How to Code Well-Care Visits for Children and Adolescents
to meet NCQA's HEDIS Quality Goals and Receive Appropriate Reimbursement and Credit for Providing Quality Care
# TABLE OF CONTENTS

Introduction ........................................................................................................................................ Page 3

National Committee for Quality Assurance (NCQA) and Healthcare Effectiveness Data and Information Set (HEDIS)........................................................................ Page 4

Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) & Bright Futures™ .................................................................................................................. Page 6

EPSDT Overview ................................................................................................................................ Page 8

Coding and Billing Guidelines........................................................................................................ Page 10

Glossary ............................................................................................................................................. Page 15

References ......................................................................................................................................... Page 18

Practice Questions .......................................................................................................................... Page 19

The Indiana Health Coverage Programs (IHCP) Family Tree......................................................... Page 21

About MDwise .................................................................................................................................... Page 22
Introduction

This booklet provides basic information on the rules for coding well child and well adolescent visits, especially as it relates to the collection and reporting of data for quality measurement purposes. If the basics of coding are not new to the reader, then the information contained in this booklet will serve as a refresher for appropriate coding and optimal reimbursement as it relates to meeting quality goals for MDwise members in the Indiana Health Coverage Program (IHCP).

State-funded health care programs such as IHCP Medicaid programs, as well as commercial insurance companies, require Managed Care Entities (MCEs) such as MDwise to meet accreditation requirements in order to participate as a provider. More than 90 percent of all MCEs are accredited by the National Committee for Quality Assurance (NCQA). Demonstrating quality performance, through claims and hybrid (medical chart review) data, is a requirement for the accreditation of managed care companies. Therefore,
accurate billing and coding are essential to the collection of quality data in order to demonstrate that the standards of quality care have been met for members in the MCEs.

Providers, who care for MDwise members, commit to providing standard elements of wellness care and screenings for their patients through contractual agreements with MDwise. These nationally accepted quality measures are the right care for the members and are considered Best Practices. Quality measures include annual wellness exams, laboratory tests, childhood immunizations and other preventive care.

Participation in pay for performance (P4P) programs, is a requirement of state and federally funded health care programs. Accurate coding, which is addressed in this booklet, allows accurate and optimal reimbursement and payment of additional funds which are awarded by the State to the MCE, when quality of care goals can be demonstrated through claims data.

Definitions, examples, and practice coding scenarios have been included at the end of this booklet, to assist the reader in practicing coding for various visit types and scenarios, especially as it relates to providing wellness care.

**National Committee for Quality Assurance (NCQA) and Healthcare Effectiveness Data and Information Set (HEDIS)**

The National Committee for Quality Assurance, also known as NCQA, is the organization that accredits MCEs and promotes health care quality for consumers. MCEs, such as MDwise, are required to meet NCQA quality measures when participating in state and federally funded health care programs, such as Indiana Medicaid and the Healthy Indiana Plan (HIP).

Employers and consumers can get reliable information about MCEs and the quality of care and services through data which is published by NCQA.* When coding accurately reflects the health care services provided, it gives the public valuable information which allows the consumer as well as
employer groups to make a choice of MCE based upon standard quality of care measures. Data about preventive care, compiled from many sources, also helps the providers know where improvement is needed and if the efforts toward wellness care are truly making a difference in keeping our communities healthy.

HEDIS, or Healthcare Effectiveness Data & Information Set, is a widely used set of quality measures, developed and maintained by the National Committee for Quality Assurance (NCQA). The data collected is used to rate the quality of MCEs. HEDIS measures are a set of quality related performance standards that NCQA promotes through the accreditation process and publishes for public view. There are over 70 HEDIS measures related to children and adults receiving wellness care.

MCEs are required to incentivize providers to meet quality of care goals in accordance with federal and state pay for performance programs (P4P). The quality goals that MCEs must meet, are those established by NCQA. Both commercial and government insurance programs use NCQA’s HEDIS quality goals to measure the quality of care for their enrolled members. Meeting quality measures is a contractual agreement that MCEs and the providers in the MCE have with payers. The P4P programs are meant to encourage improvement and incentivize the health care providers for meeting certain performance measures for quality and efficiency.

*For more information about NCQA accredited health plans, visit: [http://reportcard.ncqa.org/plan/external/Plansearch.aspx](http://reportcard.ncqa.org/plan/external/Plansearch.aspx).*
Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) & Bright Futures™

What are EPSDT, HealthWatch and Bright Futures™ and How Do These Relate to HEDIS and NCQA Quality of Care Measurements?

The EPSDT and/or HealthWatch, as the program is called in Indiana, is a wellness program to assure children get the care they need. The EPSDT program utilizes the Bright Futures™ recommendations for preventive pediatric health care. Primary Medical Providers (PMPs) are responsible for meeting these standards of care for children enrolled in the Indiana Health Coverage Program.

Bright Futures™ Promoted by the American Academy of Pediatrics (AAP)

This national health care promotion and disease prevention initiative uses a developmentally based approach to address children’s health care needs. Its purpose is to promote and improve infant, child and adolescent health within the context of family and community. Bright Futures™ is a set of principles, strategies and tools that is theory-based, evidence-driven and systems-oriented which can be used to improve the health and well-being of all children.

The centerpiece of Bright Futures™ is a comprehensive set of health supervision guidelines to provide a framework for well child care from birth to age 21. These recommendations are designed to present a single standard of care and a common language based on a model of health promotion and disease prevention. The Recommendations for Preventive Pediatric Health Care can be found at: http://pediatrics.aappublications.org.

The EPSDT program is a standard set of recommended screenings, tests and referrals which was structured to reflect the professional pediatric standard of care and emphasizes early and preventive health care to optimize child development. The Office of Medicaid Policy and
Planning recognizes the alignment of EPSDT services with the Bright Futures™ guidelines. The components of the EPSDT program include a comprehensive health and developmental history, an unclothed physical exam, appropriate immunizations, laboratory tests and health education or anticipatory guidance. In addition, dental, vision and hearing services are required including appropriate screening, diagnostic, and treatment. When potential problems are routinely identified and treated early, every child has a chance to grow and develop to their highest potential.

**Early and Periodic Screening, Diagnosis, and Treatment**

**Early**—Identifying problems early, starting at birth and every visit thereafter.

**Periodic**—Checking children’s health at periodic, age-appropriate intervals.

**Screening**—Doing physical, mental, developmental, dental, hearing, vision and other screening tests to detect potential problems.

**Diagnosis**—Performing diagnostic tests to follow up when a risk is identified.

**Treatment**—Treating the problems found without delay; early intervention can improve outcomes.

Providers who are contracted with an Indiana Medicaid Managed Care Entity or Care Management Organization such as MDwise are expected to provide all of the components of the EPSDT* services for their Healthy Indiana Plan (HIP) members ages 19–20 years, Hoosier Healthwise members up until their 21st birthday, and Care Select members up until their 21st birthday. Primary medical providers (PMPs) in Hoosier Healthwise are responsible for providing and coordinating this care for their eligible members.

*EPSDT services are available to Indiana Health Coverage Programs (IHCP) and are subject to the limitations of each benefit package. Individuals enrolled in Hoosier Healthwise Package C are eligible for these services; however, treatment may be subject to benefit limitations. EPSDT is a required component of care for all Medicaid recipients from birth to 21 years of age.
EPSDT Overview

Recommended Intervals for Well Child Screenings, as recommended by the American Academy of Pediatrics (AAP) are as follows:

- 2–5 days of age
- By 1 month
- 2, 4, 6, 9, 12, 15, 18, 24, and 30 months
- Annually starting at age 3

MDwise reports HEDIS data to NCQA about the use of services including well child visits. Comprehensive well-care exams should be provided at the intervals listed below or more often as medically appropriate. There are no annual limits to medically appropriate comprehensive well-care examinations for MDwise Hoosier Healthwise Members.

HEDIS Well Child Measures:

<table>
<thead>
<tr>
<th>Age</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–15 months</td>
<td>6 visits before the 15th month</td>
</tr>
<tr>
<td>3–6 years</td>
<td>1 visit per year</td>
</tr>
<tr>
<td>12–21 years</td>
<td>1 visit per year</td>
</tr>
</tbody>
</table>

Providing care at the recommended intervals above, allows the organization to meet HEDIS goals and demonstrate that quality care was provided as established by NCQA. Children (as well as adults) should be seen for a comprehensive wellness exam on an annual basis or more often as medically indicated. MCEs, which were created to manage the health of the member and promote wellness care, are encouraged to see new MDwise members within 90 days of enrollment to establish care with the primary medical provider. MCE providers may need to reach out to members to encourage comprehensive well child visits at the intervals listed above.
The Required Components of EPSDT Well Child Exam

In order to meet quality of care standards for participants in the HealthWatch program and claim a higher level of reimbursement for EPSDT screens, the following components of examination and screening must be provided and documented:

- A comprehensive health and developmental history, appropriate for the age and gender of the child, including an assessment of mental and behavioral health
- An age-appropriate assessment of growth and development
- A nutritional assessment
- Developmental screening at ages 9, 18 and 30 months
- Vital signs, including calculation of BMI percentile
- Simple vision and hearing testing
- An unclothed physical examination, head to toe
- Simple oral and dental screening/observation
- Referral for testing and services as indicated
- Immunizations as indicated
- Hemoglobin and lead testing as required by HealthWatch
- A hearing and vision observation at each visit and objective testing with an audiometer at 4 years old
- Health education including anticipatory guidance
Coding and Billing Guidelines

EPSDT Examination and Procedure Codes*

When a child or adolescent is seen for a comprehensive exam that meets the requirements for an EPSDT visit, including testing, screening and other required components as outlined in the HealthWatch Manual, the codes in Table I should be used. The primary diagnosis code must be V20.2 in order to qualify for enhanced reimbursement as well as to receive credit for performing a well-care examination.

TABLE I. Coding an EPSDT Visit Using a V20.2 Diagnosis Code to Receive Credit for Quality Goals and Receive Enhanced Reimbursement

<table>
<thead>
<tr>
<th>Age</th>
<th>Initial Patient Exam EPSDT Codes*</th>
<th>Established Patient Exam EPSDT Codes</th>
<th>Diagnosis Codes: Must be Primary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn</td>
<td>99461</td>
<td>99461</td>
<td>V20.2 or V20.3</td>
</tr>
<tr>
<td>Infant</td>
<td>99381</td>
<td>99391</td>
<td>V20.2</td>
</tr>
<tr>
<td>1–4 years</td>
<td>99382</td>
<td>99392</td>
<td>V20.2</td>
</tr>
<tr>
<td>5–11 years</td>
<td>99383</td>
<td>99393</td>
<td>V20.2</td>
</tr>
<tr>
<td>12–17 years</td>
<td>99384</td>
<td>99394</td>
<td>V20.2</td>
</tr>
<tr>
<td>18–20 years</td>
<td>99385</td>
<td>99395</td>
<td>V20.2</td>
</tr>
</tbody>
</table>

Reimbursement for EPSDT codes when billed with the primary diagnosis code of V20.2:

New patient/Initial exams* 99381–99385 = $75
Established exams 99391–99395 = $62

*Enhanced reimbursement for the initial patient exam is limited to the first EPSDT screen performed by a screening provider during the participant’s lifetime. If additional claims are received for initial screening from the same provider, reimbursement is allowed at the resource-based relative value scale (RBRVS) rate on file for the billed CPT® code, not the higher EPSDT rate.
Please see Section 3-1 and Appendix A for a reference guide for the required components of EPSDT testing, as well as further lists of resources:

Well-Care Procedure Codes

Well child visits which include preventive care, but do not include all of the required components of a complete EPSDT exam, should be billed using Evaluation and Management (E&M) codes and a secondary diagnosis code of V20.2 or V70.0, in order to get credit for a well child visit.

TABLE II.

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
<th>How these codes relate to HEDIS data &amp; billing for well child visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201–99215</td>
<td>Evaluation and Management codes (E&amp;M codes)</td>
<td>When a subsequent diagnosis code of V20.2 or V70.0 is added to the E&amp;M code, and the appropriate elements of care are provided &amp; documented, credit will be given for a well child visit.</td>
</tr>
<tr>
<td></td>
<td>These are office and outpatient services codes for new or established patient</td>
<td></td>
</tr>
</tbody>
</table>

Coding Well Child Visits Appropriately to Meet HEDIS Quality Care Goals

Claims for reimbursement are coded to include both a CPT® (current procedural terminology) known as “Procedure Codes” and ICD-9 (International Classification of Diseases and Related Health Problems)
known as a “Diagnosis Codes.” These codes provide information for payment purposes as well as provide information which is used to measure quality of care goals for NCQA accreditation. It is important to have both the correct CPT® and ICD-9 codes to indicate that well-care was provided so that quality of care goals can be demonstrated through claims data.

Coding Initial Prenatal Visit and Postpartum for a Well-Care Visit Credit

An initial comprehensive prenatal visit or a postpartum visit can be coded as a well-care visit for adolescent mothers, when all care is performed and documented. This allows for the collection of HEDIS quality of care data through claims data.

The initial comprehensive prenatal visit, as well as the postpartum visit, meet all the requirements of a preventive care visit and will count toward wellness care when coded properly. Use one of the routine well-care codes as a subsequent diagnosis code for an adolescent (ages 12–21 years) who has been seen for an initial comprehensive prenatal visit or a comprehensive postpartum visit. This will capture data to count toward the HEDIS Adolescent Well-Care measure when the visit meets the requirements for a preventive care visit as referenced in Table III.
### TABLE III. Coding for Prenatal and Well-Care Exam

<table>
<thead>
<tr>
<th></th>
<th>One of these CPT® codes: PLUS →</th>
<th>One of these Primary ICD-9 Diagnosis codes: PLUS →</th>
<th>One of these Subsequent ICD-9 Diagnosis codes:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prenatal visit</strong></td>
<td>59425 or 59426 or 99201-99215</td>
<td>V22.0 – Supervision of a normal pregnancy or V23 – Supervision of a high risk pregnancy</td>
<td>V20.2 – Routine child health check or V70.0 – Routine general medical examination</td>
</tr>
<tr>
<td><strong>Postpartum Visit</strong></td>
<td>59430</td>
<td>V24.2 – Routine postpartum follow-up This promotes the collection of HEDIS quality data for adolescents up to age 21 years.</td>
<td>[V20.2 or V70.0 should be added as a subsequent diagnosis code to receive credit for preventive care and receive credit for the HEDIS well-care measure.]</td>
</tr>
</tbody>
</table>

Below is a comprehensive list of “V” codes which may be used to allow data to show that well-care was provided, and therefore, improve HEDIS scores.

- V20.2
- V70.0
- V70.3

**Adding a Sick Visit Within an EPSDT Visit**

When a child is seen for a visit for a presenting problem of moderate to high severity and a complete well child EPSDT exam, reimbursement can be claimed for both services. The documentation must support both
the EPSDT exam and the presenting problem or other diagnoses. An EPSDT code with V20.2 as the primary diagnosis, with an Evaluation and Management (E&M) code and Modifier 25 to denote additional services were provided on the same day by the same provider, will allow additional reimbursement when documentation supports the provision of the separate and significant E&M codes as outlined in Table IV below.

**TABLE IV. Coding for a Problem Focused Visit Within an EPSDT Visit**

<table>
<thead>
<tr>
<th>HealthWatch EPSDT codes</th>
<th>PLUS Evaluation &amp; Management (E&amp;M) Codes</th>
<th>PLUS Modifier 25*</th>
<th>PLUS ICD-9 Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99381–99385 or 99391–99395</td>
<td>99203–99215</td>
<td>Documentation must support the use of a modifier 25</td>
<td>V20.2 must be the primary diagnosis code for the preventive visit</td>
</tr>
<tr>
<td>The components of the EPSDT visit must be provided and documented.</td>
<td>The presenting problem must be of moderate to high severity</td>
<td>See the IHCP HealthWatch manual for additional information.</td>
<td>Add multiple diagnosis codes for the presenting problem focused evaluation.</td>
</tr>
</tbody>
</table>

*If a patient is evaluated and treated for a problem during the same visit as an EPSDT exam, the problem-oriented exam can be billed along with the EPSDT visit when accompanied by the 25 modifier. **Modifier 25** means that a significant, separately identifiable evaluation and management service was provided by the same physician on the same day of the procedure or other service which was provided. In other words, two services were provided on the same day by the same provider, which could have been billed separately if the patient had been seen on two separate dates.
Glossary

**Accreditation**—A process whereby a professional association or nongovernmental agency grants recognition to a health care institution for demonstrated ability to meet predetermined criteria for established standards, such as the accreditation of hospitals by the Joint Commission.

**Best Practices**—The term “best practices” refers to those practices that have produced outstanding results in one situation and that could be adapted to another situation. Best practices can be described as a recommended course of action. In health care, best practices often refer to practices which assist a provider in meeting standard quality of care goals.

**BMI**—Body Mass Index is an indicator of body fat based upon height and weight measurements. HEDIS measures include the documentation of BMI percentile and counseling for nutrition and physical activity for members ages 2–17 years.

**Bright Futures™**—An initiative promoted by the American Academy of Pediatrics to promote and improve infant, child and adolescent health within the context of family and community. This national health care promotion and disease prevention initiative uses a developmentally based approach to address children’s health care needs. This initiative includes the *Recommendations for Pediatric Preventive Health Care* periodicity screening schedule.

**CPT® Codes**—CPT® stands for Current Procedural Terminology®. These are the numeric codes which are submitted to insurers for payment. The CPT® code set is maintained by the American Medical Association. The CPT® code set accurately describes medical, surgical, and diagnostic services and is designed to communicate uniform information about medical services and procedures among physicians, coders, patients, accreditation organizations, and payers for administrative, financial, and analytical purposes.

**Diagnosis Codes**—See ICD-9 codes.
EPSDT, Early Periodic Screening Diagnosis and Treatment—A federally mandated program which requires that Medicaid cover a very comprehensive set of benefits and services for children including “necessary health care, diagnostic services, treatment, and other measures that are needed to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.”

EPSDT/HealthWatch—The State of Indiana calls its Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program HealthWatch. This is Indiana Medicaid’s comprehensive and preventive child health program for members under the age of 21 years.

E&M Codes, Evaluation and Management Codes—Codes used for billing office visits. The CPT® codes which describe physician-patient encounters are referred to as E&M codes. E&M coding is the process by which physician-patient encounters are translated into five digit CPT® codes to facilitate billing. There are different E&M codes for different types of encounters such as office visits or hospital visits. Every billable procedure has its own individual CPT® code.

HGB/HCT, Hemoglobin or Hematocrit—These are blood counts used routinely to look for anemia in children. Testing children for anemia is recommended at periodic intervals as a part of a comprehensive well-care examination.

HC, Head Circumference—A measurement of the occipital frontal circumference of a child’s head which allows assessment of the child’s growth.

HEDIS, Healthcare Effectiveness and Data Information Set—A widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA). HEDIS is one component of NCQA’s accreditation process.

IAC, Indiana Administrative Code—These are the policies which outline the rules for the IHCP or Indiana Medicaid programs.
**ICD-9 Codes**—ICD stands for International Statistical Classifications of Diseases (most commonly known by the abbreviation ICD). ICD-9 codes classify diseases and a wide variety of symptoms, abnormal findings, complaints, social circumstances and external causes of injury or disease. Under this system, every health condition can be assigned to a unique category and given a code, up to six characters long. Such categories can include a set of similar diseases.

**IHCP, Indiana Health Coverage Program**—This State program includes Indiana Medicaid, Hoosier Healthwise, Care Select and the Healthy Indiana Plan.

**NCQA, National Committee for Quality Assurance**—A private, 501 (c)(3) not-for-profit organization dedicated to improving health care quality. Since its founding in 1990, NCQA has been a central figure in driving improvement throughout the health care system, helping to elevate the issue of health care quality to the top of the national agenda.

**MCE or MCO, Managed Care Entity or Managed Care Organization**—A health care plan that controls the financing and delivery of health services to members who are enrolled in the health care plan. The goals of managed health care are to ensure that providers deliver high-quality care that manages or controls costs and the care delivered is medically necessary and appropriate for the patient’s condition.

**Modifiers**—Modifiers are additional numbers which are attached to CPT® codes and used to supplement information or adjust the description to provide extra details concerning a procedure provided by a physician to allow for accurate billing and payment. Modifiers are numbers which are attached to CPT® codes to help give payers additional information in order to get a clear picture of the patient’s condition or services provided.

**OMPP**—Office of Medicaid Policy and Planning.
Procedure Codes—See CPT® Codes.

Standards of Care—A standard of care is a medical or psychological treatment guideline, and can be general or specific. It specifies appropriate treatment based on scientific evidence and collaboration between medical and/ or psychological professionals involved in the treatment of a given condition.

WCV, Well Child Visit—For purposes of the MDwise Hoosier Alliance Program, this includes a visit to provide preventive care for children from birth until the 21st birthday.

References

2. Bright Futures™: http://brightfutures.aap.org
6. IHCP/Indiana Health Coverage Programs, provider information: http://provider.indianamedicaid.com
7. MDwise: www.MDwise.org
8. NCQA: www.ncqa.org
Practice Questions

True or False?

1. A sick visit and a comprehensive well-care visit cannot be billed on the same date of service.

2. The addition of a well visit code to the initial comprehensive prenatal or postpartum visit that documents the required elements of care, for adolescent members, will allow a provider to receive credit for the well-care HEDIS measure.

3. EPSDT stands for Early, Periodic, Screening, Developmental, Trials and is a program which providers in the MDwise programs can opt out of.

4. Annual well-care visits can only be billed once a year for MDwise Hoosier Healthwise members.

5. When providing care for a member that includes preventive care, but does not include all of the components of a EPSDT exam, a provider will get credit for providing quality care when a V 20.2 code is added as a subsequent diagnosis code.

6. If a child is seen in the office for a sick visit, and the provider also performs a complete wellness exam, the provider can bill for the sick visit and the well visit if the visit required at least a moderate level of evaluation, and the primary ICD-9 code is a wellness code such as V20.2 along with the 25 modifier.

7. The NCQA HEDIS measure for use of services in infants requires that a minimum of six well-care visits be provided before the child turns 15 months old, in order to achieve the highest HEDIS score.
8. When billing a comprehensive well-care visit, a CPT® code of 993XX should be used and the V20.2 code must be the primary diagnosis code in order to qualify for additional reimbursement and get credit for providing a wellness exam.

9. Participating in the collection of the HEDIS measurement is voluntary for Managed Care Entities which are seeking NCQA accreditation.

Practice Question Answers:

1. **False.** A sick visit of moderate to high severity and a well visit can be billed for the same date of service for MDwise Hoosier Healthwise and Healthy Indiana members.

2. **True.** As a subsequent ICD-9 Diagnosis Code.

3. **False.** EPSDT stands for Early Periodic Screening Diagnosis and Treatment which providers cannot opt out of.

4. **False.** There are no annual limits to medically appropriate well care visits.

5. **True.**

6. **True.**

7. **True.**

8. **True.**

9. **False.** In order to be accredited by NCQA, Managed Care Entities must collect HEDIS measurements.
The Indiana Health Coverage Programs Family Tree

FSSA = Family & Social Services Administration
OMPP = Office of Medicaid Policy and Planning
Maximus = Enrollment Broker

FSSA

OMPP

MAXIMUS

Traditional Medicines

Care Select

Healthy Indiana Plan

Hoosier Healthwise

Risk-Based Managed Care

MDwise

ADVANTAGE (Care Select)

Anthem Blue Cross Blue Shield

Enhanced Services Plan (ESP)

MHS

MDwise

Anthem

MHS

MDwise

MHS

Cenpatico Behavioral Health

Anthem

MDwise

Anthem

MDwise

590 Program
About MDwise

MDwise is a local, not-for-profit Managed Care Entity (MCE), serving Hoosier Healthwise (HHW), Care Select (CS) and Healthy Indiana Plan (HIP) members. MDwise is one of three MCEs that participate in the Hoosier Healthwise Risk Based Managed Care Program.
The Mission of MDwise is to enhance member satisfaction and lower total health care costs by improving the health status of our members through the most efficient provision of quality health care services.

In the HHW and HIP programs, the Office of Medicaid Policy and Planning (OMPP) pays the contracted Managed Care Entity a capitated monthly premium for each IHCP enrollee in the MCE’s plan. The capitated premium covers the cost of the care for services covered under the MCE program and incurred by Indiana Health Coverage Program enrollees in the MCE plan. The MCE assumes financial risk for services rendered to members in its plan. OMPP withholds a percentage of the capitated rate which is paid when the MCE meets or exceeds quality expectations set by OMPP based on Healthcare Effectiveness Data and Information Set (HEDIS) scores.
**EPSDT, HealthWatch, and Bright Futures™ Quick Reference Guide**

### VITALS

<table>
<thead>
<tr>
<th>Age</th>
<th>Measurements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn–18 months</td>
<td>Weight, Height, HC, Weight for Length</td>
</tr>
<tr>
<td>24 and 30 months</td>
<td>Weight, Height, HC for 24 months only, BMI Percentile</td>
</tr>
<tr>
<td>3 years</td>
<td>Weight, Height, Blood Pressure, Vision, BMI Percentile</td>
</tr>
<tr>
<td>4–11 years</td>
<td>Weight, Height, Blood Pressure, Vision, Hearing, BMI Percentile</td>
</tr>
<tr>
<td>12–20 years</td>
<td>Weight, Height, Blood Pressure, Vision, BMI Percentile</td>
</tr>
</tbody>
</table>

### LABS

<table>
<thead>
<tr>
<th>Age</th>
<th>Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 months</td>
<td>Hgb/Hct, Blood Lead Test (required)</td>
</tr>
<tr>
<td>24 months</td>
<td>Hgb/Hct, Blood Lead Test (required)</td>
</tr>
<tr>
<td>5 years</td>
<td>Hgb/Hct</td>
</tr>
<tr>
<td>3–6 years</td>
<td>Blood Lead Test if never done before regardless of risk factors. Hgb/Hct only if clinically indicated.</td>
</tr>
<tr>
<td>Adolescent Female</td>
<td>Chlamydia, yearly, if sexually active.</td>
</tr>
</tbody>
</table>

### OTHER SCREENINGS

<table>
<thead>
<tr>
<th>Age</th>
<th>Screening</th>
</tr>
</thead>
<tbody>
<tr>
<td>9, 18 and 30 months</td>
<td>Structured Developmental Screening (this is different from a developmental surveillance performed at each visit).</td>
</tr>
<tr>
<td>12 months and beyond</td>
<td>A dental/oral screening should be done at each visit</td>
</tr>
<tr>
<td>18 and 24 months</td>
<td>Autism Screening</td>
</tr>
<tr>
<td>Any age</td>
<td>Tuberculin Skin Testing (Mantoux) should be done for kids with an increased risk of exposure to TB.</td>
</tr>
</tbody>
</table>

Hgb/Hct = hemoglobin/hematocrit; HC = Head Circumference; BMI Percentile = Body Mass Index, an indicator of body fat based upon height and weight measurements.

*This reference guide will meet the AAP Bright Futures™ and HealthWatch/EPSDT requirements for the labs, screenings and vital statistics which are required at periodic intervals, during well child visits as part of a comprehensive well child exam. See the Reference section to find complete source information.*