NC DMA

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 for without delay 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 at:

https://www.aap.org/en-us/documents/periodicity_schedule.pdf

North Carolina's ***Health Check Periodicity Schedule*** is included in this section of the Guide. It may also be found online at:

https://dma.ncdhhs.gov/medicaid/get-started/find-programs-and-services/health-check-and-epsdt

The NC *Health Check* Program recommends regular Early Periodic Screening for beneficiaries as indicated in the following State Periodicity Schedule. North Carolina 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

North Carolina's Periodicity Schedule and Coding Guide for Early Periodic Screening

Components / Screening Services	Within 1st Month	2 month	4 month	6 month	9 month	12 month	15 month	18 month	24 month	30 month
Length/Height and Weight[1]	•	•	•	•	•	•	•	•	•	•
Head Circumference[1]	•	•	•	•	•	•	•	•	•	
Weight for Length[1]	•	•	•	•	•	•	•	•		
Body Mass Index[1]									•	•
Blood Pressure[1]	*	*	*	*	*	*	*	*	*	*
Vision Screen	*	*	*	*	*	*	*	*	*	*
Hearing Screen[4]	•	*	*	*	*	*	*	*	*	*
Maternal Depression [2] *(96161)*	•	•	•	•						
Developmental Screenings[2] *(96110)*				•		•		•	•	
Autism Screenings [2] *(96110)*								•	•	
Psychosocial-Emotional/ Behav. Screens[2] *(96127)*	•	•	•	•	•	•	•	•	•	•
Oral Health Screenings[5]				•	•	*		*	*	*
Fluoride Varnish[5]				Once teeth are present, fluoride varnish may be applied up to 6 times by age 3 ½, every 3-4 months with a minimum of 60 days between procedures						
Fluoride Supplementation				*	*	*		*	*	*
Anemia[6]			*			•	*	*	*	*
Lead Screen[7]						•			•	
TB Testing	*			*		*			*	
Dyslipidemia									*	
Immunizations	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

North Carolina's Periodicity Schedule and Coding Guide for Early Periodic Screening

Components / Screening Services	3 yr	4 yr	5 yr	6 yr	7 yr	8 yr	9 yr	10 yr	11 yr	12 yr	13 yr	14 yr	15 yr	16 yr	17 yr	18 yr	19 yr	20 yr
Length/Height and Weight[1]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Body Mass Index[1]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Blood Pressure[1]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Vision Screenings	•	•	•	•	*	•	*	•	*	•	*	*	•	*	*	*	*	*
Hearing[4] *Screenings*	*	•	•	•	*	•	*	•	←-----•——→				←——•-----→			←——•——→		
Developmental Screen (96110)	•	•	•															
Psychosocial - Emot/Behavioral Screens [2] *(96127)*	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Tobacco, Alcohol, or Drug Use Assessment[3]									*	*	*	*	*	*	*	*	*	*
Depression Screening (96127)										•	•	•	•	•	•	•	•	•
Oral Health Screenings [5]	*	*	*	*														
Fluoride Varnish[5]	•																	
Fluoride Supplementation	*	*	*	*	*	*	*	*	*	*	*	*	*	*				
Anemia[6]	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Lead Screening [7]	*	*	*	*														
TB Testing	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Dyslipidemia		*		*		*	←——•-----→			*	*	*	*	*	←-----•——→			
STI[8]									*	*	*	*	*	*	*	*	*	*
HIV[8]										*	*	*	←-----•——→				*	*
Immunizations	Follow recommendations of the Advisory Committee on Immunization Practices for age appropriate immunization guidelines and the Centers for Disease Control and Prevention (CDC) 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 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 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. Maternal 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 maternal depression risk screens administered to mothers during the infant's first year postpartum.
3.	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:** • The **Centers for Medicare and Medicaid Services (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.** • **North Carolina 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 DMA's website at: https://ncdma.s3.amazonaws.com/s3fs-public/documents/files/1A23.pdf
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 http://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 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 Maternal 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
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
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 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 24 months)** 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.

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 American Academy of Pediatrics** 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 NC Tracks 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: https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/Pages/default.aspx
- The *Eat Smart Move More North Carolina* "Prescription for Health—5-3-2-1-Almost None" guide at:

  www.eatsmartmovemorenc.com/PediatricObesityTools/PediatricObesityTools.html

- The US Department of Agriculture, "MyPlate" food group recommendations at:

  http://www.choosemyplate.gov/MyPlate

- The *Pediatric Obesity Prevention and Treatment Algorithm* (NC Design Team, Contributors, and Reviewers) and related tools are available at: www.eatsmartmovemorenc.com/PediatricObesityTools/Texts/ClinicianRefGuide.pdf
- Research about multivitamin supplementation for female adolescents of childbearing age is available at:

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

  and at:

  http://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 2017 Bright Futures schedule, which can be found at:

https://www.aap.org/en-us/documents/periodicity_schedule.pdf

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:

http://pediatrics.aappublications.org/content/pediatrics/111/4/902.full.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 a 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 DMA'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 January 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. Per CMS, CPT code 99177 (Instrument-based ocular screening, bilateral, with on-site analysis) is 0.00 total RVUs. No additional reimbursement is allowed for this code.

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 follow the 2017 Bright Futures schedule, which can be found at:

https://www.aap.org/en-us/documents/periodicity_schedule.pdf

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:

https://medicalhomeinfo.aap.org/about/_layouts/15/WopiFrame.aspx?sourcedoc=/about/Documents/EHDI%20Residency%20PPT%203.1.16.pptx&action=default&DefaultItemOpen=1

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 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:
https://www.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 DMA's website at:

https://dma.ncdhhs.gov/medicaid/get-started/find-programs-and-services/health-check-and-epsdt

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

http://dma.ncdhhs.gov/find-a-doctor/medicaid-dental-providers

For further guidance regarding dental benefits, see the combined **Medicaid and Health Choice Dental Coverage Policy** at the following sites:

https://ncdma.s3.amazonaws.com/s3fs-public/documents/files/4A.pdf

https://ncdma.s3.amazonaws.com/s3fs-public/documents/files/4B.pdf

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 DMA's website at:

https://ncdma.s3.amazonaws.com/s3fs-public/documents/files/1A23.pdf

North Carolina Oral Health Periodicity Schedule

The North Carolina Division of Medical Assistance (DMA) 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 DMA 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 DMA 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 DMA 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 DMA 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: https://www.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 2006, available at: http://www.aapd.org/media/Policies_Guidelines/P_CariesRiskAssess.pdf

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 2013, available at: http://www.aapd.org/media/Policies_Guidelines/G_Periodicity.pdf

7. Bright Futures/American Academy of Pediatrics, *Recommendations for Preventive Pediatric Health Care*, American Academy of Pediatrics (2017), available at: https://www.aap.org/en-us/professional-resources/practice-support/Periodicity/Periodicity%20Schedule_FINAL.pdf

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:

http://www.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:

http://slph.ncpublichealth.com

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 2 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 6 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:

http://www.ncsicklecellprogram.org/resources.asp

Tuberculin Tests

While tuberculosis in the United States decreased from 3.8 to 3.0 per 100,000 between 2009 and 2014, (the North Carolina rate went from 2.7 to 2, a 26% decline) vigilance by providers is essential. A full report of incidence/prevalence of tuberculosis in North Carolina may be found at:

http://epi.publichealth.nc.gov/cd/tb/figures/tbannual2014.pdf

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 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
- Persons who have traveled outside the US and stayed with family and friends who live in high incidence areas, for greater than one month cumulatively
- Children and adolescents exposed to high-risk adults
- Persons with conditions that increase the risk of progression to disease once infected
    - Diabetes mellitus
    - Chronic renal failure
    - Chronic malabsorption syndrome
    - Leukemia, lymphomas, Hodgkin's disease
    - Cancer of the head or neck
    - Silicosis
    - Weight loss of >10% ideal body weight
    - Gastrectomy or intestinal bypass
    - 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: http://epi.publichealth.nc.gov/cd/lhds/manuals/tb/Chapter_II_2017.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 Gold in-tube®** 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:
http://epi.publichealth.nc.gov/cd/lhds/manuals/tb/Chapter_II_2017.pdf

Sexually Transmitted Infections/Diseases

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

http://www.cdc.gov/std/treatment/default.htm

Based on the 2017 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:
https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/human-immunodeficiency-virus-hiv-infection-screening

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.

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:

https://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:

http://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:

http://www.gottransition.org/

https://www.aap.org/en-us/about-the-aap/aap-press-room/pages/Helping-Adolescents-Transition-to-Adult-Health-Care.aspx

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 that all enrolled infants and young children receive a blood lead screen as follows:

- Screen infants with a blood lead test by 12 months of age (or earlier, if indicated),
- Screen children with a blood lead test at 24 months,
- Screen children ages 36-72 months if not previously tested or if test results aren't documented.

Recent changes in the follow-up schedule for diagnostic/confirmed blood lead levels, updated August 2017, include:

- Referral to local health department to offer an environmental investigation with a blood lead level 5-9 μ/dL
- With blood lead levels 10-44 μ/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 level greater than or equal to 5μg/dL. Capillary blood level samples 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. North Carolina Medicaid supports the use of POC blood lead

analyzers for conducting initial blood lead screens *only*. **If a POC blood lead analyzer is used for an initial screen, only a capillary sample may be used**. Venous blood level samples should be collected for confirmation of all blood lead test results ≥ 5 µg/dL and sent to a reference laboratory for analysis. The confirmation sample should not be analyzed of the POC blood lead analyzer.

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 requiring results from specimens of children outside this age group should contact the State Laboratory of Public Health at 919-807-8878. **Lead testing results also can be obtained at the *North Carolina State Laboratory of Public Health Clinical Lab Result Reporting*; at the following web address indicated below.**

https://slphreporting.ncpublichealth.com/lims/ClinicalLims/Login.aspx

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:**

http://ehs.ncpublichealth.com/hhccehb/cehu/lead/docs/2016ClinicalTrainingManualFINAL042116.pdf

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**
<5 µg/dL	• Report blood lead test result to parent and document notification • Educate family about lead sources and prevention of lead exposure **Follow-up testing: Required at age 2, earlier if risk of exposure increases**
All diagnostic (i.e., confirmation) tests should be performed as soon as possible within the specified time periods. ➢ If diagnostic test result falls into a lower category - follow response for the lower risk category below. ➢ If diagnostic or follow-up test result falls in a higher category – conduct another diagnostic test based on the higher risk category and follow response for higher risk category. ➢ Diagnostic tests should be venous; however, capillary tests are accepted if parent refuses venous. CDC protocol for capillary sampling of blood lead should be followed. ➢ Samples for diagnostic tests must be sent to an outside reference laboratory for analysis.	
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:** • Conduct nutritional assessment and refer to the WIC Program • Take environmental history to identify lead sources (use 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 <5 µg/dL (based on the rounded test result)**
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 • Provide clinical management • Refer children to CDSA* Early Intervention or CC4C** as appropriate • Refer to Social Services as needed for housing or additional assistance **Follow-up testing: Every 1 month until 2 consecutive tests are <5 µg/dL (based on the rounded 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 a specialist for possible chelation or hospitalization • Consider an abdominal x-ray to rule out an ingested object • Alert NC CLPPP by calling 919-707-5950 **Follow-up testing: Every 1 month until 2 consecutive tests are <5 µg/dL (based on the rounded 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: Every 1 month until 2 consecutive tests are <5 µg/dL (based on the rounded test result)**

Updated 8/17/17 *Children's Developmental Service Agency **Care Coordination for Children

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.

Discussion:

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. See below link for FDA warning regarding the use of venous blood samples with POC blood lead screens.

https://www.fda.gov/MedicalDevices/Safety/AlertsandNotices/ucm558733.htm

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 ≥ 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 2012, the Centers for Disease Control and Prevention (CDC) 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 (5 µ/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 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

North Carolina Department of Health and Human Services Records and Retention and Disposition Schedule for Grants

NC Division of Public Health Follow-Up Schedule for Diagnostic/Confirmed Blood Lead Levels for Children Under the Age of Six

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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:

http://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 **American Academy of Pediatrics**, 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 STAR (Screening Technical Assistance and Resource) Center for more information on screenings for the pediatric population.

The STAR Center can be found online at: https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Screening/Pages/default.aspx

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 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 **American Academy of Pediatrics**, 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 Maternal 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 maternal depression during Early Periodic Screening visits in the first year postpartum *and* the practitioner's referral of at-risk mothers to appropriate resources for

support and treatment. Treatment must address the mother-child dyad relationship, and follow-up of the infant and mother by the PCP is necessary. For more information, please visit:

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

North Carolina Medicaid will reimburse providers for up to 4 maternal depression risk screens administered to mothers 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 maternal depression screen has been positive.

Examples of Scientifically Validated Screening for Maternal 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 maternal depression at:

https://brightfutures.aap.org/materials-and-tools/tool-and-resource-kit/Pages/Developmental-Behavioral-Psychosocial-Screening-and-Assessment-Forms.aspx

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 N.C. 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 American Academy of Pediatrics 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.

https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Screening/Pages/default.aspx

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. N.C. Medicaid follows **AAP** *Bright Futures* recommendations for conducting structured risk screens during *Health Check* Early Periodic Screening visits.

Providers <u>must</u> 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 January 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 American Academy of Pediatrics 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.

https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf

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 2017 ***Bright Futures*** *"Recommendations for Preventive Pediatric Health Care"* recommends a psychosocial/behavioral assessment at every Early Periodic Screening *(Health Check)* visit. North Carolina 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 American Academy of Pediatrics 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 January 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 American Academy of Pediatrics 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: https://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: http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Pages/Primary-Care-Tools.aspx

- Find out more about scientifically validated emotional/behavioral brief screens at: https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf

  http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Pages/Addressing-Mental-Health-Concerns-in-Primary-Care-A-Clinicians-Toolkit.aspx

- Additional information on developmental screening tools is available at: https://brightfutures.aap.org/Bright%20Futures%20Documents/Developmental_Screening_Tools.pdf

- Information from the Center for Disease Control may be accessed at: http://www.cdc.gov/ncbddd/childdevelopment/screening.html

- For more information, about Alcohol and Substance Abuse Screening and Brief Intervention (CRAFFT) go to: http://www.ceasar-boston.org/CRAFFT/index.php

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:
https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/downloads/modifier59.pdf

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.

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	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 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
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

Please Note:

- No intranasal vaccines are currently coverable per NCIP/VFC program.
- 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.
- 90460 is a stand-alone immunization administration code and does not have any add-on-codes for additional vaccines. Additional vaccines can be billed with either the 90471/90472 series or billing 90460 multiple times (e.g. 90460 x 2) on the claim detail line.
- *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.

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.
- 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.
- Do NOT report the National Drug Code (NDC) with the CPT vaccine product code. NDCs should not be submitted for vaccine CPT codes to prevent denials of those details.
- Providers must use ICD 10-CM coding for all immunizations given after October 1st, 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 CPT code 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 and 90460EP 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 NC Tracks for further information. Generally, vaccine-specific guidance is published in individual articles in the Medicaid bulletin.

- CPT code 90473 can only be billed if the oral *(VFC/NCIP does not currently recommend/cover an intranasal product)* 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.

- Currently, no *intranasal* vaccines are supported by VFC/NCIP program.

- 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.

- Only rebatable drugs/biologicals may be billed to Medicaid. Refer to **March 2012 Special Bulletin,** *National Drug Code Implementation, Update,* found at:

  https://dma.ncdhhs.gov/document/january-2012-special-bulletin-national-drug-code-ndc-implementation-update

- 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 NC Tracks 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:

http://dma.ncdhhs.gov/providers/programs-services/medical/Health-Check-Early-and-Periodic-Screening-Diagnosis-and-Treatment

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 our 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.*

Please Note: VFC Program covers American Indians and Alaska Native populations regardless of other health insurance coverage.

American Indians or Alaska Natives are entitled to VFC vaccines. For American Indians or Alaska natives with *NC Health Choice* coverage, *NC Health Choice* will only reimburse a vaccine administration fee. The provider should review current *NC Health Choice* benefit plan information available on NC Tracks and on the DHHS website for details regarding eligibility groups and billing/processing of *NC Health Choice* claims. For further information, see:

http://dma.ncdhhs.gov/providers/programs-services/prescription-drugs/Physicians-Drug-Program

VFC Eligible Populations

Children birth through 18 years of age that meet at least one of the following criteria are 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.

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 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 annually (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 enroll in the North Carolina Immunization Registry.

How to Join

N.C. 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 adult patients or 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** 1-404-657-5013
- **South Carolina** 1-800-277-4687
- **Tennessee** 1-615-741-7343
- **Virginia** 1-804-864-8055

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:

http://www.immunize.nc.gov.

Select "Healthcare Providers" then select "NCIP coverage criteria" under the heading North Carolina Immunization Program Requirements (NCIP), or call the Immunization Branch Help Desk at 1-877-873-6247.

Rates

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

https://dma.ncdhhs.gov/physician-services-cpthcpcs

Section VII: Listing of 2017 NCIP/VFC Vaccines

VFC Vaccines		
Code	**CPT Description**	**VFC Vaccine Specifics**
90633	Hepatitis A vaccine, pediatric/adolescent dosage – 2 dose schedule, for IM use	12 months of age through 18 years of age
90636	Hepatitis A and B combination (HepA-HepB), adult dosage, for IM use	18 years of age and above only in LHDs, FQHCs, and RHCs
90647	Hemophilus influenza type b vaccine (Hib), PRP-OMP conjugate (3 dose schedule), for IM use	Brand name: PedvaxHIB Routine: 2 months to less than 5 years of age; High risk: Greater than 59 months through 18 years of age
90648	Hemophilus influenza type b vaccine (Hib), PRP-T conjugate (4 dose schedule), for IM use	Brand name: ActHIB, Hiberix Routine: 2 months to less than 5 years of age High risk- greater than 59 months through 18 years of age
90651	Human papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (HPV)	Brand name: Gardasil 9 Females and Males 9 through 18 years of age
90686	Influenza virus vaccine, quadrivalent split virus, preservative free, for IM use	3 through 18 years of age

VFC Vaccines		
Code	**CPT Description**	**VFC Vaccine Specifics**
90687	Influenza virus vaccine, quadrivalent, split virus, for IM use	6-35 months of age
90688	Influenza virus vaccine, quadrivalent, split virus, for IM use	3 through 18 years of age
90674	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for IM	4 through 18 years of age ** available after 10/15/16
90670	Pneumococcal conjugate vaccine, 13 valent, for IM use	Brand name: Prevnar 13 Routine: 2 months through 59 months of age High Risk: 60 months through 18 years of age with certain underlying medical conditions
90680	Rotavirus vaccine, pentavalent, 3 dose schedule, live, for oral use	Brand name: Rotateq 6 weeks through 7 months of age
90681	Rotavirus vaccine, human, attenuated (RV1), 2 dose schedule, live, for oral use	Brand name: Rotarix 6 weeks through 7 months of age
90696	Diphtheria, tetanus toxoids, acellular pertussis vaccine and inactivated poliovirus vaccine (DTaP-IPV), for IM use	4 years through 6 years of age for the booster dose only of DTaP and polio vaccines
90698	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Haemophilus influenza type b, and poliovirus vaccine, inactivated (DTaP-IPV/Hib), for IM use	2 months through 4 years of age
90700	Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), for IM use	2 months through 6 years of age
90702	Diphtheria and tetanus toxoids adsorbed (DT), for IM use	2 months through 6 years of age
90707*	Measles, mumps, and rubella virus vaccine (MMR), live, for SC use	12 months through 18 years of age*
90710	Measles, mumps, rubella, and varicella vaccine (MMRV), live, for SC use	12 months through 12 years of age
90713	Poliovirus vaccine, inactivated (IPV), for SC or IM use	2 months through 17 years of age
90714*	Tetanus and diphtheria, adsorbed	7 years through 18 years of age*
90715*	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older, for IM use	7 years through 18 years of age*
90716	Varicella virus vaccine, live, for SC use	12 months through 18 years of age
90723	Diphtheria, tetanus toxoids, and acellular pertussis vaccine, hepatitis B, and inactivated poliovirus vaccine, (Dtap-HepB-IPV), for IM use	2 months through 6 years of age

VFC Vaccines		
Code	**CPT Description**	**VFC Vaccine Specifics**
90732	Pneumococcal polysaccharide vaccine, 23-valent, (PPSV23) adult or immunosuppressed patient dosage, for SC or IM use	Only for high-risk children two years through 18 years of age
90734	Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 tetravalent NCV4 or MenACWY, for IM use	Routine**:** 11 through 18 years of age High risk: 2 months through 10 years Menveo- starts at 2 months of age Menactra- starts at 9 months of age
90620	Meningococcal recombinant protein and outer membrane vesicle vaccine, sergroup B (MenB), 2 dose schedule, for IM use	Brand name: Bexsero High risk children ages 10-18 MenB may be administered to adolescents aged 16–18 years of age who are not at increased risk for meningococcal disease based on the provider's clinical discretion. Follow ACIP guidance.
90621	Meningococcal recombinant lipoprotein vaccine, serogroup B (MenB), 3 dose schedule, for IM use	Brand name - Trumenba High risk children ages 10-18 Children aged 16-18 years without high risk conditions may also be vaccinated based on the providers clinical judgement for children who are at increased risk for disease.
90744	Hepatitis B vaccine pediatric/adolescent dosage (3 dose schedule), for IM use	Birth through 19 years of age
90746	Hepatitis B vaccine, adult dosage, for IM use, 3 dose schedule	20 years of age and older, only in LHDs

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	
J1460	Injection, gamma globulin, for intramuscular (IM) use 1cc.	Limited distribution to health depts. (LHDs) only, and only during outbreaks.
J1560	Injection, gamma globulin, IM, over 10 cc	
90371	Hepatitis B immune globulin (HBIg), human, IM	
J1571	Injection, hepatitis B immune globulin (Hepagam B), IM, 0.5 ml	
J1573	Injection, hepatitis B immune globulin (Hepagam B), IV, 0.5 ml	
J1559	Injection, immune globulin, (Hizentra), 100 mg	
J1561	Injection, immune globulin, (Gamunex/Gamunex C/Ganmaked), nonlyophilized (e.g. liquid) 500 mg	
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	
90375	Rabies immune globulin, (RIg), human, for IM 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	
90632	Hepatitis A vaccine, adult dosage, for IM use	19 years of age and above. Limited distribution to LHDs only, and only during outbreaks.

Other Vaccines Covered by Medicaid when Medically Necessary		
Code	**CPT Description**	**NCIP Vaccine Specifics**
90675	Rabies vaccine for IM 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	
J1556	Injection, immune globulin (bivigam), 500 mg	
J1557	Injection, immune globulin, (gammaplex), intravenous, non-lyophilized (e.g., liquid), 500 mg	
J1459	Injection, immune globulin (privigen), intravenous, non-lyophilized (e.g., liquid), 500 mg	
90376	Rabies immune globulin, heat-treated (RIG-HT), human, for intramuscular and/or subcutaneous use	
90396	Varicella-zoster immune globulin, human, for intramuscular use	
90721	Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Hemophilus influenza B vaccine (DTaP-Hib), for intramuscular use	
90645	Haemophilus influenza b vaccine (Hib), HbOC conjugate (4 dose schedule), for intramuscular use	
90658	Influenza virus vaccine,trivalent, split virus, for use in individuals 3 years of age and above, for intramuscular use	
90705	Measles virus vaccine, live, for subcutaneous use	
90733	Meningococcal polysaccharide vaccine (any group(s)), for subcutaneous use	
90704	Mumps virus vaccine, live, for subcutaneous use	
90675	Rabies vaccine, for intramuscular use	
90706	Rubella virus vaccine, live, for subcutaneous 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

Note: This list is subject to change. Updates regarding vaccines are published in the general Medicaid bulletins on DMA's website at:

http://dma.ncdhhs.gov/providers/medicaid-bulletins.

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

http://www.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:

1-877-873-6247.

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.