be provided in the general Medicaid bulletins in an article specifically targeted to this topic.

Providers must use purchased vaccines for Medicaid enrolled beneficiaries ages 19 and 20, who (because of their age) are not routinely eligible for NCIP/VFC vaccines. *When purchased vaccine is administered to this age group, Medicaid will reimburse providers for the vaccine product and the administration fee.*

VFC Eligible Populations

Children birth through 18 years of age must meet at least one of the following criteria to be eligible for VFC vaccine:

- Medicaid enrolled: a child who is eligible or enrolled in the Medicaid program.
- Uninsured: a child who has no medical insurance coverage
- American Indian or Alaskan Native
- Underinsured (Can only be served by deputized providers such as LHD/FQHC/RHC) Underinsured include:
    - Children who have commercial (private) health insurance but the coverage does not include vaccines,
    - Children whose insurance covers only selected vaccines (VFC-eligible for non-covered vaccines only),
    - Children whose insurance caps vaccine coverage at a certain amount -once that coverage amount is reached, these children are categorized as underinsured.

Unless specifically stated above, no VFC vaccine may be administered to an insured individual unless the patient is an underinsured child at an FQHC, RHC, Local Health Department or deputized provider.

NOTE: Children whose health insurance covers vaccinations are not eligible for VFC vaccines, even when a claim for the cost of the vaccine and its administration would be denied for payment by the insurance carrier because the plan's deductible has not been met or because the insurance did not cover the total cost of the vaccine.

Vaccine product coverage for children 19 and 20 years of age

Very infrequently, VFC vaccines (vaccines provided by NCIP/VFC, therefore free to the provider) may be administered to Medicaid beneficiaries ages 19 and older. In these cases, the CPT vaccine code for the VFC vaccine must be reported with $0.00. Vaccine procedure codes must always be included on the claim. CPT codes for vaccine products must **always** be included on the claim **without the EP modifier**.

Although NC Medicaid does not reimburse the vaccine product portion of vaccines reimbursed by NCIP/VFC, when an ACIP recommended vaccine coverable by Medicaid is not covered by another program or insurer, Medicaid will reimburse the cost of the vaccine product according to the NC Medicaid Fee Schedule.

About the North Carolina Immunization Program

In order to participate in the NCIP, medical providers must submit to the requirements of the NCIP program. These requirements include but are not limited to:

- Signing a legally-binding program agreement as requested (only physicians licensed to practice medicine in North Carolina may sign an NCIP Provider Agreement),
- Allowing N.C. Immunization Branch staff to perform periodic site visits,
- Administering vaccines according to required guidelines,
- Maintaining correct storage and handling procedures for vaccines, and
- Accounting for every dose of state-supplied vaccine received.

Who Should Join the NCIP

Health care providers who administer vaccines to children eligible for the federal Vaccines for Children (VFC) program should join the NCIP program. New NCIP participants are required to use the North Carolina Immunization Registry to enter doses administered.

How to Join

NC Medicaid providers who are not enrolled in NCIP or who have questions concerning the program should call the N.C. Division of Public Health's Immunization Branch Help Desk at 1-877-873-6247. Please note that providers who serve only insured children cannot join the NCIP.

Providers within 40 miles of North Carolina's Border

Out-of-state providers may obtain VFC vaccines by calling their state's VFC program office. VFC program telephone numbers for the states bordering North Carolina are listed below:

- **Georgia** 404-657-5013
- **South Carolina** 800-277-4687
- **Tennessee** 615-741-7343
- **Virginia** 804-864-8055

Medicaid beneficiaries birth through 18 years of age are automatically eligible for VFC vaccine, even those who are dually covered by Medicaid and another insurance plan. Because vaccines have other criteria which must be met **and vaccine criteria are subject to change,** it is recommended that providers go to the Immunization Branch web site at: immunization.dph.ncdhhs.gov/#:~:text=The%20NC%20Immunization%20Branch%20promotes%20public%20health.%20It for the most current eligibility information.

Rates

All codes reviewed are reimbursable at rates published in NC Medicaid's most current Physician Fee Schedule.

Section VII: NCIP/VFC Vaccines

A list of the VFC-supplied vaccines is located here: cdc.gov/vaccines-for-children/php/awardees/current-cdc-vaccine-price-list.html with the CDC ACIP Resolutions for each vaccine located here: cdc.gov/vaccines-for-children/hcp/vaccines-provided/index.html. Please also reference immunization.dph.ncdhhs.gov/providers/memos.htm for NCIP program and vaccine updates specific to North Carolina. Please note: Department of Public Health does not necessarily purchase all influenza vaccines on this list each year; the annual updated NC Medicaid influenza bulletin published in early September of each year can be referenced for each year's coverage.

NC Medicaid covers other vaccines and immune globulins when medically necessary. For the most updated list of covered vaccines and immune globulins, please reference the most recent PADP catalog.

Other Vaccines Covered by Medicaid when Medically Necessary		
Code	**CPT Description**	**NCIP Vaccine Specifics**
90291	Cytomegalovirus immune globulin (CMV-IgIV), human, for intravenous (IV) use	
90375	Rabies immune globulin, (RIg), human, for IM and/or subcutaneous use	
90376	Rabies immune globulin, heat-treated (RIG-HT), human, for intramuscular and/or subcutaneous use	
90389	Tetanus immune globulin (TIg), human, for IM use	
90585	Bacillus Calmette-Guerin vaccine (BCG) for tuberculosis, live for percutaneous use	
90396	Varicella-zoster immune globulin, human, for intramuscular use	
90630	IIV4 (Fluzone ® 0.5 mL pre-filled syringes only)	LHD/FQHC/RHC only: -Non-Medicaid uninsured women who are pregnant during flu season - females enrolled in the Be Smart family planning program receiving services at the LDH/FQHC/RCHC
90632	Hepatitis A vaccine, adult dosage, for IM use	19 years of age and above. Limited distribution to LHDs only, and only during outbreaks.
90371	Hepatitis B immune globulin (HBIg), human, IM	
90675	Rabies vaccine for IM use	
90733	Meningococcal polysaccharide vaccine (any group(s)), for subcutaneous use	
90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3-dose schedule), for IM use	
90747	Hepatitis B vaccine dialysis or immunosuppressed patient dosage (4 dose schedule) for IM use	
J1459	Injection, immune globulin (privigen), intravenous, non-lyophilized (e.g., liquid), 500 mg	
J1460	Injection, gamma globulin, for intramuscular (IM) use 1cc.	Limited distribution to health depts. (LHDs) only, and only during outbreaks.
J1556	Injection, immune globulin (bivigam), 500 mg	
J1557	Injection, immune globulin, (gammaplex), intravenous, non-lyophilized (e.g., liquid), 500 mg	
J1559	Injection, immune globulin, (Hizentra), 100 mg	
J1560	Injection, gamma globulin, IM, over 10 cc	
J1561	Injection, immune globulin, (Gamunex/Gamunex C/Ganmaked), nonlyophilized (e.g. liquid) 500 mg	

Other Vaccines Covered by Medicaid when Medically Necessary		
Code	**CPT Description**	**NCIP Vaccine Specifics**
J1571	Injection, hepatitis B immune globulin (Hepagam B), IM, 0.5 ml	
J1573	Injection, hepatitis B immune globulin (Hepagam B), IV, 0.5 ml	
J1562	Injection, immune globulin, (Vivaglobin), 100 mg, SC	
J1566	Injection, immune globulin, IV, lyophilized (e.g. powder), 500 mg	
J1568	Injection, immune globulin, (Octagam), IV, non- lyophilized (e.g. liquid), 500 mg	
J1569	Injection, immune globulin, (Gammagard liquid), non-lyophilized (e.g., liquid), 500 mg	
J1572	Injection, immune globulin, (Flebogamma/Flebogamma Dif), IV, non-lyophilized (e.g. liquid), 500 mg	
J2788	Injection, Rho D immune globulin, human,minidose, 50 mcg (250 i.u.)	
J2790	Injection, Rho D immune globulin, human, full dose, 300 mcg (1500 i.u.)	
J2791	Injection, Rho D immune globulin, (human) (Rhophylac) IM or IV, 100 IU	
J2792	Injection, Rho D immune globulin, IV, human, solvent detergent, 100 IU	
J7504	Lymphocyte immune globulin, antithymocyte globulin, equine, parenteral, 250 mg Brand name: Atgam	

Note: This list is subject to change. Updates regarding vaccines are published in the Medicaid provider bulletins on NC Medicaid's website at:
medicaid.ncdhhs.gov/providers/medicaid-bulletins

For the most current list vaccines coverable by Medicaid, see:

ncdhhs.servicenowservices.com/fee_schedules

Providers should refer to the Immunization Branch website for detailed information regarding vaccines, at: immunize.nc.gov

Certain vaccines are provided for those recipients 19 years of age and older through the NCIP. Questions about current coverage may also be addressed by calling the NCIP at:

877-873-6247.

Each influenza season, ACIP issues recommendations for the administration of flu vaccine. Based on these recommendations, NCIP issues coverage criteria announcements at the beginning of the season. Additional guidance may be issued throughout the flu season if the availability of vaccine changes.

Consolidated Appropriations Act (CAA) Section 5121: Requirements

CMS State Health Official Letter (SHO# 24-004)

Under amendments in Section 5121 of the CAA, 2023, starting Jan. 1, 2025, state Medicaid and CHIP programs are required to have a plan in place and to provide for the following for an eligible juvenile who is within 30 days of their scheduled date of release from a public institution following adjudication:

> In the 30 days prior to release (or not later than one week, or as soon as practicable, after release from the public institution), and in coordination with the public institution, the state must provide any screenings and diagnostic services which meet reasonable standards of medical and dental practice, as determined by the state, or as otherwise indicated as medically necessary, in accordance with the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements, including a behavioral health screening or diagnostic service. In the 30 days prior to release and for at least 30 days following release, the state must provide targeted case management services, including referrals to appropriate care and services available in the geographic region of the home or residence of the eligible juvenile, where feasible, under the Medicaid state plan (or waiver of such plan).

Mandatory Requirements of Section 5121 of the CAA, 2023

Section 5121 of the CAA, 2023 ("Section 5121") creates a new mandate in Medicaid for states, effective Jan. 1, 2025, by amending section 1902(a)(84) of the Act (42 U.S.C. 1396a) to require states to provide specific screening and diagnostic services and targeted case management (including referrals) in the 30 days prior to release from incarceration, and targeted case management (including referrals) for at least 30 days post release for eligible juveniles post adjudication. In instances where that is not possible, the statute also allows that such screening and diagnostic services may be provided no later than one week, or as soon as practicable, after release from the public institution. Section 5121 also allows for payment for such services with respect to an eligible juvenile during a 30-day period prior to release from incarceration. Accordingly, the statutory Medicaid inmate payment exclusion language has been modified to allow for payment for these services for eligible juveniles under certain circumstances.

Eligible Juveniles

An "eligible juvenile" is defined as a Medicaid enrolled beneficiary who is:

- Under 21 years of age
- Former foster care child under age 26 who meets the criteria for the group upon attaining age 18

These requirements only apply to individuals who are being held "post adjudication" as inmates of a public institution.

CAA 5121 Limitations

CAA 5121 allows for the reimbursement of screening and diagnostic services for "eligible juveniles," as noted above. That means, all preventive health check screenings should be conducted per the North Carolina Periodicity Schedule, and should include all required screenings for that age group, as defined by the Bright Futures/American Academy of Pediatrics (AAP) Periodicity Schedule. Providing these screening and diagnostic services to eligible juveniles pre-release will help identify necessary treatment services so that medical and behavioral health appointments can be scheduled prior to release and occur as soon as possible after an eligible juvenile is released.

While CAA 5121 allows for the reimbursement of screening and diagnostic services, it does not allow for the reimbursement of treatment services while the "eligible juvenile" is still incarcerated. In the event an "eligible juvenile" is in need of treatment services that do not require a referral for additional treatment to be received after their release, (i.e. sick visit, evaluation and management services), they should be referred back to the carceral facility to meet their care needs. After the "eligible juvenile" is released from the carceral facility, they are eligible to receive any treatment services found to be medically necessary.

Revision Information:

Date	Section Revised	Change
09/20/2018	Section V: Immunizations	Updated information: The National Drug Code (NDC) must now be submitted along with the CPT vaccine product code.
09/20/2018	Section III: Blood lead testing	Updated information: NC DPH Follow-up schedule for diagnostic/confirmed blood lead levels for children under the age of six
09/20/2018	Entire document	Updated website addresses, changed 'DMA' references to 'NC Medicaid'
06/3/2019	Section V: Immunizations	Updated VFC list, updated language to VFC eligible population criteria.
05/1/2020	Section V: Immunizations	Updated VFC list.
05/1/2020	Periodicity schedule	Updated Psychosocial Assessment in the Periodic Visit Footnotes to clarify.
05/1/2020	TB Testing	Updated guidelines
05/1/2020	Blood Lead Testing	Updated guidelines
06/18/2021	Section I: Health Check Overview	Updated ICD-10 Diagnosis codes for (pt > 18 years) well child exams.
01/16/2025	North Carolina Periodicity Schedule	Updated the NC Periodicity Schedule tables to show most up to date periodicity schedule recommendations
01/16/2025	Footnotes & Additional Billing Details	Updated "maternal" to "caregiver"
01/16/2025	Vision Screenings & Hearing Screenings & STI Tests	Updated date per updated periodicity schedule revisions
01/16/2025	Throughout	Removed all NC Health Choice related language as NC Health Choice Program has merged with Medicaid
01/16/2025	Tuberculin Tests	Updated language per most up to date statistics
01/16/2025	Blood Lead Screening Section	Updated language per new guidelines issued by CDC and NC DPH
01/16/2025	Throughout	Updated Links throughout
01/16/2025	Section V: Immunizations	Removed table, added link to current updated list of VFC vaccines, CDC ACIP guidelines and NCIP guidelines.
01/16/2025	Section V: Immunizations	Updated vaccine administration codes, adding 90461. Also added table showing covered stand-alone vaccine counseling codes
01/16/2025	VFC Eligible Populations	Removed NC Health Choice specific language as the Health Choice program merged with Medicaid effective 4/1/2023
01/16/2025	Added Addendum: CAA 5121	Added Addendum for CAA 5121 Justice Involved Population, and notations within sections which were not applicable for that population while incarcerated
3/11/2025	Periodicity Schedule	Updated formatting within the periodicity schedule tables
9/5/2025	99177	Updated reimbursement under North Carolina.