Kansas
Department of Health and Environment
Division of Health Care Finance

KAN Be Healthy EPSDT

This manual offers guidance to professionals that provide Medicaid services to Kansas Children

KanCare

KAN Be Healthy EPSDT

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a state and federally funded insurance plan that provides comprehensive and preventive health care services for Kansas children who are enrolled in Medicaid. Title XIX EPSDT provides services to children under age 21, Title XXI serves children under age 19 who are enrolled in the Children's Health Insurance Plan (CHIP). In Kansas, the EPSDT program is called Kan Be Healthy (KBH). KBH members are typically enrolled in one of three Managed Care Organizations (MCOs) that provide all state Medicaid services. There is a small percentage of members that will be fee for service (FFS) for short periods of time, which requires providers to follow the FFS billing guidelines and processes.

Non-covered services may be covered for EPSDT members when services are deemed medically necessary. See billing instructions on page 3 for the Early and Periodic (EP) modifier. EPSDT is key to ensuring children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services.

What is EPSDT?

Early: Assessing and identifying problems early

Periodic: Checking children's health at periodic, age-appropriate intervals

Screening: Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems

Diagnostic: Performing diagnostic tests to follow up when a risk is identified

Treatment: Control, correct, or reduce health problems found

Bright Futures™

prevention and health promotion for infants, children, adolescents, and their families™

Bright Futures Resources

Kansas follows the Bright Futures/AAP Periodicity schedule, a Centers for Medicare and Medicaid Services (CMS) approved schedule of pediatric preventive services through the Kan Be Healthy/EPSDT program. The periodicity schedule is located on the Bright Futures website.

Kansas Medical Assistance Program

Forms that may be used to document KBH screenings are located at the Kansas Medical Assistance Program (KMAP) website under the forms sections. KBH/EPSDT providers may use forms from their electronic health record (EHR) to submit to the MCOs, or KMAP when appropriate, if those forms follow the Bright Futures guidelines.

EPSDT Services

States are required to provide comprehensive services and furnish all Medicaid coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, based on certain federal guidelines. Under EPSDT Non-covered services may be covered for members when services are determined to be medically necessary. The EP modifier will be used to distinguish non-covered state plan services that are deemed medically necessary for coverage under the EPSDT benefit. Medical necessity must be established, and prior authorization (PA) must be obtained. Service limitation may be exceeded when authorized for Kan Be Healthy members. EPSDT is comprised of the following screening, diagnostic, and treatment services:

Stand-Alone Vaccine Counseling

Stand-alone vaccine counseling for non-COVID-19 vaccines will be a covered EPSDT service for ages under 21. This service can be billed by using procedure codes G0312 and G0313.

Stand-alone counseling for COVID-19 vaccines will be a covered EPSDT service for ages under 21. This service can be billed by using procedure codes G0314 and G0315.

Updated 01/26

Stand-Alone Vaccine Counseling continued

Stand-alone vaccine counseling will be covered only when the vaccine counseling and the administration of the vaccine occurs on two separate visits. Vaccine counseling is content of service when the vaccine counseling and administration of the vaccine occur at the same visit. Stand-alone vaccine counseling may also be covered when provided via telehealth.

Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5)

Effective with dates of service on or after January 1, 2026, the use of Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-5) can be applied to children from birth to five (5) years old. Clinicians are encouraged to complete ZERO-TO-THREE™ training approved by Kansas Department of Aging and Disability Services (KDADS). Training shall be made available for clinicians who evaluate and assess children for behavioral health concerns.

The following codes shall be used in the amount and frequency to thoroughly assess KAN Be Healthy (KBH) members, based upon members' individual needs and ability to participate in testing/assessment.

96112	96113

DC:0-5 is a multiaxial classification system for mental disorders in early childhood, intended to provide an age-appropriate and developmentally informed approach to assessing mental health and developmental disorders in children from birth through five years old that focuses on the development and caregiving relationships as part of understanding context of behaviors. Use of DC: 0-5 is recognized as best practice by SAMHSA (Substance Abuse and Mental Health Services Administration) and CMS (Center for Medicare and Medicaid Services). It includes:

- 42 clinical disorders and clinical examples for infants in their first year of life and a diagnostic algorithm for each disorder.
- Requires distress and functional impairment.
- Groups disorders into clusters similar to DSM-V (Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition).
- A crosswalk to other nosology's (ICD-10 and DSM-5).
- The age range of birth to 5 years old.
- Incorporates a family-relational element in Axis II.
- Differential diagnosis and acknowledges the likelihood of comorbid conditions.

Updated 10/25

Gender Transition Care

Pursuant to Senate Bill 63 (SB63), Kansas Medicaid (KanCare) has implemented restrictions on the reimbursement and coverage of gender-affirming health care services, including surgical and pharmacologic (hormonal) treatments. These changes apply to Medicaid members of all ages, with specific provisions based on age group.

Coverage Restrictions for Minors (Ages 0-17):

Effective retroactive to February 25, 2025, Kansas Medicaid shall not reimburse or provide coverage for gender-affirming health care services to individuals under age 18 when such services are:

- Performed for the purpose of presenting as a member of the opposite sex, or
- Intended as treatment for a child whose perceived gender or sex is inconsistent with their biological sex assigned at birth.
- These restrictions apply to surgical procedures including, but not limited to, those listed in Section 3(a) and 3(b) of SB63, which are differentiated by biological sex.

Coverage Restrictions for Young Adults (Ages 18-20):

Effective retroactive to June 1, 2025, Kansas Medicaid shall not reimburse or provide coverage for surgical treatment related to gender-affirming care for members aged 18 through 20 when:

- The treatment is provided for the purpose of alleviating distress due to incongruence between perceived gender and biological sex.
- Such treatments are classified as experimental under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) guidelines and are therefore not covered.

Updated 10/25

Gender Transition Care continued

Claims Processing for All Age Groups:

Claims billed with any of the following ICD-10-CM diagnosis codes in any diagnosis position will suspend for manual review:

ICD-10 Diagnosis Codes
F64.0
F64.1
F64.2
F64.8
F64.9
Z87.890

Providers must submit supporting documentation (e.g., medical records, clinical notes) for review. Contested denials require full documentation to assess medical necessity or eligibility under allowable exceptions (see below).

Exceptions to Coverage (Ages 0-20):

Under SB63 and KMAP policy, exceptions may apply in the following circumstances:

- Treatment of individuals with a medically verifiable disorder of sex development, including:
  - Ambiguous biological sex characteristics (e.g., 46 XX with virilization, 46 XY with under-virilization).
  - Diagnoses confirmed by genetic or biochemical testing showing atypical sex chromosome structure or hormone production.
- Treatment of infection, injury, disease, or disorder caused or exacerbated by a previously performed prohibited procedure.

Providers are encouraged to review SB63 in full and adjust treatment and billing practices accordingly. Please contact your Managed Care Organization (MCO) or the Kansas Medicaid Provider Assistance line with questions regarding claim processing or medical necessity documentation.

Updated 09/24

Lead Hazard Risk Assessments

Effective with enrollment dates on and after October 1, 2024, Kansas Medicaid will allow Local Health Departments (LHDs) to enroll under a new Provider Type/Provider Specialty (PT/PS) to receive reimbursement for lead hazard assessments direct or contractor services for children aged 0-20 years, if they are shown to have an Elevated Blood Lead (EBL) level equal to or greater than 10 mcg/dL.

The coverage for these assessments will be effective October 1, 2024. LHDs can provide Lead Hazard Risk Assessments directly by becoming a licensed Lead Activity Firm and employing a Risk Assessor or EBL-level investigator, or they may contract with a licensed Lead Activity Firm that employs a Risk Assessor or EBL-level investigator.

Coverage Requirements:

- A confirmatory blood lead level test with a result equal to or greater than 10 mcg/dL from a venous sample is needed.
- Prior authorization is required.

The below activities are not billable as part of a Lead Hazard Risk Assessment.

- Laboratory analysis.
- Testing of substances that must be sent off-site for analysis.
- Any non-medical activities such as removal or abatement of lead sources.
- Relocation efforts.

Covered Services:

- The following services are covered for Lead Hazard Risk Assessments and must be billed with primary diagnosis code R78.71.

Visit Type	Procedure Code	Frequency Limit
Initial Comprehensive Visit	T1029	One per calendar year
Follow-up Visit	T1029-U1	Two per calendar year

Note: With prior authorization, state plan limits may be exceeded based on a child's medical necessity.

Updated 09/24

Lead Hazard Risk Assessments continued

Lead Hazard Risk Assessment investigations of the child's home involve identifying potential sources of exposure to lead and advising parents or guardians about identified and potential sources of lead and ways to reduce exposure. This service may include but is not limited to:

- Collection of samples and/or use of an X-ray fluorescence analyzer to measure environmental lead (dust, paint, soil, or water).
- Visual examination of the dwelling and property to determine the locations of deteriorated paint and lead paint hazards.
- Identification and evaluation of any non-paint lead hazards.

Once homeowners or rental property owners are notified of the problem and have an opportunity to remedy the situation, a follow-up Lead Hazard Risk Assessment clearance investigation should be conducted to ensure that the problem is resolved. Lead abatement activities should be performed by a licensed Lead Activity Firm or Lead Renovation Firm that is certified through the Residential Lead Hazard Prevention Program.

Follow-up lead clearance investigation may include but is not limited to:

- A visual assessment to determine that all identified lead hazards have been remediated, no visible dust or debris remains, and non-paint hazards have been removed.
- For interior lead paint hazards, a collection of clearance dust-wipe samples to verify safe completion and clean-up of work.

Billing Guidelines:

If more than one child in the home has an EBL level, all services must be billed under one child's Medicaid ID only. A Lead Hazard Risk Assessment should be done in the child's primary residence. If there is a second home that a child resides in, a Lead Hazard Risk Assessment can be done on the secondary residence with prior authorization.

Enrollment Requirements for Lead Hazard Risk Assessments:

- LHDs can submit enrollment applications with the enrollment type 'Facility' and attach a copy of their Kansas Department of Health and Environment (KDHE) Risk Assessor or EBL level investigator certification and their KDHE Lead Activity Firm license to the enrollment application.
- If using a contractor for Lead Hazard Risk Assessments, the LHD must attach the contractor's KDHE Risk Assessor or EBL level investigator certification and the contractor's KDHE Lead Activity Firm license.
- Licensed LHDs must enroll with their own National Provider Identifier (NPI) (type 1) to provide the covered services with taxonomy code 251K00000X.
- LHDs will be enrolled with a new PT/PS 13/132 - Local Health Agency/Lead Hazard Risk Assessments.

Updated 09/24

Lead Hazard Risk Assessments continued

KDHE Bureau of Air, Kansas Residential Lead Hazard Prevention Program, will issue the certifications and the Lead Activity Firm license. LHDs will need one of the certifications (Risk Assessor or EBL level investigator) and the Lead Activity Firm license to enroll as the new provider specialty. LHDs would directly employ an individual to perform lead hazard risk assessments.

If the LHD decides to contract with an already established Lead Activity Firm, the LHD would first need to get a copy of the Lead Activity Firm license from the contractor, and a KDHE issued certification for either a risk assessor or an EBL level investigator for an employee of the contracted Lead Activity Firm. The LHD would submit those for enrolling under the new provider type. The contractor would perform the Lead Hazard Risk Assessments for the LHD and the LHD would bill for the services and then reimburse the contractor for the Lead Hazard Risk Assessments.

Training and Certification Requirements:

The employee or contractor performing a Lead Hazard Risk Assessment must be certified by KDHE as an EBL-level investigator or Risk Assessor and be employed by a Licensed Lead Activity Firm.

To become a Risk Assessor, one must complete the Lead Inspector and Risk Assessor Training here.

To become an EBL-level investigator, one must complete the Lead Inspector and Risk Assessor Training here.

Once the Lead Inspector and Risk Assessor Trainings are completed, the person wanting to become an EBL-level investigator should email kdhe.lead@ks.gov and inform KDHE of their wish to be enrolled in the EBL training. Certification can be obtained by following K.A.R. 28-72-6 and K.A.R. 28-72-6a and 6b, which describe the application process and requirements for the certification of risk assessors and application process and requirements for the certification of an elevated blood lead level investigator.

To become a licensed Lead Activity Firm, follow the process listed at K.A.R. 28-72-10, which describes the application process and licensure renewal requirements for Lead Activity Firms.

Registered Nurse Education Visits for Elevated Blood Lead Levels

Effective with dates of service on and after October 1, 2024, Kansas Medicaid will cover RN Elevated Blood Lead (EBL) level education visits (T1001 U1) for children aged 0-20 years with an EBL level equal to or greater than 5 mcg/dL taken from a venous blood sample.

If the initial blood lead test was a capillary sample, the confirmatory blood lead test must be a venous blood sample. If the initial blood lead test used a venous blood sample, another venous sample is not needed. LHDs must verify that the confirmatory EBL level test is a venous sample equal to or greater than 5 mcg/dL.

Updated 09/24

Service Limitations:

- The visit must include diagnosis code Z77.011 for claim billing.
- RN education visits (T1001 U1) for EBL levels are limited to 4 visits per year.
- Education visits apply to all children within a family unit.
    - If more than one child in the home has a qualifying EBL level, education must encompass all members and billed under each child's Medicaid ID with a unit of 1.0.

Covered Provider Type/Specialty:

The covered PT/PS is:

PT/PS	Description
13/131	Public Health or Welfare Agency and Clinic

Allowable Place of Service Codes:

The RN education visits are covered for the following places of service:

Code	Description
12	Home
71	State or Local Public Health Clinic

The RN education visit must be a face-to-face visit for no less than 60 minutes to allow for the assessments and education. The visit involves the RN advising parents and/or guardians of the child's blood lead level and what it means such as the impact of lead poisoning on children, risk factors and possible sources of lead exposure including steps to take to decrease lead exposure. The RN education visit should also include the assessment of the child pertaining to growth, development, behavior, nutrition. and the initiation of appropriate referrals to a health care provider. Additional education given includes the importance of a well-balanced diet, good housekeeping practices, and follow-up blood lead testing recommendations. Follow-up RN education visits can be done to assess the family's progress in complying with the recommendations provided by the RN. Education and assessments, by the RN, must be documented in the child's medical chart.

Updated 07/25

Audiology Services

Effective with dates of service on and after April 1, 2025, Kansas will cover Audiology services listed below can be performed by Audiologists (20/200) for ages 0-20 under the following guidelines:

- Limited to non-acute hearing conditions and diagnostic services related to implanted
- auditory prosthetic devices
- Excludes audiology services that are related to disequilibrium, hearing aids, or
- examinations for the purpose of prescribing, fitting, or changing hearing aids.
- Covered once per patient per 12-month period
- Unexpected discovery of an acute condition
- The audiologist must be enrolled as a Medicaid provider to perform and bill the following codes:

92622 AB	92623 AB

Augmentative Communication Devices

Augmentative communication devices (ACDs), speech generating devices (SGDs), and activation accessories are covered with PA when medically necessary. All requests require letters of MN from a physician or other qualified practitioner and an evaluation done by a speech language pathologist with recognized training and credentialing in the evaluation and prescribing of ACDs. All criteria must be met. The Augmentative and Alternative Communication Device Evaluation Form shall be submitted with the PA.

When determining medical necessity for KBH-EPSDT members, the EPSDT standard of coverage should be applied.

The EPSDT standard of coverage is as follows:

> A service need not cure a condition to be covered under EPSDT. Services that maintain or improve the child's current health condition are also covered in EPSDT because they "ameliorate" a condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. Services are covered when they prevent a condition from worsening or prevent development of additional health problems. The common definition of "ameliorate" is to "make more tolerable." The determination of whether a service is medically necessary for an individual child must be made on a case-by-case basis, considering the particular needs of the child and should consider the child's long-term needs, not just what is required to address the immediate situation. Kansas Medicaid definition of medical necessity is found at KAR 129-1-1.

Refer to section 8410 – Augmentative Communication Devices on Durable Medical Equipment Fee-for-Service Provider Manual for the criteria and evaluation requirements.

Updated 04/25

Medical Screening Services

A comprehensive KBH/EPSDT screening contains the following components:

Comprehensive unclothed physical examination,

Comprehensive health and developmental history that assess for both physical and developmental health, and includes substance use disorders,

Appropriate immunization, in accordance with the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices,

Blood lead screenings are a requirement for all Medicaid eligible children at 12 and 24 months. If there is no record of a previous blood lead test, a catch-up capillary or venous test should be performed within 72 months.

A sick child visit may be billed on the same day as a well child visit, if appropriate, using Modifier 25. Refer to the Coding Modifiers Table for more information.

Vision Screening

At a minimum, screening, diagnosis, referral, and treatment for defects in vision, including eyeglasses, is required. Vision services must be provided according to a distinct periodicity schedule developed by the state and at other intervals as medically necessary. School vision screens are a separate and distinct process and follow their own periodicity schedule as outlined in the Kansas Department of Health and Environment (KDHE) Vision Screening Guidelines.

http://www.ksits.org/download/Kansas_Vision_Screening_Guidelines.pdf

Updated 08/22

Hearing Screening

At a minimum, hearing screenings include identification of, diagnosis, referral, and treatment for defects in hearing, including hearing aids. School hearing screenings are a separate and distinct process and follow their own periodicity schedule as outlined in the KDHE Hearing Screening Guidelines.

http://www.ksits.org/download/Hearing_Guidelines.pdf

Developmental Screening

Developmental screenings include identification of, diagnosis, referral, and treatment for delays in a child's development.

Dental Screening

Dental screens are a required component of each KBH visit based on both the Kansas State and AAP Periodicity schedule. If a child does not have a dental home, a referral to a dentist should be made. Examinations by a dentist with eruption of the first tooth or at age one and continuing every six months or as recommended by a dentist. Non-Dental providers may apply fluoride varnish using code 99188 up to three times per year. Dental services may not be limited to emergency services.

https://www.aapd.org/globalassets/assets/1/7/periodicity-aapdschedule.pdf

Diagnostic Services

When a screening examination indicates the need for further evaluation of a member's health, diagnostic services must be provided. Necessary referrals should be made without delay and there should be follow-up to ensure the member receives a complete diagnostic evaluation.

Updated 08/22

Maternal Depression Screenings

Maternal Depression Screenings are reimbursable using the Current Procedural Technology (CPT) and HCPCS codes 96160, 96161, G8431, and G8510 when using one or more of the following validated screening tools:

- Edinburgh Postnatal Depression Scale (EPDS)
- Perinatal Grief Intensity Scale (PGIS)
- Postpartum Depression Screening Scale (PDSS)
- Patient Health Questionnaire 9 (PHQ-9)
- Beck Depression Inventory II (BDI-II)
- Center for Epidemiologic Studies Depression Scale (CES-D)
- Zung Self-Rating Depression Scale (SDS)

These screenings are reimbursable up to when a woman is pregnant or after a perinatal loss (stillbirth, miscarriage or neonatal death) that occurs during her Medicaid coverage period. Postpartum screenings are allowed up until the child is 12 months of age. Any screenings that occur prior to the birth of the child or after a perinatal loss, should be billed under the woman's Medicaid Identification (ID) number using CPT code 96160. Any screening that occurs after the child is born is considered an EPSDT benefit per CMS guidance, and should be billed under the infant's Medicaid ID number, using CPT code 96161. If the child does not have an assigned Medicaid ID number, CPT code 96161 can be billed under the mother's Medicaid ID number for up to 45 days postpartum. Rural Health Clinics/Federally Qualified Health Centers (RHC/FQHC) may perform these screenings and list this on their claims, but it will be included in the encounter rate.

Approved Provider Type / Provider Specialty Codes:

08-080	08-081	08-083	08-084	08-085	09-093	09-095
10-100	11-111	11-112	11-115	11-116	11-122	11-176
13-131	13-181	31-316	31-318	31-323	31-328	31-335
31-339	31-345	31-348	31-349	31-350		

Approved Place of Service Codes:

11	12	17	19	20	22	23
25	49	50	53	57	62	71
72						

Clinical staff in obstetrics and gynecology practices should be prepared to initiate medical therapy, refer patients to appropriate behavioral health resources when indicated, or both. Evidence suggests that collaborative care models implemented in obstetrics and gynecology offices improve long-term patient outcomes.

Updated 01/21

Follow-up with these patients and clinical support and training offered to staff results in greater reduction in depression prevalence. Initiation of treatment or referral to mental health care providers offers maximum benefit.

Miscarriage, Stillbirth and Neonatal Loss; Bereavement Follow-up Recommendations:

Loss of a pregnancy or death of a newborn affects every aspect of a family's life. Every effort should be made to determine the cause of the loss, to understand the family's grief responses, and to facilitate healthy coping and adjustment. The consequences of intense grief due to perinatal loss may include significant couple relationship issues, depression, anxiety, social phobia, obsessive compulsive disorder and post-traumatic stress disorder (PTSD) that may extend into the subsequent healthy pregnancies.

When the Perinatal Grief Intensity Scale (PGIS) is given shortly after the loss, it can also predict women who will continue to have intense grief 3-5 months in the future, and have higher risk for developing clinical level anxiety, depression, PTSD and couple relationship issues.

It is recommended that healthcare providers routinely screen for symptoms of depression and anxiety among women after a perinatal loss, as well as subsequent pregnancies.

Studies have shown that women who had experienced a stillbirth are twice as likely to have a high depression score compared to women who had a live birth and that women with a history of depression are especially vulnerable to persistent depression after a stillbirth, even after the subsequent birth of a healthy child. One study was the first to show that women who have no history of depression may face a risk for depression many months after a stillbirth.

Depression after a miscarriage is usually most severe immediately after a pregnancy is lost and that the depression rates dropped over the course of the year.

One of the key recommendations is that every woman who has experienced a miscarriage, stillbirth or neonatal death should receive follow-up care.

Referral and Follow-up Process on Positive Screenings Recommended by the American Academy of Pediatrics (AAP):

Immediate action is necessary if:

- Possible suicidality indicated in screening tool
- Mother expresses concern about her or her infant's safety
- Provider suspects that the mother is suicidal, homicidal, severely depressed, manic or psychotic

Updated 01/21

When a depression screen is positive, management varies according to the degree of concern and need.

Management of Postpartum Depression includes:

- Demystification (reducing guilt and shame by emphasizing how common these feelings are);
- Support resources (family and community); and
- Referrals for the mother (to a mental health professional or the mother's PCP or obstetrician), for the mother-infant dyad, for the child (for targeted promotion of social-emotional development and early intervention, and for the mother who is breastfeeding (for lactation support from an experienced provider).

Training Opportunities

Optional training will be offered to screeners, including medical providers and their clinical staff, to increase timely detection of maternal depression.

The Mental Health Integration Toolkit on the KDHE website, will be updated by Public Health and will provide guidance on screening practices and patient and provider resources. There is also a national program, Mental Health First Aid, that teaches the skills to respond to the signs of mental illness and substance use.

Treatment

Necessary health care services must be provided for treatment of all physical and mental illnesses or conditions discovered by any screening and diagnostic procedures.

Schedules for screening, vision, and hearing services must be provided at intervals that meet reasonable standards of medical practice. These screenings are required for children enrolled in Medicaid and CHIP.

When the ideal schedule is not possible to follow, KBH/EPSDT screenings may be completed at any time. Every KBH visit must have all components provided on each visit documented.

Other Necessary Health Care Services

In addition to periodic screenings, children are entitled to receive "interperiodic" screenings whenever a provider, a parent, developmental, or educational professional suspects a possible problem the member may be experiencing.

States are required to provide any additional health care services that are available under the Federal Medicaid program and found to be medically necessary to treat, correct or reduce illnesses and conditions discovered, regardless of whether the service is covered in a state's Medicaid plan.

KBH/EPSDT services may exceed any established limitations on services. It is the responsibility of the MCO, or KMAP when appropriate, to determine medical necessity on a case-by-case basis. In case of disagreement, the State will make the final decision if the issue cannot be resolved.

Updated 05/25

Kansas Medical Necessity is defined in regulation at KAR 129-1-1 (oo) and may be accessed here.

EPSDT Medical Necessity does not include experimental or investigational treatments, services or items not generally accepted as effective, and/or not within the normal course and duration of treatment. Services for caregiver or providers convenience are not allowed. Services may be limited in scope and duration. The most cost-effective treatment may be utilized.

KBH Screening Providers

EPSDT services are provided in Kansas under the KanCare Medicaid Managed Care Program. Providers must be enrolled in KanCare.

Providers who may screen KBH members include:

- Physicians
- Dentists
- Advanced Practice Registered Nurses
- Physician Assistants
- Registered Nurses (supervised by Physicians or Mid–Level practitioners)

KBH/EPSDT Referral Procedures

Immunization administration, laboratory, and blood lead level analysis may be referred to another provider if the screening agent is unable to provide them. Referrals must be documented, and documentation must include the component referred and the provider to whom the child was referred.

Referral Values

KBH/EPSDT referral values are utilized for CMS reporting purposes. Referral values, definitions, and billing instructions are as follows:

When a referral value is present, KBH indicator values (E or B, see CMS 1500 billing instructions) must also be present. Document one referral value per submitted claim as applicable. Referral values are utilized after a KBH screen has been completed.

- AV: Upon completion of the KBH screen, the screen provider initiated a referral; the member refused this referral.
- ST: A new referral request has been initiated and the member accepted the referral.
- S2: An abnormality was observed during the KBH screen; however, the member is currently under treatment for the observed condition.

CMS 1500 paper or equivalent electronic claim form

Referral values are to be claimed in Field 24H.

Updated 04/21

COB: (EPSDT/KBH referral value)

- Enter the two-digit value when an EPSDT (KBH) screen results in a referral.
- The value choices include:

  AV – The member refused the referral.
  S2 – The member is currently under treatment.
  ST – New services requested.

EPSDT / Family Planning:

- Enter E when completing an EPSDT (KBH) screen.
- Enter F when completing a family planning visit.
- Enter B when both an EPSDT (KBH) and family planning visit are completed.

834 Professional claims:

Document the referral value within the X12 claim level 2300 loop. Within loop 2300 KBH referral values should be billed in the CRC segment with appropriate data elements as follows:

- CRC01: ZZ
- CRC02: Y
- CRC03: The appropriate referral value of AV, ST, or S2. HIPAA has labeled this CRC.

KBH/EPSDT Procedure Coding: Procedure/HCPCS Codes Overview

KDHE accepts procedure codes that are approved by CMS. The codes are used for submitting claims for services provided to KBH/ESPDT members and represent services that are provided by enrolled KanCare providers. HIPAA requires providers to comply with the coding guidelines of the AMA CPT Procedure Codes and the International Classification of Disease, Clinical Modification Diagnosis Codes. KBH providers should regularly consult bulletins in the Provider Services Bulletins located on the KMAP Website; https://portal.kmap-state-ks.us/PublicPage/Public/Bulletins

Updated 10/23

Bulletins include updates on approved or updated procedure codes, program, and billing policies.

Member documentation must be maintained in the member's medical file. Immunization administration, laboratory, and blood lead level analysis can be referred to another provider if the screener is unable to provide the service. If it is not possible to complete a screening component or components, document the reason in the member record. Schedule a follow up visit to complete

the KBH screening. Components must not be left blank or undocumented. Not appropriate (NA) and generalized documentation is not acceptable. Documentation by exception is not accepted.

EPSDT Forms

Providers are free to use whatever documenting forms they prefer as long as all elements required by Bright Futures periodicity schedule screenings are met. The State does not dictate which forms providers must use. Suggested forms for KBH/EPSDT screenings are available at the KMAP website should providers choose to use them. KBH/EPSDT providers may also use forms from their EHR to submit payment to the MCO's as long as those forms follow the Bright Futures guidelines.

EPSDT Medical Necessity Form

Effective with dates of service on or after November 1, 2023, providers may submit the EPSDT Medical Necessity Form to the appropriate MCO or KMAP to request medically necessary non-covered services for EPSDT when more information is needed for consideration of coverage. The EPSDT Medical Necessity Form can be found here.

To request medically necessary non-covered EPSDT services, providers should send a request to the appropriate MCO using the standard PA process. If the MCO requests more information on the non-covered service, providers can use this form to provide additional information for the medically necessary service. Medical Necessity is defined in regulation at KAR 30-5-58 (ooo).

EPSDT Medical Necessity does not include experimental or investigational treatments, services, or items not generally accepted as effective and/or not within the normal course and duration of treatment. Services for caregiver or provider convenience are not allowed. Services may be limited in scope and duration. The most cost-effective treatment may be utilized.

The determination of whether a service is medically necessary for an individual child must be made on a case-by-case basis, considering the needs of the child.

Provider responsibilities

KBH/EPSDT providers are responsible for:

- Providing all required initial, periodic, and inter-periodic EPSDT health assessments, diagnosis, and treatment to all KBH eligible members
- Referring members to appropriate providers and specialists as needed
- Ensuring members receive vaccines and immunizations in accordance with the Advisory Committee on Immunizations Practices (ACIP) guidelines
- Addressing unresolved problems, referrals, and results from diagnostic tests including results from previous KBH/EPSDT visits
- Requesting PA and referral for medically necessary EPSDT services in the event a health, diagnostic, preventive, or rehabilitative service or treatment not otherwise covered in required for the member

Updated 04/21

- Education and anticipatory guidance to caregivers and members regarding preventive health care
- Choosing medically accepted screening tools; Bright Futures lists several acceptable screening tools

Access to records

Kansas Regulation K.A.R. 30-5-59 requires providers to maintain and furnish records to KMAP upon request. The provider agrees to furnish records, original radiographs, and other diagnostic images which may be requested during routine reviews of services rendered and payments claimed for KMAP members. If the required records are maintained on machine-readable media, a hard copy of the records must be made available.

The provider agrees to provide the same forms of access to records to the Medicaid Fraud and Abuse Division of the Kansas Attorney General's Office upon request form such office as required by K.S.A. 21-3853 and amendments there to.

Confidentiality and HIPAA Compliance

Providers shall follow all applicable state and federal laws and regulations related to confidentiality as part HIPAA in accordance with section 45 of the code of regulations parts 160 and 164.

Complaint/Grievance Process

Medicaid members and providers who have concerns regarding access to care, utilization of services, quality of services, or rights and dignity can use the following contact information:

- FFS Providers: 1-800-933-6593
- FFS Members: 1-800-766-9012
- For members assigned to an MCO, please contact the applicable MCO.

If you have a concern about the health care provided to a Medicaid member or the quality of health care services of another provider, or for issues concerning potential member fraud, contact KMAP Customer Service at 1-800-933-6593.

Billing Instructions Updated 06/25

Medical Screen:

Preventative Med office visit:

Appropriate CPT Codes

99202	99203	99204	99381*	99382*	99383*	99384*
99385	99391*	99392*	99393*	99394*	99395*	

*Codes are subject to 100% reimbursement, and no reduction in reimbursement for Physician Assistants (PAs) or Advanced Practice Registered Nurses (APRNs).

Hearing screen:

Appropriate CPT Codes

92550	92551	92552	92553	92555	92556	92557
92567	92582	92587	92622 AB*	92623 AB*		

*Limit one per 12-month period.

Vision screen:

Appropriate CPT Codes

92002	92004	92012	92014	99173

Development screening and testing:

Appropriate CPT Codes

96110	96112	96113

Emotional/Behavioral assessment:

Appropriate CPT Codes

96127

Office visit: *

Appropriate CPT Codes

New Patient	99202	99203	99204	99205
Established Patient	99213	99214	99215	

*When billing an office visit code for a KBH screen, a Z code from the list below must be used.

ICD-10 Codes

Z76.2	Z00.121	Z00.129	Z00.110	Z00.111	Z00.00	Z00.01
Z02.0	Z02.1	Z02.2	Z02.3	Z02.4	Z02.5	Z02.6
Z02.81	Z02.82	Z02.83	Z02.89	Z00.8	Z00.6	Z00.5
Z00.70	Z00.71					

Hospital visits:

Appropriate CPT Codes

99460	99461	99463	99468	99477

Refer to the Coding Modifiers Table for instructions on the use of appropriate Modifiers.

Updated 12/24

Dental codes allowable by primary care physician and health departments, as well as dental providers:

Fluoride treatment (these do not update the dental screen)

Appropriate CPT Codes

D1206 (ADA Claim Form only)	D1208* (ADA Claim Form only)	99188* (CMS 1500 Claim Form only)

One application per 120 days.

Dental codes allowable only by dental practitioners:

Codes that update the dental screen

Appropriate CPT Codes

D0120	D0140	D0145	D0150	D0170	D0999*	D9420

*Requires description of the services

Lab Codes for Hemoglobin, Blood Lead and Blood Lipids:

Appropriate CPT Codes

85018	83655	80061

Lead Hazard Risk Assessments:

Visit Type	Code	Frequency Limit
Initial Comprehensive Visit	T1029	Limit One per Calendar Year
Follow-up Visit	T1029 U1	Limit Two per Calendar Year

Immunization Administration Codes (must be accompanied with the appropriate Vaccine code for payment):

Appropriate CPT Codes

90460	90471	90472	90473	90474

Personal Care Services

Effective with date of service on and after January 17, 2024, Personal Care Services (PCS) and Private Duty Nursing (PDN) provided for EPSDT members will require Electronic Visit Verification (EVV). These service codes are to be added to those already required to be billed via the Kansas EVV system.

S5125 EP

Private Duty Nursing Services

T1000 EP

Registered Nurse (RN) Education Visits for Elevated Blood Lead (EBL) Levels:

T1001-U1*

* Limit Four per Calendar Year