PROFESSIONAL

COVERED SERVICES AND LIMITATIONS MODULE
Professional CMS-1500
Covered Services and Limitations Module

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Ambulance Services

Independent Ambulance or Hospital Based Ambulance services are reimbursed if they meet EqualityCare coverage guidelines and when the appropriate services are rendered for the beneficiary's condition.

National EMS Definitions:

**Basic Life Support (BLS):** treatment rendered by personnel certified at the Basic Emergency Care Technician (BEC) or basic Emergency Medical Technician (EMT) level, including procedures such as bandaging, splinting, basic first aid, and performing CPR.

**Basic Emergency Care Technician (BEC):** an individual who has completed an approved training program in basic emergency care sponsored by the Division, Department of Health, Office of Emergency Medical Services (OEMS), or has Division-approved equivalency training. A Basic Emergency Care Technician shall not practice alone as an ambulance attendant in Wyoming.

**Emergency Medical Technician (EMT):** an individual who has completed an approved training program that adheres to the National Emergency Medical Services Educational and Practical Blueprint or a Division-sponsored or Division-approved training program for EMT's and who continues to meet all the applicable continuing medical education recertification requirements.

Covered Services

**Emergency Transportation** - EqualityCare covers emergency transportation by either Basic Life Support or Advanced Life Support ambulance under the following conditions:

- A medical emergency exists in that the use of any other method of transportation could endanger the health of the patient; and
- The patient is transported to the nearest facility capable of meeting the patient's medical needs; and
- The destination is an acute care hospital where the patient is admitted as an inpatient or outpatient.

For purposes of this section, a medical emergency is considered to exist under any of the following circumstances:

- An emergency situation, due to an accident, injury, or acute illness; or
- Restraints are required to transport the patient (often when a psychiatric diagnosis is made); or
- The patient is unconscious or in shock; or
- Immobilization is required due to a fracture or the possibility of a fracture; or
- The patient is experiencing symptoms of myocardial infarction or acute stroke; or
- The patient is experiencing severe hemorrhaging.
Non-Emergency Transportation

Non-emergency transportation is covered when any other mode of transportation would endanger the health or life of a client and at least one of the following criteria are met:

- Continuous dependence on oxygen
- Continuous confinement to bed
- Cardiac disease resulting in the inability to perform any physical activity without discomfort
- Receiving intravenous treatment
- Heavily sedated
- Comatose
- Post pneumo/encephalogram, myelogram, spinal tap, or cardiac catheterization
- Hip spicas and other casts that prevent flexion at the hip
- Requirement for isolette in perinatal period
- State of unconsciousness or semi-consciousness

Categories of Service

Ground Services - Basic Life Support (BLS) - When medically necessary, the provision of BLS services as defined in the National EMS Education and Practice Blueprint for the EMT-Basic.

Basic Life Support (BLS) - Emergency - The provision of BLS services as described above in an emergency situation. An emergency response is one that is provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the beneficiary's health in serious jeopardy;
- Impairment to bodily functions; or
- Serious dysfunction to any bodily organ or part.

- Advanced Life Support, Level 1 (ALS1) - The Advanced Life Support, Level 1 category is the provision of an assessment by an advanced life support (ALS) provider or supplier or the provision of one or more ALS interventions.

An ALS provider/supplier is defined as a provider trained to the level of the EMT-Intermediate or Paramedic as defined in the National EMS Education and Practice Blueprint. An ALS intervention is defined as any procedure beyond the scope of an EMT-Basic as defined in the National EMS Education and Practice Blueprint.

ALS Assessment is an assessment performed by an ALS crew that results in the determination that the patient's condition requires an ALS level of care, even if no other ALS intervention is performed. In the above situation, the EMT-Intermediate or Paramedic must actually ride on the BLS transport for the BLS ambulance provider to bill an ALS service.
• Advanced Life Support, Level 1 (ALS1) Emergency - The provision of ALS1 services, as specified above, in the context of an emergency response.

An emergency response is one that is provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the beneficiary's health in serious jeopardy;
- Impairment to bodily functions; or
- Serious dysfunction to any bodily organ or part.

• Advanced Life Support, Level 2 (ALS2) - The Advanced Life Support, Level 2 category is defined as the administration of three or more different medications, and

The provision of at least one of the following ALS procedures:

- Manual defibrillation/cardioversion
- Endotracheal intubation
- Central venous line
- Cardiac pacing
- Chest decompression
- Surgical airway
- Intraosseous line

Air Services

• Fixed Wing and Rotary Wing - These air ambulance services are reimbursable when transport meets Medicaid coverage requirements, and the beneficiary's medical condition is such that transport by ground ambulance, in whole or part, is not appropriate.

Transport by fixed wing or rotary wing air ambulance may be necessary because the beneficiary's condition requires rapid transport to a treatment facility, and either great distances or other obstacles, i.e., heavy traffic, preclude such rapid delivery to the nearest appropriate facility.

Transport by fixed wing or rotary wing air ambulance may also be necessary because the beneficiary is inaccessible by a land or water ambulance vehicle.
Limitations

EqualityCare does not reimburse for the following ambulance services:

- Transportation to receive services which are not covered by EqualityCare
- Transportation which does not involve transporting a client (i.e., no-load trips)
- Transportation of family members to visit a client or to consult with their physician
- Transportation to pick up drugs at a pharmacy
- Return transportation to a client's home or nursing home if ambulance transportation is not medically necessary
- Transportation of a nursing home resident to a physician's office or outpatient hospital department if the care can be furnished in the client's care facility
- Transportation to a hospital or other health service facility for the purpose of detention ordered by a court or law enforcement agency
- Stand-by time
- Special attendants
- Unloaded mileage
- Services based on standing orders
- Specialty Care Transport (SCT)
- Paramedic Intercept (PI)

Reimbursement

An ambulance trip report must be attached to all claims. Medicare covered ambulance claims must be billed on a UB-02 claim form if the ambulance services are hospital based. All other ambulance services including non-Medicare covered ambulance services must be billed on CMS claim forms. They will be considered a CMS claim with attachments.
Ambulatory Surgical Centers (ASC)

Covered Services

EqualityCare will reimburse those surgical procedures, which are authorized for coverage under Medicare. Other surgical procedures, which are performed in ambulatory surgical centers, may also be covered.

Facility Services - Facility services include items and services furnished by an ASC in connection with a procedure normally covered on an outpatient basis in a hospital. No inpatient services are performed at an ASC. ASC facility services include the following:

- Nursing, technical, and other related services involved in patient care
- Use of surgical facility, including operating and recovery room, patient preparation area, waiting room, and other facility areas used by the patient
- Drugs, medical equipment, oxygen, surgical dressings, and other supplies directly related to the surgical procedure
- Splints, casts, and equipment directly related to the surgical procedure
- Administrative, record keeping, and housekeeping items and services
- Anesthesia materials
- Diagnostic procedures directly related to the surgical procedure, including those procedures performed before the surgery
- Blood and blood products

Professional Services - Services furnished by physicians, surgeons, or anesthesiologists in an ambulatory surgical center are billed and reimbursed separately from the ambulatory facility services. Professional services include the administration of anesthesia to ASC patients, routine pre and/or postoperative services, and the actual surgical procedure.

These services are subject to all applicable EqualityCare coverage rules, such as informed consent, medical necessity, prior authorization, and documentation requirements and provider enrollment.

Limitations

The following services are not covered when billed by an ASC or physician performing the services in an ASC:

- Take-home supplies
- Prosthetic devices
- Leg, arm, back and neck braces
- Ambulance services
- Equipment for use in patient’s home
- Cosmetic procedures

Reimbursement Guidelines

EqualityCare uses the current levels of payment established by Medicare for covered surgical procedures. If Medicare does not cover a procedure, a level of payment is established for the procedure by comparison to a similar procedure.
ASC facility charges are billed with CPT surgery codes.

Bilateral procedures, which are not designated as bilateral in CPT, are billed on two detail lines with a -50 modifier on the second detail line.

Multiple procedures: the primary surgical procedure must be billed on the first line, the secondary surgical procedure on the following line (use of 51 modifier on appropriate secondary codes).

Dental extraction/restoration is billed with appropriate HCPCS code D7111 – D7250.

Practitioners who provide services in an ambulatory surgical center must be enrolled in the EqualityCare program as an individual practitioner to receive reimbursement.
Children’s Special Health (CSH)

The CSH program provides services for high-risk pregnant women and newborns that require Level III hospital care and children with special health care needs. The purpose of the program is to identify these patients, assure diagnostic and treatment services, provide payment for authorized specialty care and provide tracking and care coordination services. CSH does not cover primary, acute or emergency care.

Questions related to CSH eligibility determination or the type of services authorized by CSH should be directed to:

Wyoming Children's Special Health
4020 House Avenue
Cheyenne, WY 82002
307-777-7941 or FAX: 307-777-5402

A patient may be eligible only for the CSH program or may be dually eligible for the CSH program and for the EqualityCare programs. Care coordination for both CSH only and dually eligible patients is provided through the Public Health Nurse’s office.

CSH has a dollar caps and service limits on some services that apply to clients who are eligible for CSH only. Please refer to the provider manual issued by CSH. The CSH provider manual is provided by CSH when a provider enrolls with the CSH program and a replacement manual may be ordered at any time from CSH.

Providers must be enrolled with EqualityCare and CSH to receive payment for CSH services. Claims for services for both programs are submitted to and processed by ACS, Inc. Medical records for visits which result from CSH referrals must be sent directly to CSH for appointment tracking and case management. An optional form is available from CSH, which may be used to submit the medical information. Providers are asked to submit the record as soon after the visit as possible to assure timely coordination of referrals and services.

Due to HIPAA compliance standards, EqualityCare has eliminated the CSH special local X-codes and replaced them with standard CPT-4 codes. To receive the higher reimbursement fees that the X-codes gave, a modifier, T(J), must be used in conjunction with the codes. Please reference the table below which contains a crosswalk from local codes to CPT codes. Specialty or subspecialty physicians, either MD’s or DO’s who provide consultations for CSH clients related to their approved condition must bill with the appropriate CPT code and the TJ modifier. If the TJ modifier is billed for a non-CSH client the claim will be denied. CSH will only reimburse approved providers for services. Services provided by residents, APN’s, dieticians, PA’s, etc., under the supervision of an approved provider, must be billed under the approved providers name. The approved provider must sign all reports and claims or the claim will be denied.

The patient’s initial CSH evaluation should be billed using 99242TJ – 99245TJ. These codes can only be used once within a 365-day period for the same diagnosis code. If a CSH consultation is required for the patient addressing a new problem/diagnosis, then these codes can be used with the new diagnosis within the 365-day period. Follow up visits for CSH clients should be billed using 99212TJ – 99215TJ. CSH reimburses only four (4) follow up visits per year for the approved condition.
All services need to be billed with routine CPT procedure codes and will be paid using the EqualityCare fee schedule. When billing for Evaluation and Management Consultation Codes, providers may use WY0000 or Children’s Special Health in field locator 17.

**NOTE: THE CODES AND MODIFIERS ARE SUBJECT TO CHANGE**

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<tr>
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<td>99242</td>
<td>TJ</td>
<td>Initial Comprehensive Pediatric Consultation Complex Disorder.</td>
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<tr>
<td>X5908</td>
<td>99243</td>
<td>TJ</td>
<td>Initial Comprehensive Pediatric Consultation Complex Disorder.</td>
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<tr>
<td>X5909</td>
<td>99244</td>
<td>TJ</td>
<td>Initial Comprehensive Pediatric Consultation Complex Disorder.</td>
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<td>X5910</td>
<td>99245</td>
<td>TJ</td>
<td>Initial Comprehensive Pediatric Consultation Complex Disorder.</td>
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<tr>
<td>X5911</td>
<td>99212</td>
<td>TJ</td>
<td>Established Pediatric Follow-up-Complex Disorder 10/Min.</td>
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<tr>
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<td>99212</td>
<td>TJ</td>
<td>Established Pediatric Follow-up- Complex Disorder 20/Min.</td>
</tr>
<tr>
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<td>99214</td>
<td>TJ</td>
<td>Established Pediatric Follow-up- Complex Disorder 30/Min.</td>
</tr>
<tr>
<td>X5914</td>
<td>99215</td>
<td>TJ</td>
<td>Established Pediatric Follow-up- Complex Disorder 30/Min.</td>
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<tr>
<td>X5915</td>
<td>99244</td>
<td>TJ</td>
<td>Genetic Clinic Initial Exam</td>
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<tr>
<td>X5916</td>
<td>99214</td>
<td>TJ</td>
<td>Genetic Follow-up Exam</td>
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<tbody>
<tr>
<td>TJ</td>
<td>Program Group, Child and/or Adolescent</td>
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Community Mental Health Center and Substance Abuse Center Services

Program Requirements

Community Mental Health Center and Substance Abuse Center Providers should refer to the Medicaid Policies and Procedures Manual for Mental Health/Substance Abuse Rehabilitative Option, EPSDT Child and Adolescent Mental Health Services, and Targeted Case Management Option Services for detailed information regarding provider qualifications and requirements, covered services and their definition, and quality assurance/utilization review standards.

The Wyoming Board of Medicine has determined that the use of the terms "medical" or "medical necessity" is within the scope of practice of licensed doctors of medicine only. The Board has determined that Community Mental Health and Substance Abuse Centers would be operating outside of their statutory authority if they continued to present themselves as providing "medical" care. Therefore, in every case where the word "medical" is used in this section, the term "mental health/substance abuse therapeutic" is substituted. In every case where the term "medically necessary" is used in this section, the term "therapeutically essential for the reduction of mental health/substance abuse disability" is substituted. In every case where the term "medical necessity" is used in this section, the term "being therapeutically essential for the reduction of mental health/substance abuse disability" is substituted. Licensed practitioners of the healing arts who are eligible under Section 204(4)(b) of this module to refer and sign for services being therapeutically essential for the reduction of mental health/substance abuse disability must sign and date the clients clinical assessment and treatment plans with the following statement, "I certify that the services in this treatment plan are therapeutically essential for the reduction of a mental health (or substance abuse) disability." Providers should refer to this module for complete service descriptions. Due to HIPAA compliance standards, EqualityCare has eliminated local codes and replaced them with the regular CPT-4 codes.

NOTE: THE CODES AND MODIFIERS ARE SUBJECT TO CHANGE

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<tbody>
<tr>
<td>X2801</td>
<td>H0031</td>
<td>U1, U4, U5</td>
<td>Clinical Assessment - Mental Health Assessment by non physician per 15 min</td>
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<tr>
<td>X2841</td>
<td>H2019</td>
<td>U1, U4, U5</td>
<td>Agency Based Individual/Family Therapy, per 15 Min.</td>
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<tr>
<td>X2841</td>
<td>H0034</td>
<td>U5</td>
<td>Comp. Medication Service - Medication Training and Support per 15 min</td>
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<td>X2853</td>
<td>H2019</td>
<td>HQ, U1, U4, U5</td>
<td>Group Therapy - Group counseling by clinician per 15 min</td>
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<td>X2892</td>
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<td>U1, U4, U5</td>
<td>Community-based Wrap-around services, per 15 Min</td>
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<td>X2893</td>
<td>H2014</td>
<td>U1</td>
<td>Individual Rehab Service - Skills Training and Development, per 15 Min</td>
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<td>X2896</td>
<td>H2014</td>
<td>HK, U1</td>
<td>Intensive Individual Rehab Service - Skills Training and Development, per 15 Min</td>
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<td>X2899</td>
<td>H2017</td>
<td>U1, U4, U5</td>
<td>Day Treatment - Psychosocial Rehabilitation Services, per 15 Min</td>
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<td>X2901</td>
<td>S5145</td>
<td>EP, U1</td>
<td>Intensive Child Treatment Services/per day</td>
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<td>G9012</td>
<td>EP, U2</td>
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<td>T1017</td>
<td>EP, U2, U3</td>
<td>Ongoing Case Management - Targeted Case Management, per 15 Min</td>
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<td>T1017</td>
<td>U2, U3</td>
<td>Adult Case Management - Targeted Case Management, per 15 Min</td>
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<td>W7301</td>
<td>T2011</td>
<td>HE</td>
<td>PASRR Level II Psychiatric Evaluation/Determination of Appropriate placement</td>
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<tr>
<td>W7302</td>
<td>T2011</td>
<td>HE</td>
<td>PASRR Level II CMHC Evaluation</td>
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<tr>
<td>U1</td>
<td>Community Mental Health</td>
</tr>
<tr>
<td>U2</td>
<td>Case Management By Community Mental Health</td>
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<tr>
<td>U3</td>
<td>Case Management by Substance Abuse</td>
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<tr>
<td>U4</td>
<td>Free Standing Substance Abuse</td>
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<tr>
<td>U5</td>
<td>Community Mental Health Substance Abuse</td>
</tr>
<tr>
<td>EP</td>
<td>Service provided as part of EPSDT</td>
</tr>
<tr>
<td>HK</td>
<td>Specialized mental health programs for high-risk populations</td>
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<tr>
<td>HQ</td>
<td>Group setting</td>
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<tr>
<td>HE</td>
<td>Mental Health Program</td>
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**Covered Services**

- Clinical Assessment
- Agency Based Individual/Family Therapy/Group Therapy
- Community Based Individual/Family Therapy
- Individual Rehabilitative Services
- Intensive Individual Rehabilitative Services - Day Treatment
- Adult Targeted Case Management
- Day Treatment
- On-going Case Management
- Transitional Case Management
- Intensive Child Treatment Services

**Psychiatrist Services**

Community Mental Health Centers will be reimbursed for psychiatric services at the same fee currently set for psychiatrists in private practices. Community Mental Health Centers must use current CPT codes when billing for these services.

CPT codes for psychiatric services in the range 90801-90899 are covered with the exception of 90875, 90876, 90880, 90882, 90885, 90887 and 90889. These codes are reserved for billing services provided directly by a psychiatrist only and should not be used for the services of other mental health professionals and counselors providing services at the agency.
Reimbursement Guidelines

When billing for services, it is necessary to combine charges for the same procedure for the same date of service onto one line, with multiple units. If the procedure is listed on more than one line for the same date of service, on the same claim form or a different claim form, it will be denied as a duplicate. This denial is consistent for all EqualityCare covered procedures and all claim types.

A $2.00 copay applies to 90804-90815.

Limitations

EqualityCare does not cover the following services or activities:

- Hospital liaison
- Consultation and education
- Emergency services not provided through face-to-face contact with the client
- Residential room, board, and care
- Substance abuse and mental health prevention services
- Recreation and socialization services
- Vocational services, including:
  - Vocational assessments and evaluation of work skills and aptitude
  - Trial work, whether paid or volunteer, including work readiness evaluation and work skills evaluation
  - Sheltered work, whether paid or volunteer
  - Job coaching, crews and enclaves
  - Groups in which the specific task is job support for employed clients
  - Job clubs
- Missed appointments
- Day care
- Psychological testing for educational diagnosis or school placement
- Remedial education
- Travel time
- Record keeping time
- Time spent in telephone calls regarding the client, except as part of EPSDT On-Going or Transitional Case Management Services and Adult Targeted Case Management Services
- Time spent writing test reports and other reports with the exception of three hours allowed for report writing by a licensed psychologist for the purpose of compiling a formal report of test findings
- Time spent in consultation with other persons or organizations on behalf of a client unless:
  - The consultation is a face-to-face contact with a collateral to implement the treatment plan of a client receiving Rehabilitative Option services; or
  - The consultation is a face-to-face contact or telephone contact to implement the treatment plan of a client receiving EPSDT Mental Health Services and Adult Targeted Case Management Services.
- Groups such as AA, NA, and other self-help groups
- DUI classes
- Progress or status reports made on behalf of a specific client.
Developmental Centers

EqualityCare covered services provided by Developmental Centers, except DD Waiver or a licensed physician or physician’s assistant shall provide authorized services only with written referral. Copies of all physician orders/referrals must be part of each individual patient's permanent developmental center clinical record and must be renewed at least every six months. Each physician referral or order must be signed and dated by the physician or physician’s assistant.

Covered Services

Diagnostic Evaluations/Assessments

Limitations and Requirements: This service is limited to children five years of age and under. A licensed physician shall provide diagnostic evaluation services only after written referral. This referral must list areas of concern. Areas to be assessed will include: physical development including fine and gross motor skills, cognitive development, speech development, and social and emotional development. Based on the individual needs of the child, the evaluation may take place in a Regional Developmental Center, a child's primary placement (if other than a Developmental Center) or the child's home. The evaluation is to be done using standardized assessment tools. If no standardized instruments are available based on the child's chronological age or suspected developmental age, criterion based assessments will be used. A comprehensive multi-disciplinary evaluation performed by the appropriate Wyoming certified or licensed professional is required for all children referred and all areas will be evaluated to gain a complete developmental overview of the child. A written report indicating assessment tools used, procedures followed and findings of the evaluation / assessment shall be developed, with a copy provided to the referring physician and a copy maintained in the child's permanent treatment record. (This service is not required in order for a client to be prescribed physical, occupational or speech therapy).

Physical, Occupational and Speech Therapy

Limitations and Requirements: This service is limited to children twenty years of age and under. Therapy shall be provided only after a written order is received from a licensed physician. EqualityCare will only reimburse those services provided by a licensed physical therapist or licensed physical therapy assistant working under the direct supervision of a licensed physical therapist; or a licensed occupational therapist or a certified occupational therapy assistant working under the direct supervision of a licensed occupational therapist; or, a certified speech therapist. EqualityCare does not cover services provided by speech therapy assistants.

EqualityCare will reimburse Developmental Centers for providing restorative and maintenance services:

- Restorative services are services, which assist an individual in regaining or improving skills or strength.

Maintenance services are those, which prevent conditions from worsening or the development of additional health problems.

Group physical, occupational and speech therapy are limited to a maximum of five children per group. Field trips are covered if they are within the scope of the plan of care and are limited to the five children.
Due to HIPAA compliance standards, EqualityCare has eliminated local codes and replaced them with standard CPT-4 codes.

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<td>Code has been deleted; use individual therapy evaluation codes.</td>
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<td>X3125 X3131</td>
<td>92506</td>
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<td>Evaluation of speech, language, voice, communication and or audio processing disorder (includes aural rehab); individual/per 15 min.</td>
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<td>X3126</td>
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<td>Treatment of speech language voice communication and/or auditory processing disorder (including aural rehab); individual/per 15 min.</td>
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<tr>
<td>X3128</td>
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<td>Treatment of speech language voice communication and/or auditory processing disorder (including aural rehab); group/per 15 min.</td>
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**Documentation**

Prior to the provision of any therapy services, the following must occur and be documented in the patient's permanent clinical record:

1. A comprehensive medical diagnostic examination by a licensed physician as well as a multi-disciplinary comprehensive evaluation must be completed as part of the Individual Education Plan/Individual Family Services Plan (IEP/IFSP). The IFSP must be completed for children ages 0-36 months.

2. Services must:
   - Be determined, in writing, to be medically necessary by a licensed physician;
   - Appear on the physician's plan of treatment/care; and
   - Have original and subsequent renewal physician written orders, which shall be for no more than six months duration.
3. The physician's plan of treatment/care shall contain:
   - Diagnosis and onset date of patient's condition;
   - Patient's rehabilitation potential;
   - Restorative and/or maintenance program goals;
   - Therapy modalities determined to be medically necessary to attain the program goals;
   - Therapy duration (not to exceed six months); and
   - Physician's signature and date signed.

4. Each therapy ordered, either independently or in combination with another, **must be described in a separate EqualityCare treatment plan that shall**:
   - State treatment goals in terms of specific outcomes associated with referral diagnosis;
   - Outline each therapy regime relative to stated goals, including modalities, frequency of each treatment session and duration of each treatment session;
   - Be updated with every change or renewal of physician orders (not to exceed six months);
   - Be signed, including professional title, and dated by each appropriate therapist; and
   - Be attached to the client's IEP/IFSP.

Ongoing documentation of services provided (progress notes) is required by each discipline billing EqualityCare for services provided and shall include each of the following:
   - Identification of the patient on each page of the treatment record;
   - Identification of the type/discipline of therapy being documented on each entry (i.e., speech vs. physical vs. occupational therapy);
   - Date and time(s) spent in each therapy session;
   - Description of therapy activities, client reaction to treatment and progress being made to stated goals/outcomes; and
   - Full signature or counter signature of the licensed therapist, professional title and date that entry was made, the signature of the therapy assistant and date the entry was made. Licensed therapist must sign progress notes of assistants within 30 days.

**Reimbursement Guidelines**

*Diagnosis Codes*

When billing EqualityCare for services provided at Developmental Centers, the diagnosis codes used shall be:
   - Consistent with the diagnosis identified by the ordering physician;
   - Related directly to the need for the services billed; and
   - Coded to the greatest degree of specificity.

*The diagnosis code 783.4 Lack of Development, shall only be used if a more specific diagnosis code is not applicable.*

** 99070: Reimbursement is based on the billed charge if it is less than $10.00. If over $10.00, the invoice is required and payment will be 15% of the invoice price plus shipping and handling.**
Time

A unit is fifteen minutes. If seven minutes or less of the next fifteen minute unit is utilized, the unit must be rounded down, however if eight or more minutes of the next fifteen minute unit is utilized, the unit can be rounded up.

Important Information regarding Physician’s Authorizations

Location of Service

If the location on the Physician’s Authorization is different from the location where the child is seen, the therapist must document the deviation from the Plan of Care in the child’s record. If this occurs on a regular basis, there must be a modification of the plan of care.

If “individual” is indicated on the Physician’s Authorization and the child is seen in a group session, the therapist may not bill for a group session for that child.

Group physical, occupational and speech therapy are limited to a maximum of five (5) children per group.

Time and Frequency

Time and frequency are required on the Physician’s Authorization and must be specific. Date ranges are not acceptable.

EqualityCare clients have the right to refuse services. If numerous therapy sessions are missed, the therapist may offer make-up sessions; however, if the child is continually non-compliant with attendance for whatever reason, the physician must be informed of the missed sessions and non-compliance of the child. All communication with the child, child’s family and physician must be documented in the child’s records.

Therapists may bill over the designated time on the Physician’s Authorization for make-up time for a missed session only if the time is documented as such. This must not be a continuing occurrence.

Clients should be seen for the amount of time and frequency noted on the Physician’s Authorization. Billing cannot exceed the Plan of Care. An extra session may be billed only if the need for a make-up session is documented within the record. This must not be a continuing occurrence.

Diagnosis

A physician must enter diagnosis codes into the child’s records. Developmental Center staff may not enter the diagnosis code from the Physician’s Authorization. Diagnosis codes may not be recorded from a previously signed Physician’s Authorization, nor can the center’s staff complete an incomplete form. The physician must assign the diagnosis code even if the diagnosis has not changed.

Field Trips

Field trips are covered if they are within the scope of the client’s Plan Of Care and are limited to five (5) children.
Family Planning Clinics

Family Planning Clinics are programs receiving Title X funding and/or Maternal Child Health (MCH) funding which provide family planning services.

Family planning services are those services that are prescribed to individuals of childbearing age for the purpose of enabling them to freely determine the number and spacing of their children.

Covered Services

**Comprehensive visits** include the following services:
- Evaluation of medical history or update
- Patient education
- Patient counseling
- Weight
- Blood Pressure
- Urinalysis; routine
- Hematocrit
- Physical Examination
- Collection of Pap smear
- GC culture
- Wet mount, when indicated
- VDRL, when indicated
- Rubella titer, if indicated

**Limited visits** include the following services:
- Evaluation of medical history or update
- Patient education
- Patient counseling
- Any other service listed under comprehensive visit that is indicated for presenting a problem

**Brief visits** includes the following services:
- Patient Evaluation
- Patient Counseling

**Examples of Contraceptive Supplies and Devices**
- Norplant
- Cervical Cap for contraceptive use
- Diaphragm for contraceptive use
- Condom, male
- Condom, female
- Spermacide
- Contraceptive pills
- Depo Provera Aq. injection 100 mg
- Depo Provera injection 150 mg
- Norplant removal
- Physician – insertion of IUD (Intrauterine device)
- IUD removal – Physician also
The number of units must be specified in field 24G of the CMS-1500 claim form for contraceptive supplies and devices. A three-month supply of oral contraceptives is allowed.

Local codes are no longer effective; please contact ACS, Inc. for any questions regarding codes. These diagnosis codes should be used for visits when any type of contraceptive management is provided:

- **V24.9** Unspecified contraceptive management
- **V25.0** General counseling and advice
- **V25.01** Prescription of oral contraceptives
- **V25.02** Initiation of other contraceptive measures (fitting of diaphragm; prescription of foams, creams, or other agents)
- **V25.09** Other Family planning advice
- **V25.1** Insertion of intrauterine contraceptive device
- **V25.4** Surveillance of previously prescribed contraceptive methods Checking, reinsertion, or removal of contraceptive device, Repeat prescription for contraceptive method, Routine examination in connection with contraceptive maintenance Excludes: presence of intrauterine contraceptive device as incidental finding V45.5)
- **V25.40** Contraceptive surveillance, unspecified
- **V25.41** Contraceptive pill
- **V25.42** Intrauterine contraceptive device (Checking, reinsertion, or removal of Intrauterine device)
- **V25.43** Implantable, subdermal contraceptive
- **V25.49** Other contraceptive method
- **V25.5** Insertion of implantable subdermal contraceptive
- **V25.8** Other specified contraceptive management - post vasectomy sperm count

**Pap Smears**

These codes should be used for visits when contraceptive management is not provided:

- **V72.3** Gynecological examination (Pap smear as part of general gynecological examination, pelvic examination - annual or periodic)
- **V76.2** Cervical Pap smear without general gynecological examination. Excludes: routine examination in contraceptive management V25.00-V25.49

This code should be used for visits when billing Pap smear handling Q0091, and chlamydia kit 99070.

- **V68.89** Other specified administrative purpose

**Pregnancy Tests**

This code should be used for visits when billing pregnancy test 81025

- **V72.4** Pregnancy examination or test, pregnancy unconfirmed (Possible pregnancy, not yet confirmed.) Excludes: pregnancy examination with immediate confirmation (V22.0-V22.1)

**Limitations**

EqualityCare does not reimburse for infertility services, including counseling, artificial insemination and reversal of sterilizations.
Health Check – EPSDT

The Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program was enacted by Congress mandating states provide eligible children under the age of 21 with well-child screening, diagnostic and medically necessary treatment services through their Medicaid programs. Services provided under EPSDT include periodic screening including vision, dental, and hearing, as well as any medically necessary treatment. The EPSDT program in Wyoming is referred to as Health Check.

When is a Health Check screening examination to be completed?
The periodic well-child screenings are to be completed according to the periodicity schedule at the back of this module and vary in components depending on the age of the child.

Who can perform a Health Check screening examination?
Physicians, physician’s assistants, nurse practitioners, nurse midwives, and public health nurses can perform Health Check screenings. Physician’s assistants and nurse practitioners who are not independently enrolled, but who work under the direct supervision of an enrolled physician, may conduct Health Check examinations and bill under the supervising physician’s provider number. Ancillary personnel in a physician’s office may assist with provision of screening testing and anticipatory guidance.

What is included in a Health Check screening examination?
Components of a Health Check screening examination vary based on the child’s age and include a comprehensive physical and the vision, dental and hearing screens. EqualityCare has developed forms that identify the age specific components required for each Health Check screening examination. Use of these forms is not required, however it is strongly recommended that the individual components listed on the forms be incorporated into the provider’s own comprehensive well-child screening forms.

What is included in the comprehensive physical and vision, dental and hearing screenings?
Components of the physical exam vary according to the age of the child and include developmental assessment, immunizations, nutritional assessment, and anticipatory guidance. See the periodicity schedule for details on what is included in the comprehensive physical and vision, dental and hearing screens. The forms at the end of this bulletin list the components required for each Health Check screening examination.

What lab screens are recommended for the Health Check examination?
- Blood lead level assessment for age 12 months and 24 months is strongly recommended for high-risk children. To determine if a child is high risk, see the Blood Lead Level Risk Questionnaire recommended by the CDC.
- Tuberculosis: Recommended for high-risk age groups.
- Hematocrit:
  - 9-12 months: routinely
  - 2-12 years: screen high risk only
  - Females 12-20 years: yearly if menstruating
  - Males 12-21 years: screen high risk only
- Cholesterol: 20-20 years: high risk only
• Pelvic and Pap:
  o All sexually active females
  o Offer to females ages 18-20 years: routinely
• Sexually Transmitted Diseases: Regularly for all sexually active patients
• Urinalysis:
  o At 5 years
  o Yearly in sexually active adolescents

What if the child needs further treatment?
All abnormalities detected during a Health Check screening examination should be referred to the appropriate specialist, including vision, dental and hearing specialists as necessary. All services provided must be medically necessary and provided in the most cost-effective manner.

NOTE: The appropriate modifier for a referral is 32, and should be reflected on the CMS – 1500.

What is considered “medically necessary”? 
“Medically Necessary” is any medical service that is required to diagnose, treat, cure or prevent an illness, injury or disease, which has been diagnosed or is reasonably suspected to relieve pain or improve and preserve health and be essential to live. The service must be:
• Consistent with the diagnosis and treatment of the child’s condition.
• In accordance with the standards of good medical practice among the provider’s peer group.
• Required to meet the medical needs of the child and undertaken for reasons other than the convenience of the child/family and the provider.
• Performed in the least costly setting required by the child’s condition.

Does EqualityCare reimburse all treatment?
EqualityCare is obligated to reimburse for all medically necessary treatment. Specific limitations for Health Check treatment services are those not approved by the FDA, those that are considered educational, those that are considered experimental and those that are not considered accepted medical practice. Some services, such as organ transplants, occupational therapy, and speech therapy require prior authorization. Contact ACS, Inc. Provider Relations Unit at 1-800-251-1268 for details.

What if the provider is unable to complete the entire Health Check screening examination?
All attempts should be made to complete the entire Health Check screening examination. If the entire screening cannot be completed, indicate this on the Health Check form and complete the exam at the next scheduled appointment.

What if the child missed his/her last Health Check examination according to the periodicity schedule?
This is called an interperiodic examination and is defined as one that is conducted outside the guidelines given in the periodicity schedule. For example, a 9-½ year old child is closer to age 10 than 8; consequently he/she would receive the exam according to the periodicity schedule for a 10-year-old.
Is a Health Check screening examination completed on an ill child?
When presented with an obviously ill child, a Health Check screening examination should not be completed. If screening results could be questionable, treatment should be provided and the Health Check screening should be rescheduled. If, however, a mild illness is detected during a Health Check examination, the examination may be completed and treatment may be provided, but only the Health Check examination can be billed. When billing for the Health Check exam, do not bill for the treatment completed on the same day.

How is a Health Check examination billed?
Local codes previously used for Health Check billing are no longer appropriate. In addition, incentive payments are no longer paid for Health Check visits. You must use diagnosis code V20.2, and you must bill with the appropriate CPT code and referral modifier when appropriate.

How are immunizations and lab tests billed?
Ancillary services such as lab tests and immunizations may be billed on the CMS-1500 with the appropriate CPT code. EqualityCare reimburses for administration of vaccines in addition to the reimbursement for the Health Check screening examination. The Wyoming Vaccine for Children Program (VFC) supplies providers with some vaccines free of charge and EqualityCare reimburses an administration fee of $10.00 when using the appropriate CPT code for these vaccines. Please do not bill the administration of vaccine code with VFC vaccine codes. Contact the VFC Program at 307-777-6001 for the list of VFC vaccines and appropriate CPT codes.

Health Check Periodicity Schedule
EqualityCare recommends the following periodicity schedule for the Health Check comprehensive physical and screenings as published by the National Center for Education in Maternal and Child, Bright Futures; Guidelines for Health Supervision of Infants, Children and Adolescents.

Comprehensive Physical: The unclothed physical examination includes specific elements as appropriate for the child’s age and health history, including: body measurements, blood pressure, pulse, general appearance, skin evaluation, facial features evaluation, ears, eyes, nose and throat inspection, pulmonary evaluation, auscultation of lung, chest configuration and respiratory movements, auscultation of heart and palpation of femoral arteries, abdominal evaluation of musculature, organs, and masses, urogenital evaluation, neurological evaluation including gross/fine motor coordination, vocalization and speech appropriateness for age, orthopedic evaluation including muscle tone and scoliosis.

Infancy: first week, 1 month, 2 months, 4 months, 6 months, 9 months
Early Childhood: 1 year, 15 months, 18 months, 2 years, 3 years, 4 years
Middle Childhood: 5 years, 6 years, 8 years, 10 years
Adolescence: Ages 11-20 each year

Dental Screen/Examination:
At each visit, parents should be educated on proper oral health care and practices that may be detrimental to their child’s oral health. Following the initial referral to a dental professional at age 3, subsequent examinations by a dental professional are recommended every six months, or more frequently as prescribed by a dentist or other authorized provider.
**Hearing Screen:**
Standardized testing should be performed on all neonates in the hospital prior to departure. A standard method of pure tone testing should also be employed by Health Check screening providers at ages 4-10, 12 and 18 years of age, or more frequently as prescribed by an authorized provider. Hearing testing may be subjective (by history), through 3 years, as well as at 11, 13-17 and 20+ years of age.

**Vision Screen:**
Vision testing is to be both objective (observation, cover test, Hirshberg light reflex) and subjective (by history) from birth through 3 years, at 10 years and at 16 years of age. Standardized vision testing should be done on newborns at risk for vision loss in the hospital prior to departure. It is recommended that children have their first full eye health and vision exam by an eye care practitioner at age 3 and yearly thereafter to ensure proper development.

Abnormalities detected during the Health Check screening examination should be directly referred to the appropriate specialist.

For more information regarding the periodicity schedule, go to the AAP website: http://www.cispimmunize.org

**EqualityCare Lead Risk Questionnaire**

Use this questionnaire when determining the need for further lead screening/testing. If the answer to the following questions is “no”, a screening test is not required, although providers should explain why the questions are asked to reinforce anticipatory guidance. If the answer to any of the following questions is “yes” or “not sure”, a blood level-screening test should be conducted.

1. Does your child live in or regularly visit a house or child care facility built before 1950?
2. Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has recently been renovated or remodeled (within the last 6 months)?
3. Does your child have a sibling or playmate who has or did have lead poisoning?
Hearing Services
Diagnostic or treatment services usually included in a comprehensive evaluation or office visit are integrated in that visit. Special services may be billed separately with the appropriate procedure codes.

Audiologist Services:
Audiology services as defined by EqualityCare are those tests referred by a physician for an EqualityCare client and provided by a licensed audiologist to include audiological function tests with a medical diagnostic evaluation and hearing aid examination.

Requirements:
- Physician orders, diagnostic, and evaluative reports must be current and maintained in the patient's record.
- Basic audio assessment MUST include at a minimum a speech discrimination test, a speech reception threshold, a pure tone air threshold, a pure tone bone threshold, tympanogram, and acoustic reflex testing.

Reporting Standards:
The audiologist report for EqualityCare clients shall contain the following information:
- Clients name, date of birth, and EqualityCare identification number.
- The results of the audiometric tests performed.
- The date the audiometric exam was performed.
- The audiologist's name, address, and license number, in typed or reprinted form.
- Report must be signed and dated by the audiologist.

The audiologist is required to send a copy of this report to the referring physician and maintain a copy in the patient’s medical record. Medicaid pays for hearing aid insurance, X5612.

Hearing Aid Examination
Requirements:
- Physician referral is required.
- The physician must indicate on the referral that there is no medical reason a hearing aid would not be effective in correcting the patient's hearing loss.
- Hearing aid examination should be in a sound attenuated room in a free field setting to determine those acoustical specifications most appropriate for the patient's hearing loss, and will include at least one follow-up visit.

Reporting Standards:
- The audiologist report for services rendered to a EqualityCare client must contain the following information:
  - Client's name, date of birth, and EqualityCare identification number.
  - The results of the audiometric tests for each ear.
  - The date the audiometric exam was performed.

A summary of the results indicating whether a hearing aid is required, the type of hearing aid, and whether monaural or binaural aids are required.

Report shall indicate the audiologist's name, address, and license number in typed or reprinted form.
Report **MUST** be signed and dated by the audiologist.

- The audiologist must provide a copy of the report to the client in order for the client to obtain a hearing aid. The client is allowed to use the hearing aid dispenser of his/her choice.
- The dispenser must retain a copy of the report in the patient's record.
- A copy of the report must be submitted with the claim.

Refer to Medical Supplies/DME Module for policy related to purchase of hearing aids.

**Hearing Aid Services**

"Hearing Aid" is defined as any wearable instrument or device designed for, offered for the purpose of, or represented as aiding persons with or compensating for impaired hearing.

"Hearing Aid Dispenser" is defined as any person, partnership, corporation, or association engaged in the sale, lease, or rental of hearing aids and licensed by the appropriate licensing agency within the state where the business is located.

**Covered Services**

- EqualityCare payment for hearing aids will be made only to enrolled hearing aid dispenser. An Audiologist is not required to have separate certification as a hearing aid dispenser.
- EqualityCare clients must be referred by a physician for audiologic function tests with medical diagnostic evaluation, and the physician must indicate that there is no medical reason a hearing aid would not be effective in correcting the patient's hearing loss.
- A hearing aid will be covered if the examination by the licensed audiologist results in a determination that a hearing aid or aids are needed when there is an average pure tone hearing loss of at least forty decibels over the frequency at 1000, 2000, 3000, and 4000 hertz.
- Ear molds must have a DME invoice; provider can write ear molds on the invoice if it is not clear.

**Reimbursement Guidelines**

**Dispensing:** EqualityCare will pay a dispensing fee for the hearing aid which will consist of the initial ordering, fitting, orientation, counseling, two return visits for the services listed and the insurance for loss or damage covered under an extended warranty. A copy of the warranty must be submitted to the Office of Medicaid upon request. These services are billed with HCPCS Level II-V procedure codes.

**Hearing Aids:** Payment will consist of the manufacturer’s invoice price. A copy of the invoice must be attached to the claims and must contain the model and serial number of the aid.

**Repair:** Repairs covered under warranty are not billable to EqualityCare. V5014 is used to bill for repair which is not covered by warranty. Claims must have an invoice attached including price/hours and actual costs.

Hearing aid insurance is covered for services not covered under warranty or when warranty expires:
- X5612 Standard hearing aid insurance, per aid, annual fee.
- X5613 Advanced hearing aid insurance, per aid, annual fee.
Laboratory Services

Covered Services

Medically necessary laboratory services are covered when a laboratory is licensed according to the state law in which the services are performed. The Federal Clinical Laboratory Improvement Amendment of 1988 (CLIA) applies to all laboratory services performed in an independent clinical laboratory as well as those laboratory tests performed in a physician's office.

Requirements

- Tests must be ordered by a physician/practitioner for a specific patient.
- The laboratory performing the test must bill tests.
- Specimen collection fees are allowed when drawing a blood sample through venipuncture or collecting a urine sample through catherization. Only one collection fee is allowed for each patient encounter.
- All of the tests in the panel must be performed in order to use the CPT code for the panel. If the laboratory is not performing all of the required tests listed in the panel code, then the panel code should not be reported. Rather, the individual CPT codes should be reported for tests performed. Panel codes that have similar lab tests should not be billed at the same time, i.e.: CPT code 80049 Basic Metabolic Panel should not be billed with 80051 Electrolyte Panel. Refer to the current American Medical Association Current Procedural Terminology (CPT) manual for specific lab tests included in each panel.

Non-covered

- Routine handling charges
- Stat fees
- Post-mortem examination
- Specimen collection fees for throat culture or Pap smears

Reimbursement

EqualityCare fees for clinical laboratory tests are based on amounts allowed by the Medicare program.
CLIA Requirements for Laboratory Codes
As of April 1, 2002

(Subject to change at any time)

The type of CLIA certificate required to cover specific codes are listed in the following table. These codes are identified by HCFA as requiring CLIA Certification; however, Wyoming EqualityCare/Medicaid may not cover all of the codes listed. Refer to the Wyoming EqualityCare/Medicaid Provider Modules for specific policy and limitations. Content is subject to change at anytime, without notice. A complete list is available at http://cms.hhs.gov/clia/waivertbl.pdf.

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**Certificate Type**

**Laboratory Tests**

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**Codes Excluded from CLIA Requirements**

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Nurse Midwife/Nurse Practitioner

Independent nurse midwife and nurse practitioner services are covered when they are in compliance with state laws or regulations in the state in which the service is performed. A nurse midwife must have completed a program of study and gained clinical experience for the management and care of mothers and their newborn infants through the maternity cycle.

The following Independent Nurse Practitioner specialties are covered:
- Anesthetists
- Pediatric
- Family
- OB/GYN
- Adult
- Geriatric

All services are billed with procedure codes covered by EqualityCare for the specific services. Special modifiers are not required.
Physical Therapy & Occupational Therapy

Covered Services

EqualityCare covers restorative therapy services when provided by or under the direct supervision of a licensed physical therapist, or licensed occupational therapist upon written orders from a physician.

Covered services must relate directly and specifically to an active treatment plan. Independent physical therapy services are only covered in an office or home setting. They are not covered in a Nursing Facility.

Services may only be provided following physical debilitation due to acute physical trauma or physical illness. All therapy must be physically rehabilitative and provided under the following conditions:

- Prescribed during an inpatient stay continuing on an outpatient basis; or
- As a direct result of outpatient surgery or injury.

Occupational Therapy interventions may include:

- Evaluations/re-evaluations required to assess individual functional status
- Interventions that develop, improve or restore underlying impairments

Manual Therapy Techniques

Covered when a physician or physical therapist applies physical therapy and/or rehabilitation techniques to improve the patient’s functioning. These techniques or therapy may include mobilization/manipulation, manual lymphatic drainage (massage), traction or other types of manipulation in one or more regions for fifteen minutes of direct patient to physician/therapist contact.

Physician’s Renewal Orders

The ordering physician must certify that:

- The services are medically necessary.
- A well-documented treatment plan is established and reviewed by the physician at least every thirty days.
- Outpatient physical therapy services are furnished while the patient is under their care.

Documentation Requirements

The physician’s and licensed physical therapist’s treatment plan must contain the following:

- Diagnosis and date of onset of patient's condition
- Patient's rehabilitation potential
- Modalities
- Frequency
- Duration (interpreted as estimated length of time until the patient is discharged from physical therapy)
- Physician signature and date of review are required
- Physical therapist's notes documenting measurable progress and anticipated goals
- Renewal orders (at least every thirty days) certifying the need for continued therapy and any changes
Limitations

CPT codes not listed in the PHYSICAL MEDICINE section are not covered.

Restorative and maintenance physical therapy is only covered for clients under the age of 21 who have chronic disabilities, through Developmental Centers or the school system.

Reimbursement includes all expendable medical supplies normally used at the time therapy services are provided. Additional Medical Supplies/Equipment provided to a patient as part of the therapy services for home use will be reimbursed through the Medical Supplies Program.

- Physical and occupational therapy visits are limited to 20 per calendar year for client’s age 21 and older.
- Visits made more than once daily are generally not considered reasonable.
- There should be a decreasing frequency of visits as the client improves.
Physician and Other Practitioner Services

EqualityCare covers services furnished by physicians and other practitioners are covered as specified in this section. Services provided in a physician’s office, under the direct supervision of a physician, by a physician's assistant, registered nurse, licensed clinical psychologist, licensed clinical social worker or board certified master's level counselor are billed with the supervising physician's EqualityCare provider number. Refer to the service descriptions within this section for additional information on specific requirements. Physician’s Assistants can enroll and receive payment for Medicare crossovers.

Refer to sections on Nurse Practitioners, Laboratory, Radiology, Hearing Services, and Physical Therapy for information applicable to these specific services when provided in a physician or practitioner’s office.
Abortion

Covered Services

Legal (therapeutic) abortions and abortion services will only be paid by EqualityCare under the following conditions. A physician must certify in writing that:

- The patient suffers from a physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place her in danger of death unless an abortion is performed; or
- The pregnancy is the result of sexual assault as defined in W.S. 6-2-301 which was reported to a law enforcement agency within five days after the assault or within five days after the time the victim was capable of reporting the assault; or
- The pregnancy is the result of incest.

The reporting requirements associated with sexual assault are defined in W.S. 35-6-117.

Reimbursement Requirements

An EqualityCare Abortion Certification Form (see the General Provider Manual for an example and billing instructions) must accompany all claims for abortion and abortion related services. This requirement includes claims from the attending physician, assistant surgeon, anesthesiologist, pathologist and hospital. The attending physician is required to supply all other billing providers with a copy of the consent form.

- In cases of sexual assault, submission of medical records is not required prior to payment; however, documentation of the circumstances of the case must be maintained in the medical records and records of agencies to which a sexual assault is reported.
- Other abortion-related procedures, including spontaneous, missed, incomplete, septic, and hydatiform mole, do not require the certification form; however, all abortion related procedure codes are subject to audit, and all pertinent records must substantiate the medical necessity and be available for review.
- RU-486 under the same guidelines as the legally induced abortion is covered when administered by a physician in the physician’s office.

Retroactive Eligibility

Reimbursement is available for those induced abortions performed during periods of retroactive eligibility ONLY IF the Abortion Certification Form is completely filled out prior to performing the induced abortion to certify that the above condition has been met.
Allergy and Clinical Immunotherapy

Coverage

Allergy testing must be performed under the direct supervision of a physician and must include observation and interpretation of the tests’ significance in relation to the history and physical examination.

Limitations

EqualityCare does not cover sublingual, intracutaneous, and subcutaneous provocative and neutralization therapy for food allergies.

Reimbursement Guidelines

An evaluation and management service code is allowed to obtain the history and conduct a physical examination. Subsequent evaluation and management may be billed when significant services are performed in addition to testing or immunotherapy.

- **Allergy Sensitivity Testing**
  - The actual number of tests performed must be entered as units in the unit’s column of the CMS-1500 claim form.

- **Allergy Immunotherapy**
  - Professional services for immunotherapy, which do not include the extract, should be billed with CPT codes for single or multiple injections.
Anesthesia Services

Coverage

Anesthesia services include pre and postoperative visits, anesthesia care during the procedure, administration of fluids and/or blood incident to the anesthesia or surgery, and the usual monitoring procedure. EqualityCare covers those anesthesia services that are rendered by a licensed anesthesiologist or Certified Registered Nurse Anesthetist (CRNA).

Only physicians should use procedure code 99360. Do not use this code in addition to charges for anesthesia, or multiply it by anesthesia time units. Standby anesthesia services are covered when the physician is physically present in the operating suite and performing the following functions:

- Monitoring the patient's condition
- Making medical judgments regarding the patient's anesthesia needs
- Standing ready to furnish anesthesia services as necessary to a specific patient who is known to be in potential need of such services

Anesthesia Consultations - rendered as a result of any direct or indirect patient care are included in the basic fee for anesthesia services and are not reimbursable separately. However, if an anesthesiologist is requested to consult with another physician or hospital anesthetist, or if a physician examines a patient to determine the appropriate agent and does not furnish direct anesthesia services, then the anesthesiologist may bill for a separate consultation.

Epidural Anesthesia - Epidural anesthesia is a covered benefit under the EqualityCare program when medically necessary.

Hospital Responsibility

A hospital, which accepts an EqualityCare patient for treatment, accepts the responsibility for making sure the patient receives all medically necessary services. The conditions of participation, which govern hospitals providing care to EqualityCare and Medicare patients, require that the governing body of the hospital assure accountability of the medical staff for the quality of care provided to patients. This means there must be an effective hospital – wide quality assurance program to evaluate the provision of patient care; and that all organized services related to patient care, including services furnished by a contractor must be evaluated and where deficiencies are identified, remedial action must be taken (42 CFR 482.12, 482.21, 482.22).

If providers (including but not limited to anesthesiologists) do not accept a particular patient for treatment, the hospital has the responsibility of assuring the delivery of these medically necessary services. If a provider accepts a pregnant EqualityCare beneficiary as a patient, she is entitled to receive the service without the imposition of deductibles, cost sharing or similar charges. Federal Medicaid law prohibits impositions of these charges. A provider agrees to accept EqualityCare payment as payment in full. A demand for additional payments would be in violation of the law.
If a provider does not accept a pregnant EqualityCare beneficiary as a patient, and the EqualityCare beneficiary accepts the arrangement as a condition of treatment through pregnancy and delivery, the arrangement is not governed by EqualityCare program requirements. For example: In such a physician non–EqualityCare patient arrangement, where a routine delivery is anticipated as part of her prenatal counseling that patient’s options for pain relief medication during childbirth may be explained to her. If she requests an epidural, it is explained that the anesthesiologist’s fee for this procedure must be paid in advance, prior to the time of hospitalization and delivery. This is not covered by EqualityCare requirements.

It is inappropriate to deny epidural services to an EqualityCare patient in childbirth because payment was not made in advance by her for the procedure under any circumstances.

**Limitations**

EqualityCare will not reimburse for anesthesia services which are performed in conjunction with a non-covered surgical procedure, or a procedure requiring client consent (hysterectomy or sterilization) when proper consent was not obtained. *Any procedure requiring informed consent must have a copy of the surgeon's consent form attached to the claim, (i.e.: hysterectomy, sterilizations and therapeutic abortions).* Charges for starting IV’s or patient intubation are included in the basic anesthesia fee and will not be paid as separate charges.

**Reimbursement Guidelines**

*CPT 00100 - 01999 Anesthesia* - CPT codes 00100 – 01999 are reimbursed, based on the units of the anesthesia procedure and the time units allowed. The total units (base units and time units) are multiplied by a conversion factor to determine the allowed amount. Medical supervision is not reimbursed.

**Time Units** - Anesthesia time which will be reimbursed by EqualityCare begins when the Anesthesiologist starts to prepare for the induction of the anesthesia and ends when the anesthesiologist is no longer in personal attendance. Submit claim for anesthesia time as the total number of minutes of anesthesia time for the surgery (ies) performed. Minutes are automatically converted by the system to reflect one unit for each fifteen-minute period.

**Base Units** - Relative Value Units for anesthesia services are based on McGraw Hill Relative Value Guide for physicians.

CPT procedures codes for introduction/injection of anesthetic agent (nerve block) diagnostic or therapeutic may be utilized. Time units are not billable for surgery codes in the CPT section 10040 - 69979.

When multiple procedures are performed during the same period of anesthesia administration, both procedures can be billed and supporting documentation must be attached to the claim.
Consultation Services

Covered Services

EqualityCare's coverage and limitations for medically necessary consultation services are in accordance with AMA CPT Coding guidelines:

- EqualityCare covers consultation services rendered by a physician whose opinion or advice is sought by a physician or other appropriate source for further evaluation and/or management of a patient for a specific problem.
- The request for a consultation from the attending physician or other appropriate source and the need for the consultation must be documented in the patient's medical record.
- The consultant's opinion and any service that was ordered or performed must also be documented in the patient's medical record and communicated to the requesting physician or other appropriate source.

Reimbursement Guidelines

A consultation initiated by a patient and/or family, and not requested by a physician, is **NOT** reported using the initial consultation code but may be reported using the codes for confirmatory consultation or office visits, as appropriate.

If, subsequent to the completion of a consultation, the consultant assumes responsibility for management of all or a portion of the patient's condition(s), the follow-up consultation codes should **NOT** be used.

In the hospital the physician receiving the patient for partial or complete transfer of care should use the appropriate inpatient hospital consultation code for the initial encounter and the subsequent hospital care codes. In the office setting, use the appropriate established patient code.

There are four subcategories of consultations:

- Office
- Initial inpatient
- Follow-up inpatient
- Confirmatory

A physician consultant providing a confirmatory consultation is expected to provide an opinion and/or advice **ONLY**. Services subsequent to the opinion are coded at the appropriate level of office visit, established patient, or subsequent hospital care if the physician has taken over the management of the patient.

If an additional request for an opinion or advice regarding the same or a new problem is received from the *attending* physician and documented in the medical record, the office consultation codes may be used again.

When billing for a consultation, the UPIN number of the referring physician must be entered in field 17A or if the referring provider does not have a UPIN then the provider name must appear in field 17 of the claim form.
Documentation

EqualityCare requires Documentation of Medical Necessity be attached to a claim submitted by the consulting physician when a client is seen for an additional consultation within one year of an initial consultation.

Medical Necessity will be reviewed in accordance with the following policy:

- Documentation that a referring physician has requested an additional consultation.
- Documentation of the medical condition and/or complications of care requiring an additional opinion or advice.
- Claims submitted without the Documentation of Medical Necessity will be denied and returned for the required attachment.
- Documentation that does not support the use of consultative services will be denied. The provider can resubmit the claims with supporting documentation for use of the consultative codes or re-code for the appropriate level of evaluation/management services.
Dermatology

Covered Services

EqualityCare covers consultative dermatological procedures, as well as medically necessary services rendered in the treatment of dermatological illnesses.

Acne surgery is a covered service. For those clients who have a disfiguring acne condition, the client's medical records MUST document the medical necessity of the procedure.

There are limitations on removal of lesions not suspected to be precancerous. If a physician finds it medically necessary to remove a benign lesion, ganglion cyst, skin tag, keloid, or wart, the client's medical records must clearly document the medical necessity and condition present that will support the procedure performed:

- Restoration of a body area affected by the lesion, cyst, keloid or wart
- Recurring infections, bleeding or irritation at the site
- Suspicious lesions or changes in any lesions causing physician concern
- Destruction of cutaneous vascular lesions for the treatment of hemangiomas and vascular malformations, i.e., port wine stains
- Documentation supporting clinical evidence that significant medical complications may occur if treatment is not rendered

Limitations

- Services performed primarily for cosmetic reasons
- Services which are not medically necessary
- Services which are done for patient convenience

If, prior to rendering the service, the provider and the client mutually agree in writing to have services performed which are not covered, and the client is informed of their financial responsibility, then the client may be billed for the services rendered.
Diabetic Training

The physician that is managing the client’s diabetic condition must order diabetic training sessions. These services would normally be provided in a group session. However, an individual training session can be provided for a client if their physician documents that it is medically necessary, due to language barriers or physical challenges, such as severely impaired hearing or sight.

EqualityCare will reimburse for these services when billed by an enrolled physician or physician’s group. EqualityCare does not enroll Certified Diabetic Educators (CDE) or a dietician. Therefore, CDE’s and dieticians that are employed by a physician or a physician’s office may furnish outpatient diabetes self-management training; however, claims must be submitted under the physician’s EqualityCare provider number.

Reimbursement Guidelines

- Diabetes outpatient self-management training services, individual session per 30 minutes, adult.
- Diabetes self-management training services, group session (2 or more) per 30 minutes, adult.

30 minutes equals one unit, you will not be allowed to bill more than 10 units (5 hours) of each service per client.
Family Planning Services

Covered Services

- Medicaid covers family planning services when provided by a physician or nurse practitioner.
- Sterilization procedures are covered only when all Medicaid sterilization guidelines are met.
- Diaphragms, condoms, creams, foams, sponges, spermicides, IUDs, and oral contraceptives are covered when prescribed by a physician or nurse practitioner and dispensed by a participating pharmacy.
- Implantable contraceptives (Norplant) and contraceptive injections are covered.

Procedures

- Norplant
- Cervical Cap for contraceptive use
- Diaphragm for contraceptive use
- Condom, male
- Condom, female
- Spermacide
- Contraceptive pills
- Depo Provera Aq. injection 100 mg
- Depo Provera injection 150 mg
- Norplant removal
- Physician – insertion of IUD (Intrauterine device)
- IUD removal – Physician also

Non-Covered Services

Medicaid does not cover services related to infertility. These services include, but are not limited to:

- Reversal of sterilizations
- Artificial insemination
- Fertility testing
- Infertility counseling

Limitations

An Evaluation/Management office service code should not be billed separately on the same day as any one of these procedures:

- Insertion of implantable capsules. This code does not include the cost of the contraceptive.
- Removal of implantable contraceptive capsules.
- Removal with reinsertion of implantable contraceptive capsules. This code does not include the cost of the contraceptive.
Reimbursement Guidelines

Family planning visits should be billed under the appropriate evaluation and management code for office/outpatient services. An “F” indicator should be entered in field 24H. Procedures, which may be billed as family planning services, include:

- Diaphragm fitting with instructions (includes initial diaphragm).
- Insertion of Intrauterine Device (IUD) – This code does not include the cost of the IUD. The IUD is billed with the appropriate HCPCS code.
- Removal of an IUD.
Home Visits (House Calls)

Covered Services:

- New patients
- Established patients

EqualityCare covers home care visits, billed by a physician, for pregnancy related conditions and infant/child related medical services provided by a registered nurse employed by the ordering physician. This benefit is not intended to replace those services available in the community through other agency programs, (Best Beginnings, PHN, Home Health, etc.) but to offer the attending physician another alternative to care for children and pregnant women in the home setting. Home visits are a covered service for the following situations:

- Episodic acute care
- High risk pregnancy monitoring
- Premature birth monitoring
- Failure to thrive
- Cases determined by the physician to need limited home monitoring

The physician is required to establish, and keep on file, protocols necessary to monitor the services performed in the home setting. Care rendered by the registered nurse must be within their scope of practice and be countersigned by the physician who ordered the visit.

The physician using the physician provider number must bill services provided. The following documentation must be included in the client's medical record:

- Documentation of physician order and treatment plan of care
- Documentation of observed medical condition, progress at each visit, any change in treatment, and client's response to treatment
- Documentation of coordination of care between office and home visit
Hospital Services
Covered Services

EqualityCare covers physician visits furnished in hospitals when the hospital admission meets the certification requirements of admissions guidelines and/or prior authorization requirements.

Limitations

EqualityCare will reimburse the admitting physician for only one initial visit per client for each hospital stay. A comprehensive inpatient hospital visit is not allowed within thirty days of a previous hospital admission with the same diagnosis.

EqualityCare will not reimburse a comprehensive hospital inpatient exam on the same day as an office visit or nursing home visit or ER visit by the same provider.

For initial inpatient encounters by physicians other than the admitting physician use initial inpatient consultation codes or subsequent hospital care codes.

Reimbursement Guidelines

- **Initial Hospital Care - New or Established Patient**
  All evaluation and management services related to and provided on the same date as an inpatient admission are considered part of that hospital admission. They are **NOT** reported separately. This applies regardless of the setting in which the services are provided, (e.g., observation status, physician's office, or hospital emergency department, etc.).

- **Subsequent Hospital Care**
  Subsequent visits are limited to one visit per day unless a Documentation of Medical Necessity form is attached and approved by EqualityCare. All subsequent hospital care Visits are to include reviewing the medical record and the results of diagnostic studies And changes in the patient's status since the last assessment by the physician.

- **Observation or Inpatient Care Services**
  These codes are used to report observation or inpatient hospital care services provided to patients admitted and discharged on the same date of service. For patients admitted to observation or inpatient care and discharged on a different date, see codes 99218-99220 and 99217, or 99221-99223 and 99238-99239.

- **Hospital Discharge Services**
  The physicians may bill for the final day of hospital care of a multiple day stay if they provide a final examination, discussion of the stay, instructions for continuing care and preparation of discharge records. These codes are **NOT** allowed when an initial or subsequent hospital visit is billed on the day of discharge. These codes are only to be used to report services provided to the patient on the date of discharge from a multiple day stay. Only one code may be used.
• **Hospital Observation Services**
These codes are used to report evaluation and management services provided to patients admitted for observation status in a hospital. It is not required that the patient be located in an observation area designated by the hospital as a separate unit. These codes are to be used based on the level of care the patient receives rather than location.

To report services provided to a patient admitted to the hospital after receiving hospital observation care services on the same date, refer to the hospital inpatient billing instructions. For a patient admitted to the hospital on a date subsequent to the date of observation status, the hospital admission is reported using the appropriate initial hospital care codes. Do not report the observation discharge in conjunction with the hospital admission.

All evaluation and management services related to and provided on the same day as an admission to observation status are considered part of that admission. Do not report them separately. This applies regardless of the setting in which the services are provided (e.g., a hospital emergency department, a physician's office, or a nursing facility, etc.).

These codes apply to all physician services provided on the same date of patient admission to observation status. Do not use these codes for postoperative recovery if the procedure is considered a global surgical procedure.

• **Observation Care Discharge Services**
This code is to be utilized by the physician to report all services (final examination of patient, discussion of hospital stay, instructions on continuing care, and preparation of discharge records) provided to a patient on discharge from “observation status” if the discharge is on a date other than the initial date of “observation status”.

• **Concurrent Care Codes**
Defined as inpatient hospital care by two or more physicians to the same patient at the same time. Physicians who are providing concurrent care should use the subsequent hospital care billing codes. EqualityCare will reimburse for these services when ALL of the following circumstances are met:
  - The physicians have different specialties or subspecialties;
  - The condition or injury involves more than one body system;
  - The condition or injury is so severe or complex that one physician alone cannot handle the patient's care; and
  - The physicians are actively co-managing the patient's treatment.

If physicians of the same or similar specialty render care to the same patient for the same condition for the same time, only the services of the attending physicians are covered.
• **Critical Care Visits**
  Critical care is the treatment of critically ill patients experiencing a variety of medical emergencies requiring the *constant attendance* of the physician. Critical care is usually, but not always, given in a critical care area. The use of these codes includes:
  - The interpretation of cardiac output measurements
  - Chest x-rays
  - Blood gases
  - Data stored in computers
  - Gastric intubation
  - Temporary transcutaneous pacing
  - Ventilator management and vascular access procedures

Any services performed, which are not listed above, should be reported separately.

The critical care codes are used to report the total duration of time spent by a physician providing constant attention to a critically ill patient. The code to report the first hour of critical care should be used only once per day even if the time spent by the physician is not continuous that day. Another code is used to report each additional 30 minutes (30 minutes = 1 unit) beyond the first hour.

Services for a patient who is not critically ill but happens to be in a critical care area are to be reported using subsequent hospital care codes not critical care.

• **Prolonged Service**
  Prolonged services that exceed three hours on the same date of service require Documentation of Medical Necessity attached to the claim. Documentation must also be accurately recorded in the patient's medical record, including the purpose and actual time the physician was detained.

• **Physician Standby Service**
  A physician required to "standby" (e.g. operative standby, standby frozen section, for c-section/high risk delivery for newborn care, for monitoring EKG) may charge for services in addition to the regular medical service each 30 minutes. This code may not be reported in addition to a CPT code for attendance at delivery.

• **Emergency Room Services**
  EqualityCare covers physician services performed in the emergency department of a hospital when furnished by:
  - A hospital-based emergency room physician;
  - A private physician who furnishes emergency room services through arrangement with the hospital; or
  - A private physician who is called to the hospital to treat an emergency.

An emergency department is defined as an organized hospital-based facility for the provision of unscheduled, episodic services to patients who present themselves for immediate attention. The facility must be available twenty-four hours a day.
EqualityCare reimburses for physician direction of emergency care systems and advanced life support when the physician is located in a hospital emergency department or critical care department and is in two-way voice communication with ambulance or rescue personnel outside the hospital. These physician-directed services include but are not limited to:

- Telemetry of cardiac rhythm
- Cardiac and/or pulmonary resuscitation
- Endotracheal or esophageal obturator airway intubation
- Administration of intravenous fluids and/or intramuscular, intratracheal, or subcutaneous drugs
- Electrical conversion of arrhythmia

In all cases the physician must document in the patient's medical record if the patient's visit to the emergency room was actually an emergency situation. Physicians are requested to report any potential abuse of emergency room visits to ACS, Inc. No distinction is made between new and established patients in the emergency department.

- *Neonatal Intensive Care*
  These codes are used to report services provided by physicians directing the care of a neonate or infant in a neonatal intensive care unit (NICU). The codes represent care starting with the date of admission to the NICU and may be reported only once per day, per patient. Once the neonate is no longer considered to be critically ill, the codes for subsequent hospital care should be utilized.

Care rendered includes management; monitoring treatment of the patient including nutritional, metabolic and hematologic maintenance; parent counseling; and personal direct supervision of the health care team in the performance of cognitive and procedural activities.

The following procedures are also included as part of the global descriptors: umbilical, central or peripheral vessel catherization, endotracheal intubation, lumbar puncture and suprapubic bladder aspiration. In addition, specific services are included in the parenthetic note following each NICU code. Any services, which are not listed above or not listed, with each NICU code should be reported separately.

- *NICU*
  The NICU covers the procedures of evaluating, managing and helping in the recovering of a very low birth weight infant (less than 1500 grams or about 3.3 pounds). These procedures apply to infants who are no longer critically ill but continue to require intensive care under the constant observation of a healthcare team supervised by a physician. This care may include cardiac and respiratory monitoring, continuous and/or frequent vital sign monitoring, heat maintenance, enteral and/or parenteral nutritional adjustments, laboratory and oxygen. Infants in this category of low birth weight are expected to require infrequent changes in respiratory, cardiovascular and/or fluid and electrolyte therapy.

- *Newborn Care*
  Newborn codes are used to report the services provided to normal or high risk newborns in several different settings.
• **Attendance at Delivery**
  This code covers attendance at delivery (when requested by delivering physician) and initial stabilization of newborn. This code may be reported in addition to the CPT code for *history* and examination, but may not be reported in addition to the newborn resuscitation code.

• **Pediatric Critical Care**
  CPT Codes are available for initial and subsequent pediatric critical care.
Hysterectomies

Covered Services

Hysterectomies are covered in the following circumstances:

Medically Necessary - A medically necessary hysterectomy will be covered when the physician or physician's representative securing the authorization to perform the hysterectomy has informed the patient verbally and in writing PRIOR to the surgery being performed that the hysterectomy will render the individual permanently incapable of bearing children. The patient must sign the written acknowledgment that she has been provided this information and does fully understand the information. It is required that the physician or physician's representative sign the written acknowledgment in ink. Signature stamps will not be accepted and may result in the claim being denied. Documentation of medical necessity must be in the patient’s record.

NOTE: The written acknowledgment of consent statement is acceptable if the patient signs the statement before or after the hysterectomy is performed.

Emergency - When a hysterectomy is performed on an emergency basis because of life-threatening circumstances and the physician determines that prior acknowledgment of consent is not possible, the physician must certify in writing that prior acknowledgment was not possible and describe the nature of the emergency.

Sterility - A hysterectomy performed on a patient who was already sterile before the surgery is not subject to the written acknowledgment requirement; however, the physician must certify in writing that the patient was sterile at the time of the hysterectomy and must state the cause of the sterility.

Limitations

Federal regulations that are established as the guideline for EqualityCare do not consider a hysterectomy to be a sterilization procedure. Therefore, hysterectomies performed solely or primarily for the purpose of rendering an individual incapable of reproducing are not covered by EqualityCare.

A copy of the completed Hysterectomy Acknowledgment Consent Form (see the General Provider Manual for an example and billing instructions) must be attached to each provider's claim. It is the responsibility of the originating physician to supply other billing providers with a completed copy of this form. The Sterilization Consent Form will not be accepted as a substitute for the Hysterectomy Acknowledgment of Consent Form.

Retroactive Eligibility

Reimbursement is available for hysterectomies performed during periods of retroactive eligibility if the physician who performed the hysterectomy certifies in writing that the client was informed prior to the operation that the hysterectomy would render her permanently incapable of bearing children and that the procedure was medically necessary.

The physician's written certification or a copy must accompany all claims submitted by the providers. A copy of the consent form is still required. It is the performing physician's responsibility to provide the written certification to other billing providers.
Incentive

In order to qualify for an incentive payment, a provider must complete the "Certification of Disproportionate Share Form". This form certifies that 25% or more of the total patients seen in the practice, or 25% or more of the group practice by a physician, nurse practitioner, or nurse mid-wife during the provider's most recent fiscal reporting period of at least six (6) months, were EqualityCare or Kid Care Patients.

Documentation must be available upon request by EqualityCare for audit purposes. Certification will apply to the billing provider number, irrespective of whether the practice is an individual or group practice. Re-certification is required every twelve (12) months.
Injections

Immune Globulins

These codes identify the immune globulin product only and are reported in addition to the administration codes 90780-90784 as appropriate.

Vaccines, Toxoids

CPT codes for vaccines identify the vaccine product only and are reported in addition to the immunization administration codes 90471, 90472 unless the VFC program supplies the vaccine. The exact vaccine product administered needs to be reported.

Separate codes are available for combination vaccines. It is inappropriate to code each component of a combination vaccine separately.

Vaccine For Children (VFC) Program

Providers must enroll with the VFC program to receive and distribute VFC vaccines. An administrative fee of $10.00 for VFC vaccines is allowed when the appropriate CPT code for the vaccine is billed. This fee is allowed in addition to the fee paid for Health Check/Well Child examination or other evaluation and management visit. A partial listing of vaccines distributed through the Wyoming Immunization Program free of charge follows. EqualityCare does not reimburse VFC vaccines purchased on the open market. For questions on the Vaccine For Children Program call the Wyoming Immunization Program at (307) 777-7952.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>90633</td>
<td>Hepatitis A vaccine, two doses.</td>
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<tr>
<td>90634</td>
<td>Hepatitis A vaccine, three doses.</td>
</tr>
<tr>
<td>90636</td>
<td>Hepatitis A and Hepatitis B vaccine, adult dose, for intramuscular use.</td>
</tr>
<tr>
<td>90645</td>
<td>Hib – Hemophilus influenza B vaccine, HbOC conjugate (4 dose schedule), for intramuscular use.</td>
</tr>
<tr>
<td>90646</td>
<td>Hib – Hemophilus influenza B vaccine, PRP-D conjugate, for booster use only, intramuscular.</td>
</tr>
<tr>
<td>90647</td>
<td>Hib – Hemophilus influenza B vaccine, PRP-OMP conjugate (3 dose schedule), for intramuscular use.</td>
</tr>
<tr>
<td>90700</td>
<td>DtaP – Diphtheria, tetanus toxoids, and acellular pertussis vaccine for intramuscular use.</td>
</tr>
<tr>
<td>90702</td>
<td>Diphtheria, and tetanus toxoids (DT) absorbed for pediatric use, for intramuscular use.</td>
</tr>
<tr>
<td>90707</td>
<td>MMR – Measles, mumps, and rubella virus vaccine, live, for subcutaneous or jet injection use.</td>
</tr>
<tr>
<td>90713</td>
<td>IPV – Poliovirus vaccine, inactivated, for subcutaneous use.</td>
</tr>
<tr>
<td>90716</td>
<td>Varicella (chicken pox) virus vaccine, live, for subcutaneous use.</td>
</tr>
<tr>
<td>90718</td>
<td>Td – Tetanus and diphtheria toxoids absorbed for use in individuals seven years or older, for intramuscular or jet injection.</td>
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<tr>
<td>90721</td>
<td>DtaP-Hib – Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Hemophilus influenza B vaccine, for intramuscular use.</td>
</tr>
</tbody>
</table>
90723  DTaP, Hepatitis B and Poliovirus Vaccine
90744  Hepatitis B vaccines, pediatric or pediatric/adolescent dosage, for intramuscular use.
90745  Hepatitis B vaccine, adolescent/high risk infant dosage, for intramuscular use.
90748  HepB-Hib - Hepatitis B and Hemophilus influenza B vaccine, for intramuscular use.
90675  Rabies vaccination – Providers may contact the Community and Family Health Division to request the rabies vaccination and immunoglobulin, which must be used together. They can be obtained either pre- or post-exposure to rabies. The patient is responsible for submission to insurance. The claim must be submitted on a CMS-1500 and may not include charges for shipping.

Bill vaccines **not** supplied by the VFC program with an appropriate CPT code for the vaccine product in addition to the appropriate immunization administration code, 90471 or 90472.

**Influenza and Pneumococcal Vaccines**

EqualityCare covers influenza vaccine and pneumococcal vaccine for patients considered at risk. When an EqualityCare client is a resident of a long-term care facility, the vaccine and administration are included in the nursing home per diem rate, and NOT paid separately.

**Therapeutic or Diagnostic Infusions** (Excludes Chemotherapy)

These procedures encompass prolonged intravenous injections. These codes require the presence of the physician during the infusion. These codes are not to be used for intradermal, subcutaneous or intramuscular or routine IV drug injections. These codes may not be used in addition to prolonged service codes.

**Therapeutic or Diagnostic Injections**

EqualityCare will cover therapeutic injections if the following conditions are met:
- The drug cannot be given orally, and
- The drug cannot be self administered, and
- The drug is reasonable and necessary for the diagnosis and/or treatment of the illness or injury for which it was prescribed.

**Limitations**

Appetite suppressants are not covered. Vitamin injections are not covered; except for Vitamin B-12, which is limited to clients with one of the following diagnosis:

- 040.2  Whipple's disease
- 094.0  Tabes Doraslis
- 123.0-123.9  Cestode infestations
- 140.0-239.9  Cancer
- 250.6  Diabetic Neuropathies
- 266.2  Postlateral Sclerosis
- 266.9  Vitamin B Complex Deficiency
Frequency of Vitamin B-12 injections is limited to the following schedule:

- One injection per day for the first week;
- One injection per week for the next four weeks; and
- One injection per month until the condition is stabilized.

Chemotherapy

EqualityCare covers chemotherapy services rendered in an inpatient, outpatient, or office setting for the treatment of cancer.

Covered Services

- Procedures for administration
- Chemotherapy drugs (for specific codes refer to the HCPCS book)
- Physicians may bill for professional office or hospital visits in addition to the administration of the chemotherapy and the cost of the drugs.

Limitations

- Preparation of the chemotherapy agent(s) is included in the service for administration of the agent.

Reimbursement Guidelines

The appropriate J-code MUST be used when submitting claims. Reimbursement for J-Codes includes an allowance for administration.

Reimbursement for therapeutic injections INCLUDES the cost of administration. This cost is already calculated into the fee for each code.

If multiple drugs are included in a single injection, separate codes may be billed for the drugs, however, the administration fee should be included with only one code.

Injection codes are NOT paid in addition to a J-code. The only exception is when the patient supplies the medication, which must be documented on the claim. CPT Codes for therapeutic injections will be reimbursed for administration of injection only.
EqualityCare no longer reimburses payment for the Miscellaneous J-Code, J3490. This policy change was made because, when using the miscellaneous J-Code the actual medication prescribed will not show up on a patient's profile for Drug Utilization Review requirements and drug rebates cannot be collected from the drug manufacturer.

J-Code fees are reviewed and updated on an annual basis. If a fee for a specific drug does not cover the provider’s cost in purchasing the drug, the fee may be updated more frequently.
Locum Tenens

Locum Tenen is a substitute doctor. The locum tenen subs for a doctor who is either on vacation, changing or turning over their practice or the substituting doctor is a resident. A locum tenen can be enrolled as a treating physician.

EqualityCare may issue a separate provider number to a physician (individual or group) to use in billing for locum tenens services. This option is generally needed when a provider routinely utilizes one or more locum tenens. Payment is made to the provider to whom the locum tenens number is issued.

It is also permissible for a provider to bill for the services of a locum tenens by using their own provider number, except when the locum tenens is assisting a surgeon. When services are billed with a locum tenens number, the medical records will need to substantiate the service that was provided by a locum tenens with an employment agreement.
Maternity Care and Delivery

Coverage

EqualityCare covers services normally provided in uncomplicated maternity cases, according to guidelines set forth in the current edition of CPT. Ultrasounds is covered when medically necessary.

EqualityCare accepts total/global care OR individual service billing for routine care.

Billing for Total/Global

**Total/Global Care**

- Billing for total/global care must include at least five antepartum visits, delivery and scheduled postpartum care.
- Charges are billed on or after the delivery using the actual date of delivery as the date of service.
- If a physician or clinic has an agreement with another physician to cover the delivery procedure, the primary physician may utilize global billing and must then reimburse the attending physician for the delivery. Without such an agreement, each physician must bill only for the actual services provided.

Billing for Individual visits:

**Antepartum Care**

- Initial visit as well as the second and third visit must be billed with the Appropriate Evaluation/Management code.
- For the fourth, fifth or sixth visit(s) Enter first and last dates and Number of visits. (Example, the client was seen on 01/01/03, 02/01/03 and 03/01/03, you would bill with 01/01/03 as the first date of service and with 03/01/03 as the last date of service. You would then bill for 3 units.) This is all billed on one line.
- For the seventh visit and any visit(s) thereafter Enter first and last Dates and number of visits. (Example, the client was seen on 04/01/03, 5/01/03, 05/15/03, 05/31/03, 06/15/03 and 06/22/03, you would bill with 04/01/03 as the first date of service and with 06/22/03 as the last date of service. You would then bill for 6 units.) This is all billed on one line.
- **Delivery Only**
- **Postpartum Care**

Do not bill with a delivery code, which includes postpartum care.
Intrathecal Injection for Labor and Delivery

Injection of anesthetic substance (including narcotics), diagnostic or therapeutic, subarachnoid or subdural, single, will be accepted by EqualityCare. This injection is not included in the global obstetric rate. Limitations are as follows:

- The maximum number of billable units will be one (1) unit. Additional units will require documentation for review. No time will be billable for this procedure.
- This code cannot be billed with any other anesthesia code unless supporting documentation is sent in for review.

EqualityCare will only reimburse physicians, anesthesiologists, and CRNAs for performing the intrathecal injection.

Reimbursement Guidelines

- If the physician meets the patient at the emergency room or admits the patient to the hospital for observation, in the instance of false labor, the appropriate ER visit code should be used.
- Pregnancies, which terminate in abortion in any trimester, must be billed using the appropriate abortion procedure code. Prenatal visits and any additional services must be billed separately.
- If the patient is considering sterilization, it is suggested that consent should be obtained at or about the twenty-fourth week of pregnancy thereby ensuring compliance with all Federal and State guidelines. When sterilization is performed at the time of delivery, it should be billed as a separate procedure. Sterilizations are reimbursed in addition to the delivery only if consent has been obtained using EqualityCare forms and requirements.
- When billing for the services of an assistant surgeon at a delivery, use the procedure code for delivery only with an -80 modifier.
- An examination to determine if the patient is pregnant is not considered an initial maternity visit unless a review of the total body system is included. It is general practice that a limited office exam for a perceived condition would be charged at the time of the pregnancy test.
Medical Supplies Furnished by a Physician/Practitioner's Office

Coverage

In general, providers must be enrolled as a medical supply provider to bill for medical supplies. However, it is not necessary for a physician office to enroll as a medical supply provider in order to bill for medical supplies incident to physician services.

Disposable Medical Supplies - A medical supply or equipment that is intended for one-time use and not for re-use and specifically related to the active treatment or therapy of the client for a medical illness or physical condition. These supplies have a medical purpose, are consumable and/or expendable and non-durable. This does not include personal care items. Following is a partial list of disposable medical supplies.

- Major surgical tray: Reimbursement may be allowed for a surgical tray if minor surgery necessitates local anesthesia and other supplies (i.e., gauze, sterile equipment, suturing material) and the surgery is performed in a physician's office. Examples of procedures requiring a major surgical tray include diagnosis biopsies, wound closures, and removal of cysts or other lesions. A suture removal tray is not considered to be a major surgical tray and will not be reimbursed as such. Reimbursement is NOT provided when the surgery is performed in a hospital.
- Ace Bandage
- Sling
- Rib Belt
- Straight Catheter Kit

Supplies and materials, which do not have a procedure code, may be billed with CPT code 99070, which will reimburse the billed amount or $10.00, whichever is less. Claims for more than $10.00 require an attached invoice. Claims billed with this code will be reviewed to determine if they should have been billed with a specific CPT code. These claims will be paid at invoice cost plus 15%.

Limitations

Expendable medical supplies normally used in the physician's office, such as gauze, dressings, syringes and culture plates, are INCLUDED in the reimbursement rate for the office visit or test performed. Only the actual cost of medical supplies, such as those listed above will be reimbursed separately.

Covered supplies and equipment prescribed by a physician and furnished by an enrolled Medical Supplier for use in the patient's home are reimbursed through the Medical Supply Program, and are subject to limitations and policies detailed in the Medical Supply Manual. Contact ACS, Inc. to determine if a code is covered.
Nursing Facility Visits

Coverage

Physician visits to patients in a nursing facility are covered when they are medically necessary and are performed to meet the requirements of continued long-term care.

Limitations

When a patient is admitted to the nursing facility in the course of an encounter in another site of service, such as office or emergency room, all evaluation and management services in conjunction with the admission are considered part of the initial nursing facility care if performed on the same date, and will not be reimbursed separately. Initial patient care may be billed only once per long term care stay unless patient has moved to a different facility. Evaluation and management codes billed in addition to code 99303 are not reimbursed when performed on the same date as the admission.

Hospital discharge or observation discharge services performed on the same date of nursing facility admission or readmission may be reported separately.

Reimbursement Guidelines

Two subcategories of nursing facility services are recognized. Both subcategories apply to new or established patients; and must be billed by the Primary Care Physician or nurse practitioner.

**Comprehensive Nursing Facility Assessments (99301-99303)**

- **99303** Initial Assessment - Evaluation and Management of a new or established patient involving a nursing facility assessment at the time of initial admission or readmission to the facility.
- **99301** Annual Assessment - Evaluation and Management of a new or established patient involving an annual nursing facility assessment.
- **99302** Intermediate Assessment - Evaluation and Management of new or established patient involving an intermediate assessment when a patient has had a major change in status, and requires a new plan of care.

**Subsequent Nursing Facility Care per day (99311-99313)**

- **99311** Subsequent nursing facility care, per day, for the evaluation and Management of a new or established patient. Problem focused.
- **99312** Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient. Expanded problem focused.
- **99313** Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient. Detailed history and exam.

**Domiciliary Rest Home or Custodial Care (Assisted Living Facility)**

The following codes are covered for evaluation and management services in a facility, which provides room, board and other personal assistance services, generally on a long-term basis. The facility's services do not include a medical component.

- **99231-99233** New Patient
- **99331-99333** Established Patient
Nursing Facility Discharge Services

Nursing facility discharge day management codes are to be used to report the total duration of time spent by a physician for the final nursing facility discharge of a patient.

- 99315  Nursing Facility discharge day management; thirty minutes or less.
- 99316  Nursing Facility discharge day management; more than thirty minutes.
Office and Outpatient Services

Covered Services

Office Visits

- New Patient Procedures
- Established Patient Procedures

*Several codes* may be used in addition to the above codes when services are provided in a physician or practitioner's office for emergency care after scheduled routine office hours.

**New Patient**

EqualityCare considers a new patient to be a patient who is new to the physician or group practice and whose medical and administrative records need to be established. A new patient visit should be submitted once per client lifetime per provider. An exception may be allowed when a patient has been absent for a period of three years.

**Established Patient**

EqualityCare considers a routine office visit for an established patient to be a limited service, CPT code 99213. If a provider furnishes services at a higher level, documentation supporting the medical necessity for such services must be maintained in the patient's medical record.

**Complex Examinations for Child Protection**

EqualityCare utilizes the following EqualityCare for specific office services:

**NOTE: THE CODES AND MODIFIERS ARE SUBJECT TO CHANGE**

<table>
<thead>
<tr>
<th>Local Code</th>
<th>CPT Code</th>
<th>Modifiers</th>
<th>Description</th>
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</thead>
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<tr>
<td>X5870</td>
<td>99202 or 99214</td>
<td>E &amp; M code for new patient</td>
<td>E &amp; M code for established patient</td>
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<tr>
<td>X5874</td>
<td>99204 or 99215</td>
<td>E &amp; M code for new patient</td>
<td>E &amp; M code for established patient</td>
</tr>
<tr>
<td>X5878</td>
<td>99205 or 99215</td>
<td>E &amp; M code for new patient</td>
<td>E &amp; M code for established patient</td>
</tr>
</tbody>
</table>
Diet Instruction
EqualityCare has established the following guidelines for diet instructions when performed by a physician, nurse or nurse practitioner:

- Services must be a required part of treatment for a well-established diagnosis such as hypertension, cardiac disease, and diabetes.
- Services must be performed by a licensed nurse or registered dietitian under physician orders, and must be billed by the physician.
- If the sole purpose of the visit was for diet instruction, the service must be coded as a routine visit using CPT code 99212.
- If obesity is the primary or only diagnosis, diet instruction is not covered.
- Diabetic self-management training is covered on newly diagnosed diabetics.

Osteopathic Manipulative Treatment (OMT)
EqualityCare will reimburse a physician for OMT Codes. These codes cannot be billed with an E/M Code on the same day of the manipulation unless the patient's condition requires a significant, separately identifiable E/M service above and beyond the usual pre-service and post-service work associated with the OMT procedure.

Psycho-social Counseling
The following codes are reimbursed, when using the proper modifier, for services provided by clinical psychologist, licensed clinical social workers or board certified master’s level counselors in physician’s offices. Co-signature by the physician is not required; the physician is responsible for supervising the mental health provider for services billed.

Supervision is defined as the ready availability of the physician for consultation and direction of the activities of the mental health professional in the office. Contact with the physician by telecommunication is sufficient to show ready availability, if such contact provides quality care. The physician maintains final responsibility for the care of the patient and the performance of the mental health professional in their office.

NOTE: THE CODES AND MODIFIERS ARE SUBJECT TO CHANGE

<table>
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<tr>
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<th>Modifiers</th>
<th>Description</th>
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<td>X3001</td>
<td>90804</td>
<td>AH (clinical psychologist)</td>
<td>Individual or family counseling, per 15 minutes</td>
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<td></td>
<td>90815</td>
<td></td>
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<tr>
<td></td>
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<td></td>
<td>90853</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>90804</td>
<td>AH (clinical psychologist)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>90815</td>
<td>AJ (clinical social worker/master’s level counselor) Use of modifiers will pay at 75% of fee</td>
<td>Group counseling, per 15 minutes</td>
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<tr>
<td></td>
<td>90846</td>
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</table>
Case Management

99361 - 99362

Medical team conferences to coordinate patient care when a patient is not present. Coordination of care with other providers or agencies is a component of evaluation and management codes and should not be billed separately.

Care Plan Oversight

99374 - 99380

Physician developing and/or revising of care plan, review of treatment plan and/or adjustment of medical therapy, within a thirty day period; fifteen to twenty-nine minutes and thirty minutes or more.

Telephone Consultations

Separate charges for telephone consultation services will NOT be covered. Charges should be included in the examination or medical service fee.
Organ Transplants

EqualityCare covers medically necessary transplants for clients under the age of 21. Prior authorization MUST be obtained before services are rendered.

EqualityCare also covers cornea transplants for all ages. Prior authorization is not required. Code V2785 (processing, preserving and transporting of corneal tissue) is a covered service.
Preventive Medicine

Preventive health services for clients under age 21 are covered through Health Check.

EqualityCare does NOT cover other routine services or examination when the procedure is performed in the absence of an illness or complaint. EXCEPTIONS to this policy are:

- Newborn care furnished in the hospital
- Immunizations
- Cancer screening services
- Screening mammography’s are limited to a baseline mammography between ages 35 and 39; one screening mammography per year after age 40. All mammograms require a referral by a physician.
- Annual gynecological exam including a PAP smear. One per year following the onset of menses. This should be billed using an extended office visit (E&M) procedure code. The actual Lab Cytology code is billed by the lab where the test is read and not by the provider who obtains the specimen.
Public Health Services

Covered Services

When billing for performing the LT101 and not for the screening, please refer to the following table:

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<thead>
<tr>
<th>Local Code</th>
<th>CPT Code</th>
<th>Modifier(s)</th>
<th>Description</th>
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<td>T1023</td>
<td></td>
<td>LT101</td>
</tr>
<tr>
<td>W7103</td>
<td>Deleted</td>
<td></td>
<td>LT101 by Phone</td>
</tr>
</tbody>
</table>
Psychiatric Services

Covered Services  90801 - 90899

EqualityCare covers medically necessary psychiatric services if provided by a physician, or when provided by one of the following mental health practitioners who are employed by or work under contract with a physician:

- A licensed clinical psychologist; or
- A licensed clinical social worker; or
- A licensed master's level counselor; or
- A licensed psychiatric clinical nurse practitioner; or
- A licensed physician's assistant.

* Providers must work under the direct supervision of the primary care psychiatrist; or be employed by or under contract with a Community Mental Health Center.

**NOTE:** Supervision means the ready availability of the supervising physician for consultation and direction of the activities of the mental health professional by telecommunication as sufficient to show ready availability when such contact is sufficient to provide quality medical care. The supervising physician shall maintain the final responsibility for the care of the patient and the performance of the mental health professional(s) he is supervising.

When billing for PASRR Level II please refer to the following table:

<table>
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<th>Local Code</th>
<th>CPT Code</th>
<th>Modifier(s)</th>
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<td>W7201</td>
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<td>PASRR Level II – Committee Consult</td>
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<td>T2011</td>
<td>HI</td>
<td>PASRR Level II – Psychologist</td>
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<tr>
<td>W7207</td>
<td>Deleted</td>
<td></td>
<td>PASRR Level II – Social Summary</td>
</tr>
</tbody>
</table>

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<tr>
<th>Modifier</th>
<th>Description</th>
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<tbody>
<tr>
<td>HI</td>
<td>Multi - Disciplinary Team</td>
</tr>
</tbody>
</table>

Limitations

EqualityCare does not cover CPT codes: 90865, 90875, 90876, 90880, 90882, 90885, 90887, 90889 and 90899.

Psychological testing (96100) is reimbursed on a per hour basis. The report writing segment, for the purpose of compiling a formal report of test findings, is limited to three hours maximum.

Reimbursement Guidelines

All services must be provided under the supervision of a psychiatrist and billed by the psychiatrist, using their provider number.
Psycho-social counseling services performed by physicians other than psychiatrists should be billed using appropriate local office visit codes listed in the “Office and Outpatient Services” section of this module.

Interpretation or explanation of results of psychiatric services to family members or other responsible persons is included in the fee for psychotherapy.

$2.00 copay applies to 90801 – 90815.

**Independent Practicing Clinical Psychologists**

Beginning March 1, 2003, independent practicing clinical psychologists can enroll and be reimbursed for their services. They must have a current license to enroll with EqualityCare.

Independent Psychologist: A licensed Psychologist who practices independently of an agency, institution or physician’s office.

**Covered Services for Independent Practicing Clinical Psychologists**

EqualityCare covers the following services provided by an enrolled licensed clinical psychologist while practicing independently of an agency, institution, or physician’s office.

**H0031 - Clinical Assessment:** Contact with the enrolled client and/or collaterals as necessary, for the purposes of completing an evaluation of the client’s mental health/substance abuse disorder(s) and treatment needs, including psychological testing if indicated, and establishing a DSM (latest edition) diagnosis.

**H2019 - Office-based individual/family therapy services:** An office-based contact with a client and/or collaterals for the purpose of developing and implementing a treatment plan for an individual client or family. The service shall be targeted at reducing or eliminating specific symptoms or behaviors that are identified in the treatment plan.

**H2021 - Community-Based Individual/Family Therapy:** Contact outside the psychologist’s office with the client and/or collaterals as necessary, for the purpose of developing and implementing the treatment plan for the client.

**H2019 + HQ - Group Therapy:** Contact with two or more unrelated clients and/or collaterals as necessary, for the purpose of implementing each client’s treatment plan.

Documentation of these services shall:

- Identify the covered services provided;
- Identify the date, length of time, and location of the service;
- Identify all persons involved;
- Contain a narrative report of the client’s condition, the issues addressed, the treatment interventions, and the client’s progress toward defined goals; and
- Contain the full signature, including licensure, of the clinical professional involved.
Limitations

Psychological testing is covered as part of the clinical assessment and is reimbursed on a 15-minute per unit basis. The report writing segment, for the purpose of compiling a formal report of psychological test findings, is limited to three hours maximum.
Sterilizations

Sterilization is defined by EqualityCare as any elective medical procedure, treatment or operation performed for the primary purpose of rendering an individual (male or female) PERMANENTLY incapable of reproducing. Sterilizations that are performed because pregnancy would be life threatening are subject to all conditions of coverage.

Coverage

Sterilization procedures must conform to Federal Regulation in either inpatient or outpatient settings. Sterilization will be covered under the program only if the following conditions are met:

- The individual is at least twenty-one years old at the time the consent for sterilization is obtained. This is a Federal requirement for sterilizations provided under the Federal Title XIX program and is not affected by any other Wyoming state law regarding the ability to give consent to medical treatment in general. **There are no exceptions.**
- The individual is mentally competent. For EqualityCare purposes, a mentally incompetent individual is a person who has been declared incompetent by the Federal, State or local court of jurisdiction for any purpose, unless the individual has been declared competent for purposes that include the ability to consent to sterilization. **There are no exceptions.**
- The individual is able to understand the content and nature of the informed consent process as required by EqualityCare regulations. A patient considered mentally ill or mentally retarded may sign the consent form if it is determined by a physician that the individual is capable of understanding the nature and significance of the sterilization procedure, which includes the concept of permanent sterility.
- The individual is not institutionalized. For purposes of EqualityCare, an institutionalized individual is a person who is:
  - Involuntarily confined or detained under civil or criminal statute in a correctional or rehabilitative facility, including a mental hospital or other facility which renders care and treatment of mental illness; or
  - Confined under voluntary commitment in a mental hospital or other facility, which renders care and treatment of mental illness.
- The individual has VOLUNTARILY given informed consent in accordance with all requirements of the EqualityCare regulations.
- At least thirty days, but not more than 180 days, have passed since the date the informed consent was signed and the date of sterilization. The day the client signs the consent form and the surgical date should not be included in the thirty day waiting period. In determining a surgical date, do not count the day that the consent was obtained or the day of sterilization.

**There are no exceptions to the 180-day limitation of the effective time period of the informed consent agreement.**
Exceptions to the thirty-day waiting period are as follows:

- Sterilization may be performed at the time of emergency abdominal surgery if at least seventy-two hours have passed since the time written informed consent was given and the emergency surgery was performed. The patient's medical record must document the medical necessity for emergency surgery.
- Sterilization may be performed at the time of a premature delivery if the informed consent was given at least thirty days before the expected date of delivery, and at least seventy-two hours have passed since the written informed consent was signed.

- A completed consent form must accompany all claims for sterilization services, including attending physicians, surgeons, anesthesiologists, and facilities. Only claims related to sterilization surgery require consent documentation to be attached. Claims for presurgical visits, tests, or services related to post-surgical complications, do not require consent documentation at the time of submission for reimbursement.

Treatment that is not for the purpose of, but results in, sterility will not require the completion of the Sterilization Consent Form. Hysterectomies require the Hysterectomy Acknowledgement Of Consent. Please see the General Provider Manual for an example of these forms and billing instructions.

- Sterilization performed during a routine scheduled C-section performed for non-emergency reasons must meet the minimum 30-day waiting period requirements.

**Informed Consent Process of Sterilization**

The informed consent process may be conducted by the physician or by the physician's designee and must comply with the following guidelines:

- Offer to answer any questions the individual may have had concerning the sterilization procedure.
- Provide the individual with a copy of the consent form.
• Verbally provide the following information PRIOR to the sterilization procedure:
  ➢ Counseling the individual that they are free to withhold or withdraw consent to the
    procedure at any time before the sterilization, without affecting the right to future
    care or treatment and without loss or withdrawal of any federally funded program
    benefits to which the individual might otherwise be entitled.
  ➢ Advise the individual of the available alternative methods of family planning and
    birth control.
  ➢ Inform the individual that the sterilization procedure is considered to be irreversible
    and permanent.
  ➢ Provide a thorough explanation of the specific sterilization procedure to be
    performed on the individual.
  ➢ Furnish the individual with a complete description of the discomforts and risks that
    may accompany or follow the procedure. This must include an explanation of the
    type and possible effects of any anesthetic to be utilized during the procedure.
  ➢ Supply the individual with a complete description of the benefits or advantages that
    may be expected as a result of the sterilization procedure.
  ➢ Advise the individual that the sterilization will not be performed until after the
    thirty-day waiting period, except under the circumstance of premature delivery or
    emergency abdominal surgery, in which the seventy-two hours must have passed
    between the informed consent and the surgery. Also advise the individual that in
    the case of premature delivery, consent must have been given at least thirty days
    prior to the expected date of delivery.
  ➢ Make suitable arrangement to ensure that the information specified above has been
    effectively communicated to the non-English speaking, blind, deaf, or otherwise
    handicapped individual to be sterilized.
  ➢ Permit the individual to be sterilized to have a witness of their choice present when
    the consent is obtained.
  ➢ Certify that the sterilization operation was requested without fraud, duress, or
    undue influence.
  ➢ Comply with all other State and local requirements.
  ➢ Certify that the EqualityCare consent form was properly filled out and signed as
    outlined in EqualityCare guidelines.
  ➢ May not obtain informed consent while the individual to be sterilized is:
    ▪ In labor or within twenty-four hours postpartum or post abortion.
    ▪ Under the influence of alcohol or other substances that affect the
      individual's state of awareness.
    ▪ Seeking to obtain or obtaining an abortion.

EqualityCare as the period of time during which the abortion decision and the arrangements for the abortion are being made defines “Seeking to obtain”.

EqualityCare as the period of time during which an individual is undergoing the abortion procedure, including any period during which preoperative medication is administered, defines “Obtaining an abortion”.

EqualityCare DOES NOT cover sterilization procedures for individual under age twenty-one, for mentally incompetent or institutionalized individuals, or for cases in which the procedure is court ordered.


Surgery

Covered Services

EqualityCare only covers surgical procedures that are medically necessary. In general, surgical procedures are covered if the condition directly threatens the life of a patient, results from trauma and demands immediate treatment, or has the potential for causing irreparable physical damage, the loss or serious impairment of a bodily function, or impairment of normal physical growth and development.

Gastric Bypass Surgery

EqualityCare will consider coverage of gastric bypass surgery on adults on a case-by-case basis, with the appropriate documentation, if it is medically appropriate for the individual to have such surgery and if the surgery is to correct an illness that was aggravated by the obesity.

To receive prior authorization and qualify for EqualityCare reimbursement, the following criteria must be met.

1. The client must meet the weight criteria for clinically severe obesity, which is a Body Mass Index (BMI) equal to or greater than 40, or 35-40 with co morbid conditions. Documentation of the client’s BMI and obesity related co morbid medical conditions exacerbated by the obesity is required.

2. The primary physician must submit a complete patient history and physical examination notes, including a five-year record of the client’s weight and documented efforts to lose weight by conventional means. Conventional means must describe at least two different non-surgical programs of dietary regimens that include appropriate exercise and supported behavioral modification program utilizing licensed mental health therapists.

3. Documentation of pre-operative psychological evaluation by a psychiatrist or licensed clinical psychologist affiliated with a clinic (not associated with the physician’s group recommending the procedure), within the last 90 days to determine if the patient has the emotional stability to follow through with the medical regimen that must accompany the surgery.

4. Documentation of the following lab work-up:
   - Liver function
   - Lipid levels for all
   - Renal panel
   - CBC
   - Thyroid panel
   - 2 fasting blood sugars or a 2 hr. Glucose Tolerance Test
   - Optional: Pulmonary Function/Sleep Study

5. The surgeon performing the gastric bypass must submit a written request documenting the CPT-4 code(s) to be used.

6. Documentation showing the client is actively participating in an ongoing dietary management program that has dietary and behavior modification components, as well as physician supervised exercise program.

7. Documentation of the post-operative plan of care, which should include behavior modification, dietary management and physician supervised exercise program.
Cochlear Device, Implantation and Replacement

Wyoming EqualityCare has instituted the following policy for Cochlear Device, Implantation and Replacement. EqualityCare reimburses for the implant, external processor and headset.

Coverage Guidelines

Prior authorization is required for the procedure, device and replacement device only. EqualityCare clients must meet all of the following criteria:

1. There must be a diagnosis of bilateral profound (90 db hearing loss) sensorineural hearing impairment that cannot be mitigated by the use of hearing aid in patients whose auditory cranial nerves can be stimulated.

2. The client must have demonstrated that they cannot benefit from hearing amplification through a trial period of at least six months.

3. There must be freedom from middle ear infection, an accessible cochlear lumen that is structurally suited to implantation, and be free of lesions in the auditory nerve and acoustic areas of the central nervous system.

4. There must be no contraindication to having the surgery.

5. The client must have the cognitive ability to use auditory clues.

6. The procedures may only be performed using FDA-approved devices.

7. Evaluation and continued treatment for cochlear transplant must be completed by a Board Certified Specialist.

In addition, the following criteria must be met for adults:

1. Must be postlinguistically deafened.

2. Must be unable to communicate through speech or other means to make their medical or basic needs known.

3. Must be highly motivated and have appropriate expectations to complete prescribed pre- and post-surgical treatment.

In addition, the following criteria must be met for children:

1. Implantation will not be considered before the age of twelve months.

2. Children may be prelinguistically deafened.
3. Family members or caregivers must have appropriate expectations, motivation and resources to assist in completion of treatment and educational services.

4. Family members must agree to accompany a young child to training sessions and be able to reinforce learning.

Initial first year calibration visits are part of the global fee for implementation. Only one cochlear device and speech processor will be allowed per year. Follow up calibration visits will be covered one per year if the implant is authorized or if the client has an existing cochlear device that needs calibration.

Additional equipment will be allowed only to replace defective equipment and will not be allowed solely to update equipment. Upgraded equipment is only allowed once every five years.

**Required Documentation**

The client’s clinical records must be specific and contain the following information:

1. A complete history and physical indicating how the diagnosis of sensorineural hearing impairment was determined.

2. Demonstration of lack of benefit from hearing amplification through a trial period of six months, using appropriate amplification.

3. The client’s ability to benefit from appropriately fitted amplification.

4. Documentation of other health conditions.

5. Notation that there has been active family involvement during the diagnosis and treatment sessions for a child who is to have a cochlear transplant.
Vagus Nerve Stimulation (VNS) for Epilepsy

Prior Authorization is required for all VNS Procedures.

To Receive PA and qualify for reimbursement, the following criteria must be met:

1. Coverage applies only to partial onset seizures (with or without secondary generalization) that are clinically recognizable and documented. A diagnosis of primary generalized seizures will not meet the criteria for VNS coverage. Documentation must be of true epileptic seizures.
2. VNS clients must be 12 years of age or older.
3. The patient must have had a diagnosis of intractable epilepsy for at least two years and have experienced at least 4-6 identifiable partial onset seizures each month. Documented seizures must have been refractory to at least three anti epileptic drugs used alone, or in combination, for at least 12 months. Drugs should include both conventional and newer FDA approved anti convulsant drugs given as add-on treatments.
4. VNS clients must not be candidates for epilepsy surgery or be a failure of prior curative epilepsy surgery. If both VNS and epilepsy surgery are options, the treating physician must clearly document why VNS is the preferred treatment.
5. Patients must have a completed Quality of Living (QOL) Assessment.
6. Mental retardation (MR) or psychoses are not contraindications by themselves. However, behavioral and somatic manifestations of MR or psychosis may obscure recognition of seizure phenomena and the evaluation of possible benefits resulting from VNS. If one of those diagnoses coexists with partial onset seizures, the physician must document how VNS will benefit the client in spite of the MR or psychosis.
7. VNS insertion will not be considered for patients with a progressive disorder including, but not limited to: brain tumor, Landau-Kleffner syndrome, or progressive metabolic and degenerative disorders. Patients must be without the diagnosis of cardiopulmonary disease, active peptic ulcer, or severe neurological disease, i.e., Parkinson’s, Multiple Sclerosis, and Stroke/Brain Attack.
8. Evaluation for the necessity of Vagus Nerve Stimulation must be completed by a Board Certified Neurologist.
9. Procedure may only be performed with FDA-approved devices and systems. (Currently, NeuroCybernetics Prostheses (NCP) System is the only FDA-approved device for this procedure).
10. Coverage is limited to stimulation of the left vagus nerve as it is less likely to cause cardiac effects.

Cosmetic Surgery

EqualityCare does not cover surgical procedures performed exclusively for cosmetic purposes. Cosmetic surgical procedures are defined as those surgical procedures intended solely to improve the physical appearance of an individual, which do not restore bodily function or correct deformity.
The following procedures are considered cosmetic and are not covered by EqualityCare:

- Tattooing to cover or create a decorative tattoo
- Subcutaneous injection of filling material to augment small, but otherwise, normal breasts
- Dermabrasion and/or superficial chemosurgery for wrinkling or the removal or treatment of decorative or self-induced tattoos
- Rhytidectomy solely for aging and/or wrinkling skin or to correct glabella frown lines or submental fat pad
- Lipectomy of the leg, hip, buttocks, or forearms or lipectomy elsewhere
- Augmentation mammoplasty to augment small or correct asymmetrical, but otherwise, normal breasts
- Removal of mammary implant material when the original insertion was for cosmetic purposes
- Reconstruction of the nipple and/or areola when asymptomatic
- Rhinoplasty for external nasal deformity without functional breathing impairment
- Injection of a sclerosing solution into spider varicose veins
- Hairplasty or hair transplant or implant, even though there may be a medical reason for the hair loss
- Ear piercing or removal of keloids following ear piercing
- Electrolysis
- Under certain circumstances, EqualityCare may cover reconstructive surgical procedures. Reconstructive surgical procedures are defined as those surgical procedures intended to improve function and appearance of any body area that has been altered by disease, trauma, congenital or developmental anomalies, or previous surgical processes.
- EqualityCare will not cover cosmetic surgeries performed at the same operative session as a covered service, and reimbursement in such cases will be limited to the allowable fee for the covered service only.

**Reimbursement**

- EqualityCare covers Contigen Implants for Type III stress urinary incontinence. The CPT Code for endoscopic injection of the implant material into the submucosal tissues of the urethra and/or bladder neck, would be the HCPCS procedure code. Code L8603 would be billable for The Collagen implant, per 2.5 cc syringe, inclusive of shipping and necessary supplies, CPT Code 95028 would be billable for the skin test procedure.
- EqualityCare will reimburse physicians, in Wyoming, who are treating EqualityCare clients postoperatively when surgical procedures are performed out-of-state.

PA required prior to service.

The nasal surgery request would not be covered if performed solely to improve the patient's appearance in the absence of any signs and/or symptom's of functional abnormalities, the procedure would be considered cosmetic.

The request for reconstructive surgery is reviewed to ensure that it will:

- Improve nasal respiratory function (relieve airway obstruction or stricture), or
- Repair defects caused by trauma (septal deviation, dislocated nasal bone fractures), or
- Treat congenital anatomic abnormalities or deformities, or
- Replace nasal tissue lost after tumor ablative surgery.
- Operating Microscope
Surgical Packages

Coverage

Normal preoperative and postoperative care included as part of surgical package includes:
- Pre-Op Lab and Radiology
- Office examinations
- Emergency room visits, and hospital visits, including discharge management
- Routine postoperative care (The number of postoperative days for each procedure is listed within the surgical fees schedule.)
- Consultations and hospital admission (when a history and physical exam have not been performed in the office) are not considered part of the surgical package.

Limitations

Services provided to diagnose or treat conditions unrelated to the surgery may be billed with a separate examination code if the primary diagnosis code reflects a different complaint or service.

EqualityCare will reimburse for surgical trays when minor surgery necessitates local anesthesia and other supplies (i.e., gauze, sterile equipment, suturing material, etc.) if the surgical procedure is performed in a physician's office. For example, procedures requiring a surgical tray would include diagnostic biopsies, wound closures, and removal of cysts or other lesions. Reimbursement is not provided when the surgery is performed in a hospital, with the exception of trays supplied by the physician, which are not billed by the hospital.

Separate Procedures

Certain procedures are commonly performed as an integral part of a total service and may not be billed separately. When such a procedure is performed independently of, and is not immediately related to, other services, it may be reported separately under its unique procedure code. When a procedure that is ordinarily a component of a larger procedure is performed alone for a specific purpose, it may be considered a separate procedure. For example, an arthrotomy performed as part of a meniscectomy should not be billed separately. An arthrotomy performed as the principal procedure, however, may be billed separately.

Incidental Procedures

Incidental procedures are those procedures performed subsequent to surgery which do not add significantly to the major surgery or are rendered incidental and performed at the same time as the major surgery (e.g., incidental appendectomies, incidental scar excisions).

EqualityCare will not reimburse separately for incidental surgical procedures, which are performed at the same time as other major surgery.
Surgical Destruction

Surgical destruction is a part of a surgical procedure, and different methods of destruction are not ordinarily listed separately unless the technique substantially alters the standard management of a problem or condition. Exceptions under special circumstances are provided for by separate codes.

Multiple Procedures

A multiple procedure is an additional, medically necessary, surgical procedure that is performed at the time of a primary medical procedure (for example, a liver biopsy performed at the time of a splenectomy). When multiple procedures are performed at the same operative session, the major procedure is billed with the appropriate CPT code. The secondary, additional, or lesser procedure(s) must be identified by adding a -51 modifier to the CPT code for the secondary procedure(s).

Bilateral Procedures

Bilateral procedures are those identical procedures requiring a separate incision that are performed at the same operative session on both sides of the body. Bilateral procedures should be billed on two claim lines by billing the first line item with the base code and the second line item by attaching the modifier -50 to the procedure code.

Assistant Surgeons

- Assistant surgeon fees are billed with an -80 modifier using the same procedure code billed by the primary surgeon.
- When a physician assistant or a registered nurse who is employed by a physician assists with surgery, the fee is billed with an -AS modifier using the same procedure code billed by the primary surgeon.

Reimbursement Guidelines

All surgical claims submitted for reimbursement for multiple surgical procedures must have an operative report attached. The following methodology applies to reimbursement for surgical procedures:

- Multiple Procedures
  The primary surgery is reimbursed at 100-percent of allowed fee. Subsequent surgical procedures are reimbursed according to modifier. Please check the CPT for correct use of modifiers.
- Bilateral Procedures
  Bill the first line with the base code and the second line with the base code and modifier of -50. The base code will be reimbursed at 100-percent of the allowable fee for the first incision and 75-percent of the allowable fee for the other incision.
• **Modifiers**
  EqualityCare recognizes the following list of modifiers when used in conjunction with CPT surgical procedure codes.
  
  -22 Unusual Procedural Services - An operative report is required. Reimbursed at allowed fee plus 20-percent.
  -50 Bilateral Procedures. Reimbursed at 75-percent of allowed fee.
  -51 Multiple Procedure. Reimbursed at 50-percent of allowed fee.
  -62 Two Surgeons - Under certain circumstances, two surgeons may be required in the management of a specific surgical procedure. Under such circumstances the separate services may be identified by adding the modifier “-62” to the procedure number by each surgeon for reporting this services. An operative report is required. Reimbursed at 100-percent of allowed fee.
  -80 Assistant Surgeons. Reimbursed at 20-percent of allowed fee.
  -AS Physician Assistant/Registered Nurse - Surgical assistant services. Reimbursed at 15-percent of allowed fee.
Radiology Services

Coverage

EqualityCare provides coverage of medically necessary radiology services, which are directly related to the patient's symptom or diagnosis when provided by independent radiologists, hospitals, and physicians. Radiology and nuclear medicine services include:

- Diagnostic radiology
- Diagnostic ultrasound
- Radiation therapy
- Oncology
- Nuclear medicine services

EqualityCare will reimburse physicians only for radiology services performed personally by the physician or under supervision of a physician.

Radiology and nuclear medicine services include a professional component and a technical component. The total radiology procedure may be divided into the professional and technical component for billing and payment when appropriate. Certain radiology procedures are designated as complete procedures and can only be billed as such.

- The professional component is the performing, interpreting and reporting of the radiological exam.
- The technical component is the provision for equipment, facility and personnel to perform the services.
- The total (complete) procedure is interventional radiologic procedure or diagnostic study involving injection of contrast media. This includes all usual pre-injection and post-injection services, supervision of the study, and interpretation of the results by a radiologist.

Supervision and Interpretation

When two physicians perform a procedure, the radiologic portion of the procedure is designated as "radiologic supervision and interpretation." If a single physician does not perform all services, the radiologist may bill using the supervision and interpretation codes, and the clinician may bill for the separate injection procedure using the appropriate surgical procedure codes.

Computerized Tomography (CT scan) is covered for diagnostic examination of the head and of certain other parts of the body when the patient's medical record documents that the scan is medically necessary based on the patient's symptoms and preliminary diagnosis.

Limitations

- Screening mammographies are limited to a baseline mammography between ages 35 and 39; one screening mammography per year after age 40. All mammograms require a referral by a physician.
- X-rays performed as a screening mechanism or based on standing orders.
- Separate consultations or procedures unless ordered by the attending physician.
- Reinterpretations, unordered X-rays, and second opinions.
Reimbursement Guidelines

EqualityCare will only accept modifiers -26 Professional Component and -TC Technical Component.

MRI codes may be billed with -22 to indicate level of service; however, reimbursement will be the same.

Multiple procedures performed on the same day must be billed with two units to avoid denial as a duplicate service.

Contrast media should be billed with HCPCS codes.
Vision Services

A licensed ophthalmologist, optometrist, or optician, within the Scope of Practice Act within their respective profession, may provide vision services.

Coverage

EqualityCare covers the following vision services for clients age 21 and over:

- Treatment of eye disease or eye injury, based on the appropriate ICD-9 diagnosis code
- Payment of deductible and/or coinsurance due on Medicare crossover claims for post surgical contact lenses and/or eyeglasses.

EqualityCare covers the following vision services for clients UNDER age 21:

- Routine eye examination with determination of refractive state:
  - Eye examination codes include determination of refractive state.
  - Determination of refractive state - should ONLY be billed when an eye examination is not performed.
- Office exams as medically necessary for the treatment of eye disease or eye injury.
- Eyeglasses: one pair of glasses is covered; additional replacement pairs are covered when medically necessary. When replacement of lenses or frames is required, documentation, which identifies the reason for replacement lenses and/or frames, is to be kept on file with the provider when replacement occurs within one year of the insurance date. Multiple pairs of glasses issued at the same time are not covered.
- Frames: EqualityCare allows up to $60.00 for standard frames. The provider may not “balance bill” the patient for glasses that cost more than the Medicaid allowable. If the client chooses to have frames which exceed $60.00, the client is responsible for payment of the frames. The optometrist should mutually agree in writing with the client that they are responsible for the bill.
- Corrective Lenses: The following corrective lenses are covered: plastic, single vision, bifocal, trifocal, with or with slab off prism. Replacements must be based on medical need, e.g. a change in prescription or replacement due to normal lens wear. If the corrective lens is replaced, the same frame should be used, if possible. Corrective lenses must be suitable for indoor or outdoor, day or night use. Specialized transmissivity, e.g. tints, UV lenses, and scratch resistant coating are covered when medically necessary and documented by an ophthalmologist and an optometrist. Poly carbonate lenses, are covered when medically necessary and documented by the ophthalmologist and optometrist. If a provider requests services for cosmetic purposes, the client must be advised in writing that this is a non-covered service and they will be responsible for the charge.
- Eyeglass Repairs: If under warranty, eyeglass repair is not billable to EqualityCare. Upon expiration of the warranty, repair of the eyeglasses can be billed.
- Contact Lenses: Lenses are covered only for correction of pathological conditions when useful vision cannot be obtained with regular lenses (i.e. Keratoconus). Prior Authorization is not required at this time; however, the medical record should document why the patient cannot be satisfactorily fitted with conventional lenses.
- Vision Therapy: Vision therapy is a covered service when performed in the physician’s office and requires Prior Authorization. The authorization request must document the appropriate diagnosis of the condition to be treated and the diagnosis for any complication. The request should estimate the number of visits required to treat the condition and the estimated range of dates for completion of the vision therapy.
Limitations

Contact lenses are not allowed for routine correction of vision. Contact lenses are not covered for clients over the age of 21. An exception would be if Medicare covers the lenses. Eyeglasses for cosmetic purposes are NOT covered.

Reimbursement Guidelines

Providers should only use appropriate HCPCS codes for material when billing EqualityCare.

Reimbursement for dispensing of frames, frame parts, and/or lenses is not allowed in addition to reimbursement for dispensing of total eyeglasses.

Providers must use the order date as the date of dispensing.
Waiver Services

Long Term Care - HCBS Waiver Services

The purpose of the Long Term Care Home and Community-Based Waiver is to offer an opportunity for additional services in the home to people who are EqualityCare eligible and functionally disabled who, but for the provision of the services, would require the level of care provided by a nursing facility. These services are available to persons 19 years and above. The LTC/HCBS Waiver serves a limited number of people statewide and has a monetary cap each month. There may not be providers for all services in all communities. The Waiver operates under a case management system. Each client has a Plan of Care prepared by a qualified Case Manager and a budget of the services required, which is approved by the Aging Division.

Referrals to the LTC/HCBS Waiver are made to the local Public Health Department. The Public Health Nurse does a functional assessment (LT101), which is also used to determine level of care for nursing facility admission. If a client has thirteen or more points, he/she has the choice of nursing facility admission or waiver services, if there are empty slots available. The client is then referred to the Department of Family Services for determination of financial eligibility, which is determined using the same guidelines as nursing facility eligibility. Waiver services cannot be provided to clients while they are inpatients of a hospital or nursing facility, or on another waiver. There may be a waiting list for LTC/HCBS services.

The services available are:

- **Case Management**: The Case Manager is responsible for the development, implementation and monitoring of the Plan of Care for each individual client. A reassessment of the level of care (LT101) and a renewal Plan of Care are required every six months. Case Managers are required to do at least one face-to-face visit a month and to maintain an LTC/HCBS Waiver record on each client. Case managers for the Consumer Directed Care are called Care Coordinators.

- **Personal Care**: A Certified Nurse’s Aid (employed by a Home Health Agency that meets the standards to be a LTC/HCBS Waiver Provider) can be assigned to care for the client in the home, providing help with activities of daily living such as bathing, dressing and grooming, meal preparation, grocery shopping and household chores which are essential to the health and welfare of the client.

  - **Consumer Directed Care**: This Personal Care option will allow LTC/HCBS clients, who are capable of directing their own care, to recruit, hire, train, schedule, evaluate and terminate their own attendants. These attendants are called Self-Help Assistants. A fiscal agent will issue their checks based on payroll records provided by the Self-Help Assistant and the consumer. Each consumer will have a Care Coordinator to prepare the Plan of Care for agency approval.

  **Who is eligible for this option?** Those who are interested in participating in Consumer-Directed Care must be on the LTC/HCBS Waiver and be capable of directing their own care.
**Who are the caregivers?** The consumers choose their own caregivers. Family members are allowed to be caregivers in this program, except for a spouse caring for a spouse or a parent caring for a minor child. The consumer must find and select their own caregivers and have a backup plan in case caregivers fail to show up for a scheduled appointment.

**What services are allowed?** The Self-Help Assistant’s duties may vary depending on the needs and requirements of each consumer. Consumer needs and requirements are determined by the Care Coordinator and documented on the Consumer Profile. The Self-Help Assistant services involve direct assistance and may include the following:

1. Assistance with activities of daily living and/or personal hygiene. These activities might include, but are not limited to: dressing, bathing, grooming, feeding, routine hair and skin care, toileting, transferring, walking, exercising and assistance with medications which are ordinarily self-administered.

2. Assistance with health maintenance tasks including urinary system management and bowel program.

3. Assistance with meal preparation. Examples of meal preparation activities include, but are not limited to, menu planning, storing, preparing and serving food.

4. Household tasks and escort services must be provided only in conjunction with direct personal assistance as described above and must be directly related to a consumer’s disability.

Household tasks include assistance with activities related to housekeeping that are essential to maintaining the consumer’s health and safety in the home. Examples of household tasks include, but are not limited to: change bed linens, light housecleaning, laundering, washing dishes and shopping. Household tasks shall not include basic homemaker services that maintain an entire household or family. When a consumer lives with a family, it is expected that the family will provide most household task services. Household tasks may not exceed one-third of the total personal assistance hours. Household tasks may not be provided if no other personal assistance needs exist.

Escort services includes accompanying and personally assisting consumers on trips to obtain medical diagnosis or treatment or shopping for items essential to the consumer’s health care and nutritional needs.

Escort services are available only to those consumers who require personal assistance services en route to or at the destination when a family member or caretaker is unable to accompany them.
**Excluded Services:** Self-Help Assistant services do not include services, which maintain an entire household or family, or are not necessary to the health and welfare of the consumer. These include, but are not limited to the following:

1) Cleaning floors and furniture in areas consumers do not use or occupy.
2) Laundering clothing or bedding the consumer does not use.
3) Shopping for groceries or household items consumers do not need for health and nutritional needs. Self-Help Assistants may shop for items consumers need but are used by the rest of the household.
4) Babysitting or friendly visiting.
5) Maintenance of pets except in the case where the animal is a certified service animal.
6) Home and outside maintenance. For example, snow removal, window washing and woodcutting.

**Who do you contact?** LTC/HCBS Waiver clients who are interested in Consumer-Directed Care should contact their Case Manager, the Independent Living Specialist for their area, or the Aging Division.

- **Respite:** Respite Care is provided in the home for a short period of time to relieve a regular caregiver. If the care is provided in the home, a Certified Nurse’s Aide must provide it.
- **Adult Day Care:** A structured program in a protective setting that provides a variety of health, social and related support services for all or part of the day, but less than 24 hour care.
- **Non-Medical Transportation:** Transportation can be provided to enable LTC/HCBS Waiver clients to gain access to waiver and other community services and resources required by the Plan of Care and help to prevent institutionalization. Transportation as an LTC/HCBS Waiver service is used when transportation cannot be arranged by any other means.
- **Personal Emergency Response System:** An electronic alarm system, programmed through the phone, which enables certain high-risk clients to summon help in the case of an emergency. PERS is intended for those individuals who live alone, or who are alone for a significant portion of the day. The LTC/HCBS Waiver allows for the installation for the system and a monthly fee.
- **Home Delivered Meals:** This service allows for one or two meals a day to be delivered to the client’s home or Adult Day Care Facility.
- **Skilled Nursing:** Services that are within the scope of the Wyoming Nurse Practice Act that will prevent or delay the institutionalization of a client. The services available under the Skilled Nursing waiver service are any of the tasks that require licensed personnel to perform that are not covered under the Home Health benefit or are not available because the client does not meet Home Health criteria. These services include, but are not limited to, filling medication boxes, filling Insulin syringes, doing venipunctures, giving injections, doing foot care, and doing catheterizations and catheter irrigations.

All of these services will not be given to all clients. They will receive only those services that the Case Manager and the multi-disciplinary team (which must include the client and/or a member of their family) decide are needed, and are approved by the Aging Division, and are within the monthly monetary cap.

Due to HIPAA Compliance standards, EqualityCare has eliminated local codes and replaced them with standard CPT-4 codes. When billing on the CMS-1500, the appropriate ICD-9 diagnosis codes must be used.
NOTE: THE CODES AND MODIFIERS ARE SUBJECT CHANGE

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<thead>
<tr>
<th>Local Code</th>
<th>CPT Code</th>
<th>Modifier(s)</th>
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<tr>
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<td>T2024</td>
<td></td>
<td>Service Assessment/Plan of Care Development (Case Management)</td>
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<td>W6002</td>
<td>T2041</td>
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<td>Supports Brokerage, Self Directed (Self Help Assistant)</td>
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<td>W6003</td>
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<tr>
<td>TF</td>
<td>Intermediate Level of Care</td>
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**Assisted Living Facility Waiver Services**

The Assisted Living Facility Waiver offers the client, 19 years of age and above, who meets the functional and financial eligibility criteria for nursing home care the ability to have their care provided in an assisted living facility. Each client must pay their room and board fee and EqualityCare funds the care required within the facility at a daily rate determined by the LT101 score. Each client has a Plan of Care prepared by a qualified Case Manager, chosen by the client, and submitted to the Aging Division for approval.

Referrals for the Assisted Living Facility Waiver are made to the Local Public Health Department. The Public Health Nurse does the functional assessment (LT101), which is also used to determine Medical Necessity for nursing facility or the Long Term Care Waiver. If a client has thirteen or more points, she/he is given a choice of nursing facility admission or assisted living facility services. The client is then referred to the Department of Family Services for determination of financial eligibility. The same guidelines are used as for Nursing facility and the Long Term Care Waiver. Waiver services cannot be provided to clients while they are inpatients of a hospital or nursing facility. A client cannot be on two waivers at the same time.

The services available are:

**Case Management** – The Case Manager is responsible for development, implementation and monitoring of the Plan of Care for each individual client. A reassessment of the medical necessity (LT101) and a renewal Plan of Care are required every twelve months to do at least one face-to-face visit a month to monitor the provision the Case Managers require of waiver services and to maintain a waiver record on each client.
**ALF Level I, II, and III** – The assisted living facility provides the personal care the client requires, 24-hour supervision and medication assistance, if necessary, at a per diem rate based on the LT101 score.

- Level I – 13-14 points
- Level II – 15-16 points
- Level III – 17 points and above

The Aging Division approves all Plans of Care.

Due to HIPAA Compliance standards, EqualityCare has eliminated the local codes and replaced them with the regular CPT-4 codes.

**NOTE: THE CODES AND MODIFIERS ARE SUBJECT CHANGE**

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Children’s Developmentally Disabled (DD) Home and Community Based Waiver Services

If services are not on the Plan of Care and preauthorized by DD, they will not be reimbursed.

Due to HIPAA Compliance standards, EqualityCare has eliminated the local codes and replaced them with the regular CPT-4 codes.

**NOTE: THE CODES AND MODIFIERS FOR THE DD WAIVERS ARE SUBJECT TO CHANGE**

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The DD Waiver for children provides home and community-based services to qualified EqualityCare eligible children from birth through twenty years of age as follows:

**T2022 - Case Management** - The assisting of waiver clients in gaining access to waiver and other State Plan services including medical, social and educational programs. Case managers will be responsible for ongoing monitoring of the provision of services included in the client's plan of care. Additionally, case managers will initiate and oversee the process of assessment and reassessment of client level of care and the review of plans of care every year. Case managers will be required to be credentialed as a Qualified Mental Retardation Professional (QMRP).

**T2024 - Service Assessment/Plan of Care Development** - The initial process of assessment of the client level of care and development of the initial plan of care.

**T2024TS - Service Assessment/Plan of Care Development Subsequent Assessment** - The subsequent reassessment of the client level of care and development of subsequent plans of care to be completed every year after the initial assessment.

**S5130 – Homemaker Service** - Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for himself/herself or others in the home.

**T1005 - Respite Care Service** - Services given to individuals unable to care for themselves and provided on a short-term basis because of the absence or need for relief of those persons normally providing care. Respite services will not be provided in Residential Habilitation.

**T2016 – Habilitation, Residential** - Assistance with acquisition of improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable individuals from eighteen through twenty years of age to reside in a non-institutional community-integrated setting, such as group homes.

**T2033 - Residential Care** - Individualized services providing an array of training, assistance and support designed to allow individuals, from birth through twenty years of age, to acquire, retain and improve self-help, socialization and adaptive skills necessary to reside in the home of an adult other than the natural or adoptive parent. The Special Family Habilitation Home provider provides transportation between the residence and other locations where habilitation occurs.

**T2013 - Habilitation Educational** - Services provided to individuals from birth through twenty years of age, to include training and/or assistance to address functional deficits in self-help, daily living skills, mobility, learning communications, survival skills, reduction of maladaptive behaviors, community access and other necessary skills either in the home of the child's natural or adoptive parents, or in a Special Family Habilitation Home.

**S5165NU - Home Modifications (New)** - Those initial physical modifications to the home, required by the client's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and, without which, the client would require institutionalization.

**S5165 – Home Modifications (Existing)** - Those physical modifications to the home, required by the client's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and, without which, the client would require institutionalization.
T1002 – RN Services - Services listed in the client's plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. The provision of this service will prevent the institutionalization of the client.

T1000 – Complex Nursing Services – delivered by an RN with CDDN certificate.

T2029NU - Specialized Equipment and Supplies (New) - Specialized medical equipment and supplies to include devices, controls or appliances, specified in the plan of care which enable clients to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This also includes items necessary to the proper functioning of such equipment, and durable and non-durable medical equipment not available under the Medicaid State Plan.

T2029 - Specialized Equipment and Supplies (Repair) - Specialized medical equipment and supplies to include devices, controls or appliances, specified in the plan of care which enable clients to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This also includes items necessary to the proper functioning of such equipment, and durable and non-durable medical equipment not available under the Medicaid State Plan.

G0238 - Respiratory Therapy - Respiratory therapy services will be provided under the prescription of a physician in accordance with the client's established plan of care and through direct contact between the therapist and client, as well as between therapist and individuals involved with the client. Without this service, certain individuals would be institutionalized.

H0004 – Behavior Health Counseling and Therapy - Services to include individual and group therapy, consultation with providers and caregivers directly involved with the individual; development and monitoring of behavior programs, participation in the individual planning process and counseling for primary caregivers.

S9470 – Nutritional Counseling Dietician Services - Services provided by a Registered Dietitian including meal planning, consultation with and training for caregivers, and educating the individual served. The service does not include the cost of meals.

T1019 - Personal Care Services - Assistance with eating, bathing, dressing, personal hygiene, and activities of daily living.

Limitations

DD Children’s Waiver does NOT cover the following services:
- Persons who are inpatients of a hospital, NF or ICF/MR
- Prevocational, Vocational Rehabilitation, or Supported Employment if services are available under Section 110 of the Rehabilitation Act of 1973
- Room and Board

However, the following services may be covered under EqualityCare’s Health Check Program:
- Diagnostic evaluations/assessments
- Physical therapy
- Occupational therapy
- Speech/Language therapy
The following services may be covered through the Department of Education:

- Special education
- Related Services
- Transportation (Educational)
- Occupational therapy (Educational)
- Physical therapy (Educational)
- Speech/Language therapy (Educational)
- School Health Nurse
Adult’s Developmentally Disabled DD) Home and Community Based Waiver Services

If services are not on the Plan of Care and preauthorized by DDD, they will not be reimbursed.

**NOTE: THE CODES AND MODIFIERS FOR THE DD WAIVIERS ARE SUBJECT TO CHANGE**

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The DD Waiver Program for adults provides home and community-based services to qualified eligible adults with mental retardation or developmental disabilities age 21 and over as follows:

**T2022 Case Management** - The assisting of waiver clients in gaining access to waiver and other State Plan services including medical, social and educational programs. Case managers will be responsible for ongoing monitoring of the provision of services included in the client's plan of care. Additionally, case managers will initiate and oversee the process of assessment and reassessment of client level of care and the review of plans of care every year. Case managers will be required to be credentialed as a Qualified Mental Retardation Professional (QMRP).

**T2024 – Service Assessment/Plan of Care Development** - The initial process of assessment of the client level of care and development of the initial plan of care.

**T2024TS - Service Assessment/Plan of Care Development Subsequent** - The subsequent reassessment of the client level of care and development of subsequent plans of care to be completed every year after the initial assessment.

**T2016 - Habilitation - Residential** - Assistance with acquisition of improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting.

**T2020 - Day Habilitation** - Assistance with acquisition, retention or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting separate from the home or facility in which the client resides. Day habilitation services will focus on enabling the individual to attain his or her maximum functional level, and will be coordinated with any physical, occupational, or speech therapies listed in the plan of care. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

**T2014 - Habilitation Prevocational** - Services aimed at preparing an individual for paid or unpaid employment, but which are not job task oriented. Includes teaching such concepts as compliance, attending, task completion, problem solving and safety. Pre-vocational services are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year. All prevocational services will be reflected in the client's plan of care as directed to rehabilitative, rather than explicit employment objectives.
T2018 - Habilitation Supported Employment - Services which consist of paid employment for persons for whom competitive employment at or above minimum wage is unlikely and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported employment is conducted in a variety of settings particularly work sites in which persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by waiver clients, including supervision and training.

T2025 – Waiver Services - Services to individuals who reside with their families within the family home. In-home support services include conducting training of the waiver client to carry out a designed program which allows the individual to acquire, retain, and improve the self-help socialization and adaptive skills necessary to reside successfully in the community.

T1019 - Personal Care Services - Personal care services include assistance with eating, bathing, dressing, personal hygiene and activities of daily living. These services may also include assistance with the preparation of meals, but do not include the cost of the meals themselves. When specified in the client's plan of care, this service may also include such housekeeping chores as bed making, dusting and vacuuming which are essential to the health and welfare of the client.

T2029NU – Specialized Medical Equipment (New) - Specialized medical equipment and supplies to include devices, controls or appliances, specified in the plan of care which enable clients to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. These services will only be covered when they are necessary to prevent institutional placement, to de-institutionalize an individual, or to allow the individual to participate in specialized services for persons with developmental disabilities.

T2029 – Specialized Medical Equipment (Repair) - Specialized medical equipment and supplies to include devices, controls or appliances, specified in the plan of care which enable clients to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. These services will only be covered when they are necessary to prevent institutional placement, to de-institutionalize an individual, or to allow the individual to participate in specialized services for persons with developmental disabilities.

S5165NU - Home Modifications (New) - Those physical adaptations to the home, required by the client's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable, the individual to function with the greater independence in the home and, without which, the client would require institutionalization. These services will not include improvements to the home which are not of direct medical or remedial benefit to the waiver client, such as carpeting, roof repair, central air-conditioning, etc. All services will be provided in accordance with applicable State or local building codes.

S5165 - Home Modifications (Repair) - Those physical adaptations to the home, required by the client's plan of care, which are necessary to ensure the health, welfare, and safety of the individual, or which enable the individual to function with the greater independence in the home and, without which, the client would require institutionalization. These services will not include improvements to the home, which are not of direct medical or remedial benefit to the waiver client, such as carpeting, roof repair, central air-conditioning, etc. All services will be provided in accordance with applicable state or local building codes.

G0152 – Services of Occupational Therapist - Occupational therapy services are services provided to people on the waiver which are identified in the person’s individual plan of care (IPC) and will be provided in accordance with the client's established plan of care and through direct contact between the therapist and client. Consultation services between the therapist and individuals involved with the client cannot be counted as part of direct treatment for waiver billing purposes.
G0153 – Services of Speech and Language Pathologist - Speech therapy services will be provided to people on the waiver which are identified in the person’s individual plan of care (IPC) and will be provided in accordance with the client's established plan of care and through direct contact between the therapist and client. Consultation services between the therapist and individuals involved with the client cannot be counted as part of direct treatment for waiver billing purposes.

S9470 – Nutritional Counseling, Dietician - Services provided by a Registered Dietitian including meal planning, consultation with and training for caregivers, and educating the individual served. The service does not include the cost of meals.

H0004 – Behavior Health Counseling and Therapy - Services to include individual and group therapy, consultation with providers and caregivers directly involved with the individual, development and monitoring of behavior programs, participation in the individual planning process, and counseling for primary caregivers.

T1002 – RN Services - Those services provided to clients who have been ordered by an attending physician to receive specific skilled nursing treatments and care including preventative and rehabilitative procedures. Skilled nursing services are those services prescribed and designated in the client’s Individual Plan of Care (IPC). These services are provided by individual Registered Nurses who are graduates of an accredited school of nursing and are currently licensed to practice in the State of Wyoming, or by skilled nursing agencies that are Medicare certified. Skilled nursing services are provided to clients who live in their family’s homes, specialized foster homes, group homes or other community settings.

T1000 – Complex Nursing Services – delivered by an RN with CDDN certificate.

G0238 – Therapeutic Procedures to Improve Respiratory Function - Those services provided to clients who have been ordered by an attending physician to receive specific respiratory therapy treatments and care including preventative and rehabilitative procedures. Respiratory therapy services are those services prescribed and designated in the client’s Individual Plan of Care (IPC). Individual respiratory therapists who are graduates of appropriate university or college curriculum and are currently nationally certified or registered by the National Board of Respiratory Care provide these services.

G0151 – Services of Physical Therapist - Those services provided to clients who have been ordered by an attending physician to receive specific physical therapy treatments and care including maintenance and restorative procedures. Physical therapy services are those services prescribed and designated in the client’s Individual Plan of Care (IPC). These services are provided by individual physical therapists that are graduates of appropriate university or college curricula and are currently licensed by the Wyoming Board of Physical Therapy or other states to practice in the State of Wyoming. Physical therapy services are part of the State of Wyoming’s EqualityCare State Plan, however, the chronic level of physical therapy services is not covered under program policy.

T1005 - Respite Care Services - Services given to individuals unable to care for themselves; provided on a short-term basis because of the absence or need for relief of those persons normally providing care. Respite care will be provided in the client's place of residence or in a facility approved by the state, which is not a private residence. Respite care can be provided in nursing facilities, intermediate care facilities for the mentally retarded, and group homes.
Limitations

The following services are not covered under DD Adult Waiver:

- Persons who are inpatients of a hospital, SNF, NF or ICF/MR (except for respite care)
- Prevocational, Vocational Rehabilitation, or Supported Employment, if services are available under section 110 of the Rehabilitation Act of 1973
- Special education and related services
- Room and Board
Acquired Brain Injury (ABI) Home and Community-Based Waiver Services

The purpose of the Acquired Brain Injury Home and Community-Based Services waiver is to provide services to eligible individuals who require the level of care provided in an Intermediate Care Facility for the Mentally Retarded, the cost of which would be reimbursed under the approved Medicaid State Plan. This waiver is limited to a target group of individuals ranging in age from twenty-one (21) through sixty-four (64) with acquired brain injury and specified functioning levels. Waiver services will not be furnished to clients while they are inpatients of a hospital, nursing facility, or an intermediate care facility for the mentally retarded. An individualized written plan of care will be developed for each client under this waiver. This plan of care will describe the habilitative, therapeutic, supportive and other services to be furnished, their frequency, and the type of provider who will furnish each service. For more information, contact the ABI waiver manager, Division of Developmental Disabilities at (800)-378-8581.

Due to HIPAA Compliance standards, EqualityCare has eliminated the local codes and replaced them with the regular CPT-4 codes. **Diagnosis code to be used: 294.**

**NOTE: THE CODES AND MODIFIERS FOR THE DD WAIVERS ARE SUBJECT TO CHANGE**

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<tr>
<td>W3161</td>
<td>G0238</td>
<td></td>
<td>Services of Respiratory Therapist</td>
</tr>
<tr>
<td>W3168</td>
<td>G0151</td>
<td></td>
<td>Physical Therapy Services</td>
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<tr>
<td>W3171</td>
<td>T1005</td>
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<td>Respite Care Services</td>
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<tr>
<td>Modifier</td>
<td>Description</td>
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<tr>
<td>TS</td>
<td>Follow-up Service</td>
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<td></td>
</tr>
<tr>
<td>NU</td>
<td>New Equipment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If services are not on the Plan of Care and preauthorized by DD, they will not be reimbursed.

The Acquired Brain Injury (ABI) Home and Community-Based Services Waiver Program provides the following home and community-based services to qualified Medicaid eligible adults age twenty-one (21) through sixty-four (64):

**T2013 – Habilitation, Educational** - Training provided to the person served or to family members that will assist them in the compensation or the restoring of cognitive function.

**T2022 - Case Management** - Assisting waiver clients in gaining access to waiver and other State Plan services including medical, social and educational programs. Case Managers will be responsible for ongoing monitoring of the provision of services included in the client’s individualized plan of care. Additionally, case managers will initiate and oversee the process of assessment and reassessment of client level of care and the review of plans of care every year. Case Managers will be required to be credentialed as a Qualified ABI Professional (QABIP).

**T2024 – Services Assessment/Plan of Care Development** - The initial process of assessment of the client level of care and development of the initial plan of care.

**T2024TS - Services Assessment/Plan of Care Development, Subsequent** - The subsequent reassessment of the client level of care and development of subsequent plans of care to be completed after the initial assessment. Habilitation: Services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings.

**T2016 – Habilitation, Residential** - Assistance with acquisition, retention, or improvement of skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting.

**T2020 - Day Habilitation** - Assistance with acquisition, retention or improvement in self-help, socialization or adaptive skills which takes place in a non-residential setting separate from the home or facility in which the individual resides. Day habilitation services will focus on enabling the individual to attain or maintain his or her maximum functional level, and will be coordinated with any physical, occupational, or speech therapies listed in the plan of care. In addition, day habilitation services may serve to reinforce skills or lessons taught in therapy or other settings.

**T2014 - Habilitation-Prevocational** - Services are aimed at preparing an individual for paid or unpaid employment, but are not job-tasked oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. All prevocational services will be reflected in the client’s plan of care as directed to habilitative, rather than explicit employment objectives.

**T2018 - Habilitation-Supported Employment** - Services which consist of paid employment for persons for whom competitive employment at or above minimum wage is unlikely and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by waiver clients, including supervision and training.
T2019 - Personal Care Services - Services include assistance with eating, bathing, dressing, personal hygiene and activities of daily living. These services may include assistance with the preparation of meals, but does not include the cost of the meals themselves. When specified in the plan of care, this service may also include such housekeeping chores as bedmaking, dusting and vacuuming which are incidental to the care furnished or which are essential to the health and welfare of the individual rather than the individual’s family.

T2029NU - Specialized Medical Equipment (New) - Specialized medical equipment and supplies to include devices, controls or appliances, specified in the plan of care which enable clients to increase their abilities to perform activities of daily living, or to perceive, control or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan.

T2029 - Specialized Medical Equipment (Subsequent) - Specialized medical equipment and supplies to include devices, controls or appliances, specified in the plan of care which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan.

S5165NU - Home Modifications (New) - Those physical adaptations to the home, required by the client’s plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and, without which, the client would require institutionalization. These services will not include improvements to the home which are not of direct medical or remedial benefit to the waiver client, such as carpeting, roof repair, central air-conditioning, etc. All services will be provided in accordance with applicable State or local building codes.

S5165 - Home Modifications (Subsequent) - Those physical adaptations to the home, required by the client’s plan of care, which are necessary to ensure the health, welfare, and safety of the individual, or which enable the individual to function with greater independence in the home and, without which, the client would require institutionalization. These services will not include improvements to the home which are not of direct medical or remedial benefit to the waiver client, such as carpeting, roof repair, central air-conditioning, etc. All services will be provided in accordance with applicable State or local building codes.

G0152 – Services of Occupational Therapist - Occupational therapy services are services provided which are in the client’s established plan of care. This can include training to become more independent in activities of daily living, increasing sensory skills, gross and fine motor function, evaluating the environment for adaptive equipment needs and teaching how to use adaptive equipment to assist in working toward independence and self reliance.

G0153 – Services of Speech and Language Pathologist - Services identified in the client’s plan of care which may include speech pathology, screening and evaluation of clients with respect to speech and hearing function and the provision of ongoing therapy. Audiology services may include screenings and evaluations of the client’s speech and hearing function, comprehensive audiological assessments, tests of pure tone air and bone conduction, speech audiometry and other procedures, as necessary, and the assessment of use of visual cues; assessment of the use of amplification; and the provision of ongoing therapy.

S9470 – Nutritional Counseling, Dietician - Services provided by a Registered Dietitian including meal planning, consultation with and training for caregivers, and educating the individual served. The service does not include the cost of meals.
H0004 – Behavior Health Counseling - Services provided by a licensed psychologist, which are within the scope of the practices of the profession. Psychological therapy services include individual and group therapy; consultation with providers and individual caregivers directly involved with the individual; development and monitoring of behavior programs; participants in the individual planning process; and counseling for primary caregivers (i.e. family problems dealing with the individual with the disability).

T1002 - RN Services - Those services provided to clients which have been ordered by an attending physician to receive specific skilled nursing treatments and care including preventative and rehabilitative procedures. Skilled nursing services are provided to clients who live in their families’ homes, specialized foster homes, group homes or other community settings.

G0238 – Services of Respiratory Therapist - Services will be provided under the prescription of a physician in accordance with the client’s established plan of care and through direct contact between therapists and clients as well as between therapists and individuals involved with the client.

G0151 - Services of Physical Therapist - Those services provided to clients who have been ordered by an attending physician to receive specific physical therapy treatments and care including maintenance and restorative procedures. Physical therapy services are those services prescribed and designated in the client’s Individual Plan of Care (IPC). These services are provided by individual physical therapists that are graduates of appropriate university or college curricula and are currently licensed by the Wyoming Board of Physical Therapy or other states to practice in the State of Wyoming. Physical therapy services are part of the State of Wyoming’s EqualityCare State Plan, however, the chronic level of physical therapy services is not covered under program policy.

T1005 - Respite Care Services - Services given to individuals unable to care for themselves; provided on a short-term basis because of the absence or need for relief of those persons normally providing care.

Limitations

The following services are not covered under the Acquired Brain Injury (ABI) Home and Community-Based Services Waiver:

- Persons who are inpatients of a hospital, SNF, NF, or ICF/MR
- Prevocational, Vocational Rehabilitation, or Supported Employment, if services are available under section 110 of the Rehabilitation Act of 1973
- Special education and related services
- Room and Board
Attachment A

Health Check Forms

The following pages contain the forms used for the Health Check section of this module. Please make copies of these forms when needed.
WELL CHILD VISIT
1-4 Week

<table>
<thead>
<tr>
<th>Concerns/Discussion</th>
<th>Developmental/Behavioral</th>
<th>Screening/Immunizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Feeding</td>
<td>□ Responds to sound</td>
<td>□ Metabolic/Hemoglobinopathy (results &amp; f/u)</td>
</tr>
<tr>
<td>□ Stool/Voiding</td>
<td>□ Early eye fixation</td>
<td>□ Hearing Screen (results &amp; f/u)</td>
</tr>
<tr>
<td>□ Sleep position</td>
<td>□ Startle reflex</td>
<td>□ Vision (exam only)</td>
</tr>
<tr>
<td>□ Support systems</td>
<td>□ Moves all extremities</td>
<td></td>
</tr>
<tr>
<td>□ Sibling adjustment</td>
<td>□ Temperament/Parent Description</td>
<td></td>
</tr>
<tr>
<td>□ Child care anticipation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Parent’s health/mood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Other concerns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Parent/Infant interaction (observe)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nutrition</th>
<th>Physical Exam</th>
<th>Anticipatory Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Breast</td>
<td>□ General (Irritability/Lethargy)</td>
<td>□ Car seat</td>
</tr>
<tr>
<td>□ Length ______ min.</td>
<td>□ Wt ______ % ______</td>
<td>□ Crib safety</td>
</tr>
<tr>
<td>□ Frequency q ______ hrs.</td>
<td>□ Ht ______ % ______</td>
<td>□ Sleep/SIDS (back only)</td>
</tr>
<tr>
<td>□ Type _____________________</td>
<td>□ HC ______ % ______</td>
<td>□ Avoidance of falls</td>
</tr>
<tr>
<td>□ Amount ______ oz.</td>
<td></td>
<td>□ Avoid cigarette smoke</td>
</tr>
<tr>
<td>□ Frequency q ______ hrs.</td>
<td>□ Monitor growth chart</td>
<td>□ Smoke alarms</td>
</tr>
<tr>
<td>□ Vitamins (if indicated)</td>
<td>□ Temp ______</td>
<td>□ Appropriate babysitters</td>
</tr>
<tr>
<td></td>
<td>□ Skin (Jaundice)</td>
<td>□ Water heater temp (&lt;125 degrees)</td>
</tr>
<tr>
<td></td>
<td>□ Nodes</td>
<td>□ “Shaken baby” counseling</td>
</tr>
<tr>
<td></td>
<td>□ Head (Fontanelle/sutures)</td>
<td>□ When to contact health professional</td>
</tr>
<tr>
<td></td>
<td>□ Eyes (Red Reflex)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Ears</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Nose</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Oropharynx</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Neck (Torticollis)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Chest/Breast</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Lungs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Cardiovascular</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Abdomen (distention)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Musculoskeletal</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Hips (Clicks)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Neuro (Moro reflex)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Evidence of Neglect/Abuse</td>
<td></td>
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</table>

**Immunizations given:**

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Immunization</th>
<th>Immunization</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Record all abnormal findings below.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Assessment and Plan: __________________________

PHN Referral (if indicated) __________________________ WIC Referral (if indicated) __________________________

Physician Signature: __________________________

*Based on Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*
# WELL CHILD VISIT

## 2 Month

**Name ___________________________**  
**Age in Months ______________**  
**Date of Visit ___________________________**

### Concerns/Discussion
- Feeding
- Stool/Voiding
- Illness/Accidents
- Sleeping position
- Fussy baby/Colic
- Child care
- Parent returning to work/school
- Parent’s health/mood
- Other concerns
- Parent/Infant interaction (observe)

### Feeding

- **Breast**
  - Length _______ min.
  - Frequency q ______ hrs

- **Formula**
  - Type ______________________
  - Amount ______ oz.
  - Frequency q ______ hrs.
  - Vitamins (if indicated)

### Nutrition

### Developmental/Behavioral
- Coos/Vocalizes
- Smiles responsively
- Reacts to Visual/Auditory cues
- Lifts head/neck (prone position)
- Temperament/Parent Description

### Physical Exam
- General
  - Wt ______ % ______
  - Ht ______ % ______
  - HC _____ % ______
  - Monitor growth chart
- Temp ______
- Skin (Jaundice)
- Nodes
- Head (Fontanelle/Sutures)
- Eyes (Red Reflex)
- Ears
- Nose
- Oropharynx
- Neck (Torticollis)
- Chest/Breast
- Lungs
- Cardiovascular
- Abdomen
- Genitalia
- Hips (Clicks)
- Neuro
- Evidence of Neglect/Abuse

### Screenings

- Metabolic/Hemoglobinopathy (results & f/u)
- Hearing Screen (results & f/u)
- Vision (exam only)

### Immunizations

- Per ACIP schedule (Record below)

### Anticipatory Guidance
- Car seat
- Sleep position (back only)
- Cigarette smoke
- Avoidance of falls
- Avoiding sleep problems
- Interaction/Stimulation for baby
- Day care selection
- Appropriate toys
- Temperature taking
- Illness instruction

---

Record all abnormal findings below.

________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________

Assessment and Plan: _______________________________________________________________________________________
________________________________________________________________________________________________________

PHN Referral (if indicated) ___________________________  WIC Referral (if indicated) ________________________________

Physician Signature: _______________________________________________________________________________________

**Based on Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents**

June 2001
Name ___________________________________ Age in Months  ______________  Date of Visit ___________________________

**Concerns/Discussion**
- □ Feeding
- □ Stool/Voiding
- □ Sleep
- □ Parent/Sibling adjustment
- □ Illness/Accidents
- □ Other concerns
- □ Parent/Infant Interaction (observe)

**Nutrition**
- □ Breast
  - Frequency q _____ hrs
- □ Formula
  - Type ______________________
  - Amount ______ oz.
  - Frequency q _____ hrs.
  - Vitamins (if indicated)

**Guidance**
- □ Introduction of solids
  - (spoon only)
- □ Breast feeding
  - (discuss supplementation)
- □ Bottle Feeding
  - Fe fortified formula only
  - No sleeping with bottle

**Developmental/Behavioral**
- □ Vocalizes/Babbles
- □ Recognizes parents’ voice
- □ Grasping objects
- □ Rolls over

**Physical Exam**
- □ General
  - Wt ______ % ______
  - Ht ______ % ______
  - HC _____ % ______
  - Monitor growth chart
- □ Temp ______
- □ Skin
- □ Nodes
- □ Head
- □ Eyes (Strabismus)
- □ Ears
- □ Nose
- □ Oropharynx
- □ Neck (Torticollis)
- □ Chest/Breast
- □ Lungs
- □ Cardiovascular (murmurs)
- □ Abdomen
- □ Genitalia
- □ Hips (Clicks)
- □ Neuro (tone/strength)
- □ Evidence of Neglect/Abuse

**Screening/Immunizations**
- □ Screening
  - F/U metabolic and hearing from birth
  - Vision (exam only)
- □ Immunizations
  - Per ACIP schedule (Record below)

**Anticipatory Guidance**
- □ Car seat
- □ Sleep position
- □ Avoidance of fall
- □ Pet safety
- □ Bathing safety
- □ Shaken baby/Abuse
- □ Choking discussion
- □ Lead poisoning hazards
- □ Plastic bags/Balloon hazards
- □ Baby “Walker” safety
- □ Illness instructions

---

Record all abnormal findings below.

________________________________________________________________________________________________________

________________________________________________________________________________________________________

________________________________________________________________________________________________________

Assessment and Plan:  _______________________________________________________________________________________

________________________________________________________________________________________________________

PHN Referral (if indicated) ___________________________  WIC Referral (if indicated) ________________________________

Physician Signature: ______________________________________________________________________________________

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*Based on Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*
# WELL CHILD VISIT

**6 Month**

<table>
<thead>
<tr>
<th>Name</th>
<th>Age in Months</th>
<th>Date of Visit</th>
</tr>
</thead>
</table>

## Concerns/Discussion
- Feeding
- Stooling
- Sleep
- Family problems
- Illness/Accidents
- Other concerns
- Observe parent/Child interaction

## Nutrition
- Breast ____ times/day
- Formula ____ bottles/day
- Solids ____ times/day

### Guidance
- Breast or Fe fortified formula until 1 yr.
- Introduce cup for water & juice
- Fe supplement if breast only
- Introduction of new solids
- Choking hazards
- No bottles in crib

## Physical Exam
- General
  - Wt _____ % _____
  - Ht _____ % _____
  - HC _____ % _____
- Monitor growth chart
- Temp ______
- Skin
- Nodes
- Head
- Eyes (Strabismus)
- Ears
- Nose
- Oropharynx
- Neck
- Chest/Breast
- Lungs
- Cardiovascular (murmurs)
- Abdomen
- Genitalia
- Hips (Clicks)
- Neuro (tone/strength)
- Evidence of Neglect/Abuse

## Screening/Immunizations

### Screening
- Hearing - exam & history
- Vision (exam & history)
- Dental
- Discuss fluoride

### Immunizations
- Per ACIP schedule (Record below)

## Anticipatory Guidance
- Car seat
- Sleep safety
- “Baby-proof” house
- Bath/Water safety
- Choking/Poisoning safety
- Prevention of falls
- Sun exposure
- Lead poisoning hazards
- Age appropriate toys
- Baby “Walker” safety
- Parent/Infant interaction
- (play, reading, etc)
- Illness instructions

## Developmental/Behavioral
- Vocalizes (“dada”, “baba”)
- Rolls over
- No head lag
- Sits with support
- Grasps and mouths objects
- Smiles, laughs, imitates sounds
- Tooth eruption

## Physical Exam

Record all abnormal findings below.

________________________________________________________________________________________________________

________________________________________________________________________________________________________

________________________________________________________________________________________________________

Assessment and Plan: ____________________________________________

________________________________________________________________________________________________________

PHN Referral (if indicated) ___________________________ WIC Referral (if indicated) ________________________________

Physician Signature: _______________________________________

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Based on Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents

June 2001
# WELL CHILD VISIT

**9 Month**

<table>
<thead>
<tr>
<th>Name ______________________</th>
<th>Age in Months ______</th>
<th>Date of Visit ___________________________</th>
</tr>
</thead>
</table>

**Concerns/Discussion**
- □ Feeding
- □ Sleep
- □ Family concerns
- □ Illness/Accidents
- □ Other concerns
- □ Observe parent/Child interaction

**Nutrition**
- □ Breast _____ times/day
- □ Formula _____ bottles/day
  - Type _____________________
- □ Solids _____ times/day
  - Type _____________________

**Guidance**
- □ Breast or Fe fortified formula until 1 yr.
- □ Water, juice, formula in cup
- □ Increase variety/amount of table foods
- □ Gradually increase use of cup
- □ Choking hazards
- □ No honey during 1st year

**Developmental/Behavioral**
- □ Babbles/Repeats sounds
- □ Gestures (points, waves, “peek-a-boo”)
- □ Understands name
- □ Creeps/Scoots
- □ Pulls to stand
- □ Sits
- □ Stranger/ Separation anxiety
- □ Teething (discuss)

**Physical Exam**
- □ General
  - Wt _____  % _____
  - Ht _____  % _____
  - HC _____  % _____
  - Monitor growth chart
- □ Temp ______
- □ Skin
- □ Nodes
- □ Head
- □ Eyes
- □ Ears
- □ Nose
- □ Oropharynx
- □ Neck
- □ Chest/Breast
- □ Lungs
- □ Cardiovascular
- □ Abdomen
- □ Genitalia
- □ Hips
- □ Neuro
- □ Evidence of Neglect/Abuse

**Screening/Immunizations**
- □ Hearing (exam & history)
- □ Vision (exam & history)
- □ Dental
  - Discuss fluoride
  - Exam and refer if abnormal
  - Educate on care
- □ Anemia Hct/Hgb
- □ Per ACIP schedule (Record below)

**Anticipatory Guidance**
- □ Car seat
- □ Injury/Accident prevention
  - (falls, choking, burns, poisoning, drowning)
- □ Bedtime routine/Sleeping through the night
- □ Interacting with child (play, read, music)
- □ Pet safety
- □ Illness instructions

---

Record all abnormal findings below.

________________________________________________________________________________________________________

________________________________________________________________________________________________________

________________________________________________________________________________________________________

Assessment and Plan: _______________________________________________________________________________________
________________________________________________________________________________________________________

PHN Referral (if indicated) ___________________________  WIC Referral (if indicated) ________________________________

Physician Signature: _______________________________________________________________________________________

---

Based on Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents  

June 2001
WELL CHILD VISIT

1 Year

Name ___________________________________ Age in Months ______________ Date of Visit ___________________________

Concerns/Discussion

☐ Speech
☐ Sleep
☐ Family concerns
☐ Illness/Accidents
☐ Other concerns
☐ Observe parent/Child interaction

Nutrition

Meals

☐ Frequency ______ times/day
☐ Food Variety _____________ 

Bottle/Breast

☐ Frequency ______ times/day

Guidance

☐ 3 meals and 2-3 snacks per day
☐ Offer variety of soft table foods
☐ Family meals
☐ Make mealtimes pleasant
☐ “Up and down” appetite normal
☐ Discuss weaning from bottle/breast
☐ Switch to whole pasteurized milk
☐ Choking hazards

Developmental/Behavioral

☐ Pulls to stand and “cruises”
☐ Social games - “peek-a-boo”
☐ Pincer grasp
☐ 2-3 Words
☐ Drinks from cup
☐ Waves “bye-bye”
☐ Feeds self with hands

☐ Temperament/Parent description

__________________________________________________________________________

Physical Exam

☐ General
☐ Wt ______ % ______
☐ Ht ______ % ______
☐ HC ______ % ______

Monitor growth chart

☐ Temp ______
☐ Skin
☐ Nodes
☐ Head
☐ Eyes
☐ Ears
☐ Nose
☐ Oropharynx
☐ Neck
☐ Chest/Breast
☐ Lungs
☐ Cardiovascular
☐ Abdomen
☐ Genitalia
☐ Hips/Extremities
☐ Neuro
☐ Evidence of Neglect/Abuse

Screening/Immunizations

Screening

☐ Hearing (exam & history)
☐ Vision (exam & history)
☐ Lead—Screen high risk (educate everyone)
☐ Anemia—Hgb/Hct (if not done at 9 months)
☐ Tuberculosis—PPD if high risk
☐ Dental
  - Discuss fluoride
  - Exam and refer if abnormal
  - Educate on care

Immunizations

☐ Per ACIP schedule (Record below)

Anticipatory Guidance

☐ Injury/Accident prevention (car, falls, burns, sunscreen, drowning)
☐ Importance of praising children (discipline discussion)
☐ Limit number of rules
☐ Encourage safe exploration
☐ Read to child
☐ Family time with child
☐ Appropriate babysitters

Immunizations given:


Record all abnormal findings below.

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Assessment and Plan: ____________________________________________________________________

__________________________________________________________________________

PHN Referral (if indicated) ___________________________ WIC Referral (if indicated) ___________________________

Physician Signature: ___________________________

Based on Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents

June 2001
### WELL CHILD VISIT

**15 Month**

<table>
<thead>
<tr>
<th>Concerns/Discussion</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Speech</td>
<td></td>
</tr>
<tr>
<td>□ Sleep</td>
<td></td>
</tr>
<tr>
<td>□ Family adjustment</td>
<td></td>
</tr>
<tr>
<td>□ Illness/Accidents</td>
<td></td>
</tr>
<tr>
<td>□ Discipline</td>
<td></td>
</tr>
<tr>
<td>□ Other Concerns</td>
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</tr>
<tr>
<td>□ Observe parent/Child interaction</td>
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<table>
<thead>
<tr>
<th>Nutrition</th>
<th></th>
</tr>
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<tbody>
<tr>
<td><strong>Meals</strong></td>
<td></td>
</tr>
<tr>
<td>□ Frequency ______ times/day</td>
<td></td>
</tr>
<tr>
<td>□ Food Variety ______</td>
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<thead>
<tr>
<th>Bottle/Breast</th>
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<tbody>
<tr>
<td>□ Frequency ______ times/day</td>
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</tr>
</tbody>
</table>

**Guidance**

- 3 meals and 2-3 snacks per day
- Whole pasteurized milk until 2 years
- Discuss weaning from bottle/breast
- Offer variety of foods
- Do not “force” or punish
- Avoid food as a reward
- Choking hazards

**Developmental/Behavioral**

- 3-10 words
- Point to 1 or 2 body parts
- Understands simple commands
- Walking
- Feeds self with fingers

### Physical Exam

- □ General
  - Wt ______ % ______
  - Ht ______ % ______
  - HC ______ % ______
  - Monitor growth chart

- □ Temp ______

- □ Skin (Nevi, café au lait spots)

- □ Nodes

- □ Head

- □ Eyes

- □ Ears

- □ Nose

- □ Oropharynx

- □ Neck

- □ Chest/Breast

- □ Lungs

- □ Cardiovascular

- □ Abdomen

- □ Genitalia

- □ Hips/Extremities

- □ Neuro

- □ Evidence of Neglect/Abuse

### Screening/Immunizations

**Screening**

- □ Hearing (exam & history)
- □ Vision (exam & history)
- □ Lead—Screen high risk (educate all parents)
- □ Anemia—Screen high risk
- □ Tuberculosis—PPD if high risk
- □ Dental
  - Discuss fluoride
  - Exam and refer if abnormal
  - Educate on care

**Immunizations**

- □ Per ACIP schedule (Record below)
- □ Review record & “catch up” as needed

### Anticipatory Guidance

- □ Injury/Accident prevention
  - (car, falls, burns, sunscreen, drowning, pets)
- □ Sleep—Discuss regular bedtime routine
- □ Discuss daycare
- □ Appropriate toys
- □ Ignore temper tantrums
- □ Discipline (time out)
- □ Discourage toilet training
- □ Care of minor injuries

**Immunizations given:**

- __________________________
- __________________________

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Record all abnormal findings below.

______________________________________________________________________________

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Assessment and Plan: ______________________________________________________________

______________________________________________________________________________

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PHN Referral (if indicated) ___________________________ WIC Referral (if indicated) ___________________________

Physician Signature: ____________________________________________

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*Based on Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*  
June 2001
**WELL CHILD VISIT**  
*18 Month*

<table>
<thead>
<tr>
<th>Name ___________________________________</th>
<th>Age in Months</th>
<th>Date of Visit ___________________________</th>
</tr>
</thead>
</table>

## Concerns/Discussion
- Sleep
- Family adjustment
- Speech
- Illnesses/Accidents
- Behavior/Discipline
- Other concerns
- Observe parent/Child interaction

## Nutrition
**Meals**
- Frequency _________ times/day
- Food variety _______________

**Bottle/Breast**
- Frequency _________ times/day

## Guidance
- 3 meals & 2-3 nutritious snacks/day
- Make meals pleasant  
  (avoid fighting or forcing)
- Family meals
- Do not “comfort” or “reward” with food
- Encourage self feeding  
  (increase spoon use)
- Variety of foods
- Expect variable intake  
  (will balance diet over several days)
- Choking concerns

## Developmental/Behavioral
- 15-20 words
- Walks well; Starting to run
- Stacks 2-3 blocks
- Uses spoon and cup
- Listens to stories (short time)
- Shows affection (“kisses”)
- Throws ball
- Temper tantrums
- Ignores instructions and requests

### Physical Exam
- **General**
  - Wt ______  % ______
  - Ht ______  % ______
  - HC ______  % ______
  - Monitor growth chart
- **Guidance**
  - Temp ______
  - Skin (Nevi, café au lait spots)
  - Nodes
  - Head
  - Eyes
  - Ears
  - Nose
  - Oropharynx (bottle tooth decay)
  - Neck
  - Chest/Breast
  - Lungs
  - Cardiovascular
  - Abdomen
  - Genitalia
  - Hips/Extremities
  - Neuro
  - Evidence of Neglect/Abuse

### Screening/Immunizations
**Screening**
- Hearing (exam & history)
- Vision (exam & history)
- Lead—Screen high risk  
  (educate all parents)
- Anemia—Screen high risk
- Tuberculosis—PPD for high risk
- Dental  
  - Discuss fluoride
  - Exam and refer if abnormal
  - Educate on care

**Immunizations**
- Per ACIP schedule (Record below)
- Review record & “catch up” as needed

## Anticipatory Guidance
- Injury/Accident prevention
- Sleep—Avoid sleeping in parents’ bed
- Discipline  
  - Praise good behavior, limit number of rules, time out discussion  
  (avoid hitting, spanking, yelling)
- Toilet training—discuss readiness signs  
  (praise successes, DO NOT PUNISH)
- Limit TV viewing
- Reading
- Do not expect child to share
- Sibling rivalry

---

**Record all abnormal findings below.**

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**Assessment and Plan:** ______________________________________________________

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**Immunizations given:**

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**PHN Referral (if indicated) ___________________________  WIC Referral (if indicated) ______________________________**

**Physician Signature: __________________________________________________________**

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*Based on Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents*  
June 2001
Name ___________________________________ Age in Years   ______________ Date of Visit ___________________________

**Concerns/Discussion**
- □ Family concerns
- □ Illnesses/Accidents
- □ Behavior/Discipline
- □ Toilet training
- □ Observe parent/Child interaction
- □ Other concerns

**Physical Exam**
- □ General
  - □ Wt ______  % ______
  - □ Ht ______  % ______
  - □ HC _____  % ______
  - Monitor growth chart
- □ Temp ______
- □ Skin (Nevi, café au lait spots)
- □ Nodes
- □ Head
- □ Eyes
- □ Ears
- □ Nose
- □ Oropharynx (bottle tooth decay)
- □ Neck
- □ Chest/Breast
- □ Lungs
- □ Cardiovascular
- □ Abdomen
- □ Genitalia
- □ Hips/Extremities
- □ Neuro
- □ Evidence of Neglect/Abuse

**Nutrition Guidance**
- □ 3 meals & 2-3 nutritious snacks/day
- □ Make mealtime pleasant
  - (avoid fighting or forcing)
- □ Family meals
- □ Do not “comfort” or “reward” with food
- □ Appropriate size utensils
- □ Offer variety of foods
- □ Can use low-fat dairy products

**Developmental/Behavioral**
- □ 2-3 word phrases; rapidly expanding vocabulary
- □ Up and down stairs
- □ Kick a ball
- □ Stacks 5-6 blocks
- □ 20 words and 2-word phrases
- □ Imitates adults
- □ Temper tantrums
- □ Throws ball
- □ Ignores instructions and requests

**Screening/Immunizations**

<table>
<thead>
<tr>
<th>Screening</th>
<th>Immunizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Hearing (exam &amp; history)</td>
<td>□ Tuberculosis—PPD for high risk</td>
</tr>
<tr>
<td>□ Vision (exam &amp; history)</td>
<td>□ Dental</td>
</tr>
<tr>
<td>□ Lead—Screen high risk</td>
<td>- Discuss fluoride</td>
</tr>
<tr>
<td>(educate all parents)</td>
<td>- Exam and refer if abnormal</td>
</tr>
<tr>
<td>□ Anemia—Screen high risk</td>
<td>- Educate on care</td>
</tr>
<tr>
<td>□ Hyperlipidemia—Screen if high risk</td>
<td>□ Immunizations given:</td>
</tr>
</tbody>
</table>

**Anticipatory Guidance**
- □ Injury/Accident prevention
  - (car, outside play, drowning, electrical, poisoning, falls, burns, copy parents)
- □ Gun safety
- □ Discuss sleep habits
  - (night waking, fears, nightmares)
- □ Discipline (Time out)
  - (avoid hitting, spanking, yelling)
- □ Ignore temper tantrums
- □ Toilet training-discuss readiness signs
  - (praise successes, DO NOT PUNISH)
- □ Normal to play with parts of body
- □ Let child explore
- □ Limit TV viewing
- □ Sibling rivalry
- □ Care of minor injuries & illnesses

**Record all abnormal findings below.**

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Assessment and Plan: __________________________________________________________

________________________________________________________________________

PHN Referral (if indicated) ___________________________  WIC Referral (if indicated) ________________________________

Physician Signature: __________________________________________________________

Based on Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents  
June 2001
**WELL CHILD VISIT**

**3 & 4 Year**

<table>
<thead>
<tr>
<th>Name ___________________________</th>
<th>Age in Years ______________</th>
<th>Date of Visit ___________________________</th>
</tr>
</thead>
</table>

**Concerns/Discussion**
- [ ] Family concerns
- [ ] Illnesses/Accidents
- [ ] Behavior/Discipline
- [ ] Daycare/Pre-school concerns
- [ ] Toilet training
- [ ] Observe parent/Child interaction
- [ ] Other concerns

**Nutrition Guidance**
- [ ] 3 meals & 2-3 nutritious snacks/day
- [ ] Offer variety of foods
- [ ] Let child choose what and how much to eat
- [ ] Have pleasant family meals
- [ ] No fighting or forcing
- [ ] Provide a good example by eating healthy yourself
- [ ] Use low-fat dairy products

**Developmental/Behavioral**
- [ ] 3-4 word sentences; intelligible to strangers most of the time
- [ ] Jumps in place and/or hops on one foot
- [ ] Rides tricycle and/or bicycle with training wheels
- [ ] Knows names, age and sex
- [ ] Starting to draw
- [ ] Throws ball overhand (4 yrs)
- [ ] Shows imagination
- [ ] Self-care skills (feeding, dressing)
- [ ] Challenges authority and discipline
- [ ] Understands “sharing”

**Physical Exam**
- [ ] General
  - Wt ______ % ______
  - Ht ______ % ______
  - Monitor growth chart
- [ ] Blood pressure ______
- [ ] Temp ______
- [ ] Skin
- [ ] Nodes
- [ ] Head
- [ ] Eyes
- [ ] Ears
- [ ] Nose
- [ ] Oropharynx
- [ ] Neck
- [ ] Chest/Breast
- [ ] Lungs
- [ ] Cardiovascular
- [ ] Abdomen
- [ ] Genitalia
- [ ] Back & Extremities
- [ ] Neuro
- [ ] Evidence of Neglect/Abuse

**Screening/Immunizations**

**Screening**
- [ ] Hearing
  - 3 yrs, exam and history
  - 4 yrs, audiologic screen (pure tone)
- [ ] Vision—Distance visual acuity
  (if cooperative)
- [ ] Lead—Screen high risk
- [ ] Anemia—Screen high risk
- [ ] Hyperlipidemia—Screen high risk

**Immunizations**
- [ ] Per ACIP schedule
- [ ] Review record & “catch up” as needed

**Sexuality Discussion**
- [ ] Answer questions at age appropriate level
- [ ] Use correct terms for genitals
- [ ] Normal to play with all body parts
- [ ] Discuss “privacy” issues

**Anticipatory Guidance**
- [ ] Injury/Accident prevention
  (gun, car/airbag concerns, swimming pool safety, pedestrian safety, bicycle safety)
- [ ] “Stranger” discussion
- [ ] Discipline
  - Praise good behavior, reasonable expectations, stress consistency, time out discussion
  (avoid hitting, spanking, yelling)
- [ ] Limit TV/Encourage physical activity
- [ ] Increase reading to child
- [ ] Preschool and school readiness
- [ ] Encourage activities with other children

**Record all abnormal findings below.**

____________________________________________________________________________________

____________________________________________________________________________________

**Assessment and Plan:**

____________________________________________________________________________________

____________________________________________________________________________________

**PHN Referral (if indicated) ___________________________  WIC Referral (if indicated) ______________________________**

**Physician Signature: ____________________________________________**

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*Based on Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*  
June 2001
WELL CHILD VISIT
5 Year

Name ___________________________________ Age in Years ______________ Date of Visit ___________________________

Concerns/Discussion
(from parent and child)

□ Family concerns
□ Illnesses/Accidents
□ Behavior/Discipline
□ Kindergarten
□ Other concerns
□ Observe parent/Child interaction

Nutrition Guidance

□ Model and encourage healthy eating habits
□ 3 meals and 2 snacks per day (stress importance of breakfast before school)
□ Make mealtimes pleasant
□ Encourage variety of foods

Developmental/Behavioral

□ Dresses without help
□ Knows address and phone number
□ Recognizes some letters and prints
□ Can count on fingers
□ Plays make-believe games
□ Says mean things to parents
□ Ignores parents

Physical Exam

□ General
□ Wt ______ % _______
□ Ht ______ % _______
□ Monitor growth chart
□ Blood pressure ______
□ Temp ______

Immunizations

□ Per ACIP schedule (Record below)
□ Review record & “catch up” as needed

Sexuality Education

□ Sexual curiosity and exploration are normal
□ Use correct terms for genitals
□ Read age appropriate books
□ Discuss “privacy” issues

Anticipatory Guidance

□ Injury/Accident prevention
  - Gun safety
  - Bicycle safety
  - Suggest swimming lessons
  - Car safety
  - Pedestrian safety
  - Playground safety
□ “Stranger” discussion
□ Discipline Issues
  - Should follow family rules
  - Respect authority
  - Time out and limiting privileges
□ Age appropriate chores
□ TV and computer rules
□ Encourage physical activity
□ Parents as role models
□ Spend time with each child
□ Encourage time with other children

Screening/Immunizations

Screening

□ Hearing—audiologic screen (pure tone)
□ Vision—Distance visual acuity
□ Lead—Screen high risk
□ Hyperlipidemia—screen high risk
□ Blood pressure
□ Urinalysis
□ Tuberculosis—PPD for high risk
□ Dental
  - Recommend dental visit
  - Discuss care and fluoride
  - Sealants for molars

Immunizations given:

_______________________________

Record all abnormal findings below.
________________________________________________________________________________________________________
________________________________________________________________________________________________________
Assessment and Plan: __________________________________________
________________________________________________________________________________________________________

PHN Referral (if indicated) ___________________________ WIC Referral (if indicated) ___________________________

Physician Signature: ___________________________

Based on Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents

June 2001
**WELL CHILD VISIT**  
6-10 Year

<table>
<thead>
<tr>
<th>Name</th>
<th>Age in Years</th>
<th>Date of Visit</th>
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<tbody>
<tr>
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</tbody>
</table>

### Concerns/Discussion
(from parent and child)
- Family concerns
- Illnesses/Accidents
- Behavior/Discipline
- School issues
- Other concerns
- Observe parent/Child interaction

### Nutrition Guidance
- Model and encourage healthy eating habits (family needs)
- 3 meals and 2 snacks per day
- Limit high fat and low nutrient foods and drinks
- Encourage variety of foods

### Developmental/School Performance
- Any concerns about development
- School attendance problems
- Acknowledge and praise school achievements
- Talk about school with child
- Parent-Teacher conference
- Parental participation in school activities

### Physical Exam
- General
  - Wt _____ % _____
  - Ht _____ % _____
  - Monitor growth chart
  - Blood pressure _____
  - Temp ______
  - Skin

### Sexuality Education
(use handouts if possible)
- Answer questions at age appropriate level
- Age appropriate books available
- Parents should:
  - Discuss puberty & sexual development (9-10 yrs)
  - Discuss menstruation with girls (9-10 yrs)
  - Discuss wet dreams with boys (9-10 yrs)
  - Discuss privacy issues

### Anticipatory Guidance
- Assure adequate amount of sleep
- Safety Issues (guns, bicycle, strangers)
- Limit TV viewing
- Discuss appropriate use of computers/internet
- Encourage physical activity
- Encourage family activities
- Discuss drugs, alcohol & cigarettes
- Meet and get to know friends
- Age appropriate chores
- Provide “personal space” for child
- Discipline Issues
  - Help build self-esteem, encourage impulse and anger control, set consequence for unacceptable behavior

### Screening/Immunizations

#### Immunizations
- Per ACIP schedule (Record below)
- Review record

#### Screening
- Hearing—Audiologic screen (pure tone)
- Vision—Distance visual acuity
- Lead—Screen high risk
- Hyperlipidemia—Screen high risk
- Blood pressure
- Tuberculosis—PPD for high risk
- Dental
  - Recommend dental visit
  - Discuss care and fluoride
  - Sealants for molars

<table>
<thead>
<tr>
<th>Immunizations given:</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Record all abnormal findings on separate sheet

Assessment and Plan: ________________________________________________
__________________________________________________________________
__________________________________________________________________

PHN Referral (if indicated) ____________________  WIC Referral (if indicated) ____________________

Physician Signature: ________________________________

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*Based on Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*  
June 2001
# WELL CHILD VISIT

## 11-14 Year

<table>
<thead>
<tr>
<th>Name</th>
<th>Age in Years</th>
<th>Date of Visit</th>
<th>Concerns/Discussion (from parent and adolescent)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ Family concerns</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ Illnesses/Accidents</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>□ Behavior/Discipline</td>
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<td></td>
<td></td>
<td>□ School issues</td>
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<td></td>
<td></td>
<td></td>
<td>□ Other concerns</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ Observe parent/Adolescent interaction</td>
</tr>
</tbody>
</table>

## Nutrition Guidance

- □ Encourage family meals
- □ 3 healthy meals/day
- □ Limit high fat & low nutrient foods and drinks
- □ Discuss weight issues & “diets”

## Developmental/School Performance

- □ Grades at school/Question excessive absences
- □ How do you feel about yourself?
- □ Peer concerns
- □ Who can you talk to?
- □ Favorite teacher/Class
- □ Involvement in activities

## Physical Exam

- □ General
- □ Wt ______  % ______
- □ Ht ______  % ______
- □ Monitor growth chart
- □ Blood pressure ______
- □ Temp ______
- □ Skin (acne)
- □ Nodes
- □ Head
- □ Eyes
- □ Ears
- □ Nose
- □ Oropharynx (teeth malocclusion)
- □ Neck
- □ Chest/Breast
- □ Lungs
- □ Cardiovascular
- □ Abdomen
- □ Genitalia (Tanner stage)
- □ Back & Extremities (scoliosis exam)
- □ Neuro
- □ Evidence of Neglect/Abuse
- □ Evidence of eating disorder

## Screening/Immunizations

- □ Per ACIP schedule (Record below)
- □ Review record

### Screening

- □ Hearing—Hx (screen if abnormal)  
  - Objective screen at 12 years
- □ Vision—Hx (screen if abnormal)  
  - Objective screen at 12 years

### Immunizations

- □ Anemia  
  - Screen menstruating females annually  
  - Screen all high risk
- □ Hyperlipidemia—Screen high risk
- □ Blood pressure-Anually
- □ Urinalysis—Minimum one time during adolescence
- □ Tuberculosis—PPD if high risk
- □ Dental  
  - Recommend dental visit  
  - Discuss care and fluoride  
  - Sealants for molars

## Sexuality Education

(Use handouts if possible)

- □ Dating discussion
- □ How to get accurate information
- □ Is adolescent sexually active?
- □ Discuss abstinence as safest way to prevent pregnancy & STD’s
- □ Discuss contraceptive methods & STD prevention, if sexually active
- □ Discuss ways to resist pressure

## Anticipatory Guidance

- □ Importance of adequate sleep
- □ Safety issues  
  (Guns/Weapons, Bicycle, Car,  
  Avoiding physical & sexual abuse or rape)
- □ Discuss drugs, alcohol, cigarettes and inhalants
- □ TV and Computer/Internet
- □ Encourage physical activity
- □ Mental Health issues—refer if concerns  
  - Improve self confidence  
  - Signs of depression  
  - Who to talk to for help

Record all abnormal findings on separate sheet.

**Assessment and Plan:**

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

**PHN Referral (if indicated) ___________________________**  
**WIC Referral (if indicated) ___________________________**

**Physician Signature: _________________________________**

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*Based on Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*  
June 2001
Well Child Visit

15-17 Year

Name ___________________________ Age in Years __________________ Date of Visit ___________________________

Concerns/Discussion
(from parent and adolescent)
□ Family concerns
□ Parent/Adolescent relationship
□ Behavior/Discipline
□ School issues
□ Other concerns
□ Observe parent/Adolescent interaction

Nutrition Guidance
□ Stress 3 healthy meals/day
□ Limit high fat & low nutrient foods and drinks
□ Discuss healthy weight & “diets”

Developmental/School Performance
□ Student to be responsible for attendance, homework, course selection and extracurricular activities
□ Discuss problems with a trusted adult
□ Identify talents and interests
□ Start thinking about plans after high school

Physical Exam
□ General
□ Wt ______ % ______
□ Ht ______ % ______
Monitor growth chart
□ Blood pressure ______
□ Temp ______
□ Skin (acne)
□ Nodes
□ Head

□ Eyes
□ Ears
□ Nose
□ Oropharynx (teeth malocclusion)
□ Neck
□ Chest/Breast
□ Lungs
□ Cardiovascular
□ Abdomen
□ Genitalia (Tanner stage)
□ Back & Extremities (scoliosis exam)
□ Neuro
□ Evidence of Neglect/Abuse
□ Evidence of eating disorder

Screening/Immunizations

Immunizations
□ Per ACIP schedule (Record below)
□ Review record

Screening
□ Hearing—Hx (screen if abnormal)
- Objective screen at 15 years
□ Vision—Hx (screen if abnormal)
- Objective screen at 15 years
□ Anemia
- Screen menstruating females annually
- Screen all high risk
□ Hyperlipidemia—Screen high risk
□ Blood pressure—Annually
□ Urinalysis—Minimum one time during adolescence
□ Tuberculosis—PPD if high risk
□ Pap smear—Annually for sexually active females

□ STD’s—Screen sexually active adolescents annually
□ Dental
- Recommend dental visit
- Discuss care and fluoride
- Sealants for molars

Sexuality Education
(use handouts if possible)
□ Identify supportive adult for teen to talk to
□ If sexually active, discuss contraception and STD prevention
□ Having sex should be a well thought out decision
□ Abstinence as safest way to prevent pregnancy & STD’s
□ Ways to resist pressure
□ Avoiding rape situations

Anticipatory Guidance
□ Importance of adequate sleep
□ Moderate to vigorous physical activity
□ TV and Computer/Internet
□ Discuss drugs, alcohol, cigarettes and inhalants
□ Safety—High risk behavior
□ Mental Health issues—refer if concerns
- Improve self confidence
- Signs of depression
- Who to talk to for help

Immunizations given:
________________________________________
________________________________________

Assessment and Plan: __________________________________________
________________________________________________________________________
________________________________________________________________________

PHN Referral (if indicated) ___________________________ WIC Referral (if indicated) ___________________________

Physician Signature: __________________________________________

Based on Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents

June 2001
**Concerns/Discussion**  
(primarily from patient)
- Living arrangements
- Post high school education
- Work issues
- Relationship with parents
- Access to healthcare
  - Question insurance
- Other concerns

**Nutrition Guidance**
- Choose and prepare healthy foods
- 3 healthy meals
- Limit high fat & low nutrient foods and drinks
- Meals with family, friends, or roommates
- Discuss healthy weight & “diets”

**School/Vocational Issues**
- Identify talents and interests
- Plan for future
  - College
  - Vocational training
  - Military
  - Job/Career

**Physical Exam**
- General
  - Wt ______ % ______  
  - Ht ______ % ______  
  - Monitor growth chart
- Blood pressure ______
- Temp ______

**Screening/Immunizations**

**Immunizations**
- Per ACIP schedule (Record below)
- Review record

**Screening**
- Hearing—Hx (screen if abnormal)
  - Objective screen at 18 years
- Vision—Hx (screen if abnormal)
  - Objective screen at 18 years
- Anemia—Screen high risk
- Hyperlipidemia—Screen high risk
- Blood pressure—Annually

- Urinalysis—Minimum one time during adolescence
- Tuberculosis—PPD if high risk
- Pap smear—Annually for sexually active females
- STD’s—Screen sexually active adolescents annually
- Dental
  - Recommend dental visit
  - Discuss care and fluoride
  - Sealants for molars

**Sexuality Education**  
(use handouts if possible)
- Abstinence as safest way to prevent pregnancy & STD’s
- Contraception and STD prevention
- Having sex should be a well thought out decision
- Ways to resist pressure

**Anticipatory Guidance**
- Living away from parents
- Discuss drugs, alcohol, cigarettes
- High risk behaviors
- Mental Health issues—refer if concerns
  - Accepting who you are
  - Signs of depression
  - Dealing with stress
  - When to ask for help and who

**Assessment and Plan:**  
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

PHN Referral (if indicated) ___________________________  WIC Referral (if indicated) ________________________________

Physician Signature: ______________________________

*Record all abnormal findings on separate sheet.*

*Based on Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*  
*June 2001*
Attachment B
Recommended Childhood Immunization Schedule

(See attached Schedule on following page)
Recommended Childhood and Adolescent Immunization Schedule -- United States, 2003

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Age</th>
<th>Birth</th>
<th>1 mo</th>
<th>2 mos</th>
<th>4 mos</th>
<th>6 mos</th>
<th>12 mos</th>
<th>15 mos</th>
<th>18 mos</th>
<th>24 mos</th>
<th>4-6 yrs</th>
<th>11-12 yrs</th>
<th>13-18 yrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B¹</td>
<td></td>
<td>HepB #1</td>
<td></td>
<td></td>
<td></td>
<td>HepB #2</td>
<td></td>
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</tr>
<tr>
<td>Diphtheria, Tetanus, Pertussis²</td>
<td></td>
<td></td>
<td>DTaP</td>
<td>DTaP</td>
<td>DTaP</td>
<td>DTaP</td>
<td>DTaP</td>
<td>DTaP</td>
<td>Td</td>
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<tr>
<td>Haemophilus influenzae Type b³</td>
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<td></td>
<td>Hib</td>
<td>Hib</td>
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</tr>
<tr>
<td>Inactivated Polio</td>
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<td>IPV</td>
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<tr>
<td>Measles, Mumps, Rubella⁴</td>
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<td></td>
<td></td>
<td>MMR #1</td>
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<tr>
<td>Varicella⁵</td>
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<tr>
<td>Pneumococcal⁶</td>
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<tr>
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</tr>
</tbody>
</table>

Vaccines below this line are for selected populations

This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2002, for children through age 18 years. Any dose not given at the recommended age should be given at any subsequent visit when indicated and feasible. Indicates age groups that warrant special effort to administer those vaccines not previously given. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and the vaccine’s other components are not contraindicated. Providers should consult the manufacturers’ package inserts for detailed recommendations.

1. Hepatitis B vaccine (HepB). All infants should receive the first dose of hepatitis B vaccine soon after birth and before hospital discharge; the first dose may also be given by age 2 months if the infant’s mother is HBsAg-negative. Only monovalent HepB can be used for the birth dose. Monovalent or combination vaccine containing HepB may be used to complete the series. Four doses of vaccine may be administered when a birth dose is given. The second dose should be given at least 4 weeks after the first dose, except for combination vaccines which cannot be administered before age 6 weeks. The third dose should be given at least 16 weeks after the first dose and at least 8 weeks after the second dose. The last dose in the vaccination series (third or fourth dose) should not be administered before age 6 months.

Infants born to HBsAg-positive mothers should receive HepB and 0.5 mL Hepatitis B Immune Globulin (HBIG) within 72 hours of birth at separate sites. The second dose is recommended at age 1-2 months. The last dose in the vaccination series should not be administered before age 6 months. These infants should be tested for HBsAg and anti-HBs at 9-15 months of age.

Infants born to mothers whose HBsAg status is unknown should receive the first dose of the HepB series within 12 hours of birth. Maternal blood should be drawn as soon as possible to determine the mother’s HBsAg status; if the HBsAg test is positive, the infant should receive HBIG as soon as possible (no later than age 1 week). The second dose is recommended at age 1-2 months. The last dose in the vaccination series should not be administered before age 6 months.

2. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP). The fourth dose of DTaP may be administered as early as age 12 months, provided 6 months have elapsed since the third dose and the child is unlikely to return at age 15-18 months. Tetanus and diphtheria toxoids (Td) is recommended at age 11-12 years if at least 5 years have elapsed since the last dose of tetanus and diphtheria toxoid-containing vaccine. Subsequent routine Td boosters are recommended every 10 years.

3. Haemophilus influenzae type b (Hib) conjugate vaccine. Three Hib conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB® or ComVax® [Merck]) is administered at ages 2 and 4 months, a dose at age 6 months is not required. DTaP/Hib combination products should not be used for primary immunization in infants at ages 2, 4 or 6 months, but can be used as boosters following any Hib vaccine.

4. Measles, mumps, and rubella vaccine (MMR). The second dose of MMR is recommended routinely at age 4-6 years but may be administered during any visit, provided at least 4 weeks have elapsed since the first dose and that both doses are administered beginning at or after age 12 months. Those who have not previously received the second dose should complete the schedule by the 11-12 year old visit.

5. Varicella vaccine. Varicella vaccine is recommended at any visit at or after age 12 months for susceptible children, i.e. those who lack a reliable history of chickenpox. Susceptible persons aged ≥3 years should receive two doses, given at least 4 weeks apart.

6. Pneumococcal vaccine. The heptavalent pneumococcal conjugate vaccine (PCV) is recommended for all children age 2-23 months. It is also recommended for certain children age 24-59 months. Pneumococcal polysaccharide vaccine (PPV) is recommended in addition to PCV for certain high-risk groups. See MMWR 2000;49(RR-9);1-38.

7. Hepatitis A vaccine. Hepatitis A vaccine is recommended for children and adolescents in selected states and regions, and for certain high-risk groups; consult your local public health authority. Children and adolescents in these states, regions, and high-risk groups who have not been immunized against hepatitis A can begin the hepatitis A vaccination series during any visit. The two doses in the series should be administered at least 6 months apart. See MMWR 1999;48(RR-12);1-37.

8. Influenza vaccine. Influenza vaccine is recommended annually for children age 26 months with certain risk factors (including but not limited to asthma, cardiac disease, sickle cell disease, HIV, diabetes, and household members of persons in groups at high risk; see MMWR 2002;51(RR-3);1-31), and can be administered to all others wishing to obtain immunity. In addition, healthy children age 6-23 months are encouraged to receive influenza vaccine if feasible because children in this age group are at substantially increased risk for influenza-related hospitalizations. Children aged ≥12 years should receive vaccine in a dosage appropriate for their age (0.25 mL if age 6-35 months or 0.5 mL if aged ≥5 years). Children aged ≥6 years who are receiving influenza vaccine for the first time should receive two doses separated by at least 4 weeks.

For additional information about vaccines, including precautions and contraindications for immunization and vaccine shortages, please visit the National Immunization Program Website at www.cdc.gov/nip or call the National Immunization Information Hotline at 800-232-2522 (English) or 800-232-0233 (Spanish).

Approved by the Advisory Committee on Immunization Practices (www.cdc.gov/nip/acip), the American Academy of Pediatrics (www.aap.org), and the American Academy of Family Physicians (www.aafp.org).