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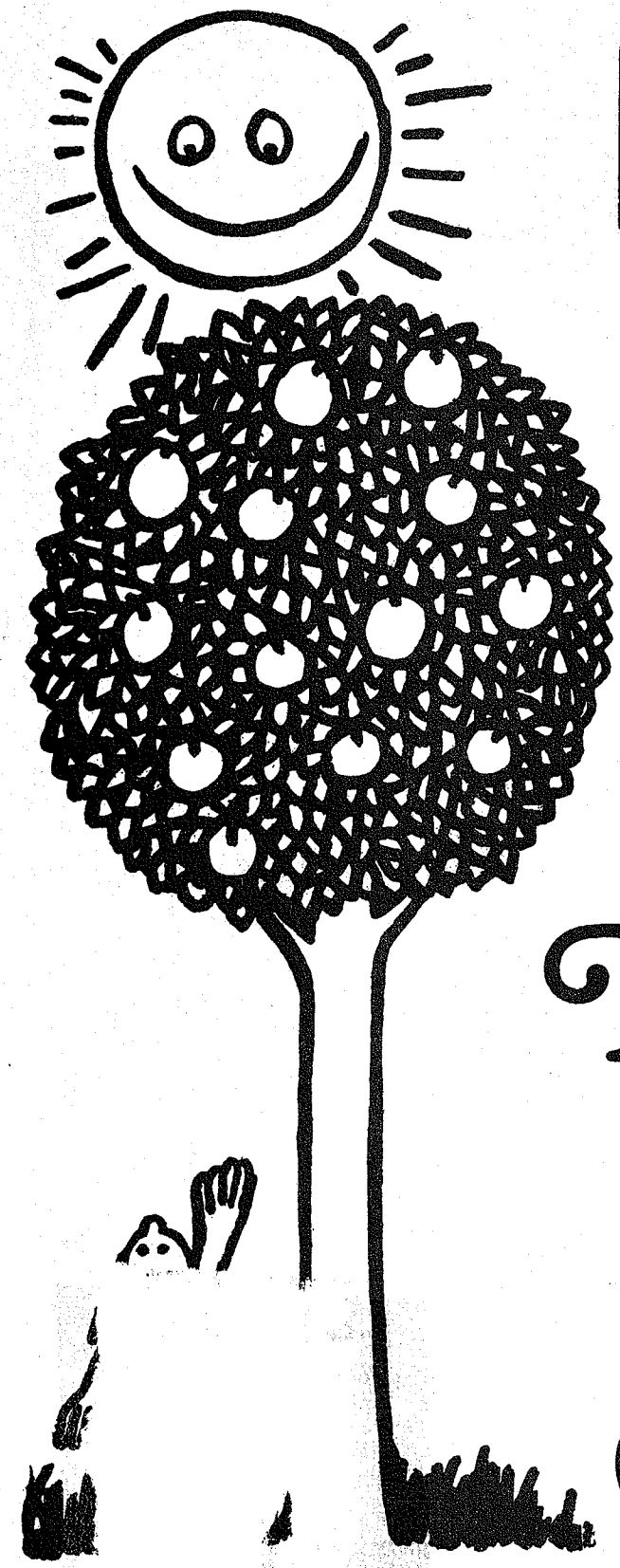


EPSDT

Provider handbook

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE

TABLE OF CONTENTS

FOREWORD

Purpose of this Handbook

This handbook has been prepared for the information and guidance of providers who participate in the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program.

CHAPTER ONE — General Information and Background
CHAPTER TWO — Screening Components
CHAPTER THREE — Completion of the EPSDT Invoice
CHAPTER FOUR — The Remittance Advice

Page changes and supplements to this handbook will be forwarded as needed.

Further Information

A. Policy and Procedure

All questions concerning policy and procedures for the EPSDT Program should be directed to:

EPSDT Section
Bureau of Income Maintenance
Minnesota Department of Public Welfare
Fourth Floor Centennial Office Building
St. Paul, Minnesota 55155
Telephone: 612-296-3883 (call collect)

B. Questions concerning *specific* EPSDT *claims* submitted for payment should be directed to:

EPSDT Claims Processing
Medical Assistance Program
Minnesota Department of Public Welfare
690 North Robert Street
Box 43170
St. Paul, Minnesota 55164

Telephone: Local - 296-7668
Long Distance - Within Minnesota: 1-800-652-9747 ext. 6-7668 (toll free)
Long Distance - Outside Minnesota: 612-296-7668 (call collect)

C. Recipient Eligibility

Eligible recipients will have a Medical Assistance ID card showing eligibility for the current month. See Appendix D for a sample of this card.

Questions about a person's eligibility should be directed to the local welfare agency.

D. Forms and Handbooks

The Child Screening Form (DPW-1973), EPSDT Envelope (DPW-1865) and other forms may be ordered free of charge from DPW Welfare Forms Supply on the Requestion Form (DPW-121). See Appendix A for a sample of this form.

Requests for additional handbooks should be sent to:
EPSDT Section
Bureau of Income Maintanance
Department of Public Welfare
Fourth Floor Centennial Office Building
St. Paul, Minnesota 55155

NOTE: Names and places used in this handbook are fictitious.

GENERAL INFORMATION AND BACKGROUND

CHAPTER ONE

A. WHAT IS EPSDT?

The Early and Periodic Screening, Diagnosis and Treatment Program is designed to bring comprehensive health care to children (age 0 to 21) eligible for Medical Assistance. Outreach efforts focus on children from families receiving Aid to Families with Dependent Children (AFDC).

The program is based on a preventive health philosophy of discovering and treating health problems before they become disabling and therefore far more costly to treat in terms of both human and financial resources. The program is comprehensive, designed to examine all aspects of a child's well-being and correct any problems that are discovered.

B. WHAT DOES EPSDT MEAN?

Early means as soon as possible in the child's life (in case of a family already receiving assistance), or as soon as a family's eligibility for assistance has been established.

Periodic means at intervals established for screening by medical, dental and other health care experts to assure that disease or disability has not appeared since the child's last evaluation. The types of procedures performed and their frequency will depend on the child's age and health history. In Minnesota, the following ages for re-screening have been established: birth to 6 months according to the physician's well-baby schedule, 9 months, 1 year, 18 months, 2 years, 4 years, every 3 years thereafter.

Screening is the use of quick, simple procedures to sort out apparently well persons from those who need more definitive study of possible physical or developmental problems.

Diagnosis is the determination of the nature or cause of physical or mental disease or abnormality through the combined use of health history, physical, developmental and psychological examination, and laboratory test and X-rays.

In Minnesota Department of Health-approved screening clinics, children are screened by nurses and trained volunteers; therefore all suspected abnormalities found in these clinics are referred to the appropriate practitioner or medical facility for definitive evaluation.

Physicians who do EPSDT screenings may diagnose and treat health problems uncovered during the screening or they may refer the child to other appropriate sources for such care.

Treatment means physician's or dentist's services or any other type of medical care and services recognized under State law, to prevent, correct or ameliorate disease or abnormalities detected by screening and diagnostic procedures.

Physicians may screen, diagnoise and treat during one office visit. For example, a hemoglobin test may show a low blood count (screening). From the test result, the physician decides that the child is suffering from anemia (diagnosis). He/she prescribes iron supplements for the child (treatment). Although in this example the entire EPSDT process took place during one office visit, the three separate components are indentifiable.

C. WHAT IS MEDICAL ASSISTANCE?

Medical Assistance (M.A., Minnesota's name for the federal Medicaid or Title XIX program) is a federal-state program which provides payment for the medical care of persons whose income and resources are inadequate to meet the cost of such care. This program includes people who receive income maintanence assistance such as Aid to Families with Dependent Children (AFDC), as well as other persons whose resources are not adequate to meet the cost of medical care. Eligibility for Medical Assistance is determined by local welfare agencies. Payment is made to a broad range of medical providers by the State Department of Public Welfare's Centralized Disbursement System.

D. WHAT IS THE RELATIONSHIP OF EPSDT TO MEDICAL ASSISTANCE?

The EPSDT Program was enacted by the United States Congress as an amendment to Title XIX (the Medical Assistance provision) of the Social Security Act. The amendment was passed because researchers had found that many children who were eligible for free health care under Medical Assistance were not receiving the care for a variety of reasons. If these children were not drawn into the health care system, their health problems would worsen and require very costly treatment in the future. Federal law mandates

efforts that reach out to parents to convince them to bring their children into the health care system. By evaluating supposedly well children, the EPSDT Program is designed to discover health problems in the early stages and treat such problems before they become far more serious.

Also, the Medical Assistance Program varies greatly among the different states in terms of what medical services are covered. Although Minnesota provided all health services before the EPSDT Program began, some states did not provide vision, hearing or dental services to children eligible for Medical Assistance. The EPSDT amendment requires that all states provide these services to children ages 0 to 21 who are eligible for Medical Assistance.

As part of the Medical Assistance Program any expenditures for health services under EPSDT are paid for from Medical Assistance funds. However, the EPSDT Program includes more than the payment of health services. Outreach to bring children into the health care system and follow-up to ensure that the child receives all needed treatment are unique to the EPSDT Program.

E. WHAT DOES FEDERAL EPSDT LAW REQUIRE OF THE STATES?

The law passed by Congress in 1967 required all states to implement an EPSDT Program for their Title XIX children. An additional amendment passed by Congress in 1972, which went into effect in July of 1974, added a penalty provision to the EPSDT law. If states do not operate an EPSDT Program according to Department of Health, Education and Welfare regulations, the federal share of a state's Title IV-A (AFDC) funds will be reduced by one percent per quarter. This penalty amendment shows Congress' determination to implement the EPSDT Program in all states.

May 18, 1979, HEW published new penalty regulations for the EPSDT Program. These regulations require states to inform recipients of the availability of EPSDT services, to provide transportation and appointment scheduling for screening and treatment examinations if the client wishes, and to provide certain follow-up services. The regulations also require that all children who accept EPSDT services be referred to a dentist for dental services. HEW will impose the penalty on any state which fails to show that 75% of the children were screened and began treatment within 120 days of acceptance, and 95% of the children were screened and began treatment within 180 days of acceptance. Cases may be exempted from this penalty liability if the state can show that the failure to receive services was due to the client's decision. Children due for a periodic re-screening and children who were never screened must be notified of the continuing availability of EPSDT services.

F. WHAT IS THE PLACE OF SCREENING IN HEALTH CARE?

The purpose of a health screening program is to bring needed medical care to children who are not receiving it. Screening programs accomplish this goal by identifying children with health problems or needs that have not been recognized or have not been fully cared for, and by ensuring that these problems are adequately diagnosed and treated.

A child may fail to receive health care for several reasons:

- because the problem can be detected only by special tests or observations,
- because the medical importance of a problem or symptom is not recognized,
- because appropriate care has not been sought for a recognized problem,
- because needed preventive services have not been utilized,
- because the child has been neglected or abused.

A health screening program supplements available health care services. EPSDT is meant to be only a fraction of the total, regular, continuing health supervision which every child requires.

G. WHO IS ELIGIBLE FOR THE EPSDT PROGRAM?

All persons from birth to age twenty-one who are eligible for Medical Assistance are also eligible for the Title XIX EPSDT Program. If the child (or parent) has a valid Medical Assistance Identification Card with the child's name and number listed, the screening provider can be certain that the child is eligible for the Title XIX EPSDT Program and that payment will be made by Medical Assistance for the screening services rendered. Even if the person eligible for Medical Assistance is a parent, he/she is eligible for EPSDT services if he/she is under 21.

H. WHO ARE EPSDT SCREENING PROVIDERS?

The following types of providers offer EPSDT screening services to Title XIX eligible children:

1. Licensed physicians, outpatient hospitals and community or public health clinics:

   Any licensed physician, any outpatient hospital, or any community or public health clinic supervised by a licensed physician can become an EPSDT screening provider.

2. Nurse-supervised screening clinics:

   Nurse-supervised screening clinics provide screening services according to standards established by the Minnesota Department of Health. They operate under the supervision of a registered nurse, public health nurse, or pediatric/family nurse practitioner. Both Early Periodic Screening (EPS) clinics and independent nurse-supervised clinics can become EPSDT screening providers by receiving approval from the Minnesota Department of Health.

3. Pre-School Screening (PSS) Clinics:

   PSS clinics have been established in all school districts in Minnesota in response to the Preschool Screening legislation passed in May, 1977. The law requires that comprehensive health and developmental screening be offered free of charge to every child at least once before entering kindergarten. School districts may contract with physicians, nurses and EPS clinics to perform the screenings. The PSS screening is equivalent to an EPSDT screening.

I. WHAT ARE THE REQUIREMENTS FOR SCREENING PROVIDER PARTICIPATION?

Any of the above health care providers may be reimbursed for EPSDT screening if they have signed a Medical Assistance Provider Agreement (see Appendix G) and further agree to:

1. Screen each Medical Assistance child according to the standards specified in Chapter Two.
2. Report all findings of EPSDT screenings on the Child Screening Form (DPW-1973).
3. Refer children for diagnosis and treatment as specified on page 15.

These additional requirements for screening providers are contained in the EPSDT Provider Agreement. (See Appendix F.) All EPSDT providers must sign the agreement.

J. WHO MAY PROVIDE DIAGNOSIS AND TREATMENT?

Any health care provider licensed under state law who has signed a Medical Assistance Provider Agreement may provide appropriate diagnostic and treatment services to a child who has been screened. In many instances, the diagnosis and treatment provider will be the same as the screening provider.

Diagnosis and treatment providers do not sign a special supplemental agreement, but they must bill according to the conditions of their Medical Assistance Provider Agreement.

K. WHAT DOES FREE CHOICE OF PROVIDER MEAN IN THE EPSDT PROGRAM?

The Medical Assistance Program provides recipients with a free choice of participating local medical provider. Since EPSDT is part of the Medical Assistance Program, the free choice provision also applies to EPS.

For screenings, free choice means that recipients are given a list of screening providers by the local welfare agency when they express an interest in EPSDT. The list includes all providers who have signed an EPSDT Provider Agreement in the local area. The recipient may then choose a screening provider from any of the providers listed.

If the screening results in a need for a referral, the recipient has free choice of diagnosis and treatment provider which extends to any provider who is enrolled in the Medical Assistance Program; the provider may or may not be an EPSDT screening provider.

L. HOW ARE EPSDT SERVICES REVIEWED?

Reimbursement claims for EPSDT services are subject to the same audit and review process as all MA services.

Additionally, EPSDT is concerned that all components of an EPSDT screening are provided consistently by all EPSDT providers. Any complaints or concerns raised by clients regarding EPSDT services are handled in the following manner:

1. The complaint is first discussed with the client to ensure that the client understands exactly what components are included in an EPSDT screening and to confirm the substance of the complaint. This discussion may resolve the issue if the client did not understand the age-related screening components.
2. If the complaint or concern about the service cannot be settled by this contact with the client, the provider will be contacted by EPSDT program staff by phone or in person to discuss the issue. The purpose of this contact is to review program requirements with the provider and to ensure that the provider understands what screening components are to be included in an EPSDT screening for different aged children. This discussion should enable the provider to review requirements for participation as an EPSDT provider and to determine if all screening components are being provided to Medical Assistance-eligible children.
3. If further concerns or complaints are received for the same provider after the contact described above, the complaint will be referred to Surveillance and Utilization Review Section (SURS) for their review and possible investigation. SURS is the administrative unit within the Department of Public Welfare which is responsible for the formal audit and review of MA services, including EPSDT.

SCREENING COMPONENTS/STANDARDS

CHAPTER TWO

The following sections explain the EPSDT screening in more detail:

A. Nurse-Supervised Clinic Screening Standards
B. Physician Screening Standards
C. Request for Variation in Screening Procedures
D. Training and Materials Available
E. Steps in the Screening Process
F. EPSDT and Well Child Care
G. Reimbursement

The nurse and physician screening standards are considered the *minimum* elements of a comprehensive screening. Other procedures may be included depending on the child's age and health history.

A. NURSE SCREENING STANDARDS

All nurse-supervised Early and Periodic Screening (EPS) and EPSDT clinics follow the standards and periodicity schedule devised by the Minnesota Department of Health (MDH). Screening performed by MDH approved nurse-supervised clinics will be reimbursed by the EPSDT program.

The EPS manual may be obtained from the Minnesota Department of Health if you would like further information on these standards. Please write to:

Supervisor
Comprehensive Child Health Screening Unit
Section of Maternal and Child Health
Minnesota Department of Health
717 S.E. Delaware Street
Minneapolis, MN 55440

B. PHYSICIAN SCREENING STANDARDS

A comprehensive screening involves the following components:

1. Physical Assessment
2. Developmental Assessment
3. Immunizations
4. Laboratory Tests (as needed)

By signing an EPSDT Provider Agreement you have agreed to complete the EPSDT screening according to certain standards. These standards were first developed by a physician committee composed of representatives from the following organizations:

Group Health Association
Hennepin County Medical Society
Minneapolis Health Department
Minnesota Academy of Family Practice
Minnesota Academy of Pediatrics
Minnesota State Medical Association
Ramsey County Medical Society
Ramsey County Nursing Service
University of Minnesota School of Public Health

The standards developed by this committee were sent to all Title XIX primary health care providers in the state for comment in April, 1977. Incorporating the comments received, physician screening standards were then promulgated by the Administrative Rule process. After public hearing was held in January, 1978, the EPSDT Rule became final in June, 1978. The entire rule is contained in Appendix E.

The pages that follow describe the screening components contained in DPW Rule 61.

B-1. PHYSICAL ASSESSMENT

Health History

A health and developmental history must be obtained from the parent or other responsible adult who is familiar with the child's health history. This may be done at the time of the screening, or prior to the screening by visiting the home or by sending a form to the child's home.

Because the health history may be helpful in assessing the need for laboratory tests and the need for referral for further diagnosis and treatment, the following items should be part of the history-taking process:

a. Lead Exposure (see B-4 for further explanation)
b. Tuberculin Exposure
c. Nutrition/Dietary Intake (see B-2)
D. Seizure History

Sample health history forms are available. Section D, page 14.

Assessment of Physical Growth

Using standard growth charts, record the child's height and weight and compare his/her measurements with the ranges considered normal for children that age.

In the younger child, occipital-frontal head-circumference measurements should be included.

Unclothed Physical Inspection

This portion of the screening should reflect normal procedures, including all areas indicated on the Child Screening Form, DPW-1973.

If there if evidence that the child has been physically abused, report this information directly to the local welfare agency according to state law requirements. This information should also be noted on the Child Screening Form in the "Comments Section."

Vision Testing

For children *under the age of three years* your test must include:

a) a history check for maternal and/or neonatal infection.

b) observation for

- pupils and light following reflex
- presence of absence of nystagmus
- muscle balance, including examination for esotropia, exotropia, large phorias
- external examination of the eyes including lids, conjunctiva and cornea
- parental concern regarding the child's vision.

For children *over the age of 3 years,* the test must include all of the above as well as a visual acuity check. This may be accomplished by the use of the STYCAR, the Snellen E Cube, the Snellen E Chart, the Snellen Alphabet Chart, or their equivalent, as appropriate to the child's age.

If you would like more detail on testing procedures, or need materials to conduct these tests, you should contact:

Minnesota Department of Health
Hearing and Vision Screening
717 Delaware Street Southeast
Minneapolis, MN 55440

Hearing Screening

To assess hearing, *all children* must be observed for:

- retardation of language acquisition (or history of such retardation)
- Failure to directionalize to sounds
- History of repeated otitis media during early life
- Parental concern regarding the child's hearing.

In addition, *children over the age of three years* must receive a *pure tone test or referral for pure tone audiometric testing,* if the above observations indicate a need for such testing.

Audiometers may be purchased from several sources. For information, contact:

Minnesota Department of Health
Hearing and Vision Screening
717 Delaware Street Southeast
Minneapolis, MN 55400

B-2. DEVELOPMENTAL ASSESSMENT

Developmental Assessment

The goal of developmental assessment is to uncover a potential problem area before it seriously harms a child's development; it is not an effort to label any child as deficient. Screening only sorts out those children who need further diagnosis and treatment from those who apparently do not.

Several things should be stressed to the parent. First, that this component is *not* an intelligence test. Second, a referral does not mean the child is retarded. Third, as stated above, the assessment is only one step in the process of correcting a potential problem area.

For children ages birth through five years, the developmental screening must be accomplished through use of the Denver Prescreening Developmental Questionnaire (PDQ). Any child who fails the PDQ must be given the Denver Developmental Screening Test (DDST) for further screening. If you do not provide the DDST, you must refer the patient to an agency that does provide it to complete this screening component.

For children ages 6-20 years, there are no screening tools available such as the DDST. You must, however, screen for fine/gross motor control, speech and socialization. Developmental questions should be included on the health history for this age group.

Estimates of developmental maturity may be based on observation and direct testing of the child, parental report of the child's present behavior, parental history of the child's development, and parental concerns over development.

Nutritional Status

Physical and laboratory determinations as well as the nutrition intake information obtained in the health history will usually yield information useful in assessing nutritional status.

When a history reveals that a child's diet lacks two or more daily servings from one of the four basic food groups, the parent/child must be referred for nutritional counseling even if there are no objective signs of poor nutrition. Nutritional counseling for these patients, as well as those with detectable nutritional deficiencies, must be available from your own clinic, or through referral to a nutritionist, dietician, public health nurse, or agricultural extension service.

Sexual Development

All children must be checked for appropriate sexual development. Special emphasis should be given to children who have reached puberty.

At the request of the parent/child counseling on normal development, birth control, and venereal disease, as well as appropriate prescriptions and testing, must be provided. A referral to appropriate resources should be made if you cannot or choose not to provide this service through your office.

All females who have reached puberty must be given the option of receiving a pelvic examination with appropriate testing (Gc, Pap Smear, and other tests at your descretion).

B-3. IMMUNIZATIONS

Assess immunization status from the health history according to the Recommended Schedule of Immunizations. This schedule, developed by the Minnesota Department of Health and approved by the Minnesota State Medical Association is contained on the following page. Needed immunizations must be offered and administered according to this schedule.

If possible, needed immunizations should be provided during the screening.

B-4. LABORATORY PROCEDURES

The following laboratory procedures must be provided:

a. Tuberculin Testing

Tuberculin testing must be performed for all children once at fifteen months of age, or at their first screening, whichever is later. Additional tuberculin testing at later ages may be given if the child's history indicates the possibility of exposure.

Note: EPSDT recognizes the differences of opinion regarding the necessity for tuberculin testing. If you do not view this test as necessary, please request a variation from the screening standards. (See Page 14).

b. Undue Lead Absorption

Exessive lead exposure has serious and largely irreversible effects on the central nervous system (CNS). These effects vary from severe brain damage to altered neuropsychologic behavior of considerable consequence which may be recognized by parents, teachers, and clinicians at attentional disorders, learning disabilities, or emotional disturbances which impair progress in school. Undue lead absorption also affects the bone marrow, impairing the formation of blood cells. Kidney damage can also occur. Minor symptomology (e.g., malaise, anorexia, irritability) may often be attributed to some other cause or there may even be no overt symptoms. Only a laboratory analysis will determine whether a child has undue lead absorption.

Undue lead absorption has long been associated with urban, low-income areas. However, large scale screening studies of children without symptoms have demonstrated in recent years that the number with undue lead absorption is greater than previously thought. Because the possible consequences of undue lead absorption are so severe and because detection and treatment are possible, screening providers are urged to consider the possibility of undue lead absorption in all children screened.

Current evidence does not justify the need to screen every child for undue lead absortpion through Erythrocyte Protoporphyrin (EP) or Blood Lead determination. The following three step progression should be used to perform undue lead abosrption screening:

1) **Health History Questions**

The Minnesota Department of Health recommends pre-screening for potential environmental hazards via a set of simple questions as a part of your individual health history on a child. The questions most highly weighted are:

- Does the child chew any unusual things such as woodwork, pencils, crib, paint chips, plaster?
- Does the child live in a house built before 1950 that has peeling paint on the walls, woodwork, ceiling, doors or exterior of the house?
- Does the child seem tired, fussy or cranky for more than 4-6 hours everyday?

Additionally significant may be:

- Does the child live adjacent to a major freeway?
- Does any family member work in a lead processing plant?
- Does the child play on grounds where old buildings have been demolished and filled?

A "yes" response to any of the above, indicates the need to screen for undue lead absorption. A positive history of vomiting and a low hematocrit or hemoglobin would also be determinants for a lead screening.

2) **Free Erythrocyte Protoporphyrin (FEP) Test**

If the health history indicates a need for further screening, an FEP test may be performed.

FEP is a simple laboratory procedure which utilizes the same blood source as the hemoglobin/hematocrit specimen. Complete procedures for FEP testing is contained in the "FEP/Blood Lead Instruction/Procedure Card" (DPW-2384). Samples of this card and the FEP Testing Lab Slip (DPW-2383) are contained on pages 12 and 13. Additional cards and lab slips may be ordered from DPW via the Requisition Form (see Appendix A).

FEP tests are processed *free-of-charge* to EPSDT physician providers through a contractual agreement with Children's Health Center of Minneapolis. Physicians may include a charge for administering the test on the Laboratory Section of the Child Screening Form, DPW-1973.

3) **Blood Lead Determinations**

If the FEP is elevated, a blood lead determination should be made. Complete procedures for blood lead determinations is found on the sample DPW-2384. Blood lead kits and processing are provided *free-of-charge* by the MDH Laboratory.

Results of FEP and/or Blood Lead must be reported in line 46 of the EPS/EPSDT Child Screening Form (DPW-1973). Physicians may include a charge for administering the test on the Laboratory Section of the Child Screening Form, DPW-1973.

If elevated blood lead is discovered, an immediate investigation into the source

FREE ERYTHROCYTE PROTOPORPHYRIN SPECIMEN COLLECTION AND TRANSPORT

1. Specimen may be collected by finger or heel puncture.
2. Collect blood into capillary tubes used to spin hematocrits.
3. Plug both ends with sealing clay.
4. Tape tubes securely onto a piece of rigid cardboard. If you have corrugated cardboard available, tubes can be placed between the corrugations.
5. Place cardboard and completed EP Lab Slip into envelope addressed to:

   Chemistry Laboratory
   Children's Health Center
   2525 Chicago Ave. So.
   Minneapolis, MN 55404

6. Be sure to write HAND CANCEL on outside of envelope.
7. Results will be mailed to you. Elevated results will be telephoned to you.

BLOOD LEAD DETERMINATION PROCEDURES

1. If the FEP level is elevated (greater than 50 ug/dl), a blood lead determination should be made.
2. The Minnesota Department of Health Laboratory will provide blood lead kits and processing at no charge. Kits may be obtained by contacting:

   PSS Nursing Consultant
   Maternal and Child Health Section
   Minnesota Department of Health
   717 Delaware St., S.E.
   Minneapolis, MN 55440
   612/296-5220

3. Instructions for obtaining and transporting the sample will be sent with the kit.
4. If the results are elevated, MDH Laboratory staff will telephone the results to your office. Results within normal limits will be mailed.

DPW-2384 (5-79)

Send all copies with specimen to:

Chemistry Laboratory
Children's Health Center
2525 Chicago Ave. So.
Minneapolis, MN 55404

FEP TESTING

White – Physician
Yellow – DPW-EPSDT
Pink – Children's Lab
Green – Children's EDP

TO BE COMPLETED BY MD OFFICE — ALL BLANKS MUST BE FILLED IN.

Child's name	Physician		
Address	Address		
M.A. ID #	M.A. Provider #	Hemotocrit	
Birthdate	Date Drawn	Date Sent	

TO BE COMPLETED BY LABORATORY

(0017-4) FEP (FREE ERYTHROCYTE PROTOPORPHYRIN) = _____UG/ml whole blood

Normal ≤ 50 UG/ml whole blood

Laboratory:

Date received_____ Date repit_____Tech._____

DPW-2383 (5-79)
PZ-02383-01

should be initiated through *referral to the local or county health department for an environmental assessment.*

c. Urine Screening

All children over the age of two years must be tested at their first screening for the presence of glucose, ketones, protein and other abnormalities in their urine.

Females at or near the ages of four and ten must be tested for bacteriuria.

d. Anemia Testing

All children must be tested for anemia using either a micro-hematocrit determination or a hemoglobin concentration. These tests should be done near the ages of six months, one year, two years, four years, and fifteen years.

e. Sickle Cell Testing

Screening for the sickle cell gene can help to accomplish two objectives:

1) to provide medical care for patients with sickle cell *anemia.* Screening of newborns for the disease may therefore provide early diagnosis.

and

2) to prevent the disease through genetic counseling for those persons with sickle cell *trait.* Testing persons older than 13 or 14 years who possess reproductive potential is therefore relevant for the population known to be at risk.

If sickle cell testing is indicated, only one test is needed. If the sickle cell trait is found, the patient must be referred for genetic counseling if they so desire.

f. Other laboratory testing

Tests for cervical cancer, venereal disease, pregnancy and parasites should be performed when indicated.

Results for any test(s) not printed on the Child Screening Form (DPW-1973) should be recorded in the "Comments Section" of the form.

Note: Any test performed as part of the screening may be charged on the Child Screening Form. It is not necessary to complete a Practitioner Invoice to obtain reimbursement for these procedures.

D. Training and Materials Available

D.1. Training

Training or consultation on any of the screening components may be arranged at your request. All such training and consultation is provided by the Minnesota Department of Health through a contract with the Minnesota Department of Public Welfare.

If you are interested in this service, please contact:

EPSDT Section
Bureau of Income Maintenance
Department of Public Welfare
4th Floor - Centennial Office Building
658 Cedar Street
St. Paul, MN 55155
Telephone: 612/296-3883 (call collect)

D.2. Materials Available 5

Many helpful forms and charts related to screening services are available by order from the Minnesota Department of Health. Any of the following items may be ordered directly from the Minnesota Department of Health by using "Requisition for EPS/EPSDT/PSS Forms, (517-29). (See Appendix B, page 43.)

Nutrition Assessment Summary
Food Intake Record
Growth and Head Circumference Charts
  Boys (2-18 years)
  Infant Boys (0-36 months)
  Girls (2-18 years)
  Infant Girls (0-36) months
Individual Health History Forms
  0-6 years
  7-13 years
  14-21 years

Denver Developmental Screening Manual
Denver Developmental Screening Kit
Denver Developmental Screening Test (DDST) Sheets
Prescreening Developmental Questionnaires (PDQ)

E. THE STEPS IN THE EPSDT SCREENING PROCESS

From the Perspective of a Child:

1. The parent is informed of the availability and importance of EPSDT services at the time of application for Aid to Families with Dependent Children (AFDC) or Medical Assistance.
2. If the parent accepts EPSDT services for his/her child, the local welfare agency gives a Referral for Screening Form (DPW-1997) and a list of screening providers in the area to the parent. An example of DPW-1997 is on page 16.
3. The parent makes an appointment for screening for the child with one of the screening providers listed.
4. The parent brings the child to be screened, along with the Referral for Screening Form and a current Medical Assistance identification card.
5. The child is screened according to the guidelines explained in Chapter Two, pages 10-14.
6. After the child is screened, the results are discussed with the parent and child, and the blue copy of the screening invoice (DPW-1973) is given to the parent for his/her information.
7. If the child needs further diagnosis and treatment, the screener gives the parent an EPSDT Referral for Diagnosis and Treatment Form (DPW-1998) and the violet copy of the screening invoice which the parent will take to the provider of diagnosis and treatment. An example of DPW-1998 is on page 17.
8. The parent takes the child to the recommended provider of diagnosis and treatment and the child receives the needed care.
9. The provider of diagnosis and treatment bills Medical Assistance for the service rendered to the child.
10. The local welfare agency provides follow-up throughout the process in order to assure that every child who requests EPSDT receives the

screening and any needed diagnosis and treatment. The information needed to perform the follow-up is supplied by the Department of Public Welfare based on the screening invoices received.

From the Perspective of the Screening Provider:

1. When a child arrives for an EPSDT screening appointment, ask to see the current Medical Assistance identification card and the Referral for Screening Form (DPW-1997).
   Note: *The DPW-1997 does not verify eligibility for MA. You must see a* **current MA ID** *card or contact the county welfare agency for this information.*
2. Screen the child according to the procedures outlined in Chapter Two, pages 10-14.
3. Record the screening findings on the Child Screening Form (DPW-1973).
4. Talk to the parent about the screening, explaining in detail the findings and any recommendations for diagnosis and treatment.
   Note: *Give the parent the blue copy of the invoice for his/her information.*
5. If the child needs further diagnosis and/or treatment, complete a Referral for Diagnosis and Treatment Form (DPW-1998) for each health care provider to whom the child is being referred. Give the parent the referral form and the violet copy of the invoice to bring to the provider of diagnosis and treatment.
6. Complete the Child Screening Form (PDW-1973) and type in the charges. Submit the invoice to the Medical Assistance Program for payment and/or information purposes.
7. If you (the screener) provide diagnosis and treatment as a result of the screening, submit the charges for the diagnosis and treatment procedures on the provider's regular Medical Assistance invoice.

F. EPSDT SCREENINGS AND WELL CHILD CARE

It is the intent of the EPSDT program to help children receive preventive health care. You, as a health care provider, can assist in reducing duplication of services by coordinating your ongoing well child care with EPSDT. *The following types of health care services should be coordinated with EPSDT wherever possible:*

- newborn, or well-baby check-ups
- back-to-school physicals
- camp or athletic physicals
- day care or Head Start physicals
- routine well-child physical exams

Essentially, any time you see an EPSDT-eligible child (i.e., the child has a valid MA ID card and is between birth and age 21) for preventive health care, you should follow the EPSDT screening standards and report and bill the screening on the EPS/EPSDT Child Screening Form (DPW-1973). In doing so, you will help prevent another, less timely and possibly duplicative well child visit by fulfilling both needs at one time.

Newborn/Well Baby Care

To coordinate newborn care with EPSDT, you should:

1) compare your well-baby exam with the EPSDT components applicable for newborns and infants.
2) If identical or similar, add the additional EPSDT components to the well-baby check of an MA-eligible child.
3) explain to the parent that you will be providing an EPSDT screening at appropriate times, so long as the child remains eligible for Medical Assistance.
4) report the findings and bill, using the EPS/EPSDT Child Screening Form (DPW-1973) rather than the Practitioner Invoice.

School, Camp, Athletic, and Day Care Physicials

If the parent/child requests a physical and you know they are eligible for EPSDT, you should:

1) Perform all EPSDT components, including a physical exam.
2) Report the findings to EPSDT and bill MA using the EPS/EPSDT Child Screening Form (DPW-1973) rather than the Practitioner Invoice (in addition to completing the physical form provided by the camp, school, etc.)

Requests for EPSDT Screenings

a) After a Well Child Exam has been performed:

If a parent/child calls for an appointment for an EPSDT screening and you have recently seen the patient for well-child care, you should:

1) volunteer to report the findings of the completed exam on the EPS/EPSDT Child Screening Form (DPW-1973).
2) perform any screening components omitted during the physical and report these on the DPW-1973 as well.
3) bill for the screening using the DPW-1973 if you have not previously billed MA for these services on the Practititioner Invoice.

or

4) submit the DPW-1973 for information only (mark box 61) if you have already billed MA for this service.

b) Before a Well Child Exam is scheduled

If a parent calls for an appointment for an EPSDT screening and you know you will be seeing the patient for routine well child care (e.g., well baby check-ups), you should:

1) tell the parent you will coordinate the EPSDT screening and the well child check-up at the next scheduled exam time.
2) report the findings and bill the next scheduled exam on the DPW-1973.

EPSDT REFERRAL / SCREENING

TO: PROVIDER OF EPSDT SCREENING DATE _____

_____, M.A. # _____
is eligible for screening services under the Title XIX Early and Periodic Screening, Diagnosis and Treatment Program. Under EPSDT, a comprehensive screening consists of:

- Health History
- Developmental Assessment
- Unclothed Physical Assessment
- Sexual Development
- Dental Assessment
- Hearing Test
- Vision Test
- Hematocrit/Hemoglobin, Urinalysis and other laboratory tests as indicated
- Immunizations
- Nutritional Assessment

Medical Assistance will pay the entire cost of this screening if the recipient has a current Medical Assistance Identification Card and you/your clinic has signed an EPSDT Provider Agreement. Be sure to verify the above MA # by checking the client's current MA ID card.

If you have not signed an EPSDT Provider Agreement, please call the phone number shown below. We will be happy to assist you in enrolling as an EPSDT screening provider. If you request it, we will arrange for training and consultation on any of the screening components shown above. We will also assist you in the billing and reporting requirements of the EPSDT program. Only enrolled EPSDT providers will be reimbursed for EPSDT screenings.

Submit bills for this service to the Minnesota Medical Assistance Program on the EPSDT Invoice, DPW-1973. If you do not have the correct forms or instruction manual for completing the forms, please call the number below and ask to have them mailed to you. These invoices can also be ordered from Centennial Stores on DPW-121, Requisition for DPW Forms, in the same manner as other Medical Assistance forms.

Thank you for your cooperation. Any questions about EPSDT should be addressed to:

EPSDT Program
Bureau of Income Maintenance
Department of Public Welfare
Centennial Office Building, Fourth Floor
St. Paul, MN 55155
Telephone: 612/296-3883

Issued by:

_____ BY _____ _____
Local Welfare/Social Service Agency Signature Title

PZ-01997-03
DPW-1997
(1-79)

EPSDT REFERRAL

Dear Parent:

Attached is your copy of the results of your child's screening under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. Your child should see a health care professional for diagnosis and treatment of a suspected health or developmental problem uncovered during the EPSDT screening. Your local welfare agency will assist you in obtaining these services by:

- Supplying the names and addresses of health care providers in your community if you need them.
- Arranging transportation or other services you need to keep appointments for diagnosis and treatment.
- Telling you which services can be paid by the Medical Assistance Program and which need prior authorization from the state.

Please contact your local welfare/social services agency if you would like this help.

Remember, the most important part of the EPSDT Program is following up on the screening findings and getting your child the health care he or she needs.

DPW-1998
(10-78)

G. Reimbursement

EPSDT screening providers may request reimbursement for outreach that they routinely perform for children screened in their own facility. Examples of outreach activities include:

1) phone calls or postcards to remind clients of their appointment for EPSDT
2) re-scheduling of missed appointments
3) assistance in arranging needed diagnosis and treatment resulting from screening
4) periodic re-notification to clients that a child is due for another EPSDT screening.

Outreach and follow-up agreements are negotiated between DPW and the screening provider. Reimbursement is based on a cost per child basis and is available only if a screening is actually completed. The fee negotiated between DPW and the provider is billed in the "Outreach" space of the EPS/EPSDT Child Screening Form, box 65 (DPW-1973) by the screening provider.

This type of agreement will benefit those screening providers who screen a relatively large number of Title XIX children or who are a major source of EPSDT screening in a county.

Note: EPS clinics have an outreach charge incorporated in their unit fee.

Requests for outreach reimbursement must be in writing and include:

- Name of provider
- Name of contact person in the provider's office
- A description of the outreach activities to be performed
- A description of how information will be documented
- The fee which will be charged for these services, based on actual costs

The request for reimbursement must be sent to:

EPSDT Supervisor
Minnesota Department of Public Welfare
4th Floor - Centennial Office Building
658 Cedar Street
St. Paul, MN 55155

A response to the request will be made in writing, showing the effective date that the outreach charge will be accepted on the DPW-1973.

COMPLETION OF THE EPS/EPSDT CHILD SCREENING FORM

CHAPTER THREE

GENERAL DESCRIPTION

EPS/EPSDT Child Screening Form (DPW-1973) is designed to serve as both an invoice for payment and a report of screening findings. The sections for recording screening findings must be filled out *in pencil* by the screener. The sections for provider and recipient information, charges, and referrals must be *typed.* Invoices which are completely handwritten or folded will be accepted, but the manual keying required will delay payment considerably. Manual keying has a low priority.

Invoices are processed for payment every two weeks. The Department of Finance mails the warrants (checks) under separate cover. The payment subsystem produces a Remittance Advice that explains which invoices have been paid, which are rejected, and indicates, by codes, the reason for rejection. On alternate pay runs, the Remittance Advice will also list those invoices which are suspended in the system for further processing. These suspended invoices will be paid or rejected at a future date.

A. SUBMISSION DATE

Invoices should be submitted as soon as possible after the screening: After your invoice is run through DPW's payment system, the invoice is sent to the county welfare agency. The county uses the invoice to document in their records that a screening has taken place and to follow-up on any diagnosis and treatment that may be indicated. Since Federal regulations mandate that children receive needed diagnosis and treatment sevices within 120 to 180 days of the date they accept screening, county welfare agencies also use the returned invoice (or lack of a returned invoice) to determine what type of follow-up efforts should be made to assist the recipient in obtaining the screening they have indicated they desire. Because of this process, it is *very important* that your invoices are submitted for payment as soon as possible.

B. INVOICE COMPLETION

This form is designed to be processed mechanically. High-speed optical character reading equipment will transmit the information directly from a well-prepared invoice to a computer tape for processing. To insure prompt payment of claims, follow these procedures when preparing invoices:

Do **not** write on the back of an invoice. If explanatory information will not fit into the "Comments Section", attach the information to the invoice with a paper clip. **(Do Not Staple.)**

Do **not** fold, or otherwise multilate the invoices.

Before mailing the completed invoice, separate the original from the copies.

Mail the original (top) to:

Minnesota Medical Assistance Program
Department of Public Welfare
Box 43200
St. Paul, Minnesota 55164

The second copy (green) is the screener's file copy.

The third copy (blue) is given to the parent or child.

The fourth copy (purple) should be given to the parent or child who will give it to the provider of any needed diagnosis and treatment. Copies should be made if a child is referred to more than one provider.

The Provider Information, Recipient Information, and Charges sections, and any entries in the referral boxes should be typed. The typist should follow these procedures:

- CAPITALIZE all letters of the alphabet.
- Type only in the white areas. **DO NOT** type in the brown shaded areas.
- Keep type faces clean to ensure readable print.
- Use **black ribbon** only and change ribbons as needed to ensure bold and dark characters.
- Strive for accuracy. When correcting errors, use correction fluid or correction tape sparingly. Careful erasing is also acceptable if no trace of the first entry remains.
- All dates entered on the invoice are to be entered in the following format: the two-digit month, followed by the two-digit day, followed by the two-digit year.
- All monetary amounts must be entered in the dollars and cents format (12.56), omiting the dollar ($) sign.
- Punctuation marks, commas, apostrophes and periods must **not** be used. Simply leave a space when necessary.

SEND FORM TO: Minnesota Medical Assistance Program -- DPW -- P.O. Box 43200, St. Paul, Minnesota 55164

EPSDT/EPS
CHILD SCREENING FORM

CLAIM PROCESSING DOCUMENT CONTROL NUMBER 1

ELITE PICA — TYPEWRITER ALIGNMENT — USE CAPITAL LETTERS ONLY — ELITE PICA

PROVIDERS NAME 2 | PROVIDER ID # 3 | OWN REFERENCE # 4 | BILLING DATE 5

CITY/STATE/ZIP 6 | SCREENING DATE 9 | SCREENING IS INITIAL 10 PERIODIC 11

CHILD'S NAME (LAST, FIRST, INITIAL) 12 | MEDICAL ASSISTANCE NUMBER 13 | SEX 14 | BIRTHDATE 15

PHYSICAL RESULTS

	ABNORMAL	REFERRAL CODE
WEIGHT	☐	16
HEIGHT	☐	17
HEAD CIRCUMFERENCE	☐	18
PULSE	☐	19
BLOOD PRESSURE	☐	20
IF PHYSICAL NOT DONE (ITEMS 21 THROUGH 33), ☐ MARK BOX		
HEAD	☐	21
EYES	☐	22
EARS	☐	23
NOSE	☐	24
PHARYNX	☐	25
NEUROLOGICAL	☐	26
NECK	☐	27
CHEST/LUNGS	☐	28
HEART	☐	29
ABDOMEN	☐	30
GENITALS/SEXUAL DEVELOPMENT	☐	31
MUSCULAR/SKELETAL	☐	32
SKIN	☐	33
VISION	☐	34
HEARING	☐	35
AUDIOMETER USED	YES ☐	
NUTRITION	☐	38

DEVELOPMENTAL

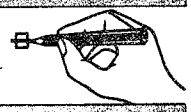
	ABNORMAL	REFERRAL CODE
FINE MOTOR	☐	39
GROSS MOTOR	☐	40
SPEECH/LANGUAGE	☐	41
SOCIAL/EMOTIONAL	☐	42

LAB TESTS

	NORMAL	ABNORMAL	REFERRAL CODE
URINE	☐	☐	44
HEMOGLOBIN/HEMATOCRIT	☐	☐	45
BLOOD LEAD	☐	☐	46
TB	☐	☐	47
PELVIC/PAP SMEAR	☐	☐	48
VENEREAL DISEASE	☐	☐	49
SICKLE CELL	☐	☐	50
OTHER	☐	☐	51

TEST USED: PDQ ☐ DDST ☐ OTHER ☐

MARK WITH A STRAIGHT HORIZONTAL LINE



IMMUNIZATIONS

	CURRENT	GIVEN	REFERRED	RECORD NOT AVAILABLE
DTP/Td OR DT	☐	☐	☐	☐
MMR OR POLIO	☐	☐	☐	☐
MEASLES (RUBEOLA) OR OTHER	☐	☐	☐	☐

MUMPS: CURRENT ☐ GIVEN ☐ REF ☐ N/A ☐

RUBELLA (GERMAN): CURRENT ☐ GIVEN ☐ REF. ☐ N/A ☐

REFERRED TO 52

ACTUAL READINGS — OPTIONAL

HEMOGLOBIN/HEMATOCRIT	HEIGHT	HEAD CIRCUMFERENCE	PULSE	BLOOD PRESSURE	HEMOGLOBIN/HEMATOCRIT
53	54	55	56	57	58

ENTER NUMBER OF MONTHS SINCE LAST HEALTH MAINTENANCE EXAM 59 | REFERRAL CODE 60

CHARGE INFORMATION

PHYSICAL 62

LAB TESTS 63

IF NOT FOR PAYMENT 61 ENTER X

IMMUNIZATIONS 64

OUTREACH 65

TOTAL 66

COMMENTS SECTION — PLEASE EXPLAIN ALL BOXES MARKED ABNORMAL AND/OR OTHER

PROVIDER CERTIFICATION

This is to certify that all information given on this form is true, accurate and complete and all medical services indicated have been rendered. I understand that payment and satisfaction of this claim will be from Federal, State and Local funds, and that any false claims, statements or documents or concealment of a material fact may be prosecuted under applicable Federal or State laws. I certify that all applicable screening standards have been followed.

X _____ 67 Authorized Signature

Top Copy (Brown) to DPW - 2nd (Green) Provider - 3rd (Blue) Parent/Child - 4th (Purple) Referral

PZ-001973-02 (7/79)

SEND FORM TO: Minnesota Medical Assistance Program -- DPW -- P.O. Box 43200, St. Paul, Minnesota 55164

EPSDT/EPS
CHILD SCREENING FORM

CLAIM PROCESSING DOCUMENT CONTROL NUMBER

ELITE PICA — TYPEWRITER ALIGNMENT — USE CAPITAL LETTERS ONLY — ELITE PICA

2 PROVIDERS NAME	3 PROVIDER ID #	4 OWN REFERENCE #	5 BILLING DATE	
6 CITY/STATE/ZIP			SCREENING DATE 9	SCREENING IS INITIAL 10 PERIODIC 11
12 CHILD'S NAME (LAST, FIRST, INITIAL)	13 MEDICAL ASSISTANCE NUMBER — — — — —		14 SEX	15 BIRTHDATE

Complete the invoice according to the following step by step directions:

SEND FORM TO:

Minnesota Medical Assistance Program
DPW — P.O. Box 43200
St. Paul, Minnesota 55164

B.1. IDENTIFYING INFORMATION 1-15

CLAIM CONTROL NUMBER

Box 1. **Claims Processing Document Control Number**
Leave this space BLANK
The department assigns a number to each invoice before it is processed. This number prints out on your Remittance Advice and is the identifying number to use when making *any* inquiries about this claim.

PROVIDER INFORMATION

Box 2. **Provider's Name**
Enter the name of the screening clinic or other screening provider.

Example: MIDWEST SCREENING CLINIC

Note: This field may be left blank, if the clinic or provider name is stamped on the bottom of the invoice.

Box 3. **Provider ID#**
Enter the 7 digit provider identification number assigned by the Department of Public Welfare.

Example: 1612345

Box 4. **Own Reference Number**
Up to nine letters or numbers of the provider's choice may be entered in this space. Anything typed in this space will appear on the Remittance Advice.

Example: JACKSONBA or 123456789

NOTE: The recipient's name on the Remittance Advice is printed out from the Medical Assistance identification number. If this number is incorrectly submitted, the claim will be rejected and the Remittance Advice will have a series of asterisks in place of the recipient's name. For this reason, it may be useful to use the recipeint's name as your "Own Reference Number." Then, the name will *always* appear on the Remittance Advice.

Box 5. **Billing Date**
Enter the date the invoice is completed using two digits for the month, two digits for the day, and two digits for the year.

Example: | 03 | 01 | 80 |

Box 6. **City/State/Zip Code**
Enter the city, state and zip code of the provider.

Example: ANYTOWN MN 55123

Box 9. **Screening Date**
Enter the date the child was screened using two digits for the month, two digits for the day, and two digits for the year.

Example: | 02 | 20 | 80 |

Box 10-11. **Screening is Initial, Periodic**
Enter an "X" in *box 10, Initial* if this is the first time the child has been screened to your knowledge.
Enter an "X" in *box 11, Periodic* if this is a periodic re-screening.

Box 12. **Child's Name**
Enter the child's full name exactly as it appears on the Medical Assistance identification card: last name, then first name, followed by middle initial, if available.

Example: JACKSON BARBARA J.

Box 13. **Recipient's Medical Assistance I.D. Number**
Enter the 16 digit number as shown on the Medical Assistance identification card. DO **NOT** type in the dashes. Leave a SPACE where dashes occur on the card. Note: Fach person in a family has a distinct number.

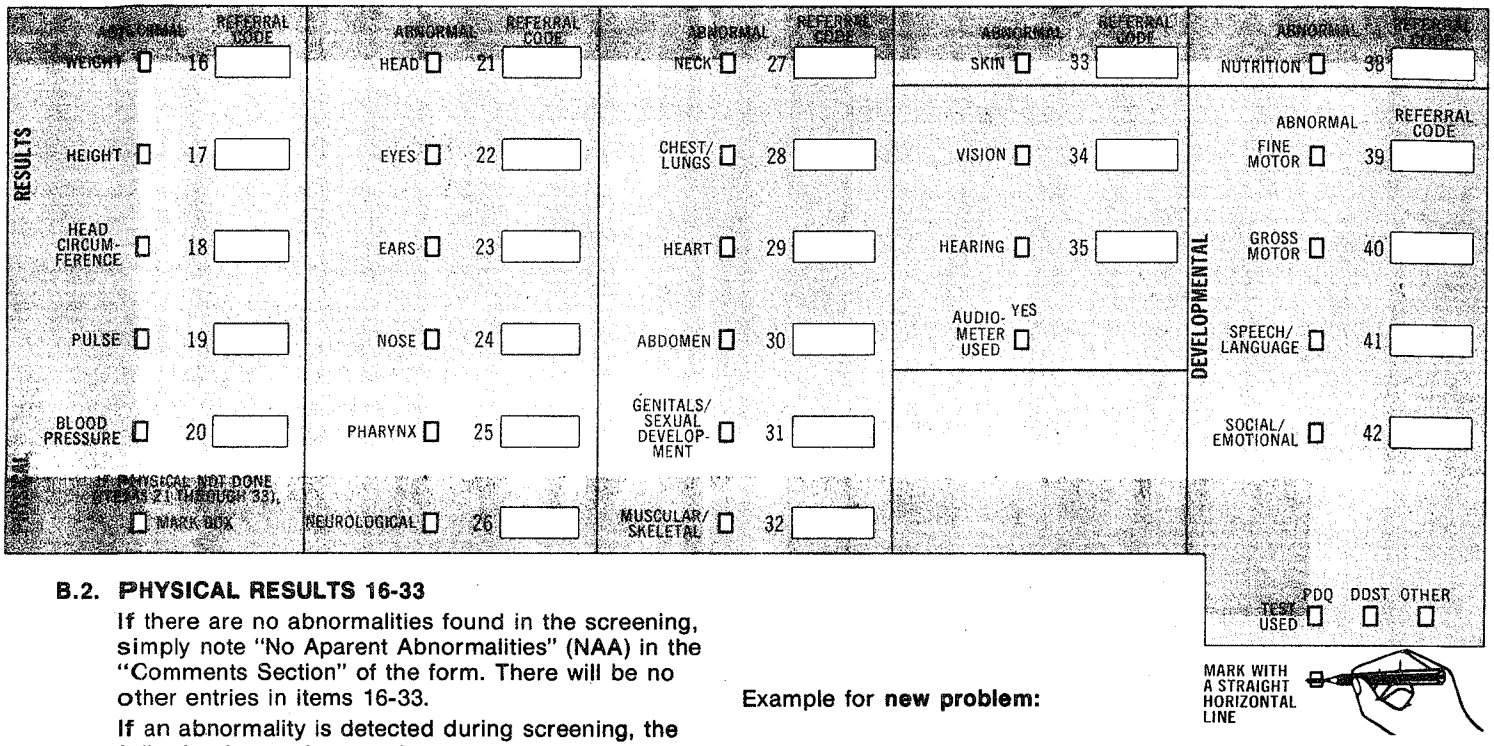
Example: 00 0 000 000 0000 000

Box 14. **Sex**
Enter the child's sex: F = female, M = male.

Example: F M

Box 15. **Birthdate**
Enter the child's birthdate **exactly** as it appears on the **Medical Assistance** identification card, using 2 digits for the month, 2 digits for the day, and 2 digits for the year.

Example: 08 16 70



B.2. PHYSICAL RESULTS 16-33

If there are no abnormalities found in the screening, simply note "No Aparent Abnormalities" (NAA) in the "Comments Section" of the form. There will be no other entries in items 16-33.

If an abnormality is detected during screening, the following instructions apply:

Mark components as "abnormal" by drawing **one straight heavy line** horizontally through the appropriate square with a **# 2 soft lead pencil. Use the guide dots indicated on the form.**

Example:

	Abnormal	Referral Code
Skin	⊟	33

Enter code from the list on page 00 in the appropriate "referral code" box if a referral is recommended for additional evlauation, diagnosis or treatment at this time. These codes indicate the type of health care provider or facility suggested. *Referral Codes must be typed.*

Note: Be sure to include yourself as a referral code if you will be treating the child for a problem found.

In addition to the referral code, the referral code box must be designated either "X" for existing problem or "N" for new problem.

"X" (existing) means the problem was known to the provider and/or family prior to the screening. It should be entered if the child is already being or has been treated for the problem requiring referral.

"N" (new) means the problem was not known to the provider and/or family prior to the screening.

Example for **existing problem:**

	Abnormal	Referral Code
Skin	⊟	20X

Example for **new problem:**

	Abnormal	Referral Code
Skin	⊟	20N

Note: If the abnormality does not require further diagnosis and treatment at this time, leave the referral code box BLANK.

Note: If a physical is not performed during the screening, mark the box at the bottom of the left hand column reading "If Physical Not Done (Items 21 through 33) Mark Box." The mark must be a horizontal line drawn through the guide dots with a **# 2 soft lead pencil.**

Note: **Do not record actual readings for weight, height, pulse and blood pressure items 16-20 in the referral code boxes.** Acutal readings, if recorded, are entered in boxes 53-58 or in the "Comments Section".

B.3. VISION AND HEARING RESULTS 34-35

Record any abnormalities and referrals as explained in the Physical Results section.
In addition, *if an audiometer was used* to test hearing, *mark the "Yes" box* with a horizontal line drawn through the guide dots with a # 2 soft lead pencil.

B.4. NUTRITION RESULTS 38

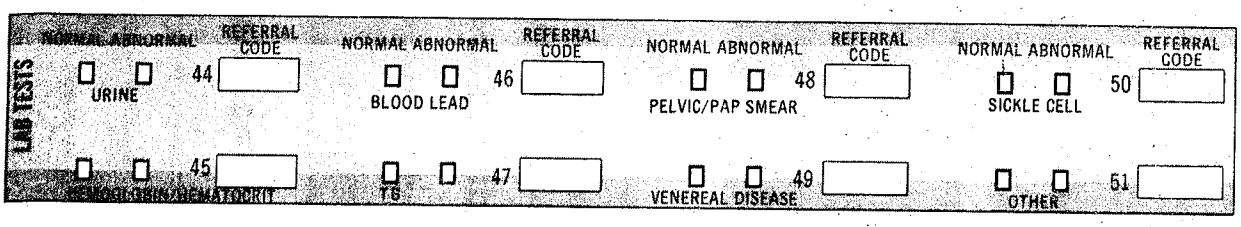
Follow the procedure stated in "Physical Results" section to complete these lines.

B.5. DEVELOPMENTAL RESULTS 39-42

Lines 39-42: Follow the procedure stated in the "Physical Results" section to complete these lines.

Test Used: Indicate the developmental test used by

drawing a horizontal line through the guide dots shown on the form.



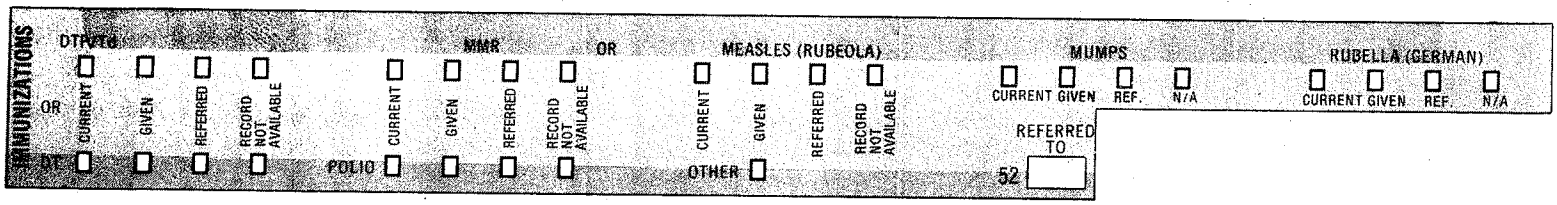
B.6. LAB TEST RESULTS 44-51

Lines 44-50: Draw one straight heavy line with a **# 2 lead pencil** through the guide dots in the appropriate square to indicate laboratory results as normal or abnormal.

Leave spaces blank for those laboratory tests which were not done for this child.

Type in the appropriate referral code if a referral results from an abnormal lab test. **Be sure to use the "X" (existing) or "N" (new) code** as explained in the "Physical Results" section.

Line 51: **Other** — If any lab test(s) are performed, other than the ones indicated, use this line to record the findings and appropriate referral. The lab test performed should be noted in the "Comments Section" of the form.



B.7. IMMUNIZATION RESULTS 52

Findings must be recorded by marking the appropriate box:

Current:

Mark this box if, *prior to the screening,* the immunization was *up-to-date* according to the child's age and health history. No portion of the immunization series was administered during the screening and there was no referral for the immunization at a later time.

Given:

Mark this box if the child received any portion of the immunization *during* the screening.

Referred:

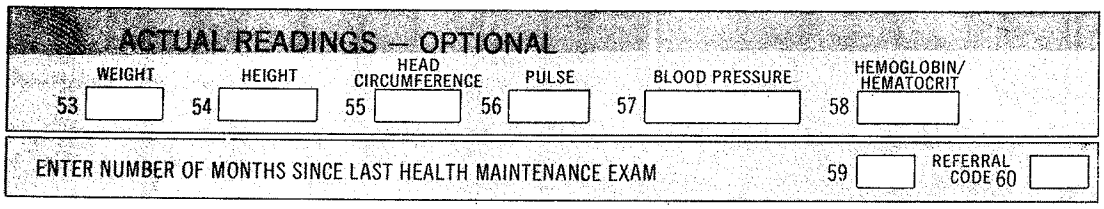
Mark this box if the immunization was *not current* prior to screening, *no portion* of the immunization was administered *during* the screening, *and* the child was referred for this immunization at a later time (e.g., a referral could occur if the child was ill at the time of the screening and immunization was not advisable at that time).

Record Not Available or N/A:

Mark this box if you cannot obtain sufficient information to determine the immunization status.

Note: "Record not Available" and "Given" would both be marked if the child's immunization status was not known prior to the screening and, based on this lack of information, the immunization series was begun during the screening. This is the only time two boxes would be marked for the same immunization.

Box 52. **Referred to:**
If the child requires a referral for any further immunization, enter the code here.



B.8. ACUTAL READINGS 53-58

Completion of this section is *optional.* If used, enter the actual readings for weight, height, pulse, blood pressure and hemoglobin/hematocrit.

Note: Do not record actual readings for these items on any other area of the form.

B.9. ENTER NUMBER OF MONTHS SINCE LAST HEALTH MAINTENANCE EXAM 59-60

Box 59 The parent/child must be asked the number of months that have elapsed from the child's last health maintenance exam to the month of the screening.

For 0-3 years use the number of months.

Example: 2 ½ years = 30 months.

59 [30]

For over 3 years, enter 99

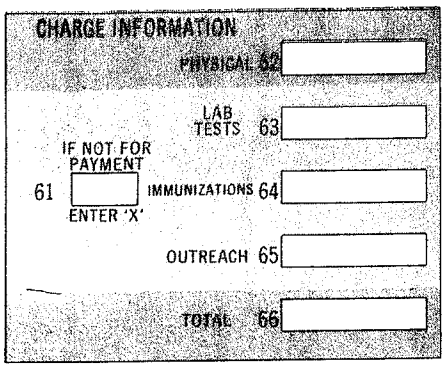
Example: 3 ½ years

59 [99]

Box 60: **Referral Code**

Physicians: Leave this box **BLANK.**

EPS and EPSDT Nurse Supervised Clinics: Refer to instructions in the EPS Manual.



B.10 CHARGE INFORMATION 61-66

Box 61: **If not for Payment, Enter "X"**

If this form is being submitted for *reporting purposes only* (not for billing purposes), enter "X" in Box 61.

This section applies to Health Maintenance Organizations (HMO's) and to providers whose computerized systems require that all charges be submitted on the Practitioner Invoice (DPW-1497) or Outpatient Hospital Invoice (DPW-1852).

Note: Even if Box 61 is marked, actual charges must be entered in Box 62-66. These figures will be used to calculate state expenditures for screening.

Box 62: **Physical:** Enter the charge for the Physical and Developmental portions of the screening.

Box 63: **Lab Tests:** Enter the charges for all lab tests performed as part of the screening. This applies both to the tests specified on the form as well as any other lab tests that were deemed necessary to the screening.

Box 64: **Immunizations:** Enter charges for any immunization given during the screening.

Box 65: **Outreach:** Charges for Outreach are applicable only for those clinics or providers who have outreach procedures approved by the EPSDT section at DPW (see page 00).

Box 66: **Total:** Enter the total of boxes 62-65.

Example:

Physical	62	23.00
Lab Tests	63	5.00
Immunizations	64	3.00
Outreach	65	1.00
Total	66	32.00

COMMENTS SECTION — PLEASE EXPLAIN ALL BOXES MARKED ABNORMAL AND/OR OTHER

PROVIDER CERTIFICATION
This is to certify that all information given on this form is true, accurate and complete and all medical services indicated have been rendered. I understand that payment and satisfaction of this claim will be from Federal, State and Local funds, and that any false claims, statements or documents or concealment of a material fact may be prosecuted under applicable Federal or State laws. I certify that all applicable screening standards have been followed.

X _____
67 Authorized Signature

Top Copy (Brown) to DPW - 2nd (Green) Provider - 3rd (Blue) Parent/Child - 4th (Purple) Referral

PZ-001973-02 (7/79)

B.11. COMMENTS SECTION

All abnormalities should be explained in this section. Since parent education is a major goal of the EPSDT Program, this section should be used to explain to the parent(s), in non-technical language, all problem areas or recommendations.

If any laboratory screening tests not listed above were provided, indicate the results here.

Insertion of the parent's name is recommended.

If additional sheets are used, attach them with a paper clip. Do **NOT** write on the back of an invoice.

This area may also be used to record any information you feel would be helpful to your record keeping system but is not provided on the form itself.

B.12. PROVIDER CERTIFICATION

The invoice must be signed to be processed. Signatures may be written, rubber-stamped, typed or computer generated. Unsigned invoices will be returned.

C. CODES FOR REFERRALS

Use these codes when completing the "Referral" boxes on DPW-1973:

Code #	Type of Health Care Provider
01	Inpatient Hospital
02	Outpatient Hospital
10	Mental Health Center
11	Rehabilitation Center
12	Crippled Children's Service
14	Psychologist (Group Practice)
20	Physician or Osteopath
24	Health Maintenance Organization
30	Dentist
35	Optometrist
36	Podiatrist
37	Chiropractor
38	Nurse (Independent Practitioner)
39	Physical Therapist
40	Speech Therapist
41	Occupational Therapist

42	Psychologist
43	Audiologist
52	Public Health Nursing Service
54	Family Planning Clinic
60	County Nursing Service
94	Schools
95	Yourself (the screening provider)
96	Other

D. MAILING AND DISTRIBUTING THE INVOICE

Mail the original invoice to the address printed at the top of the form:

MN Medical Assistance Program
Department of Public Welfare
Box 43200
St. Paul, MN 55162

Do not fold the invoice for mailing.

Use the pre-addressed EPSDT Envelope (DPW-1865). These envelopes may be ordered from DPW by requisition. See Appendix A for this information.

THE REMITTANCE ADVICE

CHAPTER FOUR

The current status of all caims and adjustments processed in the past two weeks is shown on the provider's Remittance Advice. The Remittance Advice explains in detail what claims have been paid, what charges if any have been reduced, what claims have been suspended for further processing, and what claims have been rejected. This report is mailed to each provider who had one or more claims or adjustments processed or in suspense at the time of the most recent warrant (check) printing.

Claims are reported in an alphabetical listing by patient name. All paid claims print out first, followed by a section of suspended claims, a section of rejected claims and then any claim adjustments. Suspended claims are only listed on alternate Remittance Advice, or approximately once a month. Each claim status report identifies the claim by patient name, patient Medical Assistance ID number, provider's own reference number (if submitted on the invoice by the provider), a claim reference number generated by the State, the date of service and the billing date.

A. WARRANTS (CHECKS)

The check explained by the Remittance Advice is printed, signed and mailed separately by the State Department of Finance. It will be delivered by first class mail a few days before or after the Remittance Advice. If a provider has all claims rejected or in suspense during a payment cycle, the provider will receive a Remittance Advice but no check.

Checks cannot be directly forwarded. Address changes should be reported to the EPSDT Claims Processing Unit as soon as possible.

B. CLAIMS STATUS

If there is a question regarding the status of a specific claim call:

EPSDT CLAIMS PROCESSING UNIT
Local - 296-7668
Long Distance - Within Minnesota
1-800-652-9747 ext. 6-7668
Long Distance - Outside Minnesota
612-296-7668 (call collect)

ALL INQUIRIES REGARDING CLAIMS MUST INCLUDE THE CLAIM REFERENCE NUMBER REPORTED ON THE REMITTANCE ADVICE. HAVE THE APPROPRIATE REMITTANCE ADVICE AVAILABLE FOR REFERENCE WHEN CALLING.

B.1. PAID CLAIMS

Claims which are paid will be reported as:

PAY		PAY
S	or	A

The "S" indicates that the claim was paid at the submitted dollar amount. The "A" represents allowable charge and means that the submitted charge was higher than the Department of Public Welfare maximum. Payment is made at the price submitted or at the allowable level, whichever is lower.

Some billing errors on the part of the provider may result in an incorrectly paid claim. For example, if a charge of 22.50 was typed on the invoice like this:

2 2.50

the optical character reading equipment would pick up the charge as 2.50 and pay the claim at that level.

Appendix C details the procedure to follow when a claim is under or over paid due to billing and processing errors.

B-2. SUSPENDED CLAIMS

Claims are suspended for further processing and error correction. DO NOT RESUBMIT SUSPENDED CLAIMS. They will be paid or rejected when all internal errors have been resolved.

A claim may be reported in suspense simply because the invoice arrived just before a pay cycle, and there was insufficient time to complete the processing cycle.

All claims which are not completed according to the instructions in Chapter Three will suspend. For example if your typewriter is out of alignment and types only partial characters, the machine processing system will only pick up partial data. The remainder of the data must then be manually entered at the state office.

Example: ^{o}ut of alig$_{n}$ment

If a claim is reported in suspense for over two months, contact the EPSDT Claims Processing Unit.

PROVIDER NUMBER 1601234 (1)

MINNESOTA DEPARTMENT OF PUBLIC WELFARE
MEDICAL ASSISTANCE PROGRAM

REMITTANCE ADVICE

(2) DATE OF PAYMENT 03/26/79 (3) WARRANT NUMBER 42224815 (4) PAGE NUMBER 001

PROVIDER'S OWN REFERENCE NO.	CLAIM REFERENCE NUMBER	DATE OF INVOICE	LINE ITEM CODE	DATE OF SERVICE	SERVICE CODE	CLIENT LIABILITY	AMOUNT FROM OTHER SOURCES	AMOUNT BILLED	AMOUNT PAID	STATUS	EXPLANATION CODES OR COMMENTS
					EPSDT TRANSACTIONS						
				(5)	PHYSICAL CHARGE	IMMUNIZ CHARGE	LAB CHARGE	OUTREACH CHARGE			
JACKSON	BARBARA (6)	= RECIPIENT NAME			RECIPIENT ID		(7) = 62-2-000-000-1234-103			PAY (8)	
JACKSONBA (9)	760751234567100	03/01/79		02/20/79	12.00	5.00	3.00	1.00	21.00	S (17)	
* * PAID INVOICE *										PAY (20)	
(18)	(10)	(11)		(12)	(13)	(14)	(15)	(16)	(19)		
XXXXXXXXXXXXXXXXXXXXXXXX	= RECIPIENT NAME			RECIPIENT ID =			62-2-000-000-4321-105			SUS	PENDED FOR FURTHER PROCESSING
KILEYMATH	760751234576100	03/01/79		02/18/79					0.00	SUS	
* * SUSPENDED INVOICE STILL IN PROCESS * * * * * * *											
MILLER	KAREN =	RECIPIENT NAME		RECIPIENT ID =		92-2-000-000-5736-108				REJ	
MILLERKAR	760751211154100	02/15/79		02/03/79	12.00	7.00	4.00	1.00			
* * REJECTED INVOICE *									0.00	REJ	103,00103,00700 (21)

DEBIT BALANCE USED (22) 0.00
DEBIT BALANCE REMAINING (23) 0.00
PAGE TOTAL (24) 26.00
WARRANT TOTAL (25) 26.00

PROVIDER NAME AND ADDRESS (26)
MIDWEST SCREENING CLINIC
123 ANYSTREET
ANYTOWN, MN 55123

DPW-1849 (6-74)
STOCK NO 397

PROVIDER NUMBER 1604321 (A1)

MINNESOTA DEPARTMENT OF PUBLIC WELFARE
MEDICAL ASSISTANCE PROGRAM

REMITTANCE ADVICE

(A2) DATE OF PAYMENT 03/26/79 (A3) WARRANT NUMBER 42224815 (A4) PAGE NUMBER 006

PROVIDER'S OWN REFERENCE NO.	CLAIM REFERENCE NUMBER	DATE OF INVOICE	LINE ITEM CODE	DATE OF SERVICE	SERVICE CODE	CLIENT LIABILITY	AMOUNT FROM OTHER SOURCES	AMOUNT BILLED	AMOUNT PAID	STATUS	EXPLANATION CODES OR COMMENTS
					EPSDT TRANSACTIONS						
				(A5)	PHYSICAL CHARGE	IMMUNIZ CHARGE	LAB CHARGE	OUTREACH CHARGE			
ANDERSON	ERIC (A6)	= RECIPIENT NAME			RECIPIENT ID =		27-8-000-001-2345-104			PAY (A8)	
ANDERICA (A9)	760751191132100	WARRANT DATE = 01/15/79			CLAIM ADJUSTED =		760051234567100 (A12)			A (A17)	
	(A10)		00 (A13)	(A11)	ANDERIC (A14)		REASON = 04				
* * * * PAID ADJUSTMENT * * * * * * * * * * * *							(A15)	(A16)	5.00 (A19)	PAY ADJUST (A20) (A21)	

DEBIT BALANCE USED (A22) 0.00
DEBIT BALANCE REMAINING (A23) 0.00
PAGE TOTAL (A24) 5.00
WARRANT TOTAL (A25) 150.00

PROVIDER NAME AND ADDRESS (A26)
ANY SCREENING CLINIC
123 ANYSTREET
ANYTOWN, MN 55123

DPW-1849 (6-74)
STOCK NO. 397

B-3. REJECTED CLAIMS

A claim is rejected when it cannot be paid from the information that was submitted on the invoice. A rejection code always appears on the Remittance Advice to explain why the claim was rejected. Rejected claims may be re-submitted if the errors indicated by the rejection codes can be eliminated. Claims should be re-submitted on the Child Screening Form, DPW-1973.

B-4. UNREPORTED CLAIMS

Inquiries about claims which have not been reported on a Remittance Advice within sixty days of submission must include the provider's ID number, provider's own reference number (if used on the invoice), the patient's Medical Assistance ID number, date of service, date of billing and patient's name.

C. DETAILED DESCRIPTION OF REMITTANCE ADVICE

The provider Remittance Advice is printed on a general purpose form used for all medical care providers.

The preceding page illustrates an example of a Remittance Advice which has numbers to identify the position of each item of information presented. Each item of information is defined as follows:

1. **Provider Number**
   This is the provider's seven digit Medical Assistance ID number assigned by the State Department of Public Welfare at time of enrollment.
2. **Date of Payment**
   This is the date shown on the check (warrant) which this Remittance Advice explains. If no check is issued, this is the date the Remittance Advice was prepared. This date can be used to sequence the 26 Remittance Advices which most providers will receive each year.
3. **Warrant Number**
   This is the number of each warrant (if any) that this Remittance Advice explains.
4. **Page Number**
   This is the number of the page within the provider's Remittance Advice.
5. **EPSDT**
   This item indicates that the following claims were for screening services.
6. **Recipient Name**
   The patient's name as is shown on the Medical Assistance ID card. This name will differ from the name reported on the invoice if the number submitted was not copied correctly from the ID card and happens to be the number assigned to another recipient. The name will be absent if an invalid recipient ID number was reported on the invoice.

   NOTE: **Suspended** claims may have no name or the wrong name printed on the Remittance Advice. Ignore this. Claims are suspended for further processing and correction.
7. **Recipient ID**
   This is the patient's Medical Assistance ID number as reported on the invoice.
8. **Status**
   The codes for claim status are:

   PAY = PAID
   SUS = SUSPENDED
   REJ = REJECTED
9. **Provider's Own Reference Number**
   This is the number or name the provider entered in the "Own Reference Number" box on the invoice.
10. **Claim Reference Number**
    This number was entered on the invoice by the State Department of Public Welfare when the invoice arrived for processing. This number uniquely identifies this claim and should be used if there are questions about payment or rejection of this claim.
11. **Date of Invoice**
    This is the "Billing Date" reported on the invoice.
12. **Date of Service**
    This is the "Screening Date" reported on the invoice.
13. **Physical Charge**
    This is the amount requested on the invoice for the physical assessment.
14. **Immunization**
    This is the amount requested on the invoice for immunizations that were given.
15. **Lab Charge**
    This is the amount requested on the invoice for the laboratory procedures.
16. **Outreach**
    This is the amount requested on the invoice for outreach (see page 00).
17. **Payment Level**
    The letter inserted here indicates the payment level in the following way:

    A = Paid Allowable Charge
    S = Paid Submitted Charge
18. **Claim Summary**
    This is a written out statement indicating whether the claim was paid, suspended for further processing or rejected.
19. **Amount Paid**
    This is the amount paid for this invoice.
20. **Status**
    This is a repetition of the code indicating whether the invoice was paid, rejected or suspended for further processing.
21. **Explanation Codes and Comments**
    If the claim was rejected, codes indicating the errors made will appear here. See the list at the end of this section.
22. **Debit Balance Used**
    This amount is usually zero. This is the net debt of the provider to the Medical Assistance Program which was deducted from the amount paid to the provider on this payment cycle.

    The debt to the Medical Assistance Program is the result of a previous adjustment transaction. When a debit balance is used, the amount is printed out only on the last page of the Remittance Advice.

23. **Debit Balance Remaining**
This is the net remaining debt of the provider to the Medical Assistance Program, as of the Date of Payment. Any remaining debt will be deducted from future payments to the provider. This amount prints out only on the last page of the Remittance Advice.

24. **Page Total**
This is the total net dollars reported paid on the given page.

25. **Warrant Total**
This is the net amount paid to the provider on the date of payment. This amount should be the same as the amount of the check from the same date. This amount prints out on the last page of the Remittance Advice.

26. **Provider Name and Address**
This is the name and "pay to" address of the provider.

D. CLAIM ADJUSTMENTS ON THE REMITTANCE ADVICE

Appendix C details the procedures to use when requesting adjustment to a paid claim. Processed adjustments print out on the Remittance Advice after all the paid, suspended and rejected claims. Because an adjustment must refer back to an original paid claim, more information must print out on the Remittance Advice. Page 28 has the items of information numbered for identification. Each item of information is defined as follows:

A-1.-A-7. **Provider and Recipient Information**
See the explanation for items 1-7 on page 29.

A-8. **Status**
See Item 8 above. For adjustments transactions, there are two additional status codes.

DEB = MONEY OWED TO THE STATE
HST = TRANSACTION GOING INTO HISTORY

A-9. **Provider's Own Reference Number**
This is the provider's "Own Reference Number" used on the Adjustment Request Form.

A-10. **Claim Reference Number**
This is the number assigned by the state to the adjustment document at the beginning of processing.

A-11. **Warrant Date**
This is the original date of payment for the claim that is being adjusted.

A-12. **Claim Adjusted**
This is the claim reference number from the Remittance Advice that reported payment for the claim being adjusted.

A-13. **Line Item Code**
Does not apply to EPSDT. It will always be 00.

A-14. **Provider's Own Reference Number**
This is the number or name used on the original invoice as the provider's "Own Reference Number".

A-15. **Reason Code**
This is a two digit code giving the reason for the adjustment. See the list at the end of this chapter.

A-16. **Amount Billed**
This is the amount of adjustment requested, credited or debited to the provider. Debits are marked with a minus sign.

A-17. **Allowable Charge**
This indicates allowable level of payment as follows:
A = Paid allowable charge
S = Paid submitted charge

A-18. **Summary Line**
This is a written statement indicating whether the adjustment is paid, suspended or rejected.

A-19. **Amount Paid**
This is the amount credited or debited to the provider. Debits are marked with a minus sign.

A-20. **Status**
See A-8 above.

A-21. **Explanation Codes and Comments**
See the list at the end of this chapter.

A-22.-A-26. **Remittance Advice Summary**
See the explanation of items 22 to 26 on page 29.

E. REJECTION REASONS AND ERROR CODES

When an invoice or part of an invoice is rejected a code or series of codes will appear in the Explanation Codes or Comments column of the Remittance Advice. They will indicate the primary reason the invoice or line was rejected and any other error or processing problems present in the claim at the time of rejection.

1. Primary Reject Reason-Entire Claim

When an entire claim is rejected the first code will be preceded by two asterisks (**147). This is the main reason for rejection of the claim. It alone would cause the claim to be rejected. Find the code in this appendix and take whatever correction action is necessary before resubmitting the claim.

2. Reject Reason-Single Line

When a line from an invoice is rejected, that line will be printed and followed by the three digit reason code in the Explanation column. Find this code in this appendix and take necessary corrective action before resubmitting the line on a new invoice.

3. Supplemental Error Codes

When an entire claim is rejected a series of additional five digit codes may follow the primary reject reason code. One of these codes will usually be a repetition of the three digit reject reason preceded by two zeros (00147). The additional codes, if any, point to other possible errors on the invoice. Some of these may have been caused by the claims processing system and others may be caused by errors on the invoice as submitted.

The first two digits indicate the line number with which the error is associated. If the error is not line related 00 will precede the three digit code.

The last three digits indicate a code in this section. Find this code and check your file copy of the invoice to see if the

error appears there. Correct any errors you find before resubmitting a new invoice. If you do not find the error on your file copy you may assume the error was caused during claims processing and resubmit as before (remember this is for supplemental error codes only — primary reject reasons must be corrected before resubmission).

4. Example: **147,00147, 07188, 00209

**147	The claim was rejected because the Recipient's Medical Assistance Number was missing or incomplete. This must be corrected on any new invoice submitted.
00147	Repetition of primary reject reason.
07188	Service Date on line 07 is invalid. Check your file copy to see if the date was on the invoice and that it is a possible calendar date. If it is alright on the file copy resubmit the same way (this would mean that the error code was caused within the claims processing system and would be corrected for an invoice with a Recipient's Medical Assistance Number).
00209	Technical processing problem. This requires no action on the part of the provider.

5. Rejects for Eligibility Reasons

If the primary reject reason indicates the person was ineligible at time of service, or not listed on the State's Case Information File, check your file copy to make sure the Recipient's Medical Assistance Number was properly reported. If the number was correct other sources of payments should be sought or an inquiry made to the County Welfare Department to verify the client's welfare status.

6. Definitions

For use in understanding the explanations of Reject Reasons and Codes the following terms are defined.

Not numeric - is not 0, 1, 2, 3, 4, 5, 6, 7, 8, or 0.

Invalid - a) is an incorrect item for that location on the invoice. Example: Codes specified in the Handbook must be used - TPL Codes, Insurance Company Codes, Injury Codes, Place of Service Codes, etc.

Invalid - b) data is not presented according to the correct format for that location on the invoice. Example: Dates must be 12/05/78 not 12/05/978 and not 12/5/78.

Invalid - c) data is impossible. Example: There is no such date as 12/41/78.

Technical Processing Problem - an Error Code which may appear on the Remittance Advice but is solely for DPW use in the Invoice Processing System. If a Primary Reject Reason or Line Item Reject Reason is listed as a technical processing problem in the following pages, call for clarification and/or correction.

ERROR CODES

051-069	These error codes indicate technical processing problems and can generally be ignored by the provider.
071	There are no line items on this invoice.
072	Maximum number of line items has been exceeded (billings cannot be continued from one invoice to another).
073	A line item number was repeated on the invoice.
074	Technical processing problem—provider may ignore this code.
075	Total Number of Lines Used is missing or in error.
076	Gross Total Charges in not equal to summ of line item charges.
100	Provider ID # is not numeric.
101	Billing Date is invalid or missing.
102	Procedure Code is missing.
103	First two digits of Recipient's Medical Assistance Number must be 01 through 89.
104	Third digit of Recipient's Medical Assistance Number is not a valid Medical Assistance program code.
105	Fourteenth digit of Recipient's dical Assistance Number is not valid.
106	Last two digits of Recipient's Medical Assistance Number are not numeric or do not represent the person named on the invoice.
107	Prior Authorization number is not numeric.
108	Admission date is invalid.
109	Attending Physician's ID # is not numeric.
110	Admission date is missing.
111	Date Dispensed invalid.
112	Drug Code or Supply Code is missing.
113	Quantity is missing.
114	Discherge date is invalid.
115	Amount Received from Other Sources is invalid.
116	From Date is invalid.
117	Through Date is invalid.
118	Prescription Number is missing
119	Procedure/Service Code is missing.
120	Service Code is missing.
121	Days Supply is not numeric.
122	Refill is not numeric.
123	Service date is invalid.
124	Item Code is invalid.
125	Primary Diagnosis Code is missing.
126	Charge for the line item is missing.
127	Charge for the line item is not numeric.
128	Service date is missing.
129	TPL Code (Third Party Liability) is invalid.
130	Primary Diagnosis Code is invalid - wrong format or value. (Remember if H-ICDA Codes are used an H must precede the code.)
131	Secondary Diagnosis Code is invalid. (See 130 above.)
132	Gross Total Charges is missing.
133	Drug Code format is invalid.
134	Gross Total Charges is not numeric.
135	Net Billed to MA is not numeric.
136	Net Billed to MA is missing.
137	Place of service is invalid.
138	Date of Pickup is invalid.
139	# Persons Sharing Ride is not numeric.
140	Charge code is missing.
141	Submitted Rate/Mile is not numeric.
142	Type Code is invalid.
143	Destination Code is invalid.
144	MD's ID # is not numeric.
145	MD's ID # is invalid.
146	Supply Code is not numeric.
147	Recipeient's Medical Assistance Number is missing or incomplete. Must contain 16 digits.
148	Admission Date is invalid.

149 Total Days is not numeric or is missing.
150 Patient type is missing.
151 Type (modifier) code is invalid.
152 Hospital service code is missing.
153 Financial class is missing
154 Admit source is missing.
155 Individual Group Member Number is zeroes, or not numeric.
156 Tooth number is invlaid or missing where required. A thru T or 1 thru 32 are valid.
157 Service Code (2 Digit Code) is invalid.
158 Type of Bills is 4 (Medicare Crossover claim cannot be submitted on a Practitioner invoice.)
160 Total adjustment amount is not numeric.
161 Units of service is not numeric.
162 Refill number is missing.
164 Claim Reference Number of Original Invoice to be Adjusted is invalid.
165 Warrant Date From Remittance Advice is invalid. This refers to the warrant date of the original claim which you are trying to adjust.
167 Pints of Blood Furnished is missing.
168 Pints of Blood Furnished is not numeric.
169 Pints of Blood Not Replaced is missing.
170 Pints of Blood Not Replaced is not numeric.
171 Charge Per Pint of Blood is missing.
172 Charge Per Pint of Blood is not numeric.
173 its is not numeric or is invalid.
174 Rate is not numeric.
176 Gross Charge is missing from line item.
177 Gross Charge is not numeric on line item.
178 Not covered charge is not numeric.
179 Units/Days or Units/Miles is missing.
180 Rate is missing from line item where required.
181 Total claim charge is missing.
182 Net claim charge is missing.
183 Type of Bill is invalid or missing.
184 Leave Days is not numeric.
185 Reason for Final Bill is invalid.
186 Discharge Code is invalid.
187 Destination Facility ID # is not numeric.
188 Service Date (or From Date) is invalid.
198 Service Date (or Through Date) is invalid.
190 Technical processing problem—provider may ignore this code.
191 Allowed # Billings in zero or missing.
192 Total Authorized Charges is not numeric.
193 Allowed Billings is not numeric.
194 Authorized Charge is not numeric.
195 Technical processing problem—provider may ignore this code.
196 Medicare Deductible amount is not numeric.
197 Service date is invalid.
198 Co-Insurance amount is not numeric.
199 Amount Receivable from dicare is not numeric.
200 Sum of Requested Increase does not equal computed sum of increase.
201 Sum of Requested Decreases does not equal computed sum of decreases
202 Reason for Change for Third Party Adjustment is invalid.
203 Third Party Underpayment is not numeric.
204 Third Party Underpayment is zero when Reason for Change indiciates otherwise.
205 Third Party Overpayment is not numeric.
206 Third Party Overpayment is zero when Reason for Change indicates otherwise.
207 Third Party Overpayment and Third Party Underpayment both contain amounts.
208-209 Technical processing problems—provider may ignore these codes.
210 Submitted charge is missing.
211 Original Line Number is missing or not numeric.
212 Technical processing problem—provider may ignore this code.
213 Provider ID # is missing.
214 Provider ID # is invalid.
215 Attending/Referring/Prescribing Physician ID # is invalid.
216 Individual Group Member Number is invalid.
217 Destination Facility ID# is invalid.
218 Recipient Sex code is invalid or missing.
219 Recipient Birthdate is invalid or missing.
220 Date Ins. Billed is invalid.
221 Injury Code is invalid or missing.
222 Line item Requested Increase is not numeric.
223 Line item Requested Increase is zero when Reason for Change indicates otherwise.
224 Line item Requested Decrease is not numeric.
225 Line item Requested Decrease is zero when Reason for Change indicates otherwise.
226 Line item Requested Increase and Requested Decrease both contain amounts.
227 Technical processing problem—provider may ignore this code.
228 Prescriber ID# is missing or not numeric.
229 Prescriber ID# is invalid.
230 Submitted Base Rate is not numeric.
231 Procedure Date is invalid.
233 Procedure Code or Service Code is not numeric.
234 Procedure Code or Service Code is invalid.
235 Total of Non-Covered Charges is not numeric.
236 Amount of Other Payments for Non-Covered Charges is not numeric.
237-239 Technical processing problems—provider may ignore these codes.
240 Date of screen is invalid.
241 Screen code is not numeric.
242 Outreach charge is not numeric.
243 Line-item information is missing.
246 Prescribing MD# is not numeric.
247 Code must be 1, 2, 3, 0, or blank.
248 Prescribing MD# is invalid.
249 Quantity is invalid.
250 Prescribing MD# is missing.
251 Days Supplying is missing or is equal to zero.
251 Days Supply is missing or it equal to zero.
252 Prescribing MD# is invalid.
280-300 Technical processing problems—provider may ignore these codes.
301 Provider ID# is not on file with DPW.
302 Primary Diagnosis Code is invalid.
303 Service Date is after current date.
304 Gross Total Charge is less Amount Received from Other Sources is not equal to Net Billed to M.A.
305 Procedure Code or Service Code is not on file of valid codes.
306 Through Date is prior to From Date.
307 Processing Date is prior to Through Date.
308 Processing Date is prior to Billing Date.
309 Place of service conflicts with Procedure Code or Service Code.
310 Type (MRVI modifier) conflicts with Procedure Code.
311 Technical processing problem—provider may ignore this code.
312 Secondary Diagnosis Code is invalid.
313 Sum of all Charges is not equal to Gross Total Charges.

314 Drug Code or Supply Code is not on file.
315 Procedure Code or Service Code is invalid for this provider type.
316 Date Dispensed is after the processing date.
317 Technical processing problem—provider may ignore this code.
318 From Date is after Through Date.
319 From Date is before Admission Date.
320 Final Net Billed to MA is incorrectly calculated. (Check to see that correct type of bill was submitted.)
321 Blood Pints Furnished is less than Blood Not Replaced.
322 Total Days is not equal to sum of accommodation days charged on line items. The item days for Nursery should not included in Total Days if this billing includes mother and baby charges.
323 Invalid Item Code on a billing for late charges. Room charges may not be billed as late charges.
324 Hospital service code is invalid.
325 Units/Days of Service times Rate does not equal line-item Not Covered charge.
326 Line-item total charges are less than the line-item non-covered charges.
327 Through Date is after processing date.
328 From Date is after processing date.
329 The sum of line-item Not Covered Charges is not equal to the Total of Non-Covered Charges.
330 Date of Pick-up is after the processing date.
331 Recipient's Age is incompatible with the Primary Diagnosis Code.
332 Recipient's Age is incompatible with the Primary Diagnosis Code.
333 Reciepient's Age is incompatabile with the Secondary Diagnosis Code.
334 Sum of Column A (Gross Charge) is not equal to Total of Gross Charges.
335 Through Date minus From Date minus Leave Days does not equal Total Days on a final bill OR Through Date minus From Date minus Leave Days does not equal Total Days minus one day on on interim bill.
336 Sum of line item Gross Charges is not equal to Gross Total Charges.
337 Technical processing problem—provider may ignore this code.
338 Admission Date is after processing date.
339 Provider's rate is not on record for this service.
340 Technical processing problem—provider may ignore this code.
341 Amount of Other Payments for Non-Covered Charges exceeds Total of Non-Covered Charges.
342 Amount of Other Payments for Non-Covered Charges exceeds Amount Received or Receivable from Other Sources.
343 Technical processing problem—provider may ignore this code.
344 Supply Code is invalid for this provider type.
345 Technical processing problem—provider may ignore this code.
346 The Submittee Charge is less than one dollar.
347 Prescribing MD# is not on file with DPW.
348 Refil exceeds maximum allowable number.
349 Prescription Number must contain three significant digits.
350 Technical processing problem—provider may ignore this code.
351 Recipient's Age is incompatible with the Procedure Code.
352 Technical processing problem—provider may ignore this code.
353 Procedure or Service requires Prior Authorization and no Prior Authorization # is on the invoice.
354 The provider's effective dates do not precede Service Date.
355 Procedure Code or Service Code does not require Prior Authorization.
356 Provider ID# designates pharmacist or medical supplier and Claim Reference Number of original Invoice to be Adjusted does not end in 01 thru 08.
or
Provider ID# does not designate pharmacist or medical supplier and Claim Reference Number of Original Invoice to be Adjusted does not enter in 00.
357 Warrant Date from Remittance Advice is after Submission Date.
358 This service is not covered by Medical Assistance.
359 Pharmacist or supplier can only adjust one claim per Adjustment Request.
360 Provider used a restricted Third Party Adjustment Reason Code.
361 Corrected Service Code is invalid for the type of provider.
362 Line item Requested Increases plus Third Party Underpayment does not equal Sum of Requested Increases.
363 Technical processing problem—provider may ignore this code.
364 Same Original Line Number may not be adjusted more than once.
365-367 Technical processing problems—provider may ignore these codes.
368 Third Party Reason for Change code is invalid.
369 Reason for Change is invalid.
370 Service Code (2 Digit Code) is invalid.)
371 Third Diagnosis in invalid.
372 Billing Date precedes the Date of the Screen.
373 Screen Code must be 105, 070, 080, 114, 115, 200, or 299.
374 Referral provider type is not valid for screening code listed.
375 Billing Date precedes the Service Date.
376 Technical processing problem—provider may ignore this code.
377 Total Claim Charge is not equal to the Sum of the physical, laboratory and immunication charges.
378 Disregard this claim since it was generated from the mechanized Medicare Part B Payment System, and it is a duplication of the charges you submitted on your Hospital Invoice.
379 Recipient's Age is incompatible with the Third Diagnosis Code.
380 First Diagnosis Code is invalid.
381 Second Diagnosis Code is invalid.
382 Third Diagnosis Code is invalid.
383 First Diagnosis Code is invalid.
384 Second Diagnosis Code is invalid.
385 Medicare non-covered code is invalid.
386 First Diagnosis Code is incompatible with the procedure code.
387 Second Diagnosis Code is incompatible with the proceure code.
388 Recipient's Sex is incompatible with the Second Diagnosis Code.
389 Recipient's Sex is incompatible with the Third Diagnosis Code.
390 First Diagnosis Code is invalid.
391 Second Diagnosis Code in invalid.
392 Third Diagnosis Code is invalid.

393 Technical processing problem—provider may ignore this code.
397 Invalid combination of MRVI modifiers in the Type Box.
398 Recipient Sex is incompatible with Procedure Codes or Service Code.
399 Recipient Sex is incompatible with ICDA code.
400 Sex association with Procedure Code is incompatible with sex associated with the ICDA code.
401 Tooth number is required for this service.
402 Admit source is invalid.
403 Technical processing problem—provider may ignore this code.
404 Discharge disposition code is invalid.
405 Charge code is invalid.
406 Quantity is not within the allowable range.
407 Drug is not covered on this Service Date.
408 Supply is not covered on this Service Date.
409 Provider is not eligible for first or only Service Date.
410 Provider is not eligible for last Service Date
411 Provider is suspended and not eligible for first or only Service Date.
412 Provider is suspended and not eligible for last Service Date.
413 Technical processing problem—provider may ignore this code
Provider ID# is not on active file.
415 Provider is terminated and not eligible for first or only Service Date.
416 Provider is terminated and not eligible for last Service Date.
417 Patient type is invalid.
418 Inpatient Hospital miscellaneous charges exceed $50.
419 Outpatient hospital miscellaneous charges which exceed $50 must be itemized.
420 Line-item submitted charge does not equal the gross total charge.
421 Submitted adjustment charge does not equal the total adjustment charge.
422 Medicare crossover non-covered lines are not equal to the MA charge.
424 Medicare crossover gross total charge is not equal to adjustment plus other charges plus MA charge plus the deductible plus co-insurance plus Medicare payment.

428 The financial class is invalid.
429 Technical processing problem—provider may ignore this code.
430 Medicare Crossover procedure billed on the wrong invoice. Please rebill on the proper invoice.
431 This service denied by Medicare is not covered by Medical Assistance.
432 This Podiatry service denied by Medicare should be billed on a Practitioner Invoice (PDW 1497) indicating "8" in the Type of Bill box.
433 This supply denied by Medicare should be billed on a Supplier Invoice (DPW 1858) with a note typed at the bottom stating "Rejected 433 from" the date of the Remittance Advice.
434 dicare Crossover Service was not filed within the specified time limit.
435 This service denied by Medicare should be billed on a Medical Transportation Invoice (DPW 1857) indicating "8" in the Type of Bill box.
436 Medicare crossover professional component should be billed on the appropriate invoice.
437 Duplicate claim submitted to Medicare.
438 Duplicate cataract eye glasses must be prior authorized.
439 Technical processing problem—provider may ignore this code.
440 Deductible and coinsurance cannot both be equal to zero on a Medicare Crossover billing.
441 Deductible plus coinsurance cannot be greater than the total claim charge for a dicare Crossover billing.
442 Total claim charges minus the Amount Received from Other Sources minus Amount Received from Medicare does not equal the Net Claim Charge.
443 EPSDT Line-Item is blank, or Abnormal and Normal have been checked.
444 This Medical Transportation provider cannot use Type of Bill equal to 4.
445-447 Technical processing problems—provider may ignore these codes.
448 This product was removed from the market by the F.D.A.
449 Recipient must be less than 22 years old for EPSDT.
450 Claim billed on the wrong invoice.
451 Provider is not enrolled to provide services in this category.
452 Medicare Crossover Calculation not equal to the Final Net Bill.
453 Invalid Item Code.
454 This service not covered by Medicare is also not covered by Medical Assistance.
455 This supply denied by Medicare should be billed on a Supplier Invoice (DPW 1858) with a note typed at the bottom stating "Rejected 455 from" the date of the Remittance Advice.
456-459 Technical processing problems—provider may ignore these codes.
461 Provider type is invalid.
462 Technical processing problem—provider may ignore this code.
463 Service Date precedes the first date for which the provider is allowed to bill.
464-466 Technical processing problems—provider may ignore these codes.
467 DPW does not pay claims over 1 year old.
468-469 Technical processing problems—provider may ignore these codes.
470 Last two digits of NDC code are blank.
471 Technical processing problem—provider may ignore this code.
473 Only one unit of therapy is allowed per day.
474 A non-Medicare certified provider cannot bill for thereapy provided to non-residents.
475 Technical processing problem—provider may ignore this code.
477 A non-Medicare certified provider cannot use type of bill equal to 4.

502-504 Technical processing problem—provider may ignore these codes.
505 This service is billed on the worng invoice.
506 The Catastrophic Health Expense Protection Program (CHEPP) does not cover over-the-counter drugs.
507 The Catastrophic Health Expense Protection Program (CHEPP) does not cover this service.

508 The Catastrophic Health Expense Protection Program (CHEPP) does not cover non-durable supplies.

509 Technical processing problem—provider may ignore this code.

510 The Catastrophic Health Expense Protection Program(CHEPP) does not cover EPSDT screenings.

511 The Catastrophic Health Expense Protection Program (CHEPP) does not cover these services.

512 Provider has indicated that he does not want to participate in the Catastrophic Health Expense Protection Program (CHEPP).

513 Provider has indicated that he does not want to participate in the General Assistance Medical Care Program(GAMC).

514 This General Assistance Medical Care (GAMC) invoice should be billed to the county.

or

Dates of Service are prior to the effective date for the Catastrophic Health Expense Protection Program (CHEPP).

515 Invalid recipient ID number.

516 Home Health Care must bill each date of service on a separate line for the Catastrophic Health Expense Protection Program (CHEPP).

517 Technical processing problem—provider may ignore this code.

518 Provider has indicated that he does not want to participate in the Medical Assistance Program (MA).

519 The General Assistance Medical Care Program (GAMC) does not cover EPSDT screenings.

520-522 Technical processing problems—provider may ignore these codes.

523 dical Supply rental is greater than one-half of the purchase price.

524 Medical supply transaction code is invalid.

525 Technical processing problem—provider may ignore this code.

527 Transaction code must be 01, 02, 03, 04 or 52.

528 This supply requires prior authorization.

529 Technical processing problem—provider may ignore this code.

530 This procedure should be billed to Medicare.

531 its for a surgical procedure cannot be greater than one.

532 Technical processing problem—provider may ignore this code.

535 Invalid provider type for this supply code.

536 Technical processing problem—provider may ignore this code.

567 DPW cannot pay a claim which is over 2 years old.

569 These services are not covered by Medical Assistance for that diagnosis.

570 Technical processing problem—provider may ignore this code.

571 Reimbursement Amount equal zero.

572-582 Technical processing problems—provider may ignore these codes.

583 Reimbursement Amount is equal to zero.

584 Charge line-item is a negative amount.

599-602 Technical processing problem—provider may ignore these codes.

603 Vision Care procedure code 80802 cannot be billed with procedure codes 80810 or 80820. Complete eyeglass replacement should be billed using 80103, 80104 or 80113, 80114 with the appropriate material codes.

604 The monthly maximum for personal care services is $500.

605 Unable to identify the original claim to which the late charges should relate. Late charges must match Recipient's Medical Assistance Number and Dates of Service.

606 Item Code on the late charge invoice is the same as an Item Code on the original claim. Item codes may not be repeated.

607-609 Technical processing problems—provider may ignore these codes.

610 Claim Reference Number of Original Invoice to be Adjusted cannot be found in file of paid claims.

611 Provider ID# on Claim Reference Number of Original Invoice to be Adjusted does not match Provider ID# on the Adjustment Request.

612 Technical processing problem—provider may ignore this code.

613 Only one initial therapy evaluation is allowed per calendar year.

614 Restorative and maintenance therapy cannot be billed for the same date of service.

618 Original Line Number could not be located on Original Invoice to be Adjusted.

619 Original Line Number to be adjusted was on a rejected line on the Original Invoice. (Such a rejected line should be resubmitted on a new invoice for reconsideration.)

620 Technical processing problem—provider may ignore this code.

622 Third Party Requested Increase must be less than or equal to the amount entered in Amount Received From Other Sources box on the Original Invoice.

623 Requested Decrease must be less than or equal to the amount dical Assistance paid on the Original Invoice.

625 Third Party Requested Decrease must be equal to the amount Medical Assistance paid on the Original Invoice.

626 Line-Item Requested Decrease must be equal to the amount Medical Assistance paid on the Original Invoice.

627 Personal care services cannot be billed while the recipient is in the hospital.

628 Duplicate Adjustment.

630 Number of visits (Units) for Office/Hospital/Medical Services (MRVI Codes 90000-00220) exceeds the allowable limit for a calendar month.

631 Number of visits (Units) for Extended Care Services (MRVI Codes 903000-90470) exceeds the allowable limit for a calendar month.

632 Number of visits (Units) for Psychiatric Services (MRVI Code 90841) exceeds the allowable limit for a calendar year.

633 Number of visits (Units) for Psychiatric Services (MRVI Code 90848) exceeds the allowable limit for a calendar year.

634 Number of visits (Units) for Psychiatric Services (MRVI Code 90849) exceeds the allowable limit for a calendar year.

635 Number of visits (Units) for Psychiatric Service (MRVI Code 90853) exceeds the allowable limit for a calendar year.

636 Number of visits (Units) for Psychiatric Service (MRVI Code 90862) exceeds the allowable limit for a calendar year.

637 Only one visit (Unit) for Psychiatric Service (MRVI Code 90898) is allowed per day.

638 Number of visits (Units) for Opthamological/Otorhinolaryngoligicservices (MRVI Codes 92000 thru 92598) exceeds the number allowed in a calendar month.

639 Number of visits (Units) for Emergency Room Services (MRVI Codes 90500-90699) exceeds the number allowed for a calendar month.

641 Number of visits (Units) accumulated Antepartum and Postpartum Care (MRVI Codes 59420 and 59430) exceeds the number allowed for a calendar month.

642 Number of Units of a MRVI Code in the 90000 series exceeds the number allowed for a calendar month.

643 The same Radiology procedure (MRVI Code 70000 thru 89999) exceeds the number allowed for a calendar month.

645 Total OB Care (MRVi Code 594003) should include all antepartium and postpartum care.

647 This procedure appears to be a duplicate. The dates of service for this procedure overlap with another line on this claim.

648 This procedure appears to be a duplicate. The dates of service overalp with a previous claim.

649 Duplicate service code on the same invoice.

650 A patient must not see two practitioners on the same Service Date for medical visits unless on practitioner is a consultant.

651 A claim for a surgery procedure cannot have the same Service Date as a claim for Medical services (MRVI Codes 60000 thru 99999) unless the Medical service is a consultation service.

652 Number of Nursing Home visits (Units) exceeds the number allowed for a week.

653 Different providers cannot bill for the same surgery procedure, or the same non-physician procedures on the same date, unless modifier F & G are used along with the same surgery procedure or if Pathology & Radiology procedure appear on the same billing.

654 Cannot have procedure codes for Antepartum Care, Postpartum Care, and Normal Delivery during the same time period covered by a total OB Care package.

655 Cannot have procedure codes for Antepartum and Postpartum Care during the same time period as medical service codes.

656 Claims with Emergency Room Services should not occur within 1 day of another claim with Emergency Room Services.

657 Medicare crossover claims conflict if the Service Dates overlap, Provider ID#'s are identical, and the Deductible and Co-insurance are equal.

658 Medicare crossover claims conflict with Practitioner Invoice for the same category of service and Service Dates overlap.

659 The number (Units) of Nursing Home dical Services is excessive for the time period covered.

660 For Place of Service of Inpatient Hospital (3) the Units exceed the allowable limits.

661 MRVI modifier S is required for multiple Inpatient visits for one Service Date.

662 The Catastrophic Health Expense Protection Program (CHEPP) covers only 180 Home Health visits.

663 Duplicate Medicare crossover claim.

644 Duplicate Medicare crossover claim.

665 Vision Care procedure codes 80101, 80102, 80103, 80104, 80113, or 114 cannot be billed more than once a year unless they are prior authorized.

666 Vision Care procedure codes 80802, 80803, 80804, **80810** or **80820** cannot be billed with procedure codes 80103, 104, 80113 or 80114.

667 Vision Care procedure code 80105 cannot be billed with procedure codes 80101, 81012, 103, 80104, 80113, 80114.

668 Duplicate Medicare crossover claim.

669 Medicare Crossover Claim conflicts with Medical Transportation Claim.

670 Prescription refills are limited to six months from the original dispensing date.

671 The allowable number of prescriptions for the same drug has been exceeded.

672 Duplicate Compound or C Pharmacy Claim. A previous claim covered the same Drug/Supply and Service Date.

673 Duplicate refill number.

674 Pharmacy claim conflicts with an Inpatient Hospital Invoice for the same recipient.

675 Duplicate Pharmacy Claim. A previous claim from the same provider covered the same NDC Code and Service Date.

676 Duplicate Pharmacy Claim. A previous claim from a different provider covered the same Drug/Supply Code and Service Date.

677 Medicare Crossover claim conflicts with a claim submitted on a supply invoice.

678 Duplicate Medical Transportation Claim.

679 Outpatient Emergency Room Physician services conflict with another Physician claim.

680 Two institutional claims overlap.

681 Claim conflicts with another claim for Medical Transportation on the same date.

682 Medical Transportation claim is for service which falls within period covered by an Inpatient Hospital Invoice.

683 Service Dates for claim overlap service dates covered by an Inpatient Hospital Invoice.

684 Outpatient service for Psychiatry, Dentistry, or Therapy cannot be billed while Recipient is in Inpatient Care.

685 Inpatient Hospital service dates overlap with another claim from the same provider.

686 Prior Authorization is required when this service is performed twice on the same date of service.

687 This service exceeds the limitations of the Medical Assistance Program (MA).

688 Duplicate Claim A previous claim covered the same Procedure Code and Dates of Service.

689 Duplicate Claim A previous claim covered the same Procedure/Drug/Supply Code and Service Date.

690 Duplicate Claim. Two or more lines on the same invoice duplicate each other.

691 Number of visits exceeds the allowable limit per calendar year.

692 The number of Therapy visits (Units) exceeds the number allowed for a calendar year.

693 Daily average allowance for Physical Therapy has been exceeded.

694 Duplicate screening exam.

697 Dates of service cannot overlap within a claim.

698 Duplicate claim.

700 Recipient's Medical Assistance Number as reported on the invoice cannot be found in the Case Information File.

701 Birthdate reported on the invoice does not match birthdate on the Case Information File. Most frequently this indicates that an improper Recipient's dical Assistance Nuer was reported. Special attention should be given to the final two digits of the MA ID# which differentiate family members.

702 Sex reported on the invoice does not match sex on Case Information File. See comments under 701 above.

703 Recipient was ineligible for payments on first or only Service Date under MA ID number used. Special attention to current ID for period of service.

704 Recipient was ineligible for payments on last Service Date.

705 Recipient is ineligible for payments on the date of service.

706 The Case Information File indicates this recipient has dicare coverage but there is no indication this service has been billed to dicare.

707 Refer to 706.

708 Technical processing problem—provider may ignore this code.

709 First two digits of Recipient's Medical Assistance Number are not between 01 and 89.

710 Third digit of Recipient's Medical Assistance Number is not a valid Medical Assistance program code.

711 Fourteenth digit of Recipient's Medical Assistance Number is not valid.

712 Last two digits of Recipient's Medical Assistance Number are not numeric or do not represent the person named on the invoice.

713 The Case Information File indicates that this recipient has Medicare coverage, but there is no indication on this invoice that this service has been billed to Medicare.

714 Recipient is enrolled in HMO. Contact the HMO for payment.

715 Recipient was ineligible for payments on the first or only Service Date under the MA-ID used.

716 Medical Supply for recipient in long term care facility should be provided by the facility.

717 Recipient is enrolled in an HMO. Contact the HMO for payment.

720 Maximum number of prior authorized billings for this service has been exceeded.

712 The provider prior authorized to deliver this service does not match the Provider ID# shown on the invoice.

723 Procedure requiring Prior Authorization was not included on the Prior Authorization indicated by the Prior Authorization # on the invoice.

724 The Prior Authorization # on this invoice does not match anything in the file of Prior Authorization.

725 This service has already been Prior Authorized (Duplicate Prior Authorization).

726 The Prior Authorized amount for this service is $0.00.

727 The Tooth Number or Letter for which this service was Prior Authorized does not match the Tooth Number or Letter on the invoice.

or

Transaction code on this invoice does not match the transaction code on the prior authorization.

728 Technical processing problem—provider may ignore this code.

729 Authorization for this claim is outdated.

or

The Prior Authorization for this claim was denied.

730 Other Charges covered by MA but not by Medicare exceeds $100.00 and no explanation was attached.

731 This recipient is restricted to certain providers and the provider ID# does not match any of the specified provider.

732 Pharmacy code indicates that the recipient resides in a Long Term Care facility, however, our Case Information file indicates the recipient does not reside in a Long Term Care facility.

733 This orthodontic service must be itemized according to the initial placement fee and monthly billings.

734 Personal care services cannot be billed while a recipient resides in a Long Term Care facility.

738 The Case Information File indicates this recipient has Medicare coverage, but there is no indication that this service has been billed to Medicare.

722 Inpatient Hospital Extension/Adverse Decisions Notice and Physician Recertification (DPW 1931) does not have a matching Inpatient Hospital Admission Notice and Physician Certification (DPW 1819) on file.

773 Services billed extend more than 72 hours after the utilization review committee's denial.

774 Inpatient Hospital Extension/Adverse Decision Notice and Physician Recertification (DPW 1931) not received and hospital stay is more than 60 days.

775 Inpatient Hospital Invoice does not have a matching Inpatient Hospital Admission Notice and Physician Certification (DPW 1819) on file.

776 Physician's certification of need for private room has not been received.

777 See 775 above.

780-789 Technical processing problems—provider may ignore these codes.

800-802 Technical processing problems—provider may ignore these codes.

803 Physician's name is missing.

804 Provider should recalculate the submitted charge.

805 This claim was denied by the Medical Assistance consultants.

806 Procedure Code is vague. Please resubmit with a more definitive Procedure (Service) Code or submit a verbal description of the Service under Procedure Name or as an attachment to the invoice.

807 This service is not covered by the Minnesota Medical Assistance Program.

808 This claim exceeds the allowable number of services for this diagnosis.

809 Minnesota Medical Assistance does not cover reductions which have been made by a Medicare Intermediary.

810 With regard to the diagnosis, this service is not covered by Medical Assistance.

811 Recipient is not eligible for service under the Recipient's dical Assistance Number shown on the invoice.

812 Allowable charge under Minnesota Medical Assistance is less than the Amount Received from Other Sources. Net payment equals $0.00.

813 Procedure Code shown is "By Report" or unlisted and requires written description of the service.

814 Description of service is insufficient to accurately determine payment amount.

815 The service description and procedure code are inconsistent.

816 This service must be billed on the proper invoice type (i.e., Supplies must be on Medical Supplier Invoice. Transportation on Medical Transportation Invoice, Dental on Dental Invoice, etc.)

817 Primary Diagnosis is required.

818 Please resubmit this claim with complete data on any insurance claims or amounts received from insurance companies.

819 Recipient is an HMO participant. Provider should contact HMO for payment.

820 Recipient's Name cannot be found on Central Case Information File.

821 Services rendered must be itemized on the invoice for payment.

822 This line item has been combined with another line item on this invoice.

823 No Benefit is payable for Co-Insurance if the provider does not submit an assigned claim to the appropriate Medicare Carrier.

824 Medicare Professional Component should be billed on an Inpatient or Outpatient Invoice.

825 This service denied by dicare should be billed on a Medical Transportation Invoice (DPW 1857) indicating "8" in the Type of Bill box.

826 Supply denied by Medicare should be billed on a Supply Invoice (DPW 1858) with a note typed at the bottom "Service not covered by Medicare."

827 This service denied by Medicare is also not covered by Medical Assistance (same as EC 431.)

828 This podiatry service denied by Medicare should be billed on a Practitioner Invoice (DPW 1497) indicating "8" in the Type of Bill box.

829 Authorizing physician's prescription not attached to invoice.

830 Medicare calculation is incorrect.

831 Additional payment is not warranted.

832 Supply rejected by county responsibility.

833 Inpatient and Outpatient 42 days. Automatic Reject.

834 Prior Authorization omitted for supply requiring a Prior Authorization.

835 Claim covered when submitted by authorized provider.

836 This service denied by Medicare should be rebilled on a practitioner Invoice indicating "8" in the Type of Bill box.

837 Point of origin and/or destination is missing.

843 This claim has been denied by our consultants because it represents a duplication of services and/or materials within a 12-month period.

851 Rebill this service or supply to Medicare.

852 Rebill this service by sending the Medicare Explanation of Benefit sheet.

853 The consent form must be signed 72 hours prior to the surgery. This claim may **not** be resubmitted.

854 The consent form is inappropriate with respect to Federal guidelines. Please refer to Inpatient Hospital Bulletin #13 or Outpatient #12 or Physician #17. This claim may **not** be resubmitted.

855 Consent form is **not** attached to the claim.

856 Consent form is illegible.

857 The witness signature on the consent form is missing. This claim may **not** be resubmitted.

858 The recipient's signature is missing on the consent form. This claim may **not** be resubmitted.

859 This sterilization claim has been denied by the dical Advisory Unit because the recipient is under 21 years of age. This claim may **not** be resubmitted.

860 This sterilization claim has been denied by the Medical Advisory it because the requested Operative report and/or other information is missing.

861 This sterilization claim has been denied because the recipient is mentally retarded and therefore cannot give informed consent. This claim may **not** be resubmitted.

900 Technical processing problem—provider may ignore this code.

ORDER FORM FOR DPW FORMS

APPENDIX A

The Requisition for DPW Forms (DPW-121) is used to order all forms referenced with a DPW-XXX in the text of this handbook. The forms that may be ordered are listed on the following example DPW-121. All forms are **free-of-charge.**

It is advisable to request a three month supply when ordering. You should allow about three weeks from the time of ordering to the arrival of your order.

Complete the DPW-121 as follows:

1. Mail the completed requisition to this address.
2. Your name and address must be indicated.
3. The requisition must be signed and dated.
4. The form number of the item ordered must be listed.
5. The title of the form must be indicated.
6. The quantity of forms ordered should be listed in this column.

The Provider should retain the pink copy and mail the rest intact to the Department.

Note: It is necessary to order additional REQUISITIONS when completing an order.

REQUISITION FOR DPW FORMS FROM CENTENNIAL STORES

Mail this requisition to:

FORMS MANAGEMENT
DEPARTMENT OF PUBLIC WELFARE
CENTENNIAL OFFICE BUILDING
ST. PAUL, MINNESOTA 55155

1

FOR DPW APPROVAL

SEND FORMS ORDERED TO: 2

AGENCY OR NAME: Midwest Clinic

ADDRESS: 202 Main Street

CITY: Hometown | STATE: MN | ZIP CODE: 55175

PLEASE SIGN REQUISITION HERE: 3

Your Signature

DATE: 03/10/80

4 Form number	5 Form Title	6 Quantity	DPW or Centennial Stores use only ACTION TAKEN (see reverse)
DPW- 1973	EPS/EPSDT Invoice		
DPW- 1865	EPSDT Envelope		
DPW- 1998	Referral for Treatment		
DPW- 2384	FEP Instruction Sheet		
DPW- 2383	FEP Testing Lab Slip		
DPW-			
DPW-			
DPW-			
DPW-			
DPW-			
DPW-			
DPW-			
DPW-			
DPW-			
DPW-			
DPW-			

Send WHITE, LABEL, and BLUE copies with stub intact to DPW.
Retain PINK copy.

DPW-121
(1-76)

ORDER FORM FOR MDH FORMS

APPENDIX B

The Requisition for EPS/EPSDT/PSS Forms (517-29) is used to order forms from the Minnesota Department of Health (MDH).

The following example of the requisition form shows all the EPS, EPSDT and PSS forms available from MDH. You should select materials from the EPSDT column.

Complete the order form as follows:

1. Mail the completed requisition to this address.
2. The Provider's name and address must be indicated.
3. Enter the quantity desired.

Note that additional requisition forms are ordered by indicating a quantity in the last line on the form.

REQUISITION FOR EPS/EPSDT FORMS

1

Mail this requisition to: Comprehensive Child Health Screening Unit
Minnesota Department of Health
717 S.E. Delaware Street
Minneapolis, Minnesota 55440

Send order to: 2

Name _____
Address _____
_____ Zip Code _____

FOR OFFICE USE ONLY

☐ UPS ☐ Parcel Post
☐ Other _____
Packer _____ Date Sent _____
Weight _____ Charge _____

ALLOW 4-6 WEEKS FOR DELIVERY

Please print or type. Order only the quantity of materials to be used within the next two to three months.

3

Title	Forms available to: EPS	Forms available to: EPSDT	Form #	Quantity
Denver Developmental Screening Test Sheets	yes	yes	517-1	
Dental Assessment Form (for use by nurses)	yes	yes	517-2a	
Dental Assessment Form (for use by dental professionals)	yes	yes	517-2b	
Family and Perinatal History	yes	yes	517-3	
Food Intake Record	yes	yes	517-4	
Grow Power Brochures (EPS)	yes	no	517-5	
Grow Power Posters (EPS)	yes	no	517-7	
Growth and Head Circumference Charts				
Boys (2-18 Years)	yes	yes	517-9	
Infant Boys (0-36 Months)	yes	yes	517-10	
Girls (2-18 Years)	yes	yes	517-11	
Infant Girls (0-36) Months)	yes	yes	517-12	
Hearing Checksheet	yes	yes	517-13	
Hearing Record	yes	yes	517-14	
Immunization Record	yes	no	517-15	
Individual Health Histories				
0-6 Years	yes	yes	517-16	
7-13 Years	yes	yes	517-17	
14-21 Years	yes	yes	517-18	
Laboratory Procedures Flow Chart	yes	no	517-19a	
Nutrition Assessment Summary	yes	no	517-19b	
Parental Consent for Screening	yes	no	517-20	
Release of Information	yes	no	517-21	
Survey for Parents	yes	no	517-22	
Tracking Record	yes	no	517-23	
Vision Record	yes	no	517-24	
Denver Developmental Screening Manual	yes	yes	517-25	
Denver Developmental Screening Kit	yes	yes	517-26	
Prescreening Developmental Questionnaires (PDQ)	yes	yes	517-28	
Requisition for EPS/EPSDT Forms	yes	yes	517-29	
EPSDT Invoice	yes	no	517-30	

ADJUSTMENTS TO PAID CLAIMS

APPENDIX C

The Adjustment Request form (DPW-1854) is the form used to make corrections to claim which the EPSDT Program has incorrectly paid. The corrections can be credits to or debits from the provider due to mistakes caused by the provider, the claims processing system or a third party insurance group. This form **cannot** be used to collect for rejected claims. The form is one used by all providers and can be very efficient when properly completed.

When a payment problem arises it will be necessary to anlayze the situation first before completing the adjustment. The following steps are designed to aid in this analysis.

A. Study the problem as it appears on the Remittance Advice (R.A.). It is an underpayment or an overpayment?

B. Compare the information about the claim listed on the R.A. with the file copy of the invoice itself. Check to see if these match the recipient I.D., and, the charge billed. This comparison will show any mistake made when the invoice itself was interpreted by the optical reading equipment.

C. When the situation has been analyzed, the adjustment form can be prepared. It will be necessary to have these items presented: 1) the remittance advice from which the claim was incorrectly paid, 2) the green copy of the invoice, and 3) the adjustment code list. Please note that only **one** claim can be adjusted on each form.

The following description is a step-by-step explanation to assist in the correct completion of the Adjustment Request form. A sample of the form itself follows this description.

Box 1 — Claims Processing Document Control Number

Leave this space BLANK. When the Adjustment Request is processed by the Medical Assistance Program, a number is assigned to it and printed mechanically on the adjustment on this space.

Box 2 — Provider's Name

Enter the name of the physician or clinic. Remember to use all capital alphabetic characters on this form.

Example: MIDWEST CLINIC

Box 3 — Provider I.D. Number

Enter the seven digit M.A. provider identification number.

Example: 0212345

Box 4 1— Own Reference Number

Completion of this box is optional. It is designed to hold a combination of up to nine numbers, capital letters or spaces. Assigning a unique reference number to each Adjustment form will enable the provider to cross reference his/her copy of it.

Box 5 — Submission Date

Enter the date this Adjustment Request is completed. Use a six digit format for this date. Use only a hyphen to separate month, day and year. Do **NOT** use a slash.

Example: 02-11-

Box 6 — Street Address

Enter the business address of the provider.

Example: 202 S. MAIN ST.

Box 7 — City/State/Zip

Enter the city, state, and postal zip code of your office. Standard state abbreviations are acceptable.

Example: HOMETOWN MN 55123

Box 8 — Claim Reference Number of Original Invoice to be Adjusted.

Enter the claim reference number from the remittance advice where the claim was incorrectly paid.

Example: 770580761233701

Box 9 — Own Reference Number from Original Claim

Enter the reference number from box 4 on the original invoice. If there was no number used, leave this blank.

Example: 1076026

Box 10 — Warrant Date from Remittance Advice

Enter the date of payment from the top of the remittance advice. Again, this is a six digit date with a hyphen used to separate month, day, and year.

Example: 12-08-76

Boxes 15-30

Leave these boxes BLANK.

Box 31 — Reason for Change

SEND REQUESTS TO: Minnesota Medical Assistance Program -- Department of Public Welfare, Box 30197, St. Paul 55175

ADJUSTMENT REQUEST

FIGURE 3

CLAIMS PROCESSING DOCUMENT CONTROL NUMBER
1

ELITE PICA — TYPEWRITER ALIGNMENT — ELITE PICA

USE CAPITAL LETTERS ONLY

PROVIDER INFORMATION

PROVIDER'S NAME 2 | PROVIDER ID # 3 | OWN REFERENCE # 4 | SUBMISSION DATE 5

STREET ADDRESS 6

CITY/STATE/ZIP 7 | CLAIM REFERENCE NUMBER OF ORIGINAL INVOICE TO BE ADJUSTED 8 | OWN REFERENCE NUMBER FROM ORIGINAL CLAIM 9 | WARRANT DATE FROM REMITTANCE ADVICE 10

RECIPIENT INFORMATION

RECIPIENT'S NAME (LAST, FIRST, INITIAL) 11 | RECIPIENT'S MEDICAL ASSISTANCE NUMBER 12 | SEX 13 | BIRTHDATE 14

	ORIGINAL LINE NUMBER	REASON FOR CHANGE	CORRECTED SERVICE CODE	CORRECTED TYPE	CORRECTED UNITS	REQUESTED INCREASE	REQUESTED DECREASE	DELETE
1	15	16	17	18	19	20	21	22
2	23	24	25	26	27	28	29	30

THIRD PARTY ADJUSTMENTS ONLY

REASON FOR CHANGE	THIRD PARTY UNDERPAYMENT	THIRD PARTY OVERPAYMENT	DELETE
31	32	33	34

IF CONTINUATION PAGE 35 OF 36

	SUM OF REQUESTED INCREASES	SUM OF REQUESTED DECREASES
TOTALS 37	38	

FOR OFFICE USE ONLY

DO NOT COMPLETE THESE ITEMS 39 | 40 | 41 | 42 | 43

DO NOT HAND WRITE OR MARK ABOVE THIS LINE

EXPLANATION OR COMMENTS

PROVIDER CERTIFICATION

This is to certify that the information given above is correct. I understand that any payment and satisfaction of this claim will be from Federal, State and Local funds, and that any false claims, statements or documents or concealment of a material fact may be prosecuted under ar ble Federal or State laws.

X
44 Authorized Signature

FOR DEPARTMENT USE ONLY

X
45 Approved by

DPW 1854 (8-74)

REASON CODES FOR CLAIM ADJUSTMENTS

CREDIT TO PROVIDER

I.Provider Errors

Underpayment due to:
* Misc. (explanation must be included)
11 Incorrect service
12 Incorrect number of units (quantity)
13 Incorrect modifier or type
14 Incorrect submitted charge
*15 Overstated Medicare collection

II.System Errors

Underpayment due to
31 Reference file (fee schedule)
32 Misscanned information
*33 Medicare coinsurance/deductible
*39 Misc. (explanation must be included)

III.Third Party Collections

Underpayment due to:
*21 Overstated health insurance recovery
*24 Overstated Workmen's Compensation recovery
*29 Other (explanation must be included)

DEBIT TO PROVIDER

I.Provider Errors

Overpayment due to:
*60 Misc. (explanation must be included)
61 Incorrect service code
62 Incorrect number of units (quantity)
63 Incorrect modifier or type
64 Incorrect submitted charge
Later collection from Medicare

II.System Errors

Overpayment due to:
*80 Duplicate payment
81 Reference file (fee schedule)
82 Misscanned information)
*83 Medicare coinsurance/deductible
*87 Payment to wrong provider
*88 Payment for ineligible recipient
*89 Misc. (explanation must be included)

III.Third Party Collections

Overpayment due to:
*71 Health insurance recovery
*74 Workmen's Compensation recory
*75 Auto insurance recovery
*79 Other (explanation must be included)

Box 32 — Third Party Underpayment

Enter the total amount of underpayment on the claim.

Box 33 —Third Party Overpayment

Enter the total amount of overpayment on the claim.

Box 37 — Sum of Requested Increase

Enter the amount shown in Box 32.

Box 38 — Sum of Requested Decreases

Enter the amount shown in Box 33.

EXPLANATION OR COMMENTS

This is a section in which you may list any special information which may clarify this adjustment. It is often helpful to include the page number from the remittance advice where the claim was incorrectly paid. If other materials are attached, indicate here.

Box 44 — Provider Certification

This will verify that the provider is submitting correct information. The signature may be written, rubber-stamped or typewritten.

MEDICAL ASSISTANCE IDENTIFICATION CARD

OTHER PERSONS COVERED
Listed here are names, birthdates, OHC codes, and ID numbers of other family members. NOTE: The grantee/sequence numbers are different for each member of the family. Enter the proper number on the invoice.

OTHER HEALTH COVERAGE
This indicates any other health insurance coverage.
- Y - indicates there is other coverage.
- N - indicates no other coverage.
- A - indicates Part A Medicare.
- B - indicates Part B Medicare.

SIGNATURE & DATES
The person whose name is shown must have signed the card. Cards are issued for a one month period. If a current card is not presented, inquire with the county welfare agency about eligibility.

CUT ALONG THIS LINE

OTHER PERSONS COVERED

NAME		I.D.	
Peter	FIRST	87-2-000-008-7654-103	
Patterson	LAST	BIRTHDATE 05/04/70 -N	OHC
Patty	FIRST	87-2-000-008-7654-104	
Patterson	LAST	BIRTHDATE 01/21/72 -N	OHC
	FIRST / LAST	BIRTHDATE	OHC
	LAST / FIRST	BIRTHDATE	OHC
	LAST / FIRST	BIRTHDATE	OHC
	LAST / FIRST	BIRTHDATE	OHC
	LAST	BIRTHDATE	OHC

STATE OF MINNESOTA — MEDICAL IDENTIFICATION

SIGNATURE Patterson, Wright

BIRTHDATE	OHC	VALID FROM	TO
10/21/36	N	09/01/78	09/30/78

NAME Patterson Wright
ADDRESS 690 Elm Lane
CITY, STATE Hometown, Minnesota 55123

ID NUMBER 87-2-000-008-7654-101

DEPARTMENT OF PUBLIC WELFARE

DPW-1851 (4-77)

MEDICAID PAYS FOR SERVICES RECEIVED ONLY ON DATES YOU ARE CERTIFIED AS ELIGIBLE

CUT ALONG THIS LINE

RESPONSIBLE COUNTY
These two digits refer to the county responsible for the recipient's financial payments.

PROGRAM CODE
This code identifies the program under which the recipient becomes eligible for medical services.

CASE NUMBER
This ten digit number is assigned by the county welfare agency to each case as the person becomes eligible for assistance.

GRANTEE/SEQUENCE NUMBER
This number uniquely identifies each member of the family. Person 101 is usually the head of the household. Services rendered must be identified with that person's own number.

RECIPIENT IDENTIFICATION NUMBER
This is the number which the provider must enter accurately on the billing invoice. This allows the centralized processing system to perform various edits related to recipient eligibility, duplicate payments, and appropriateness of the sevice to the recipient's unique situation.

DPW 61 Early and Periodic Screening, Diagnosis and Treatment

A. Introduction

This rule governs the administration of the Early and Periodic Screening, Diagnosis and Treatment Program (hereinafter referred to as the EPSDT Program). This program is mandated by Section 1905(a)(4)(B) of the Social Security Act.

The purpose of the EPSDT Program is to identify potentially handicapping conditions in children eligible for Medical Assistance, to provide diagnosis and treatment for conditions identified, and to encourage the entrance of children into the health care system.

Note: It is the intention of the Department, in order to ensure effective delivery of EPSDT services, that parents be involved with the child throughout the screening, diagnosis and treatment process. However, since the program includes "children" through age twenty, the Department recognizes that some children, including teenagers and adults who are eighteen through twenty, may be able to supply requested information themselves and may not wish to have their parents involved in the screening process. To allow for such cases, references in this rule are made to "parent/child". In using this language, the Department intends that health providers and local welfare agencies involve the parent whenever possible in the program, but also recognize the right of the child to privacy.

B. Definitions

1. Child: For purposes of this rule, any individual from birth through twenty years of age who is eligible for Medical Assistance.

2. Commissioner: The Commissioner of Public Welfare.

3. Department: The Department of Public Welfare.

4. Diagnosis: Determination of the nature or cause of physical or developmental disease or abnormality through the use of health history, physical, developmental, and psychological examination, laboratory tests and x-rays.

5. EPSDT Equivalent Clinic: A facility which provides screening services according to Minnesota Department of Health EPS standards, provides follow-up services, and is monitored by the Minnesota Department of Health. Such facilities provide comprehensive care in a sequence incompatible with the completion of the EPSDT billing form.

6. EPSDT Provider Agreement: An agreement between a provider of screening services and the Department that the provider, in order to qualify for Medical Assistance reimbursement, will screen each Medical Assistance child according to the appropriate screening standards specified in Section D of this rule, will report all findings on the EPSDT billing form, and will refer children according to procedures specified in Section G.2. of this rule.

7. Follow-up: Efforts by local agencies to ensure that the screening, diagnosis and treatment services needed by a child are obtained.

8. Local agency: The county welfare board, multi-county welfare board, or human service agency established in accordance with state law and responsible for the administration of the EPSDT Program at the county level.

9. Medical Assistance: Program authorized under Title XIX of the Social Security Act to provide medical care for individuals whose resources do not enable them to purchase such care.

10. Minnesota Department of Health-Approved EPS Clinic: An agency which provides screening services according to Minnesota Department of Health screening and administrative standards, which operates under the supervision of a registered nurse, public health nurse, or pediatric/family nurse practitioner, and which qualifies for Medical Assistance and other public third party reimbursement.

11. Nurse-Supervised EPSDT Clinic: A facility or individual which provides screening services according to Minnesota Department of Health screening standards and Department of Public Welfare administrative standards. Such clinics operate under the supervision of a registered nurse, public health nurse, or pediatric/family nurse practitioner, and qualify for Medical Assistance reimbursement.

12. Outreach: Efforts by the Department or local agencies to inform and encourage persons to avail themselves of services which they might not otherwise request without such assistance.

13. Periodic: At regular, fixed intervals established for screening by health care experts to assure that disease or abnormality is not incipient or has not appeared since the child's last evaluation.

14. Physician-Supervised EPSDT Clinic: A facility or individual which provides screening services according to physician screening standards, which operates under the supervision of a licensed physician, and which qualifies for Medical Assistance reimbursement.

15. Screening: The use of quick, simple procedures to sort apparently well children from those who need more definitive study of possible physical or developmental problems.

16. Treatment: The use of medical care and services to prevent, correct or ameliorate disease or abnormalities detected by screening and diagnostic procedures.

C. Eligibility

1. All persons from birth through age twenty who are eligible for Medical Assistance are eligible for the EPSDT Program.

2. Eligibility for the EPSDT Program terminates when Medical Assistance eligibility terminates, regardless of the child's status in the EPSDT process.

D. Physician Screening Standards

A licensed physician must provide the following components in order for an examination to be reimbursed as a screening under the EPSDT Program.

1. Health History: A health and developmental history must be obtained from the child, the parent, and/or another responsible adult who is familiar with the child's health history and must include information on lead and tuberculosis exposure, nutrition intake, and seizure history.

2. Assessment of Physical Growth: The child's height and weight must be measured and compared with the ranges considered normal for children of that age. Head circumference measurements must be taken for children under three years of age.

3. Physical Examination: The following areas must be checked according to accepted medical procedures: pulse, respiration, blood pressure, head, eyes, ears, nose, mouth, pharynx, neck, chest, heart, lungs, abdomen, spine, genitals, extremities, joints, muscle tone, skin, and neurological examination.

4. Dental Inspection: The mouth must be examined for any obvious dental problems. A child who is three years of age or older must be referred to a dentist for preventive care if she/he has never been to a dentist or if it has been one year since the last dental appointment.

5. Vision:

   a. Children under the age of three years:

      (1) Must be checked for a history of:

         (a) Maternal and/or neonatal infection.

         (b) Family history of ocular abnormalities.

      (2) Must be observed for:

         (a) Pupils and light following reflex.

         (b) Presence/absence of nystagmus.

         (c) Muscle balance - examination for esotropia, exotropia, large phorias.

         (d) External examination of eyes, including lids, conjunctiva and cornea.

         (e) Parental concern regarding child's vision.

   b. Children over the age of three years:

      (1) Must be checked for all of the items contained in Section D.5.a.

      (2) Must, in addition, be checked for visual acuity. A test such as the STYCAR, the Snellen E Cube, the Snellen E Chart, and the Snellen Alphabet Chart, or their equivalent, must be used.

6. Hearing:

   a. Children under the age of three years must be observed for:

      (1) Retardation of language acquisition or history of such retardation.

      (2) Failure to directionalize to sounds.

      (3) History of repeated otitis media during early life.

      (4) Parental concern regarding child's hearing.

   b. Children over the age of three years:

      (1) Must be observed for all of the items contained in Section D.6.a. (1) through (4) above.

      (2) Must receive a pure tone audiometric test or referral for pure tone audiometric testing if items (1) through (4) above indicate the need for audiometric testing.

7. Developmental Screening:

   a. For children ages birth through five years, the Denver Prescreening Developmental Questionnaire (PDQ) must be completed. All children who fail the PDQ must be screened further by use of the Denver Developmental Screening Test (DDST). If the screener does not provide the DDST, referral must be made to an agency that does provide it.

   b. For children ages six through twenty years, the provider must screen for the following areas according to his/her standard procedures: fine/gross motor development, speech, and socialization. Developmental questions must be included on the health history for this age group.

8. Sexual Development:

   a. Sexual development appropriate to the child's age must be checked for all children, with special emphasis given to children who have reached puberty.

   b. At the request of the parent/child, counseling on normal development, birth control and venereal disease, as well as appropriate prescriptions and testing, must be provided by the screener, or referral to appropriate resources must be made.

   c. The option to receive a pelvic examination with appropriate testing (GC, Pap Smear, other tests at provider's discretion) must be offered to all females who have reached puberty.

9. Nutritional Status:

   a. A child having any detectable nutritional deficiencies must receive nutritional counseling or must be referred for such counseling.

b. When a child's history reveals that his/her diet regularly lacks two or more daily servings from one of the four basic food groups, the parent/child must receive nutritional counseling or must be referred for nutritional counseling even if there are no objective signs of poor nutrition.

10. Immunizations: The immunization status of all children must be checked. Needed immunizations must be offered and provided if requested. Immunizations must be administered according to the Recommended Schedule of Immunizations developed by the Minnesota Department of Health and approved by the Minnesota State Medical Association.

11. Laboratory Tests:

a. Tuberculin Testing: Must be performed for all children once at fifteen months of age or at their first screening, if this screening occurs later than fifteen months. A child may receive additional tuberculin testing at later ages if his/her history indicates the possibility of exposure.

b. Lead Absorption Testing: Must be performed on all children whose history and physical findings indicate the possibility of exposure to undue levels of lead in the environment or atmosphere.

c. Urine Testing: All children over the age of two years must be tested at their first screening for the presence of glucose, ketones, protein and other abnormalities in the urine. Females (at or near the ages of four and ten) must be tested for bacteriuria.

d. Anemia Testing: All children must be tested for anemia by use of either a microhematocrit determination or a hemoglobin concentration. This test should be done near the ages of six months, one year, two years, four years, and fifteen years.

e. Sickle Cell Testing: Tests for sickle cell disease or trait must be offered to all children known to be at risk and must be provided if requested by the parent/child. Only one sickle cell test is needed. If sickle cell trait is found, parent/child must be referred for genetic counseling if they so desire.

f. Other Laboratory Tests: Tests for cervical cancer, venereal disease, pregnancy and parasites should be performed when indicated and charged as part of the screening examination.

12. Variation From Screening Procedures: If a provider wishes to substitute other procedures for those contained in Section D.1. through D.11., or wishes to omit any of the required procedures, written application must be made to the EPSDT Section in the Department. All such requests shall be reviewed by a Physician Advisory Committee and a decision on the request shall be made by the Committee, in writing within 30 days of the receipt of the request.

E. Nurse Screening Standards

The Department will recognize as screening providers all nurse-supervised EPS and EPSDT clinics which follow the screening standards and periodicity schedule devised by the Minnesota Department of Health. Screenings performed by these providers will be reimbursed under the EPSDT Program.

F. Periodicity Schedule

1. The Department will offer all children who have been screened the opportunity for re-screening at the following ages: six months, nine months, one year, eighteen months, two years, four years, and every three years thereafter. The Department will notify all eligible recipients of the availability of screening services at least once a year.

2. For physician-supervised EPSDT clinics, screening components must be provided according to the attached Physician EPSDT Periodicity Schedule.

G. Conditions of Screening Provider Participation in the EPSDT Program

1. All screening providers must complete the EPSDT billing form with one total charge submitted for the complete screening package.

   (a) The parent/child must be provided with a copy of the billing form.

   (b) Screening providers which are designated as EPSDT Equivalent Programs by the Department need not complete the billing form. In order to receive such a designation, a facility must screen children according to Minnesota Department of Health standards, must provide follow-up services to those children, and must be monitored by the Minnesota Department of Health. EPSDT Equivalent Programs may submit screening statistics in aggregate form.

2. All screening providers must complete a screening referral form, supplied by the Department, and provide this form to the parent/child in every instance when a child is referred for further diagnosis and treatment.

3. All screening providers must sign an EPSDT Provider Agreement whereby they agree to the provisions of Sections G.1. and G.2 above.

4. In order to qualify for Medical Assistance reimbursement, screening providers must follow all requirements for Medical Assistance Program participation as specified in DPW Rule 47.

5. All screening providers shall be reimbursed according to their usual and customary fee until six months after this rule is published. At that time, the Department will establish one maximum screening fee for physician supervised clinics and another maximum screening fee for nurse supervised clinics.

   Each of these maximum fees shall be equal to the seventy-fifth percentile of all screening charges submitted by each group during that six month period. After the maximum fees are established, screening providers shall be reimbursed according to their usual and customary fee or the Department's maximum fee, whichever is lower. The maximum fee shall be updated yearly.

6. Health Maintenance Organizations which participate in the Medical Assistance Program must provide EPSDT services as part of their contract with the Department for their enrollees at no extra charge to the Department, and must complete the EPSDT billing form for each child screened.

7. Screening providers may, after notifying the Department, elect to provide one or more of the screening components by referral to other providers. In such cases, the screening provider must ensure that the child receives the components for which he/she was referred before the screening is billed.

8. Screening providers may provide an outreach component as part of the screening and may charge for the extra outreach service after they have submitted a budget to the Department which justifies the outreach charge.

9. The Department must provide:

   a. Training on screening components to all providers who sign the EPSDT Provider Agreement and who request such training.

   b. Assistance in obtaining the forms and materials needed in the screening process.

10. The parent/child who requests screening services has free choice of all local screening providers who have signed EPSDT Provider Agreements.

H. Conditions of Diagnosis and Treatment Provider Participation in the EPSDT Program

1. Any health care provider licensed under state law who has signed a Medical Assistance Provider Agreement is eligible to provide appropriate diagnostic and treatment services to a child who has been screened.

2. Diagnosis and treatment providers must bill according to regular Medical Assistance procedures as outlined in DPW Rule 47. In addition, providers who diagnose or treat a child who has been screened, pursuant to Sections D and E, above, must complete the billing invoice so as to indicate that this child is being diagnosed or treated as part of the EPSDT Program. The Department will make payments according to regular Medical Assistance procedures as specified in DPW Rule 47.

3. Diagnosis and treatment providers must follow all requirements for Medical Assistance Program participation as specified in DPW Rule 47.

4. The child or parent of the child who is referred for diagnosis and treatment as a result of a screening has free choice of all local diagnosis and treatment providers who are enrolled in the Medical Assistance Program.

I. Local Agency Responsibilities

1. Outreach

   a. The local agency must notify all applicants for programs which include Medical Assistance eligibility about the EPSDT Program if the applicant or any of his/her children are under 21 years of age.

      (1) The notification must include an oral and written explanation of the program.

(2) The notification must take place within thirty days of the date of application.

(3) The local agency must obtain a definite response in writing from each applicant for each child in the family within thirty days of the date of notification.

b. The Department will notify, in writing, parents, whose children have been screened, of their eligibility for re-screening at periodic intervals. The Department will also re-notify parents whose children have never been screened of their continuing eligibility for an initial screening. The local agency will receive the response and must handle the response per Section I.2. through I.6.

2. Response to a Screening Request

a. The local agency must provide each parent/child who accepts EPSDT services with a written list of screening providers in the area.

b. The local agency must, in writing, offer transportation to each parent/child who accepts EPSDT services and must provide transportation to the screening site to each child who requests such transportation or for whom such transportation is requested.

c. The local agency must, in writing, offer assistance in making the screening appointment to each parent/child who accepts EPSDT services and must provide such assistance to each child who requests it or for whom such assistance is requested.

3. Follow-up After a Screening Request

a. The local agency must make one additional offer of assistance to each parent/child who accepted screening services and was not screened within sixty days.

b. This offer of assistance may be done by a home visit, telephone call, or letter.

4. Follow-up for Diagnosis and Treatment

a. The Department, through the screening provider, will notify each parent/child who is referred for diagnosis and treatment, in writing, that the local agency will provide assistance, including transportation, in obtaining the needed diagnosis and treatment.

(1) If requested, the local agency must provide names and addresses of providers of the needed diagnostic and treatment services.

(2) If requested, the local agency must provide transportation to the diagnostic and treatment site.

b. The local agency must make one additional contact, within sixty days of the screening, with each parent/child who was referred for diagnosis and treatment in order to ascertain if needed diagnosis and treatment has been obtained.

(1) This contact must be made by either a home visit or telephone call.

(2) If diagnosis and treatment has not been obtained, the local agency must offer assistance, including transportation and/or a list of diagnosis and treatment providers, and must provide such assistance if requested.

(3) If the local agency has previously been informed that the child has received the needed diagnosis and treatment, this contact need not be made.

5. Local agencies must provide EPSDT notification and follow-up services to non-English speaking, illiterate and disabled applicants and recipients by a mode of communication which will enable them to fully understand and utilize the program.

6. Children in Foster Care Eligible for Medical Assistance

a. The local agency must accept EPSDT services for all foster children who are dependent/neglected state wards and who are eligible for Medical Assistance, except when such acceptance would not be in the best interests of the child.

b. The local agency must discuss the availability of EPSDT services with the parents of all foster children who are eligible for Medical Assistance and who are under the legal custody of the local agency or whose parents have entered into a voluntary placement agreement with the local agency except when the natural parents are not available for such a discussion. If the parent is not consulted, the local agency must decide whether or not to accept EPSDT services for the child and must document the reasons for such a decision. The local agency must assist the parent in deciding whether to accept EPSDT services.

c. The local agency must provide the case management services defined in Section I.2. through I.4. above to all foster children for whom EPSDT services are accepted.

d. The Department will notify the local agency in writing when foster children who are eligible for Medical Assistance are eligible for periodic re-screenings. The local agency must handle these notifications as specified in Section 6.a. and 6.b. above.

7. Documentation

Local agencies must document the completion of requirements in Section I.1. through I.4. above on forms prescribed by the Department.

8. Inter-Agency Coordination

Local agencies must cooperate, whenever possible, with other agencies which provide health services to children so that duplication of services is avoided. Examples of such agencies are local nursing services, local Head Start agencies, and local school districts.

9. Reimbursement for EPSDT Staff

   a. Local agencies which intend to claim Title XIX federal financial participation at seventy-five percent for salaries and expenses of EPSDT administrative support staff must obtain written authorization from the Department by submittal of a plan that meets state and federal program requirements.

   b. Local agencies which intend to claim Title XIX federal financial participation at seventy-five percent for contracts with outside agencies to perform EPSDT administrative support services must obtain written authorization from the Department by submittal of a plan that meets state and federal program requirements.

EPSDT PERIODICITY CHART

INTERVALS	MONTHS						YEARS					
	0-5	6-7	8-11	12-15	16-19	20-35	3-4	5-7	8-10	11-13	14-17	18-21
Health History	X	X	X	X	X	X	X	X	X	X	X	X
Assessment of Physical Growth:												
• Height	X	X	X	X	X	X	X	X	X	X	X	X
• Weight	X	X	X	X	X	X	X	X	X	X	X	X
• OFC	X	X	X	X	X	X						
Physical Examination	X	X	X	X	X	X	X	X	X	X	X	X
Dental							Direct referral to a dentist					
Vision	X	X	X	X	X	X	X	X	X	X	X	X
Hearing	X	X	X	X	X	X	X	X	X	X	X	X
Developmental:												
• PDQ/DDST	X	X	X	X	X	X	X					
• Interview/History Only								X	X	X	X	X
Sexual Development	X	X	X	X	X	X	X	X	X	X	X	X
Nutrition Review	X	X	X	X	X	X	X	X	X	X	X	X
Immunization Review	X	X	X	X	X	←	←	X	←	←	X	←
Tuberculin				X	←	←	←	←	←	←	←	←
Lead Absorption Testing		IF HISTORY INDICATES										
Urine						X	←	←	←	←	←	←
Bacteriuria (females)							X	←	X	←	←	←
Anemia Testing		X	←	X	←	X	X	←	←	←	X	←
Sickle Cell	AT PARENT'S OR CHILD'S REQUEST											
Other Lab Tests	AS INDICATED											

← Procedure to be completed if not done at the previous visit, or on the first visit.

RECOMMENDED IMMUNIZATION SCHEDULE

PRIMARY IMMUNIZATION SCHEDULE FOR NORMAL INFANTS AND CHILDREN STARTING IN INFANCY

Approximate Age	Immunization
2 months	DTP, TOPV
4 months	DTP, TOPV
6 months	DTP
15 months	MEASLES, MUMPS, RUBELLA
18 months	DTP, TOPV
4-6 years (before or at school entrance)	DTP, TOPV
14-16 years (or 10 years after above)	Td – thereafter every 10 years

ABBREVIATIONS:

DTP – Diphtheria & Tetanus Toxoid combined with Pertussis Vaccine
Td – Tetanus & Diphtheria Toxoid (Adult type)
TOPV – Trivalent Oral Polio Vaccine

SPECIAL NOTES:

1. If the recommended dose of DTP or TOPV is missed at 18 months, the booster dose recommended at school entrance is adequate protection for pre-school children.

2. If the primary series of either DTP or TOPV is interrupted for more than the scheduled period of time, it is not necessary to restart either series (see reverse side).

3. Always observe the minimal interval between doses. A 2 month interval is recommended for TOPV, but if only DTP (Td) is needed, the interval may be shortened to 1 month (see reverse side).

4. Td is the toxoid recommended for persons 7 years of age and older. DTP is recommended for persons up to 7 years of age.

5. It is generally recommended that live virus vaccines be given at least 1 month apart, however, more than one live virus vaccine may be given simultaneously if given at separate sites of injection. Therefore, measles, mumps, rubella, and polio can all be administered at the same time if the need is present.

6. Children who 1) were given inactivated measles virus vaccine, 2) were immunized with measles vaccine prior to 12 months of age, or 3) received live virus measles vaccine within 3 months of a killed virus measles vaccine should receive live, further attenuated measles virus vaccine as soon as possible.

7. Report all uncommon vaccine reactions and suspect cases of immunizable diseases to the local health agency or directly to the Minnesota Department of Health, Immunization Unit, 717 S.E. Delaware Street, Minneapolis, Minnesota 55440, phone 612/296-5237.

IF THE ABOVE SCHEDULE IF NOT ADHERED TO
SEE REVERSE SIDE

Approved by
Minnesota Medical Society

Distributed by
Minnesota Department of
Health

Date
February, 1978

SPACING OF IMMUNIZATIONS IF NOT STARTED IN INFANCY

COUNT ALL PREVIOUS DTP/Td DOSES, REGARDLESS OF HOW FAR BACK THEY GO, THEN REFER TO THE APPROPRIATE "PAST HISTORY" SECTION FOUND BELOW. GIVE FURTHER DTP/Td IMMUNIZATIONS IF INDICATED. DO THE SAME WITH TOPV.

FOR CHILDREN AGES 1 THROUGH 6

PRIORITY SHOULD BE GIVEN TO THE ADMINISTRATION OF MMR. It can be given simultaneously with other vaccines or, if not, no sooner than one month after the administration of another live virus vaccine. MMR should not be given sooner than 15 months of age.

PAST HISTORY: NUMBER OF DOSES	SUGGESTED SCHEDULE OF DTP AND TOPV IMMUNIZATIONS				
	First	Second	Third	Fourth	Fifth
None	DTP, TOPV ①	DTP, TOPV: No sooner than 2 months after 1st dose(s) ①	DTP: 2 months after 2nd dose ① TOPV: 6-12 months after 2nd dose	DTP: 12 months after 3rd dose ② TOPV: No sooner than 24 months after 3rd dose ③	DTP: No sooner than 2 years after 4th dose, or at school entrance ③
One					
Two					
Three					
Four					

① An interval of 2 months should be observed between TOPV doses; if only a DTP dose is needed, the interval may be shortened to 1 month.

② Optimum spacing between 3rd and 4th dose is 12 months but this can be shortened to 6 months for children who have fallen behind.

③ Optimum time to give 5th DTP or 4th TOPV is just prior to school entrance.

FOR CHILDREN AGES 7 AND ABOVE

PRIORITY SHOULD BE GIVEN TO THE ADMINISTRATION OF MMR. It can be given simultaneously with other vaccines or, if not, no sooner than one month after the administration of another live virus vaccine. Rubella vaccine should not be given to women of child-bearing age, unless upon the advice of a physician.

Routine polio immunization is NOT recommended for persons age 18 and older.

PAST HISTORY: NUMBER OF DOSES	SUGGESTED SCHEDULE OF Td AND TOPV IMMUNIZATIONS				
	First	Second	Third	Fourth	Booster
None	Td, TOPV ①	Td, TOPV: No sooner than 2 months after 1st dose ①	Td, TOPV: No sooner than 6 months after 2nd dose	Td: Refer to footnote ②	Td booster every 10 years
One					
Two					
Three					
Four (or more)					

① An interval of 2 months should be maintained between TOPV doses; if Td is needed but TOPV is not, the interval may be shortened to one month.

② (a) Give a 4th dose of Td if 3rd DTP was given before the sixth birthday. Give no sooner than 6 months following the 3rd dose.

(b) If 3rd dose of DTP/Td was given after the sixth birthday, refer to "Booster" section.

EPSDT

Provider Agreement

The State of Minnesota, Department of Public Welfare, hereby enters into agreement with

_____

(Provider)

to participate in the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program for eligible Medical Assistance recipients between the ages of 0 to 21 subject to the following stipulations, terms, and conditions:

The screening provider agrees to:

1. Provide all screening components, according to the attached standards, for each recipient requesting EPSDT services.
2. Report screening findings on the EPSDT Invoice, DPW-1973.
3. Use the Referral for Diagnosis and Treatment form, DPW-1998, when referring a recipient for additional evaluation or treatment.

The Department of Public Welfare agrees to:

1. Arrange for training and consultation on any of the screening components as requested by the provider.
2. Provide training and consultation on billing and reporting procedures as requested by the provider.

NOTE: This agreement is executed in addition to the Title XIX Agreement and includes all conditions of that Agreement.

_____
Name of Provider

By: _____

Title: _____

Date: _____

Minnesota Department of Public Welfare

By: _____

EPSDT Program Representative

Date: _____

STATE OF MINNESOTA

DEPARTMENT OF PUBLIC WELFARE

PROVIDER AGREEMENT

The State of Minnesota, Department of Public Welfare, hereby enters into agreement with

_____
(Provider)

to participate in the Minnesota Medical Assistance Program (Title XIX) for services provided to eligible recipients subject to the following stipulations, terms, and conditions:

1. To keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan.

2. To furnish the State agency with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency may from time to time request.

3. The provider agrees to comply with Title VI of the Civil Rights Act of 1964, and any amendments thereto, and the rules and regulations thereunder.

_____
Name of Provider

By: _____

Title: _____

Date: _____

Minnesota Department of Public Welfare

By: _____

Medical Assistance Section

Date: _____

DPW-1818
(3-75)