

## Child and Adolescent Health Services Summary

The Child and Adolescent Health (CAH) Services Summary provides information on specific child and adolescent health services provided for Medicaid Fee-For-Service, Medicaid MCO, and non-Medicaid children. For complete guidelines for services, refer to the EPSDT *Care for Kids* Informing and Care Coordination Handbook, the I-Smile™ Oral Health Coordinator Handbook, the Medicaid Screening Center Manual, the **signify**community™ CAH User Manual, and the **signify**community™ Oral Health User Manual. The following information is based upon Medicaid and Child and Adolescent Health program guidelines known to date. Information is presented in three categories: Presumptive Eligibility, Informing & Care Coordination, and Direct Care Services.

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## Presumptive Eligibility

Service	Description in brief	Documentation	Cautions	Billing to IDPH
<p>Presumptive Eligibility</p> <p><i>Note: To provide PE services, all agency Hawki outreach coordinators and other MCAH staff must be certified as Qualified Entities (QE) under the supervision and authority of a Presumptive Provider Organization (agency). To become a QE, staff must complete web-based training provided by DHS.</i></p>	<p>Presumptive Eligibility (PE) for children allows children to obtain Medicaid covered services while a formal Medicaid eligibility is being determined by the Iowa Department of Human Services.</p> <p>Duties of a Qualified Entity (QE) include:</p> <ul style="list-style-type: none"> <li>• Date stamp the application for PE for children when received by the QE</li> <li>• Clarify information on the application, if necessary</li> <li>• Inform the family that all applications are referred to DHS for ongoing Medicaid eligibility determination</li> <li>• Enter information from the application into the PE system (MPEP –Medicaid Presumptive Eligibility Portal)</li> <li>• Provide a Notice of Action (NOA) to the family that reflects the information entered from the application within 2 business days of the date stamped on the application</li> <li>• Maintain documentation to support the PE decision for the child(ren). This may include but is not limited to the application, clarification of any information provided by the family, and copy of the NOA.</li> </ul>	<p>In <b>signify</b>community™ CAH: Create a bundle for documenting the Presumptive Eligibility service. ‘Add’ an ‘Activity Bundle’ – Episode – Child and Adolescent Health – Bundle – Presumptive Eligibility Bundle.</p> <p>Include:</p> <ol style="list-style-type: none"> <li>1. County of service</li> <li>2. Location of service</li> <li>3. Contacted person</li> <li>4. NOA #/Results of NOA</li> <li>5. Client/family feedback</li> <li>6. Documents kept on file and documents given to family</li> <li>7. Medicaid coverage explained</li> <li>8. First and last name of QE &amp; credentials of service provider.</li> </ol> <p>Maintain a signature log of first and last name of provider, credentials, full signature, and initials.</p> <p>Be sure to complete an Intake Assessment.</p>	<ol style="list-style-type: none"> <li>1. A family requesting presumptive eligibility for a child must complete the Application for Health Coverage and Help Paying Costs (Form 470-5170) <b>AND</b> the Addendum to the Application for Presumptive Eligibility.</li> <li>2. The PE system will electronically transmit the PE application to DHS for review of ongoing Medicaid Eligibility. Do not send the application or NOA to DHS or IDPH.</li> <li>3. The QE must keep records of the PE determinations (application, clarifications of info on the application, and a copy of the NOA).</li> </ol>	<p>Bill cost of presumptive eligibility to IDPH. Bill the service per family (not per child).</p> <p>A Billing Report is sent each month to IDPH by <b>signify</b>health™ for payment of services.</p> <p>Interpretation provided for the presumptive eligibility service is billable to IDPH as fee-for-service.</p>
<p>For more information on Presumptive Eligibility or becoming a Qualified Entity, call 855-889-7985 or email <a href="mailto:IMEMPEPSupport@dhs.state.ia.us">IMEMPEPSupport@dhs.state.ia.us</a>. For more detail on service entry into <b>signify</b>community™, see the CAH User Manual.</p>				

## Informing & Care Coordination

Service	Description in brief	Documentation	Cautions	Billing to IDPH
Informing	<p>Explaining the services available under Medicaid’s EPSDT program to families of newly Medicaid enrolled children.</p> <p>This service applies to all children in <b>signifycommunity™</b> CAH with an Informing Bundle. Inform families of newly eligible children within 30 days of the initial inform.</p> <p>Informing consists of:</p> <ul style="list-style-type: none"> <li>◆ initial inform: first contact made on behalf of a newly eligible child – typically written communication</li> <li>◆ inform follow-ups: attempts to make personal contact with the family. A minimum of two phone attempts are required at different times of the day (a.m. and p.m.). A follow-up letter is required if the two phone attempts do not result in a completion.</li> <li>◆ inform completion: personal contact made with the family via phone or face-to-face to dialogue about the services available under EPSDT and needs of the family. This is the purpose of informing. Information</li> </ul>	<p>In <b>signifycommunity™</b> CAH: Document the initial inform, inform follow-ups, and inform completion for each newly Medicaid eligible child in the family.</p> <p style="text-align: center;"><i>Initial Inform</i></p> <ol style="list-style-type: none"> <li>1. County of service</li> <li>2. Location of service</li> <li>3. Statement that Informing letter or packet was sent</li> <li>4. First and last name of service provider &amp; credentials.</li> </ol> <p style="text-align: center;"><i>Inform Follow-up</i></p> <ol style="list-style-type: none"> <li>1. County of service</li> <li>2. Location of service</li> <li>3. The specific time of day the attempt was made. Place in ‘Time in’ field.</li> <li>4. Description of the attempt to reach the family and the result of this attempt. Report a summary of a phone message. If no phone number, describe resources searched to locate one.</li> <li>5. First and last name of service provider &amp; credentials.</li> </ol>	<ol style="list-style-type: none"> <li>1. The informing service does not end with the mailing of an initial inform letter/packet. Inform follow-ups and/or completion is required. Inform completion is the ultimate goal of the service.</li> <li>2. Either follow-ups or completions are to be accomplished within a month of the initial informing service.</li> <li>3. For families with a phone number, an inform follow-up letter is sent only following two failed phone attempt(s).</li> <li>4. Inform completion consists of direct dialogue with the family and cannot be accomplished through written methods or by leaving phone messages.</li> <li>5. If a family hangs up prior to explaining EPSDT services, the informing service would not be considered complete. This would be considered an inform follow-up.</li> <li>6. The entirety of the inform completion contact is part of informing. Do not bill care coordination for any portion of this contact. However, provide the family information and linkages as needed.</li> <li>7. Verbal contact with the family within 12 months of the initial inform provides the opportunity for completing the informing service. If 1<sup>st</sup> verbal contact is beyond 12 months of the initial inform, provide care coordination.</li> </ol>	<p>Bill cost of informing to IDPH for the family (not per child).</p> <p>The billing for informing includes the initial inform, inform follow-ups, and inform completion activities. Billing for the entirety of the informing process may occur following the provision of the initial inform.</p> <p>If there is more than one child in the family, submit the claim under the name of the youngest child receiving Informing services.</p> <p>A Billing Report is sent each month to IDPH by <b>signifyhealth™</b> for payment of services.</p> <p>Interpretation provided for the inform completion is billable to IDPH as fee-for-service.</p>

	<p>provided should be age-appropriate for the child.</p> <p>Age appropriate examples include:</p> <ul style="list-style-type: none"> <li>• immunizations – during early childhood and adolescence</li> <li>• developmental screening for early childhood</li> <li>• annual well visits for adolescents.</li> </ul>	<p><i>Inform Completion</i></p> <ol style="list-style-type: none"> <li>1. County of service</li> <li>2. Location of service</li> <li>3. Contacted person</li> <li>4. Explanation of full benefits and services under EPSDT</li> <li>5. Medical provider and timeframe of past or upcoming medical appointments</li> <li>6. Dental provider and timeframe of past or upcoming dental appointments</li> <li>7. Immunization status</li> <li>8. Client/family feedback</li> <li>9. Referrals, outcomes, &amp; plan for follow-up</li> <li>10. First and last name of service provider &amp; credentials.</li> </ol> <p>Maintain a signature log of first and last name of provider, credentials, full signature, and initials.</p> <p>Be sure a current Intake Assessment is on file.</p>		
<p>For more information on informing services, refer to the EPSDT <i>Care for Kids</i> Informing and Care Coordination Handbook. For more detail on service entry into <b>signify</b>community™, see the CAH User Manual.</p>				

Service	Description in brief	Documentation	Cautions	Billing to IDPH
Care coordination	<p>Helping a client to access the health care system (medical, dental, mental health or other Medicaid programs/services).</p> <p>Dental care coordination is provided for Medicaid and non-Medicaid clients.</p> <p>Medical care coordination is provided for Medicaid fee-for-service (non-MCO) and non-Medicaid clients.</p> <p>It includes:</p> <ul style="list-style-type: none"> <li>◆ Providing information about available medical, dental, mental health and support services based on family need</li> <li>◆ Answering questions about health care coverage</li> <li>◆ Assisting with establishing medical and dental homes</li> <li>◆ Advocating for the child</li> <li>◆ Working with private providers on behalf of the child</li> <li>◆ Reminding families that well child screenings are due. This involves the Care Coordination Report which includes:               <ol style="list-style-type: none"> <li>1. In Agency: Children due for a well child exam who are in your agency home.</li> <li>2. No Agency: Children due for a well child exam who are not in an agency home.</li> </ol> </li> <li>◆ Assisting with scheduling appointments (outside agency)</li> <li>◆ Follow-up to assure that clients received services</li> </ul>	<p>In <b>signifycommunity™</b> CAH: Document care coordination under 'Type – Service – Care Coordination'. Under 'Type of Service', select the type of care coordination provided.</p> <p>Time in and time out is required. Report in the designated fields in <b>signifycommunity™</b>.</p> <p>Include:</p> <ol style="list-style-type: none"> <li>1. County of service</li> <li>2. Location of service</li> <li>3. Contacted person</li> <li>4. Concerns and issues addressed</li> <li>5. Staff response to concerns and issues</li> <li>6. <b>If</b> coordinating periodic medical or dental check-ups:           <ul style="list-style-type: none"> <li>• Medical provider and timeframe of past or upcoming medical appointments</li> <li>• Dental provider and timeframe of past or upcoming dental appointments</li> <li>• Assess immunizations</li> </ul> </li> <li>7. Referrals, outcomes, &amp; plan for follow-up</li> <li>8. Client/family feedback</li> <li>9. First and last name of service provider &amp; credentials.</li> </ol> <p>Be sure a current Intake Assessment is on file.</p>	<ol style="list-style-type: none"> <li>1. Must involve phone or face-to-face contacts with the family or provider(s) on behalf of child.</li> <li>2. Must involve helping to access medical, dental, mental health or other Medicaid related programs/services.</li> <li>3. May not bill care coordination for           <ul style="list-style-type: none"> <li>▪ written reminders for check-ups</li> <li>▪ activities in an inform completion</li> <li>▪ unsuccessful attempts to reach families</li> <li>▪ activities that are part of a postpartum home visit</li> <li>▪ activities that are part of direct care e.g., Do not bill cc for               <ul style="list-style-type: none"> <li>○ Making CAH agency appointments</li> <li>○ Reporting lab results to the family/medical home for tests conducted by the CAH agency</li> <li>○ Referral for treatment resulting from direct care provided by the CAH agency</li> </ul> </li> </ul> </li> <li>4. Care coordination to arrange transportation may be billed when provided on the same day as a direct care service.</li> <li>5. Interpretation for care coordination provided on the same day as the care coordination service is billable.</li> </ol>	<p>Bill cost to IDPH for</p> <ul style="list-style-type: none"> <li>• dental care coordination for all Medicaid enrolled clients and</li> <li>• medical care coordination for Medicaid fee-for-service (non-MCO) clients. This includes clients on presumptive eligibility.</li> </ul> <p>Billing is per client.</p> <p>A Billing Report is sent each month to IDPH by <b>signifyhealth™</b> for payment of services.</p> <p>The time for documenting care coordination may be included in the minutes reported if the documentation is completed on the same day as the care coordination service.</p>

	<ul style="list-style-type: none"> <li>◆ Assisting with missed appointments</li> <li>◆ Arranging for medical transportation or interpreter</li> <li>◆ Completing components of the Child Health Development Record (CHDR) – Development; Family History; Social History; Family Risk Factors; Anticipatory Guidance</li> </ul>	<p>If using the CHDR, in <b>signifycommunity™</b> enter ‘Type – Service – Care Coordination’. Under ‘Type of Service’, select ‘CHDR’. The CHDR form is in the <b>signifycommunity™</b> Library and can be attached to the service. Document the completion of specific CHDR components, summarize topics discussed, and report outcomes including referrals and plans for follow-up.</p> <p>If providing care coordination for transportation, document care coordination under ‘Type – Service – Care Coordination Transportation’.</p> <p>Include:</p> <ol style="list-style-type: none"> <li>1. County of service</li> <li>2. Location of service</li> <li>3. Contacted person</li> <li>4. Type of Medicaid service the client is receiving from the trip (e.g. medical, pharmacy, dental, mental health)</li> <li>5. Trip Date: Date of planned trip</li> <li>6. Transportation type: Type of ride to be provided (cab, bus, volunteer, or transportation broker)</li> <li>7. First and last name of service provider &amp; credentials.</li> </ol> <p>Maintain a signature log of first and last name of provider, credentials, full signature, and initials.</p>	<ol style="list-style-type: none"> <li>6. Medical care coordination may be billed if a dental direct service is provided by other staff (RDH) on the same day (only if no medical direct care was provided).</li> <li>7. Dental care coordination by RDH may be billed if a medical direct service is provided by other staff on the same day (only if no dental direct care was provided).</li> <li>8. Care coordination may be provided to meet a variety of needs for a client. Staff may care coordinate periodic well child check-ups. They may also provide care coordination that is targeted to other specific client needs.</li> <li>9. Medical care coordination for Medicaid MCO clients is the responsibility of the MCO. This includes reminders for well child exams for this population. Reminders for well child exams remain the responsibility of the Child Health agency for Medicaid fee-for-service (non-MCO) clients.</li> </ol>	<p>Interpretation provided for billable care coordination is billed to IDPH as fee-for-service.</p> <p>Payment for care coordination for Title V clients (non-Medicaid) is through grant funds.</p>
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For more information on care coordination services, refer to the EPSDT *Care for Kids* Informing and Care Coordination Handbook. For more detail on service entry into **signifycommunity™**, see the CAH User Manual.

Service	Description in brief	Documentation	Cautions	Billing to IDPH
Texting for care coordination	<p>Helping a client to access the health care system (medical, dental, mental health or other Medicaid programs/services) through the use of text messaging. A two-way text exchange is required.</p> <p>Dental care coordination is provided for Medicaid and non-Medicaid clients.</p> <p>Medical care coordination is provided for Medicaid fee-for-service (non-MCO) and non-Medicaid clients.</p>	<p>In <b>signify</b>community™ CAH:</p> <ul style="list-style-type: none"> <li>• Document care coordination under 'Type – Service – Care Coordination'.</li> <li>• Under 'Type of Service', select the type of care coordination provided.</li> <li>• Under 'Interaction Type', select 'Text'.</li> </ul> <p>For 'Time in and Time out' estimate the time for texting, reading, and responding. Do not exceed one 15-minute unit.</p> <p>Include:</p> <ol style="list-style-type: none"> <li>1. County of service</li> <li>2. Location of service</li> <li>3. Contacted person</li> <li>4. Concerns and issues addressed</li> <li>5. Staff response to concerns and issues</li> <li>6. Referrals, outcomes, &amp; plan for follow-up</li> <li>7. Client/family feedback</li> <li>8. First and last name of service provider &amp; credentials.</li> </ol> <p>Maintain a signature log of first and last name of provider, credentials, full signature, and initials.</p>	<ul style="list-style-type: none"> <li>• Texts with no response are not billable.</li> <li>• Medicaid related services must be the central topic of the care coordination exchange.</li> <li>• Texts may not include protected health information (such as social security number, Medicaid ID# or NOA#).</li> </ul>	<p>Bill cost to IDPH for</p> <ul style="list-style-type: none"> <li>• dental care coordination for all Medicaid enrolled clients and</li> <li>• medical care coordination for Medicaid fee-for-service (non-MCO) clients. This includes clients on presumptive eligibility.</li> </ul> <p>Billing is per client.</p> <p>A Billing Report is sent each month to IDPH by <b>signify</b>health™ for payment of services.</p> <p>Payment for care coordination for Title V clients (non-Medicaid) is through grant funds.</p> <p>Do not exceed one 15-minute unit when billing texting for care coordination.</p>
<p>For more information on care coordination services, refer to the EPSDT <i>Care for Kids</i> Informing and Care Coordination Handbook. For more detail on service entry into <b>signify</b>community™, see the CAH User Manual.</p>				



Service	Description in brief	Documentation	Cautions	Billing to IDPH
<p>Emailing for care coordination</p>	<p>Helping a client to access the health care system (medical, dental, mental health or other Medicaid programs/services) through the use of email. This is typically used only when phone or face-to-face care coordination is not possible.</p> <p>A two-way email exchange is required. A protocol for saving the email communications must be developed by the agency (e.g. client chart, paper file, or electronic file).</p> <p>Dental care coordination is provided for Medicaid and non-Medicaid clients.</p> <p>Medical care coordination is provided for Medicaid fee-for-service (non-MCO) and non-Medicaid clients.</p>	<p>In <b>signifycommunity™</b> CAH:</p> <ul style="list-style-type: none"> <li>• Document care coordination under 'Type – Service – Care Coordination'.</li> <li>• Under 'Type of Service', select the type of care coordination provided.</li> <li>• Under 'Interaction Type', select 'Email'.</li> </ul> <p>For 'Time in and Time out', estimate the time for emailing, reading, and responding.</p> <p>Include:</p> <ol style="list-style-type: none"> <li>1. County of service</li> <li>2. Location of service</li> <li>3. Contacted person</li> <li>4. Concerns and issues addressed</li> <li>5. Staff response to concerns and issues</li> <li>6. Referrals, outcomes, &amp; plan for follow-up</li> <li>7. Client/family feedback</li> <li>8. First and last name of service provider &amp; credentials.</li> <li>9. Maintain email communications per protocol.</li> </ol> <p>Maintain a signature log of first and last name of provider, credentials, full signature, and initials.</p>	<ul style="list-style-type: none"> <li>• Emails with no response are not billable.</li> <li>• Medicaid related services must be the central topic of the care coordination email exchange.</li> <li>• Use of personal email accounts is NOT allowed. Emails sent must be from the employee's agency email address. All responses from the client or provider must be sent to the employee's agency email address.</li> <li>• Assure that any emails containing protected health information are sent via a Secure Mail system.</li> <li>• Unsecured email may NOT include protected health information such as social security number, Medicaid ID#, or NOA#.</li> <li>• Full disk encryption is especially important and required on computers used.</li> <li>• Agencies must assure that electronic information is protected through regular system back-ups. (See Iowa's Title V Administrative Manual for Community Based Programs – 304 Protecting Client Records.)</li> </ul>	<p>Bill cost to IDPH for</p> <ul style="list-style-type: none"> <li>• dental care coordination for all Medicaid enrolled clients and</li> <li>• medical care coordination for Medicaid fee-for-service (non-MCO) clients. This includes clients on presumptive eligibility.</li> </ul> <p>Billing is per client.</p> <p>A Billing Report is sent each month to IDPH by <b>signifyhealth™</b> for payment of services.</p> <p>Payment for care coordination for Title V clients (non-Medicaid) is through grant funds.</p>
<p>For more information on care coordination services, refer to the EPSDT <i>Care for Kids</i> Informing and Care Coordination Handbook. For more detail on service entry into <b>signifycommunity™</b>, see the CAH User Manual.</p>				



Service	Description in brief	Documentation	Cautions	Billing to IDPH
Home visit for care coordination	<p>When a home visit is made for the purpose of providing care coordination services. This includes care coordination for a medical/dental/mental health condition to:</p> <ul style="list-style-type: none"> <li>◆ Provide information about health care services.</li> <li>◆ Coordinate access to care and/or care with provider</li> <li>◆ Assist in making health care appointments</li> <li>◆ Make referral appointments</li> <li>◆ Coordinate access to needed medical support services (transportation or interpreter services)</li> <li>◆ Follow-up to assure services were received.</li> </ul> <p>Dental care coordination is provided for Medicaid and non-Medicaid clients.</p> <p>Medical care coordination is provided for Medicaid fee-for-service (non-MCO) and non-Medicaid clients.</p>	<p>In <b>signifycommunity™</b> CAH:</p> <ul style="list-style-type: none"> <li>• Document care coordination under ‘Type – Service – Care Coordination Home Visit’.</li> <li>• Select the ‘Type of Service’ for the care coordination provided.</li> <li>• Under ‘Interaction Type’, select ‘Home Visit’.</li> </ul> <p>Time in and time out is required in these designated fields.</p> <p>Include:</p> <ol style="list-style-type: none"> <li>1. County of service</li> <li>2. Location of service</li> <li>3. Contacted person</li> <li>4. Concerns and issues addressed</li> <li>5. Staff response to concerns and issues</li> <li>6. <b>If</b> coordinating periodic medical or dental check-ups: <ul style="list-style-type: none"> <li>• Medical provider and timeframe of past or upcoming medical appointments</li> <li>• Dental provider and timeframe of past or upcoming dental appointments</li> <li>• Assess immunizations</li> </ul> </li> <li>7. Referrals, outcomes, &amp; plan for follow-up</li> <li>8. Client/family feedback</li> <li>9. First and last name of service provider &amp; credentials.</li> </ol> <p>Be sure a current Intake Assessment is on file.</p> <p>Maintain a signature log of first and last name of provider, credentials, full signature, and initials.</p>	<ol style="list-style-type: none"> <li>1. Use only face-to-face time to determine minutes of service. Do not include travel time in determining minutes of service.</li> <li>2. The entirety of the maternal health postpartum home visit is part of the maternal health services. Any care coordination on behalf of the baby is considered part of this postpartum visit. Do not bill child health care coordination for any part of this maternal health visit.</li> <li>3. If the purpose of the home visit is to provide direct care services, home visit for care coordination cannot be billed. If the purpose of the home visit is for nursing or social work services, use codes S9123 for the home visit for nursing services or S9127 for the social work home visit. (See guidelines below.)</li> </ol>	<p>Bill cost to IDPH for</p> <ul style="list-style-type: none"> <li>• dental care coordination for all Medicaid enrolled clients and</li> <li>• medical care coordination for Medicaid fee-for-service (non-MCO) clients. This includes clients on presumptive eligibility.</li> </ul> <p>Billing is per client.</p> <p>A Billing Report is sent each month to IDPH by <b>signifyhealth™</b> for payment of services.</p> <p>Interpretation provided for a billable home visit for care coordination is billed to IDPH as fee-for-service.</p> <p>Payment for care coordination for Title V clients (non-Medicaid) is through grant funds.</p>

For more information on the home visit for care coordination, refer to the EPSDT *Care for Kids* Informing and Care Coordination Handbook. For more detail on service entry into **signifycommunity™**, see the CAH User Manual.

## Direct Care Services

Specific direct care services provided by a Title V Child and Adolescent Health agency are identified in the approved application submitted to IDPH for the Child and Adolescent Health program.

Service	Description in brief	Documentation	Cautions	Billing to Medicaid
Medical transportation (local)	Transportation to <i>local (in-town)</i> medical, dental, mental health services. Includes transportation parking fees and tolls.	<p>In <b>signifycommunity™</b> CAH:</p> <ul style="list-style-type: none"> <li>Document in-town transportation services under 'Type – Service – Transportation'.</li> <li>Under 'Type of Service', select the correct service code and description of the transportation service.</li> </ul> <p>Complete in <b>signifycommunity™</b> CAH:</p> <ol style="list-style-type: none"> <li>Service fields. Complete the 'Mileage' field if the transportation service is paid per mile.</li> <li>First and last name of service provider &amp; credentials</li> <li>The invoice of cost for the transportation service must be accessible. This may be reported in the 'Comments' field or maintained on a transportation log.</li> <li>If the Title V agency keeps a service log containing key information, the 'Comments' in <b>signifycommunity™</b> CAH must include a reference to this record.</li> </ol>	<ol style="list-style-type: none"> <li>Transportation must be to a Medicaid covered service. The transportation service must be on the date the Medicaid service was received.</li> <li>Local transportation billed should align with the agency's Transportation Plan.</li> <li>There is no payment for the transportation service if the client does not show up for the ride.</li> <li>This does not include out-of-town transportation services.</li> <li>Access2Care is the transportation broker for Medicaid fee-for-service (non-MCO) clients. They arrange and pay for transportation (both in-town and out-of-town) to Medicaid covered services Contact Access2Care at 1-866-572-7662.</li> <li>Each Medicaid MCO has their own transportation broker for serving MCO enrolled clients: <ul style="list-style-type: none"> <li>Amerigroup: Logisticare at 844-544-1389</li> <li>Iowa Total Care: Access2Care at 833-404-1061.</li> </ul> </li> </ol>	<p>The following are billable codes for billing IME for Medicaid fee-for-service (non-MCO) clients. This includes clients on presumptive eligibility:</p> <ul style="list-style-type: none"> <li>Code A0110: Non-emergency bus (per round trip)</li> <li>Code A0100: Non-emergency taxi (per round trip)</li> <li>Code A0130: Non-emergency wheel chair van (per round trip)</li> <li>Code A0090: Non-emergency by volunteer (per mile)</li> <li>Code A0120: Non-emergency mini-bus or non-profit transportation system (per round trip)</li> <li>Code A0170: Parking fees, tolls</li> </ul> <p>Bill actual cost of transportation for the date the transportation was provided to the health related appointment.</p>
<p>For more information on transportation services, refer to the EPSDT <i>Care for Kids</i> Informing and Care Coordination Handbook and Medicaid's Screening Center Manual. For more detail on service entry into <b>signifycommunity™</b>, see the CAH User Manual.</p>				

Service	Description in brief	Documentation	Cautions	Billing to IME or Medicaid MCO
<p>Interpretation services</p>	<p>Services that include:</p> <ul style="list-style-type: none"> <li>• Sign language or oral interpretive services</li> <li>• Telephonic oral interpretive services</li> </ul> <p>(Note: Interpretation services for PE, informing, and care coordination are billable to IDPH as FFS.)</p>	<p>In <b>signifycommunity™</b> CAH:</p> <ul style="list-style-type: none"> <li>• Document interpreter services under ‘Type – Service – Health Services’.</li> <li>• Under ‘Type of Service’, select the correct service code and description of the interpretation service.</li> </ul> <p>Complete in <b>signifycommunity™</b> CAH:</p> <ol style="list-style-type: none"> <li>1. Service fields.</li> <li>2. Time in and time out</li> <li>3. In the ‘Comments’ field, report: <ul style="list-style-type: none"> <li>• The service for which the interpretation was provided</li> <li>• Name of interpreter or company</li> <li>• Cost of service</li> </ul> </li> </ol> <p>If the Title V agency keeps a service log containing the above information, the ‘Comments’ in <b>signifycommunity™</b> CAH must include a reference to this record.</p>	<ol style="list-style-type: none"> <li>1. Billable interpretation services are provided by interpreters who provide <b>only</b> interpretation services. Agency staff with other roles cannot have split FTEs that include billable interpretation.</li> <li>2. Interpreters are either employed or contracted by the CAH agency billing the services.</li> <li>3. Service providers who are also bilingual are not reimbursed for interpretation, only for their medical/dental services.</li> <li>4. Interpretation services must facilitate access to Medicaid covered services. Providers may bill Medicaid only if the services are offered in conjunction with another Medicaid covered service.</li> <li>5. There is no payment for written translation of printed documents.</li> <li>6. It is the responsibility of the provider to determine the interpreter’s competency. <ul style="list-style-type: none"> <li>• Sign language interpreters should be licensed pursuant to IAC 645 Chapter 361.</li> <li>• Oral interpreters should be guided by the standards developed by the National Council on Interpreting in Health Care (<a href="http://www.ncihc.org">www.ncihc.org</a>).</li> </ul> </li> </ol>	<p>Bill the IME for interpretation for any direct care service provided for Medicaid fee-for-service (non-MCO) clients. This includes interpretation for direct care for clients on presumptive eligibility. Also bill the IME for interpretation related to any dental direct care service.</p> <p>Bill the MCO for MCO enrolled Medicaid clients for interpretation related to direct care medical services provided.</p> <p>Use Code T1013 for sign language or oral interpretive services (15-minute unit)</p> <p>For 15 minute units:</p> <ul style="list-style-type: none"> <li>• 8-22 min.= 1 unit</li> <li>• 23-37 min.= 2 units</li> <li>• 38-52 min. = 3 units</li> <li>• 53-67 min.= 4 units</li> </ul> <p>Reimbursable time may include the interpreter’s travel and wait time.</p> <p>Use Code T1013 with UC modifier for telephonic oral interpretive services (per minute unit)</p> <p>Use the diagnosis code that pertains to the service being interpreted. If the interpretation is for presumptive eligibility, informing, or care coordination, use Z76.89 as the ICD10 diagnosis code.</p>
<p>For more information on interpretation services, refer to the EPSDT <i>Care for Kids</i> Informing and Care Coordination Handbook and Medicaid’s Screening Center Manual. For more detail on service entry into <b>signifycommunity™</b>, see the CAH User Manual.</p>				

Service	Description in brief	Documentation	Cautions	Billing to IME or Medicaid MCO
Health screening (well child exam)	The initial or periodic well child exam per Iowa’s EPSDT <i>Care for Kids</i> Periodicity Schedule and as described in the Medicaid Screening Center Manual.	<p>In <b>signifycommunity</b>™ CAH:</p> <ul style="list-style-type: none"> <li>• Document under ‘Type – Service – Health Services’.</li> <li>• Under ‘Type of Service’, select the correct service code and description.</li> </ul> <p>Report the total time of the service (duration).</p> <p>Complete in <b>signifycommunity</b>™ CAH:</p> <ol style="list-style-type: none"> <li>1. Service fields.</li> <li>2. First and last name of service provider &amp; credentials</li> <li>3. In the ‘Comments’ field, reference client’s chart for full detail/ description/ clinical record of service provided.</li> </ol> <p>In the client’s record: Documentation must adhere to requirements in IAC 441-79.3(2).</p>	<p>When providing direct care services, any care coordination provided on the same date of service is considered part of the direct care service. Do not bill this activity separately as care coordination.</p> <p>Examples include:</p> <ul style="list-style-type: none"> <li>▪ Reporting lab results to the family or medical home from tests conducted at the Title V agency cannot be billed as care coordination. It is considered part of the direct care.</li> <li>▪ Arranging an appointment for treatment services resulting from a well-child exam provided by the Title V agency cannot be billed as care coordination. It is considered part of the direct care.</li> </ul> <p>Document any care coordination activity in conjunction direct care as part of the documentation for the direct care service.</p> <p><i>Objective</i> visual screens (99173/99174) and <i>objective</i> hearing screens (92551/92555) are billed separate from the well child exam code if provided on the same day.</p>	<p>Bill the IME for Medicaid fee-for-service (non-MCO) clients. This includes clients on presumptive eligibility.</p> <p>Bill the MCO for MCO enrolled Medicaid clients.</p> <p>Use the following well child exam codes:</p> <ul style="list-style-type: none"> <li>• Initial screen: Code 99381: 0-12 mo. Code 99382: 1-4 yr. Code 99383: 5-11 yr. Code 99384: 12-17 yr. Code 99385: 18-21 yr.</li> <li>• Periodic screen: Code 99391: 0-12 mo. Code 99392: 1-4 yr. Code 99393: 5-11 yr. Code 99394: 12-17 yr. Code 99395: 18-21 yr.</li> </ul> <p>Use modifier U1 for a screen that results in a referral for treatment.</p>
<p>For more information on direct care services, refer to Medicaid’s Screening Center Manual. For more detail on service entry into <b>signifycommunity</b>™, see the CAH User Manual.</p>				

Service	Description in brief	Documentation	Cautions	Billing to Medicaid
Oral Health Services	<p>Services:</p> <ul style="list-style-type: none"> <li>◆ Initial oral screen by a non-dentist, once or again if not seen in 3 years</li> <li>◆ Periodic oral screen by a non-dentist, every 6 mo.</li> <li>◆ Initial oral exam by a dentist, once or again if not seen in 3 years</li> <li>◆ Periodic oral exam by a dentist, every 6 mo.</li> <li>◆ Oral evaluation and counseling with primary caregiver for patient under 3 yr of age, every 6 mo.</li> <li>◆ Caries risk assessment and documentation, with a finding of low, moderate or high risk (provided with every screen)</li> <li>◆ Child prophylaxis, every 6 mo.</li> <li>◆ Adult prophylaxis, every 6 mo.</li> <li>◆ Sealant, once per tooth</li> <li>◆ Silver Diamine Fluoride (SDF), interim caries arresting medicament, per tooth, every 6 mo.</li> <li>◆ Bitewing x-ray, single film, once over 12 mo.</li> <li>◆ Bitewing x-ray, two films, once over 12 mo.</li> <li>◆ Bitewing x-ray, four films, once over 12 mo.</li> </ul>	<p>In <b>signifycommunity™</b> OH:</p> <ol style="list-style-type: none"> <li>1. Enter all services (whether billable or not).</li> <li>2. Document under 'Type – Service – Dental'. Under 'Type of Service', select the correct service code and description.</li> <li>3. Document dental care coordination under the 'Type – Service – Care Coordination'. Under 'Type of Service', select the type of care coordination.</li> </ol> <p>For sealants and SDF, the tooth number and surface must be documented.</p> <p>For fluoride varnish and SDF, the product and concentration must be documented.</p> <p>Time in and time out is required for Codes D1310 and D1330.</p> <p>For services where billing is NOT based upon timed units, report the total time of each service (duration).</p>	<ol style="list-style-type: none"> <li>1. A dental referral must be provided at the time of each oral screen/exam.</li> <li>2. When providing direct oral health services, care coordination activity provided on the same date of service is considered part of the direct care service. Do not bill this separately as care coordination. Example: <ul style="list-style-type: none"> <li>• Assistance provided on the same day as a direct dental service (e.g. oral screen) is considered part of the direct care and is not billable care coordination.</li> <li>• Follow-up to the referral that is done on subsequent days (from the direct service) can be billed as care coordination.</li> </ul> </li> <li>4. If an initial screen is provided by a non-dentist, use only Code D0190 with a CC modifier. When providing subsequent screens, use either D0190 (no modifier) or D0145 as appropriate.</li> <li>5. If an initial exam is provided by a dentist, use only Code D0150. When providing subsequent exams, use either D0120 or D0145 as appropriate.</li> <li>5. The client's risk level must be assessed and recorded each time an oral screening is provided.</li> <li>6. Code D0145 is billable only for children under three years of age if counseling with the primary caregiver is provided during a screen.</li> <li>7. Codes D0145 and D1330 cannot be billed on the same date.</li> </ol>	<p>Oral health direct care services are billable to IME for all Medicaid enrolled children. This includes children on presumptive eligibility.</p> <p>Use the following dental codes:</p> <ul style="list-style-type: none"> <li>◆ D0190 w/CC modifier: Initial oral screen by non-dentist (Add TD modifier when provided by RN)</li> <li>◆ D0190: Periodic oral screen by non-dentist (Add TD modifier when provided by RN)</li> <li>◆ D0150: Initial oral exam by dentist</li> <li>◆ D0120: Periodic oral exam by dentist</li> <li>◆ D0145 DA: Oral evaluation and counseling with caregiver (child under age 3) (Add TD modifier when provided by RN)</li> <li>◆ Risk Assessment (One per screen, add TD modifier when provided by RN) <ul style="list-style-type: none"> <li>○ D0601 Low risk</li> <li>○ D0602 Moderate risk</li> <li>○ D0603 High risk</li> </ul> </li> <li>◆ D1120: Prophylaxis (age 12 yr. and younger)</li> <li>◆ D1110: Prophylaxis (age 13 yr. and older)</li> <li>◆ D1351: Sealant per tooth (posterior teeth up to age 18)</li> <li>◆ D1354: Silver diamine Fluoride</li> </ul>

	<ul style="list-style-type: none"> <li>◆ Topical application of fluoride varnish, 4 times a year at least 90 days apart</li> <li>◆ Nutritional counseling for the control and prevention of oral disease, every 6 mo.</li> <li>◆ Oral hygiene instruction</li> <li>◆ Dental care coordination (Refer to Care Coordination p. 5-9)</li> </ul>	<p>Complete in <b>signifycommunity™</b> OH:</p> <ol style="list-style-type: none"> <li>1. Service fields.</li> <li>2. First and last name of service provider &amp; credentials</li> <li>3. In the ‘Comments’ field, reference client’s chart for full detail/ description/ clinical record of service provided.</li> </ol> <p>In the client’s record: Documentation must adhere to requirements in IAC 441-79.3(2).</p>	<ol style="list-style-type: none"> <li>8. For Codes D1310 and D1330, a minimum of 8 minutes must be provided to bill the service.</li> <li>9. For both sealant applications and bitewing films, report the number of teeth sealed or the number of bitewing films taken, not the number of clients that will receive the service.</li> <li>10. Prophylaxis, sealants, SDF, and bitewings must be provided by an RDH only.</li> <li>11. SDF may only be provided at a WIC clinic or CAH agency office visits. A parent must be present and sign an additional consent form.</li> <li>12. When billing SDF, include the ICD-10 code used for the oral screening. At a minimum, this must include Z01.21 - dental exam with abnormal findings and K02.9 – dental caries.</li> <li>13. For services provided by a RN, the TD modifier must be included with the procedure code for dental screening, fluoride varnish, and counseling codes.</li> <li>14. Assure that one of the diagnosis “Z” codes is provided for each procedure code.</li> <li>15. If diagnosis codes Z01.21 is used, dental screen with abnormal findings, at least one of the K diagnosis codes must be included. Up to 3 K codes may be included.</li> </ol>	<ul style="list-style-type: none"> <li>◆ D0270: Single bitewing film</li> <li>◆ D0272: Two bitewing films</li> <li>◆ D0274: Four bitewings films</li> <li>◆ D1206: Topical fluoride varnish (Add TD modifier when provided by RN)</li> <li>◆ D1310: Nutritional counseling for control &amp; prevention of oral disease (15-minute unit) (Add TD modifier when provided by RN)</li> <li>◆ D1330: Oral hygiene instruction (15-minute unit) (Add TD modifier when provided by RN)</li> </ul>
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For more information on oral health direct care services, refer to the I-Smile Handbook and Medicaid’s Screening Center Manual. For more detail on service entry into **signifycommunity™**, see the Oral Health User Manual.



Service	Description in brief	Documentation	Cautions	Billing to IME or Medicaid MCO
<p>Immunization administration with counseling</p>	<p>Administration of immunizations and counseling for children through 18 years of age. It includes</p> <ul style="list-style-type: none"> <li>• Immunization administration through any route.</li> <li>• Counseling by a qualified health professional.</li> </ul> <p>Counseling for each component of the vaccine is required. It shall include reviewing immunization records, explaining the need for the immunizations, and providing anticipatory guidance (education) &amp; follow-up instructions when administering vaccine. It includes provision of the most current VIS.</p> <p>Must be provided by a registered nurse or higher (ARNP, PA, MD, DO)</p>	<p>In <b>signifycommunity™</b> CAH:</p> <ul style="list-style-type: none"> <li>• Document under ‘Type – Service – Health Services’.</li> <li>• Under ‘Type of Service’, select the correct immunization administration service code and description.</li> </ul> <p>Report the total time of the service (duration).</p> <p>Complete in <b>signifycommunity™</b> CAH:</p> <ol style="list-style-type: none"> <li>1. Service fields.</li> <li>2. First and last name of service provider &amp; credentials</li> <li>3. In the ‘Comments’ field reference client’s chart, IRIS, and/or Master Index Card for full description of both the immunizations administered.</li> <li>4. Report detail of the counseling provided in the ‘Comments’ field or reference the client chart for this information.</li> </ol> <p>In client’s chart, IRIS, and/or Master Index Card: Documentation must adhere to requirements in IAC 441-79.3(2). Note the review of record, need for immunization, anticipatory guidance provided, provision of VIS, date of VIS, follow-up plan, and any parent/guardian concerns or questions.</p> <p>Assure entry of immunizations in IRIS.</p>	<p>Typically, VFC vaccine is used for children through age 18 years (at no cost to the agency or to the family). Vaccine may be billed for Medicaid enrolled children over the age of 18 years (ages 19 and 20 years).</p> <p>If there is a shortage of VFC vaccine, an IME Informational Letter will be provided with instructions for billing vaccine.</p> <p>Due to NCCI edits, the following services will not pay when billed on the same date as 90460:</p> <ul style="list-style-type: none"> <li>• E &amp; M</li> <li>• Well child exam codes</li> </ul> <p>(See IME Informational Letter #1219)</p>	<p>Bill the IME for Medicaid fee-for-service (non-MCO) clients. This includes clients on presumptive eligibility.</p> <p>Bill the MCO for MCO enrolled Medicaid clients.</p> <ul style="list-style-type: none"> <li>• Use 90460 for each vaccine administered. Submit your cost per your cost analysis.</li> <li>• For vaccines with multiple components (combination vaccines): Report 90461 for each additional component beyond the first component in the vaccine. Submit a nominal cost for accounting of the additional components.</li> </ul> <p>Examples:</p> <ul style="list-style-type: none"> <li>• HPV: 90460</li> <li>• Influenza: 90460</li> <li>• MMR: 90460, 90461 - 2 units</li> <li>• Tdap: 90460, 90461 - 2 units</li> </ul>
<p>For more information on direct care services, refer to Medicaid’s Screening Center Manual. For more detail on service entry into <b>signifycommunity™</b>, see the CAH User Manual.</p>				

October 2019



Service	Description in brief	Documentation	Cautions	Billing to IME or Medicaid MCO
Immunization administration	<p>Administration of immunizations</p> <p>These codes may be useful for children over the age of 18 years.</p>	<p>In <b>signifycommunity™</b> CAH:</p> <ul style="list-style-type: none"> <li>• Document under ‘Type – Service – Health Services’.</li> <li>• Under ‘Type of Service’, select the correct immunization administration service code and description.</li> </ul> <p>Report the total time of the service (duration).</p> <p>Complete in <b>signifycommunity™</b> CAH:</p> <ol style="list-style-type: none"> <li>1. Service fields.</li> <li>2. First and last name of service provider &amp; credentials</li> <li>3. In the ‘Comments’ field reference client’s chart, IRIS, and/or Master Index Card for full description of both the immunizations administered.</li> </ol> <p>In client’s chart, IRIS, or Master Index Card: Documentation must adhere to requirements in IAC 441-79.3(2).</p> <p>Assure entry of immunizations in IRIS.</p>	<p>Typically, VFC vaccine is used for children through age 18 years (at no cost to the agency or to the family). Vaccine may be billed for Medicaid enrolled children over the age of 18 years (ages 19 and 20 years).</p> <p>Do not bill 90471 with 90473.</p> <p>For subsequent immunization administration, use either 90472 or 90474 (as appropriate) with 90471 or 90473.</p> <p>Do not use these immunization administration codes if using ‘immunization administration with counseling’ (Code 90460/90461).</p> <p>If a child needs vaccine outside of the VFC cohort or if the child is ages 19 or 20 years old, Medicaid can be billed for the vaccine.</p> <p>If there is a shortage of VFC vaccine, an IME Informational Letter will be provided with instructions.</p> <p>Due to NCCI edits, the following services will not pay when billed on the same date as these immunization administration codes:</p> <ul style="list-style-type: none"> <li>• E &amp; M</li> <li>• Well child exam codes</li> </ul>	<p>Bill the IME for Medicaid fee-for-service (non-MCO) clients. This includes clients on presumptive eligibility.</p> <p>Bill the MCO for MCO enrolled Medicaid clients.</p> <ul style="list-style-type: none"> <li>• Use Code 90471 for initial administration of vaccine (single or combination), subcutaneous or intramuscular</li> <li>• Use Code 90472 for subsequent administrations of vaccine (single or combination) subcutaneous or intramuscular on same day as Code 90471</li> <li>• Use Code 90473 for administration of one vaccine (single or combination) by intranasal or oral means</li> <li>• Use Code 90474 for subsequent administrations of vaccine (single or combination) by intranasal or oral means on the same day as Code 90473</li> </ul> <p>Bill the appropriate administration code(s) and the code(s) for the VFC vaccine (at \$0.00).</p>

For more information on direct care services, refer to Medicaid’s Screening Center Manual.

For more detail on service entry into **signifycommunity™**, see the CAH User Manual.

Service	Description in brief	Documentation	Cautions	Billing to IME or Medicaid MCO
Blood draw	<p>Collection of venous blood by venipuncture</p> <p>Collection of capillary blood specimen</p> <p>Handling or conveyance of specimen for transfer to a laboratory</p>	<p>In <b>signifycommunity™</b> CAH:            Create a bundle for documenting the blood draw. ‘Add’ an ‘Activity Bundle’ – Episode – Child and Adolescent Health – Bundle – Lead Bundle.</p> <p>Report the total time of the service (duration).</p> <p>Complete in <b>signifycommunity™</b> CAH:</p> <ol style="list-style-type: none"> <li>1. Service fields.</li> <li>2. First and last name of service provider &amp; credentials</li> <li>3. In the ‘Comments’ field, reference client’s chart for full detail/ description/ clinical record of service provided.</li> <li>4. If completing a Childhood Lead Poisoning Questionnaire, add this ‘Survey’ and complete fields.</li> </ol> <p>In the client’s record:            Documentation must adhere to requirements in IAC 441-79.3(2).</p> <p>If a CLPPP, assure entry in HLPPPS.</p>	<p>A blood lead draw and handling/conveyance cannot both be billed. Only one of the three codes can be billed.</p> <p>15 µg/dL and above require venous draw confirmatory test.</p> <p>Venous blood lead levels of 20 µg/dL or higher result in automatic eligibility for Early ACCESS services for children ages 0-3.</p> <p>Do not bill any of these codes if billing ‘blood lead analysis’ (Code 83655).</p>	<p>Bill the IME for Medicaid fee-for-service (non-MCO) clients. This includes clients on presumptive eligibility.</p> <p>Bill the MCO for MCO enrolled Medicaid clients.</p> <p>Use only one of the following:</p> <ul style="list-style-type: none"> <li>• Code 36415 for venous draw.</li> <li>• Code 36416 for capillary draw.</li> <li>• Code 99000 for handling and conveyance to lab</li> </ul> <p>Note that these codes may deny as ‘incidental services’ if billed in conjunction with other direct care services.</p>
<p>For more information on direct care services, refer to Medicaid’s Screening Center Manual.            For more detail on service entry into <b>signifycommunity™</b>, see the CAH User Manual.</p>				

Service	Description in brief	Documentation	Cautions	Billing to IME or Medicaid MCO
Blood lead analysis	Collection of blood sample <b>and</b> lab analysis of blood lead level using the Lead Care II	<p>In <b>signifycommunity™</b> CAH: Create a bundle for documenting the blood draw. ‘Add’ an ‘Activity Bundle’ – Episode – Child and Adolescent Health – Bundle – Lead Bundle.</p> <p>Report the total time of the service (duration).</p> <p>Complete in <b>signifycommunity™</b> CAH:</p> <ol style="list-style-type: none"> <li>1. Service fields.</li> <li>2. First and last name of service provider &amp; credentials</li> <li>3. In the ‘Comments’ field, reference client’s chart for full detail/ description/ clinical record of both the lead draw and the use of the Lead Care II.</li> <li>4. If completing a Childhood Lead Poisoning Questionnaire, add this ‘Survey’ and complete fields.</li> </ol> <p>In the client’s record: Documentation must adhere to requirements in IAC 441-79.3(2).</p> <p>If a CLPPP, assure entry in HLPPPS.</p>	<p>Do not bill codes 36415, 36416, or 99000 when using ‘blood lead analysis’ (Code 83655). The scope of Code 83655 includes the lead draw.</p> <p>The Lead Care II is the only CLIA waived testing device approved by IDPH. <b>Child Health agencies using the Lead Care II must report the results of all blood lead testing electronically to the Bureau of Lead Poisoning Prevention.</b></p> <p>If a blood lead test result of 15 µg/dL or higher is obtained from a Lead Care II, a venous sample must be drawn and sent to a reference lab for a confirmatory test.</p>	<p>Bill the IME for Medicaid fee-for-service (non-MCO) clients. This includes clients on presumptive eligibility.</p> <p>Bill the MCO for MCO enrolled Medicaid clients.</p> <p>Use Code 83655. Include the QW modifier to indicate a CLIA waived test.</p> <p>Venous blood lead levels of 20 µg/dL or higher result in automatic eligibility for Early ACCESS services for children ages 0-3.</p>

For more information on direct care services, refer to Medicaid’s Screening Center Manual.  
For more detail on service entry into **signifycommunity™**, see the CAH User Manual.

Service	Description in brief	Documentation	Cautions	Billing to IME or Medicaid MCO
Other lab services	Hematocrit level  Hemoglobin level  Tuberculosis skin test	In <b>signifycommunity</b> <sup>TM</sup> CAH: <ul style="list-style-type: none"> <li>• Document under 'Type – Service – Health Services'.</li> <li>• Under 'Type of Service', select the correct service code and description.</li> </ul> Report the total time of the service (duration).  Complete in <b>signifycommunity</b> <sup>TM</sup> CAH: 1. Service fields. 2. First and last name of service provider & credentials. 3. In the 'Comments' field, reference client's chart for full detail/ description/ clinical record of the service provided.  In the client's record: Documentation must adhere to requirements in IAC 441-79.3(2).	If hemoglobin testing is covered by the WIC program, it cannot be billed to Medicaid.	Bill the IME for Medicaid fee-for-service (non-MCO) clients. This includes clients on presumptive eligibility.  Bill the MCO for MCO enrolled Medicaid clients.  <ul style="list-style-type: none"> <li>• Code 85014: Hct</li> <li>• Code 85018: Hgb</li> <li>• Code 86580: TB</li> </ul>
Vision Screening	Screening test of visual acuity, quantitative, bilateral. The screening test used must employ graduated visual acuity stimuli that allow a quantitative estimate of visual acuity (e.g. Snellen Chart). (Code 99173)  Instrument-based Ocular Screening (using approved instrument) (Code 99174)	In <b>signifycommunity</b> <sup>TM</sup> CAH: <ul style="list-style-type: none"> <li>• Document under 'Type – Service – Health Services'.</li> <li>• Under 'Type of Service', select the correct service code and description.</li> </ul> Report the total time of the service (duration).  Complete in <b>signifycommunity</b> <sup>TM</sup> CAH: 1. Service fields. 2. First and last name of service provider & credentials. 3. In the 'Comments' field, reference client's chart for full detail/ description/ clinical record of the service provided. Include type of screening performed, tool used, results, referral/follow-up needed, and family questions/ concerns.  In the client's record: Documentation must adhere to requirements in IAC 441-79.3(2).	Medicaid does not allow billing for an on-line vision screen.	Bill the IME for Medicaid fee-for-service (non-MCO) clients. This includes clients on presumptive eligibility.  Bill the MCO for MCO enrolled Medicaid clients.  Use Code 99173 for visual acuity  Use Code 99174 for instrument-based ocular screening
For more information on direct care services, refer to Medicaid's Screening Center Manual. For more detail on service entry into <b>signifycommunity</b> <sup>TM</sup> , see the CAH User Manual.				

Service	Description in brief	Documentation	Cautions	Billing to IME or Medicaid MCO
Hearing Screening – Pure tone; air only	This is a hearing screening for both ears that typically involves the use of a device that produces a series of tones.	<p>In <b>signifycommunity</b><sup>TM</sup> CAH:</p> <ul style="list-style-type: none"> <li>• Document under ‘Type – Service – Health Services’.</li> <li>• Under ‘Type of Service’, select the correct service code and description.</li> </ul> <p>Report the total time of the service (duration).</p> <p>Complete in <b>signifycommunity</b><sup>TM</sup> CAH:</p> <ol style="list-style-type: none"> <li>1. Service fields.</li> <li>2. First and last name of service provider &amp; credentials.</li> <li>3. In the ‘Comments’ field, reference client’s chart for full detail/ description/ clinical record of the service provided. Include type of screening performed, tool used, results, referral/follow-up needed, and family questions/concerns.</li> </ol> <p>In the client’s record: Documentation must adhere to requirements in IAC 441-79.3(2).</p>	<p>There is no CPT code for the OAE hearing screen in Medicaid’s Screening Center package.</p> <p>Refer as needed for further evaluation (e.g., an audiologist).</p>	<p>Bill the IME for Medicaid fee-for-service (non-MCO) clients. This includes clients on presumptive eligibility.</p> <p>Bill the MCO for MCO enrolled Medicaid clients.</p> <p>Use Code 92551</p>
Speech audiometry	This is a hearing screening: Speech Audiometry – threshold only	<p>In <b>signifycommunity</b><sup>TM</sup> CAH:</p> <ul style="list-style-type: none"> <li>• Document under ‘Type – Service – Health Services’.</li> <li>• Under ‘Type of Service’, select the correct service code and description.</li> </ul> <p>Report the total time of the service (duration).</p> <p>Complete in <b>signifycommunity</b><sup>TM</sup> CAH:</p> <ol style="list-style-type: none"> <li>1. Service fields.</li> <li>2. First and last name of service provider &amp; credentials.</li> <li>3. In the ‘Comments’ field, reference client’s chart for full detail/ description/ clinical record of the service provided. Include type of screening performed, tool used, results, referral/follow-up needed, and family questions/concerns.</li> </ol> <p>In the client’s record: Documentation must adhere to requirements in IAC 441-79.3(2).</p>	<p>There is no CPT code for the OAE hearing screen in Medicaid’s Screening Center package.</p> <p>Refer as needed for further evaluation (e.g., an audiologist).</p>	<p>Bill the IME for Medicaid fee-for-service (non-MCO) clients. This includes clients on presumptive eligibility.</p> <p>Bill the MCO for MCO enrolled Medicaid clients.</p> <p>Use Code 92555</p>
<p>For more information on direct care services, refer to Medicaid’s Screening Center Manual.  For more detail on service entry into <b>signifycommunity</b><sup>TM</sup>, see the CAH User Manual.</p>				

Service	Description in brief	Documentation	Cautions	Billing to IME or Medicaid MCO
Developmental test	<p>Developmental test <b>with interpretation and report.</b> This serves to identify children who may need more comprehensive evaluation.</p> <p>Use recognized instruments such as:</p> <ul style="list-style-type: none"> <li>◆ Ages and Stages Questionnaire (ASQ)</li> <li>◆ Parent’s Evaluation of Developmental Status (PEDS)</li> <li>◆ The Modified Checklist for Autism in Toddlers (M-CHAT)</li> </ul>	<p>In <b>signifycommunity™</b> CAH:</p> <ul style="list-style-type: none"> <li>• Document under ‘Type – Service – Health Services’.</li> <li>• Under ‘Type of Service’, select the correct service code and description.</li> </ul> <p>Report the total time of the service (duration).</p> <p>Complete in <b>signifycommunity™</b> CAH:</p> <ol style="list-style-type: none"> <li>1. Service fields.</li> <li>2. First and last name of service provider &amp; credentials.</li> <li>3. Add a ‘Survey’ (ASQ-3 or M-CHAT) appropriate for the child’s age, and complete the scores.</li> <li>4. In the ‘Comments’ field, reference client’s chart for full detail/ description/ clinical record of the service provided as needed to complete the documentation.</li> </ol> <p>Capture in documentation:</p> <ul style="list-style-type: none"> <li>• Name /copy of tool used (fully completed) w/service provider signature, credentials, and date</li> <li>• Narrative report on the results and interpretation of results</li> <li>• Referrals /action taken/next steps</li> <li>• Family feedback /questions/ concerns</li> </ul> <p>In the client’s record: Documentation must adhere to requirements in IAC 441-79.3(2).</p>	<p>Do not use E &amp; M for the following activities, as these are included in the scope of the developmental testing service:</p> <ul style="list-style-type: none"> <li>• Explaining the purpose of a developmental test</li> <li>• Scoring and interpretation of results of the test</li> <li>• Anticipatory guidance and</li> <li>• If indicated, referral for evaluation.</li> </ul> <p>Adjusting age for prematurity is necessary if a child was born more than 3 weeks before his or her due date and is chronologically under 2 years of age. There is an online calculator at the following link.  <a href="http://agesandstages.com/age-calculator/">http://agesandstages.com/age-calculator/</a></p>	<p>Bill the IME for Medicaid fee-for-service (non-MCO) clients. This includes clients on presumptive eligibility.</p> <p>Bill the MCO for MCO enrolled Medicaid clients.</p> <p>Use Code G0451</p>
<p>For more information on direct care services, refer to Medicaid’s Screening Center Manual. For more detail on service entry into <b>signifycommunity™</b>, see the CAH User Manual.</p>				

Service	Description in brief	Documentation	Cautions	Billing to IME or Medicaid MCO
Emotional/behavioral assessment	<p>This is an emotional/behavioral assessment that includes the scoring and documentation (narrative description) of the service.</p> <p>The Ages &amp; Stages Questionnaire: Social-Emotional (ASQ:SE) is approved for use.</p>	<p>In <b>signifycommunity™</b> CAH:</p> <ul style="list-style-type: none"> <li>• Document under ‘Type – Service – Health Services’.</li> <li>• Under ‘Type of Service’, select the correct service code and description.</li> </ul> <p>Report the total time of the service (duration).</p> <p>Complete in <b>signifycommunity™</b> CAH:</p> <ol style="list-style-type: none"> <li>1. Service fields.</li> <li>2. First and last name of service provider &amp; credentials.</li> <li>3. Add a ‘Survey’ (ASQ:SE-2) appropriate for the child’s age, and complete the score.</li> <li>4. In the ‘Comments’ field, reference client’s chart for full detail/ description/ clinical record of the service provided as needed to complete the documentation.</li> </ol> <p>Capture in documentation:</p> <ul style="list-style-type: none"> <li>• Name /copy of tool used (fully completed) w/service provider signature, credentials, and date</li> <li>• Narrative report on the results and interpretation of results</li> <li>• Referrals /action taken/next steps</li> <li>• Family feedback /questions/ concerns</li> </ul> <p>In the client’s record: Documentation must adhere to requirements in IAC 441-79.3(2).</p>	<p>Do not use E &amp; M for the following activities, as these are included in the scope of the emotional/behavioral assessment:</p> <ul style="list-style-type: none"> <li>• Explaining the purpose of an emotional/behavioral assessment</li> <li>• Scoring and reporting of results</li> <li>• Anticipatory guidance and</li> <li>• If indicated, referral for further evaluation.</li> </ul>	<p>Bill the IME for Medicaid fee-for-service (non-MCO) clients. This includes clients on presumptive eligibility.</p> <p>Bill the MCO for MCO enrolled Medicaid clients.</p> <p>Use Code 96127</p>
<p>For more information on direct care services, refer to Medicaid’s Screening Center Manual.  For more detail on service entry into <b>signifycommunity™</b>, see the CAH User Manual.</p>				



Service	Description in brief	Documentation	Cautions	Billing to IME or Medicaid MCO
Nutrition counseling	<p>Medical nutrition therapy - initial nutrition assessment and intervention, face-to-face with the individual</p> <p>Nutrition reassessment and intervention, face-to-face with individual</p> <p>Must be provided by a licensed dietitian.</p>	<p>In <b>signifycommunity™</b> CAH:</p> <ul style="list-style-type: none"> <li>• Document under 'Type – Service – Health Services'.</li> <li>• Under 'Type of Service', select the correct service code and description.</li> </ul> <p>Time in and time out are required for this service.</p> <p>Complete in <b>signifycommunity™</b> CAH:</p> <ol style="list-style-type: none"> <li>1. Service fields.</li> <li>2. First and last name of service provider &amp; credentials.</li> <li>3. In the 'Comments' field, reference client's chart for full detail/ description/ clinical record of the service provided.</li> </ol> <p>In the client's record: Documentation must adhere to requirements in IAC 441-79.3(2).</p>	<ol style="list-style-type: none"> <li>1. Use for medically necessary therapeutic nutrition services beyond those provided through the WIC program. Assure that criteria for providing this service are met.</li> <li>2. For Codes 97802 and 97803, a minimum of 8 minutes must be provided to bill the service.</li> </ol>	<p>Bill the IME for Medicaid fee-for-service (non-MCO) clients including clients on presumptive eligibility.</p> <p>Bill the MCO for MCO enrolled Medicaid clients.</p> <p>Use Code 97802: Initial nutrition assessment &amp; counseling (15-minute unit)</p> <p>Use Code 97803: Nutrition reassessment and counseling (15-minute unit)</p> <p>For 15 minute units:</p> <ul style="list-style-type: none"> <li>• 8-22 minutes = 1 unit</li> <li>• 23-37 minutes = 2 units</li> <li>• 38-52 minutes = 3 units</li> <li>• 53-67 minutes = 4 units</li> </ul>
Counseling for obesity	<p>This is face-to-face behavioral counseling for obesity.</p> <p>Must be provided by a licensed dietitian or an RN.</p>	<p>In <b>signifycommunity™</b> CAH:</p> <ul style="list-style-type: none"> <li>• Document under 'Type – Service – Health Services'.</li> <li>• Under 'Type of Service', select the correct service code and description.</li> </ul> <p>Time in and time out are required for this service.</p> <p>Complete in <b>signifycommunity™</b> CAH:</p> <ol style="list-style-type: none"> <li>1. Service fields.</li> <li>2. First and last name of service provider &amp; credentials.</li> <li>3. In the 'Comments' field, reference client's chart for full detail/ description/ clinical record of the service provided.</li> </ol> <p>In the client's record: Documentation must adhere to requirements in IAC 441-79.3(2).</p>		<p>Bill the IME for Medicaid fee-for-service (non-MCO) clients. This includes clients on presumptive eligibility.</p> <p>Bill the MCO for MCO enrolled Medicaid clients.</p> <p>Use Code G0447 (15 minutes)</p>
<p>For more information on direct care services, refer to Medicaid's Screening Center Manual.  For more detail on service entry into <b>signifycommunity™</b>, see the CAH User Manual.</p>				

Service	Description in brief	Documentation	Cautions	Billing to IME or Medicaid MCO
Nursing assessment/evaluation	<p>Nursing contact for the purpose of providing assessment and evaluation of a known medical condition such as:</p> <ul style="list-style-type: none"> <li>◆ Failure to thrive</li> <li>◆ Asthma</li> <li>◆ Diabetes</li> </ul> <p>Must be provided by a registered nurse.</p> <p>Must include:</p> <ul style="list-style-type: none"> <li>◆ Medical history including chief complaint</li> <li>◆ Nursing assessment</li> <li>◆ Evaluation</li> <li>◆ Plan of care</li> </ul>	<p>In <b>signifycommunity</b>™ CAH:</p> <ul style="list-style-type: none"> <li>• Document under ‘Type – Service – Health Services’.</li> <li>• Under ‘Type of Service’, select the correct service code and description.</li> </ul> <p>Report the total time of the service (duration).</p> <p>Complete in <b>signifycommunity</b>™ CAH:</p> <ol style="list-style-type: none"> <li>1. Service fields.</li> <li>2. First and last name of service provider &amp; credentials.</li> <li>3. In the ‘Comments’ field, reference client’s chart for full detail/ description/ clinical record of the service provided.</li> </ol> <p>In the client’s record: Documentation must adhere to requirements in IAC 441-79.3(2).</p>	Intended for nursing assessment/evaluation outside of the home setting	<p>Bill the IME for Medicaid fee-for-service (non-MCO) clients. This includes clients on presumptive eligibility.</p> <p>Bill the MCO for MCO enrolled Medicaid clients.</p> <p>Use Code T1001: Nursing assessment/evaluation</p> <p>This is an encounter code and is not based upon a timed unit.</p>
<p>For more information on direct care services, refer to Medicaid’s Screening Center Manual. For more detail on service entry into <b>signifycommunity</b>™, see the CAH User Manual.</p>				

Service	Description in brief	Documentation	Cautions	Billing to IME or Medicaid MCO
Home visit for nursing services	<p>Home visit made for the purpose of providing nursing services including:</p> <ul style="list-style-type: none"> <li>◆ Medical history</li> <li>◆ Nursing assessment</li> <li>◆ Evaluation</li> <li>◆ Nursing services</li> <li>◆ Plan of care</li> </ul> <p>Must be provided by a registered nurse.</p>	<p>In <b>signifycommunity™</b> CAH:</p> <ul style="list-style-type: none"> <li>• Document under 'Type – Service – Health Services'.</li> <li>• Under 'Type of Service', select the correct service code and description.</li> </ul> <p>Time in and time out are required for this service.</p> <p>Complete in <b>signifycommunity™</b> CAH:</p> <ol style="list-style-type: none"> <li>1. Service fields.</li> <li>2. First and last name of service provider &amp; credentials.</li> <li>3. In the 'Comments' field, reference client's chart for full detail/ description/ clinical record of the service provided.</li> </ol> <p>In the client's record: Documentation must adhere to requirements in IAC 441-79.3(2).</p>	<ol style="list-style-type: none"> <li>1. A home visit for care coordination service cannot also be billed for any portion of the home visit for nursing services.</li> <li>2. The entirety of the maternal health postpartum home visit is part of the maternal health services. Any care coordination on behalf of the baby is considered part of this postpartum visit. Do not bill the child health home visit for nursing services in addition.</li> <li>3. This code is based upon an <b>hourly</b> unit of service.</li> <li>4. A full 60 minutes of service must be spent on this home visit before oral health direct care can be separately billed.</li> </ol>	<p>Bill the IME for Medicaid fee-for-service (non-MCO) clients. This includes clients on presumptive eligibility.</p> <p>Bill the MCO for MCO enrolled Medicaid clients.</p> <p>Use Code S9123 (per hour)</p> <p>For time spent, include only face-to-face time. Do not include travel time or time documenting the service.</p> <p>For billings to IME: A limit of ten units (hours) per client over a period of 200 days is placed on this code Payment for services beyond this limit will require documentation to support the medical need for more visits.</p>
<p>For more information on direct care services, refer to Medicaid's Screening Center Manual.  For more detail on service entry into <b>signifycommunity™</b>, see the CAH User Manual.</p>				

Service	Description in brief	Documentation	Cautions	Billing to IME or Medicaid MCO
Social work home visit	<p>Home visit made for the purpose of providing social work services including:</p> <ul style="list-style-type: none"> <li>◆ Social history</li> <li>◆ Psychosocial assessment</li> <li>◆ Counseling services</li> <li>◆ Plan of care</li> </ul> <p>Must be provided by a BSW or licensed social worker.</p>	<p>In <b>signifycommunity™</b> CAH:</p> <ul style="list-style-type: none"> <li>• Document under 'Type – Service – Health Services'.</li> <li>• Under 'Type of Service', select the correct service code and description.</li> </ul> <p>Report the total time of the service (duration).</p> <p>Complete in <b>signifycommunity™</b> CAH:</p> <ol style="list-style-type: none"> <li>1. Service fields.</li> <li>2. First and last name of service provider &amp; credentials.</li> <li>3. In the 'Comments' field, reference client's chart for full detail/ description/ clinical record of the service provided.</li> </ol> <p>In the client's record: Documentation must adhere to requirements in IAC 441-79.3(2).</p>	<ol style="list-style-type: none"> <li>1. A home visit for care coordination service cannot also be billed for any portion of the home visit for social work services.</li> <li>2. The entirety of the maternal health postpartum home visit is part of the maternal health services. Any care coordination on behalf of the baby is considered part of this postpartum visit. Do not bill the home visit for social work services in addition.</li> </ol>	<p>Bill the IME for Medicaid fee-for-service (non-MCO) clients. This includes clients on presumptive eligibility.</p> <p>Bill the MCO for MCO enrolled Medicaid clients.</p> <p>Use Code S9127</p> <p>This is an encounter code and is not based upon a timed unit.</p>

For more information on direct care services, refer to Medicaid's Screening Center Manual.  
For more detail on service entry into **signifycommunity™**, see the CAH User Manual.

Service	Description in brief	Documentation	Cautions	Billing to IME or Medicaid MCO
<p>Evaluation and Management</p>	<p>Evaluation and management (E &amp; M) for an office visit with an established client.</p> <p>Examples include but are not limited to E &amp; M pertaining to:</p> <ul style="list-style-type: none"> <li>◆ Follow-up visits subsequent to a full well child screen (on a date following the screen)</li> <li>◆ Lead risk assessment (lead questionnaire), education about lead poisoning, and follow-up instructions when doing a blood lead draw.</li> <li>◆ Service provided to an existing client at follow-up for an oral problem detected during previous screening service.</li> </ul> <p>Must be provided by a RN.</p>	<p>In <b>signifycommunity™</b> CAH:</p> <ul style="list-style-type: none"> <li>• Document under ‘Type – Service – Health Services’.</li> <li>• Under ‘Type of Service’, select the correct service code and description.</li> </ul> <p>Report the total time of the service (duration).</p> <p>Complete in <b>signifycommunity™</b> CAH:</p> <ol style="list-style-type: none"> <li>1. Service fields.</li> <li>2. First and last name of service provider &amp; credentials.</li> <li>3. In the ‘Comments’ field, reference client’s chart for full detail/ description/ clinical record of the service provided. Specify what the E &amp; M is related to (e.g. lead test)</li> </ol> <p>In the client’s record: Documentation must adhere to requirements in IAC 441-79.3(2).</p>	<p>E &amp; M is a clinical encounter direct care service. This code <b>cannot</b> be used for:</p> <ul style="list-style-type: none"> <li>◆ Providing care coordination services</li> <li>◆ E &amp; M on the same day as a full well child screen</li> <li>◆ Explaining the purpose of a developmental test, interpretation of the test, anticipatory guidance, and needed referral for evaluation when conducting a developmental or social/emotional screening. (These activities are already included in the G0451 and 96127 codes.)</li> </ul> <p>Do not bill E &amp; M related to immunization administration. Instead use ‘immunization administration with counseling’ (Code 90460/90461).</p>	<p>Bill the IME for Medicaid fee-for-service (non-MCO) clients. This includes clients on presumptive eligibility.</p> <p>Bill the MCO for MCO enrolled Medicaid clients.</p> <p>Use Code 99211</p> <p>This encounter code can only be used once per day per client.</p>
<p>For more information on direct care services, refer to Medicaid’s Screening Center Manual. For more detail on service entry into <b>signifycommunity™</b>, see the CAH User Manual.</p>				

Service	Description in brief	Documentation	Cautions	Billing to IME or Medicaid MCO
Preventive medicine counseling	<p>Use of this code is intended for:</p> <ul style="list-style-type: none"> <li>◆ Counseling, risk factor reduction, and behavioral change intervention services related to testing for chlamydia and/or gonorrhea.</li> </ul> <p>Must be provided by a RN</p>	<p>In <b>signifycommunity™</b> CAH:</p> <ul style="list-style-type: none"> <li>• Document under 'Type – Service – Health Services'.</li> <li>• Under 'Type of Service', select the correct service code and description.</li> </ul> <p>Time in and time out are required for this service.</p> <p>Complete in <b>signifycommunity™</b> CAH:</p> <ol style="list-style-type: none"> <li>1. Service fields.</li> <li>2. First and last name of service provider &amp; credentials.</li> <li>3. In the 'Comments' field, reference client's chart for full detail/ description/ clinical record of the service provided. Specify what the preventive medicine counseling is related to (i.e. chlamydia and/or gonorrhea screening)</li> </ol> <p>In the client's record: Documentation must adhere to requirements in IAC 441-79.3(2).</p>	<p>This service is provided at an encounter separate from a preventive exam by a practitioner.</p> <p>Codes 99401 and 99402 will not pay if another counseling-type code is billed for the client on the same day</p> <p>Code 99000 may be used for handling and conveyance of the chlamydia and/or gonorrhea specimens to a lab for analysis.</p>	<p>Bill the IME for Medicaid fee-for-service (non-MCO) clients. This includes clients on presumptive eligibility.</p> <p>Bill the MCO for MCO enrolled Medicaid clients.</p> <p>Use Code 99401 (15-minute unit)</p> <p>Use Code 99402 (30-minute unit)</p> <p>For determining a 15-minute unit:</p> <ul style="list-style-type: none"> <li>• 8-22 minutes = 1 unit</li> </ul> <p>For determining a 30-minute unit:</p> <ul style="list-style-type: none"> <li>• 16-45 minutes = 1 unit</li> </ul>
<p>For more information on direct care services, refer to Medicaid's Screening Center Manual. For more detail on service entry into <b>signifycommunity™</b>, see the CAH User Manual.</p>				

Service	Description in brief	Documentation	Cautions	Billing to IME or Medicaid MCO
Depression Screening	<p>This is depression screening using the Patient Health Questionnaire-9 (PHQ-9)*.</p> <ul style="list-style-type: none"> <li>• A caregiver of a child health client (96161)</li> <li>• An adolescent (G0444) (annual depression screen)</li> </ul> <p>Must be provided by an RN or a person with at least a bachelor's degree in social work, counseling, sociology, psychology, family and community service, health or human development, health education, or individual and family studies.</p> <p>*Note: The Edinburgh Postnatal Depression Scale (EPDS) may be used as the tool for caregiver depression screening for up to one year following the birth of the child.</p>	<p>In <b>signifycommunity™</b> CAH:</p> <ul style="list-style-type: none"> <li>• Document under 'Type – Service – Health Services'.</li> <li>• Under 'Type of Service', select the correct service code and description.</li> </ul> <p>Time in and time out are required for Code G0444. For code 96161, report the total time of the service (duration).</p> <p>Complete in <b>signifycommunity™</b> CAH:</p> <ol style="list-style-type: none"> <li>1. Service fields.</li> <li>2. First and last name of service provider &amp; credentials.</li> <li>3. Add a 'Survey' with scores when providing a PHQ-9 or EPDS.</li> <li>4. In the 'Comments' field, reference client's chart for full detail/ description/ clinical record of the service provided as needed to complete the documentation.</li> </ol> <p>Capture:</p> <ul style="list-style-type: none"> <li>• Who the depression screening is for – caregiver or adolescent</li> <li>• Name of the screening tool including date/ version of tool</li> <li>• Results/scoring</li> <li>• Interpretation of results</li> <li>• Client questions/ concerns</li> <li>• Referral/follow-up</li> </ul> <p>In the client's record: Documentation must adhere to requirements in IAC 441-79.3(2).</p>	<p>Documentation for a depression screening for a caregiver is located in the child's record.</p> <p>Assure that referral resources are available as needed.</p> <p>Assure that staff providing the service have been appropriately trained.</p>	<p>Bill the IME for Medicaid fee-for-service (non-MCO) clients. This includes clients on presumptive eligibility.</p> <p>Bill the MCO for MCO enrolled Medicaid clients.</p> <p>Use Code G0444 for annual depression screening for adolescents (15-minute unit)</p> <p>Use Code 96161 for caregiver of a child health client. Bill under the child's Medicaid number.</p> <p>Code 96161 is an encounter code and is not billed based upon time.</p>

For more information on direct care services, refer to Medicaid's Screening Center Manual.  
 For more detail on service entry into **signifycommunity™**, see the CAH User Manual.



Service	Description in brief	Documentation	Cautions	Billing to IME or Medicaid MCO
<p>Domestic Violence Screening</p>	<p>This is domestic violence screening using the Abuse Assessment Screen (AAS).</p> <ul style="list-style-type: none"> <li>An adolescent (Code 96160)</li> <li>A caregiver of a child health client (Code 96161)</li> </ul> <p>Must be provided by an RN or a person with at least a bachelor's degree in social work, counseling, sociology, psychology, family and community service, health or human development, health education, or individual and family studies.</p>	<p>In <b>signifycommunity™</b> CAH:</p> <ul style="list-style-type: none"> <li>Document under 'Type – Service – Health Services'.</li> <li>Under 'Type of Service', select the correct service code and description.</li> </ul> <p>Report the total time of the service (duration).</p> <p>Complete in <b>signifycommunity™</b> CAH:</p> <ol style="list-style-type: none"> <li>Service fields.</li> <li>First and last name of service provider &amp; credentials.</li> <li>An AAS form is in the <b>signifycommunity™</b> Library and may be completed and attached to the service.</li> <li>In the 'Comments' field, reference client's chart for full detail/ description/ clinical record of the service provided as needed to complete the documentation. Capture: <ul style="list-style-type: none"> <li>Who the domestic violence screening is for – caregiver or adolescent</li> <li>Name of the screening tool including date/ version of tool</li> <li>Results/scoring</li> <li>Interpretation of results</li> <li>Client questions/ concerns</li> <li>Referral/follow-up</li> </ul> </li> </ol> <p>In the client's record: Documentation must adhere to requirements in IAC 441-79.3(2).</p>	<p>Documentation for a domestic violence screen for a caregiver is located in the child's record.</p> <p>Assure that referral resources are available as needed.</p> <p>Assure that staff providing the service have been appropriately trained.</p>	<p>Bill the IME for Medicaid fee-for-service (non-MCO) clients. This includes clients on presumptive eligibility.</p> <p>Bill the MCO for MCO enrolled Medicaid clients.</p> <p>Use Code 96160 if the screen is provided for an adolescent.</p> <p>Use Code 96161 for caregiver of a child health client. Bill under the child's Medicaid number.</p> <p>Codes 96160 and 96161 are encounter codes and are not billed based upon time.</p>
<p>For more information on direct care services, refer to Medicaid's Screening Center Manual. For more detail on service entry into <b>signifycommunity™</b>, see the CAH User Manual.</p>				

Service	Description in brief	Documentation	Cautions	Billing to IME or Medicaid MCO
Mental health assessment	<p>A mental health clinical assessment using a nationally recognized validated tool.</p> <p>This involves an integrated evaluation across a full range of life domains which leads to the development of an effective, comprehensive, and individualized plan of care. It is a thorough assessment of the individual’s clinical and psychosocial needs and functional level.</p> <p>Must be administered by a licensed social worker (LISW, LMSW) or other licensed mental health professional.</p>	<p>In <b>signify</b>community™ CAH:</p> <ul style="list-style-type: none"> <li>• Document under ‘Type – Service – Health Services’.</li> <li>• Under ‘Type of Service’, select the correct service code and description.</li> </ul> <p>Report the total time of the service (duration).</p> <p>Complete in <b>signify</b>community™ CAH:</p> <ol style="list-style-type: none"> <li>1. Service fields.</li> <li>2. First and last name of service provider &amp; credentials.</li> <li>3. In the ‘Comments’ field, reference client’s chart for full detail/ description/ clinical record of the service provided. Include: <ul style="list-style-type: none"> <li>• Name of the assessment tool including date/ version of tool</li> <li>• Description of findings</li> <li>• Plan of care</li> <li>• Client questions/ concerns</li> <li>• Referral/follow-up</li> </ul> </li> </ol> <p>In the client’s record: Documentation must adhere to requirements in IAC 441-79.3(2).</p>	Assure that referral resources are available as needed.	<p>Bill the IME for Medicaid fee-for-service (non-MCO) clients. This includes clients on presumptive eligibility.</p> <p>Bill the MCO for MCO enrolled Medicaid clients.</p> <p>Use Code H0031</p> <p>This is an encounter code and is not billed based upon time.</p>
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Service	Description in brief	Documentation	Cautions	Billing to IME or Medicaid MCO
Mental health services (e.g. psychosocial/counseling)	This is a psychosocial/counseling service that may be provided by a person with at least a bachelor's degree in social work, counseling, sociology, psychology, family counseling, or a registered nurse.	<p>In <b>signify</b>community™ CAH:</p> <ul style="list-style-type: none"> <li>• Document under 'Type – Service – Health Services'.</li> <li>• Under 'Type of Service', select the correct service code and description.</li> </ul> <p>Report the total time of the service (duration).</p> <p>Complete in <b>signify</b>community™ CAH:</p> <ol style="list-style-type: none"> <li>1. Service fields.</li> <li>2. First and last name of service provider &amp; credentials.</li> <li>3. In the 'Comments' field, reference client's chart for full detail/description/ clinical record of the service provided.</li> </ol> <p>In the client's record: Documentation must adhere to requirements in IAC 441-79.3(2).</p>	<p>This psychosocial service shall include:</p> <ul style="list-style-type: none"> <li>• Demographic factors</li> <li>• Mental &amp; physical health history and concerns</li> <li>• Family composition, patterns of functioning, and support systems</li> <li>• Identified needs</li> <li>• A plan of care based on the above</li> <li>• Counseling and anticipatory guidance as appropriate</li> <li>• Referral and follow-up services</li> </ul>	<p>Bill the IME for Medicaid fee-for-service (non-MCO) clients. This includes clients on presumptive eligibility.</p> <p>Bill the MCO for MCO enrolled Medicaid clients.</p> <p>Use Code H0046</p> <p>This is an encounter code and is not billed based upon time.</p>
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Service	Description in brief	Documentation	Cautions	Billing to IME or Medicaid MCO
<p>Alcohol and/or substance abuse screening w/ brief intervention</p>	<p>This is alcohol and substance abuse screening with brief intervention which includes administration of the following:</p> <ul style="list-style-type: none"> <li>• CRAFFT for adolescents under age 18 years</li> <li>• SBIRT for clients age 18 to 21 years</li> <li>• Brief intervention</li> </ul> <p>Must be provided by an RN or social worker (BSW or licensed).</p>	<p>In <b>signifycommunity™</b> CAH:</p> <ul style="list-style-type: none"> <li>• Document under ‘Type – Service – Health Services’.</li> <li>• Under ‘Type of Service’, select the correct service code and description.</li> </ul> <p>Time in and time out are required for Codes 99408 and 99409. For Code 96161, report the total time of the service (duration).</p> <p>Complete in <b>signifycommunity™</b> CAH:</p> <ol style="list-style-type: none"> <li>1. Service fields.</li> <li>2. First and last name of service provider &amp; credentials.</li> <li>3. Add the appropriate ‘Survey’.</li> <li>4. In the ‘Comments’ field, reference client’s chart for full detail/ description/ clinical record of the service provided as needed to complete the documentation. Capture: <ul style="list-style-type: none"> <li>• Name of the tool including date/ version of tool</li> <li>• Results/scoring</li> <li>• Interpretation of results</li> <li>• The nature and outcome of the brief intervention</li> <li>• Client questions/ concerns</li> <li>• Referral/follow-up</li> </ul> </li> </ol> <p>In the client’s record: Documentation must adhere to requirements in IAC 441-79.3(2).</p>	<p>Brief intervention is a required component of the service. It incorporates principles of motivational interviewing.</p> <p>The CRAFFT includes</p> <ul style="list-style-type: none"> <li>• Administration of the tool</li> <li>• Brief intervention</li> </ul> <p>SBIRT = Screening, Brief Intervention, and Referral to Treatment</p> <p>The SBIRT includes:</p> <ul style="list-style-type: none"> <li>• Two question pre-screen</li> <li>• AUDIT - Alcohol Use Disorders Identification Test</li> <li>• <b>AND/OR</b> DAST – Drug Abuse Screening Test</li> <li>• Brief intervention</li> </ul> <p>The tools listed above are ‘Surveys’ in <b>signifycommunity™</b> CAH. Add the appropriate survey to the service, and complete the fields.</p>	<p>Bill the IME for Medicaid fee-for-service (non-MCO) clients. This includes clients on presumptive eligibility.</p> <p>Bill the MCO for MCO enrolled Medicaid clients.</p> <p>Use Code 99408 for the child (15-30 minutes)</p> <p>Use Code 99409 for the child (over 30 minutes)</p> <p>For a billable service the following must be provided and documented:</p> <ul style="list-style-type: none"> <li>• The CRAFFT with brief intervention</li> <li>OR</li> <li>• The AUDIT and/or DAST with brief intervention</li> </ul> <p>If providing this service for a child’s caregiver (over age 21, bill the service as a caregiver risk assessment – Code 96161 - under the child’s Medicaid number.</p>
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Service	Description in brief	Documentation	Cautions	Billing to IME or Medicaid MCO
<p>Annual alcohol screening</p> <p>Alcohol and/or drug screening</p>	<p>Annual alcohol screening</p> <p>Alcohol or drug abuse screening</p> <p>These screenings involve administration of the following tools:</p> <ul style="list-style-type: none"> <li>• CRAFFT for adolescents under age 18 years</li> <li>• AUDIT and/or DAST for clients age 18 to 21 years</li> </ul> <p>Must be provided by an RN or social worker (BSW or licensed).</p>	<p>In <b>signifycommunity</b>™ CAH:</p> <ul style="list-style-type: none"> <li>• Document under ‘Type – Service – Health Services’.</li> <li>• Under ‘Type of Service’, select the correct service code and description.</li> </ul> <p>For Code G0442, time in and time out are required for a minimum of 15 minutes of service. For Codes H0049 or 96161, report the total time of the service (duration).</p> <p>Complete in <b>signifycommunity</b>™ CAH:</p> <ol style="list-style-type: none"> <li>1. Service fields.</li> <li>2. First and last name of service provider &amp; credentials.</li> <li>3. Add the appropriate ‘Survey’.</li> <li>4. In the ‘Comments’ field, reference client’s chart for full detail/ description/ clinical record of the service provided as needed to complete the documentation. Capture: <ul style="list-style-type: none"> <li>• Name of the tool including date/ version of tool</li> <li>• Results/scoring</li> <li>• Interpretation of results</li> <li>• Client questions/ concerns</li> <li>• Referral/follow-up</li> </ul> </li> </ol> <p>In the client’s record: Documentation must adhere to requirements in IAC 441-79.3(2).</p>	<p>Use the following tools:</p> <ul style="list-style-type: none"> <li>• CRAFFT</li> <li>• AUDIT - Alcohol Use Disorders Identification Test</li> </ul> <p><b>AND/OR</b></p> <ul style="list-style-type: none"> <li>• DAST – Drug Abuse Screening Test</li> </ul> <p>These codes <i>do not</i> include the brief intervention component.</p> <p>The tools listed above are ‘Surveys’ in <b>signifycommunity</b>™ CAH. Add the appropriate survey to the service, and complete the fields.</p> <p>Codes G0442 and H0049 cannot both be billed for the same day for the same client.</p> <p>Codes G0442 and H0049 cannot be billed in conjunction with Code 99408.</p>	<p>Bill the IME for Medicaid fee-for-service (non-MCO) clients. This includes clients on presumptive eligibility.</p> <p>Bill the MCO for MCO enrolled Medicaid clients.</p> <p>Use Code G0442 for annual alcohol screening (15 minutes)</p> <p>Use Code H0049 for alcohol and/or drug screening. This is an encounter code.</p> <p>For a billable service, the following must be provided and documented:</p> <ul style="list-style-type: none"> <li>• The CRAFFT</li> <li>OR</li> <li>• The AUDIT and/or DAST</li> </ul> <p>If providing this service for a child’s caregiver (over age 21), bill the service as a caregiver risk assessment – Code 96161 - under the child’s Medicaid number.</p>

For more information on direct care services, refer to Medicaid’s Screening Center Manual.  
For more detail on service entry into **signifycommunity**™, see the CAH User Manual.

Service	Description in brief	Documentation	Cautions	Billing to IME or Medicaid MCO
Counseling for alcohol misuse	<p>This is face-to-face behavioral counseling for alcohol misuse.</p> <p>Must be provided by a RN or social worker (BSW or licensed).</p>	<p>In <b>signifycommunity</b>™ CAH:</p> <ul style="list-style-type: none"> <li>• Document under 'Type – Service – Health Services'.</li> <li>• Under 'Type of Service', select the correct service code and description.</li> </ul> <p>Time in and time out are required.</p> <p>Complete in <b>signifycommunity</b>™ CAH:</p> <ol style="list-style-type: none"> <li>1. Service fields.</li> <li>2. First and last name of service provider &amp; credentials.</li> <li>3. In the 'Comments' field, reference client's chart for full detail/ description/ clinical record of the service provided.</li> </ol> <p>In the client's record: Documentation must adhere to requirements in IAC 441-79.3(2).</p>		<p>Bill the IME for Medicaid fee-for-service (non-MCO) clients. This includes clients on presumptive eligibility.</p> <p>Bill the MCO for MCO enrolled Medicaid clients.</p> <p>Use Code G0443 (15 minutes)</p>
<p>For more information on direct care services, refer to Medicaid's Screening Center Manual. For more detail on service entry into <b>signifycommunity</b>™, see the CAH User Manual.</p>				