CSI - Ohio

The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Medicaid (ODM)

Regulation/Package Title: Healthchek: Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Covered Services

Rule Number(s):

SUBJECT TO BUSINESS IMPACT ANALYSIS:

To Be Rescinded: 5160-14-03

NOT SUBJECT TO BUSINESS IMPACT ANALYSIS, INCLUDED FOR INFORMATION ONLY:

To Be Rescinded: 5160-14-01, 5160-14-02, 5160-14-04, 5160-14-05, 5160-14-09

New: 5160-14-01, 5160-1-14

Date: June 23, 2017

Rule Type:

- ☐ New
- ☐ Amended
- ☑ 5-Year Review
- ☑ Rescinded

The Common Sense Initiative was established by Executive Order 2011-01K and placed within the Office of the Lieutenant Governor. Under the CSI Initiative, agencies should balance the critical objectives of all regulations with the costs of compliance by the regulated parties. Agencies should promote transparency, consistency, predictability, and flexibility in regulatory activities. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

77 SOUTH HIGH STREET | 30TH FLOOR | COLUMBUS, OHIO 43215-6117

CSIOhio@governor.ohio.gov

Regulatory Intent

1. **Please briefly describe the draft regulation in plain language.**
   Please include the key provisions of the regulation as well as any proposed amendments.

   Rules setting forth coverage and payment policies for Medicaid services provided under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit—known in Ohio as "Healthchek"—are currently set forth in six rules located in Chapter 5160-14 of the Ohio Administrative Code. The rules are being proposed for rescission and will be replaced with a single new rule, 5160-1-14, "Healthchek: early and periodic screening, diagnostic and treatment (EPSDT) covered services."

   One rule in Chapter 5160-14 is subject to CSIO review: Rule 5160-14-03, "Healthchek: early and periodic screening, diagnosis, and treatment (EPSDT) screening visits." This rule lists the components of an EPSDT screening visit and requires providers to make appropriate referrals. Paragraph (K)(3)(d) of rule 5160-14-03 requires providers to inform individuals of all tests performed, give results of each test, and provide health education regarding sexually transmitted infections. Paragraph (M) of rule 5160-14-03 requires health education, including counseling, anticipatory guidance, and risk factor reduction intervention, as part of each initial and periodic Healthchek (EPSDT) visit.

2. **Please list the Ohio statute authorizing the Agency to adopt this regulation.**

   Section 5164.02 of the Ohio Revised Code.

3. **Does the regulation implement a federal requirement? Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?**
   If yes, please briefly explain the source and substance of the federal requirement.

   Yes, the regulation enables ODM to maintain approval to administer and enforce a federal law and participate in a federal program in accordance with Section 1905(a)(4)(B) of the Social Security Act, Section 1905(r) of the Social Security Act, 42 CFR 440.345, and Section 5124(A) of the State Medicaid Manual (EPSDT Services).

   Section 5124(A) of the State Medicaid Manual (EPSDT Services) provides detailed information on how States must implement the EPSDT requirements set forth in Section 1905(a)(4)(B) of the Social Security Act and 42 CFR 440.345.

4. **If the regulation includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.**

   This regulation does not exceed a federal requirement.

5. **What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?**

   This rule describes the screening components that the Healthchek (EPSDT) provider shall complete and document as part of initial and periodic Healthchek (EPSDT) screening visits.

6. **How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?**

   The success of EPSDT coverage and payment regulation can be measured by ODM's quality assessments, improvement activities, and correct payment of EPSDT claims. ODM maintains a set of quality measures that assess performance in the key program areas of access, clinical quality, and consumer satisfaction. Quality measures are grouped by population streams: Healthy Children, Healthy Adults, Women of Reproductive Age, Behavioral Health, and Chronic Conditions. Several of these measures help to ensure the EPSDT regulation is successful in terms of outcomes. ODM requires each of its Medicaid managed care plans (MCPs) to be accredited by the National Committee for Quality Assurance (NCQA). This accreditation requires plans to calculate quality measure results using the Healthcare Effectiveness Data and Information Set (HEDIS) and to conduct annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Surveys. This assessment contains well-child measures, which can include screenings, diagnostics, and treatment for Medicaid recipients younger than 21 years of age. In cases where standards, based on national Medicaid benchmarks, are not met, the MCPs receive a financial penalty. ODM has also worked with the Governor's office on Payment Innovation, which has transformed many volume-based fee-for-service payments to value-based payments that reward better health outcomes. These Payment Innovation models--Comprehensive Primary Care (CPC) Payment Model that increases access to patient-centered medical homes (PCMH) statewide and an Episode-Based Payment Model that rewards higher-quality, value-based care--include value-based payment for screenings, diagnostics, and treatment for Medicaid recipients younger than 21 years of age. Finally, the success of this regulation can be measured by the correct payment of EPSDT claims by the Medicaid Information Technology System (MITS).

Development of the Regulation

7. **Please list the stakeholders included by the Agency in the development or initial review of the draft regulation.**
   If applicable, please include the date and medium by which the stakeholders were initially contacted.

   The Agency sent the draft regulation by e-mail to the following stakeholders on January 6, 2017 and January 30, 2017.

   American Academy of Family Physicians, American Academy of Pediatrics (Ohio Chapter), Association of Ohio Health Commissioners , Children's Defense Fund, Disability Rights Ohio, Head Start, Lead Testing, Legal Aid Society of Columbus ,

Ohio Academy of Family Physicians, Ohio Association of Advanced Practice Nurses, Ohio Association of Child Caring Agencies, Ohio Association of Community Health Centers , Ohio Association of County Behavioral Health Authorities, Ohio Association of County Boards of Developmental Disabilities, Ohio Association of Health Plans, Ohio Association of Medical Equipment Services, Ohio Association of Physician Assistants, Ohio Chapter of American College of Physicians , Ohio Children's Hospital Association, Ohio Council of Behavioral Health and Family Services Providers, Ohio Dental Association, Ohio Department of Development Disabilities, Ohio Department of Education, Ohio Department of Health, Ohio Department of Health (Office of Rural Health Centers), Ohio Department of Youth Services, Ohio Developmental Disabilities Council, Ohio Family and Children's First Council Association, Ohio Hospital Association, Ohio Job and Family Services Directors Association, Ohio Job and Family Services Office of Children and Families, Ohio Medical Directors Association, Ohio Nurses Association, Ohio Occupational Therapy Association, Inc., Ohio Ophthalmological Society, Ohio Optometric Association, Ohio Osteopathic Association, Ohio Physical Therapy Association, Ohio Poverty Law Center, Ohio Psychiatric Physicians Association, Ohio Psychological Association, Ohio Speech-Language-Hearing Association, Ohio State Chiropractic Association, Ohio State Medical Association, Public Children's Services Association of Ohio, and Voices for Ohio's Children

The Agency also included its Medicaid managed care plans and sister agencies (as listed above) in the initial review of the draft regulation.

8. **What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?**

   No concerns were expressed on the proposed rescission of rule 5160-14-03.

9. **What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?**

   The use of scientific data does not apply to the development of this regulation.

10. **What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives?**

    ODM considered maintaining the existing six EPSDT rules, but determined instead that unnecessary provisions (e.g., provisions already required in Ohio Administrative or Revised Code or federal regulations) could be omitted. Removing unnecessary provisions, allowed ODM to consolidate six rules into one new rule.

11. Did the Agency specifically consider a performance-based regulation? Please explain. Performance-based regulations define the required outcome, but don't dictate the process the regulated stakeholders must use to achieve compliance.

The concept of performance-based regulation does not apply to these services.

12. What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?

Rules involving Medicaid providers are housed exclusively within agency 5160 of the Ohio Administrative Code. Within this division, rules are generally separated out by topic. It is clear which rules apply to which type of provider and item or service; in this instance, there was no duplication.

In addition, rule 5160-14-03 was reviewed by legal staff to ensure it does not duplicate an existing Ohio regulation.

13. Please describe the Agency's plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.

This rule is being proposed for rescission. Necessary provisions are being moved to a new EPSDT rule. To ensure the regulated community is aware of the rescission, ODM created a placeholder rule to direct the regulated community to the new EPSDT rule.

Adverse Impact to Business

14. Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:

a. Identify the scope of the impacted business community:

This rule affects providers that render medically necessary services to Medicaid-eligible individuals younger than twenty-one years of age.

b. Identify the nature of the adverse impact (e.g., license fees, fines, employer time for compliance); and

The nature of the adverse impact is provider time for compliance for the report of required information.

Paragraph (K)(3)(d) of rule 5160-14-03 requires providers to inform adolescents of all tests performed, give results of each test, and provide health education regarding sexually transmitted infections.

Paragraph (M) of rule 5160-14-03 requires health education as part of each initial and periodic Healthchek (EPSDT) visit including counseling, anticipatory guidance, and risk factor reduction intervention. Health education must be designed to assist parents and individuals in understanding what to expect in terms of the individual's development and to provide information about the benefits of healthy lifestyles and practices, and disease prevention. Providers are required to encourage parents and individuals (if age appropriate) participating in the program to take advantage of screening services, dental services, vision services, and hearing services covered under Medicaid.

c. Quantify the expected adverse impact from the regulation.

The adverse impact to providers rendering EPSDT services is not directly attributable to rule 5160-14-03. Informing patients of all tests performed, giving results of each test, and providing health education are components of a standard office visit.

According to Labor Market Information (LMI) data published by the Ohio Department of Job and Family Services (ODJFS), the median statewide hourly wage associated with a physician performing the above-mentioned services is $79.38; adding 30% for fringe benefits brings the figure to $103.20. Therefore, the estimated cost of a physician informing a patient of all tests performed, giving results of each test, and providing health education during a half hour office visit is approximately $51.60.

According to LMI data published by ODJFS, the median statewide hourly wage associated with other types of providers (e.g., nurse practitioners, advanced practice registered nurses) who may perform the above-mentioned services ranges from $30.03 to $46.34; adding 30% for fringe benefits brings the range from $39.04 to $60.24. Therefore, the estimated cost of other types of providers informing a patient of all tests performed, giving results of each test, and providing health education during a half hour office visit ranges from approximately $19.52 to $30.12.

The amount ODM pays a provider for rendering a standard office visit that would include informing a patient of all tests performed, giving results of each test, and providing health education ranges from $38.93 to $89.93 (based on time spent) per visit.

15. Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?

ODM determined that the regulatory intent justified the adverse impact to the regulated business community because the regulation was enacted to enable ODM to maintain approval to administer and enforce a federal law and participate in a federal program.

Regulatory Flexibility

16. Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.

The regulation outlines actions all providers must take in order to properly conduct and EPSDT screening. The requirements are applied uniformly and no exception is made based on an entity's size.

17. How will the agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?

This rule imposes no sanctions on providers.

18. What resources are available to assist small businesses with compliance of the regulation?

The Bureau of Provider Services renders technical assistance to providers through its hotline, (800) 686-1516.

Policy questions may be directed via e-mail to the Non-Institutional Policy section of ODM's policy bureau, at noninstitutional_policy@medicaid.ohio.gov.

5160-1-14 **Healthchek: early and periodic screening, diagnostic, and treatment (EPSDT) covered services.**

(A) Definitions.

(1) "Healthchek" is Ohio's early and periodic screening, diagnostic, and treatment (EPSDT) benefit for all medicaid recipients younger than twenty-one years of age, described in 42 U.S.C. 1396d(r) (as in effect 10/2017).

(2) "Bright futures guidelines" are the American academy of pediatrics bright futures guidelines for preventive health care (rev. 2/2017), available at http://www.aap.org.

(3) "Medical necessity" and "medically necessary" have the same meaning as in rule 5160-1-01 of the Administrative Code.

(4) "Prior authorization" is one of two processes:

(a) For members of a medicaid managed care plan (MCP), it is the process established by the medicaid MCP as required by rule 5160-26-05.1 of the Administrative Code.

(b) For all other medicaid recipients, it is the process outlined in rule 5160-1-31 of the Administrative Code.

(B) Providers. Healthchek screening, diagnostic, and treatment services may be rendered by eligible providers in an appropriate discipline, acting within the scope of practice authorized under state law and as set forth in agency 5160 of the Administrative Code.

(C) Coverage. For medicaid-eligible individuals younger than twenty-one years of age, healthchek covers the following services and items:

(1) Screening services.

(a) Healthchek screening services include, but are not limited to, all of the following procedures:

(i) A comprehensive health and developmental history, including assessment of both physical and mental health development, as well as substance abuse disorders;

(ii) A comprehensive unclothed physical exam, when appropriate;

(iii) Immunizations appropriate to age and health history;

(iv) Laboratory tests, including lead blood level assessment appropriate to age and risk factors, as required by the centers for medicare and medicaid services (CMS);

(v) Nutritional status assessment; and

(vi) Health education, counseling, anticipatory guidance, and risk factor reduction intervention provided to an individual younger than twenty-one years of age and, as applicable, to another person responsible for the individual younger than twenty-one years of age.

(b) Healthchek screening services are covered at the following frequency:

(i) For immunizations, in accordance with the schedule regarding the appropriate periodicity, dosage, and contraindications applicable to pediatric vaccines established by the advisory committee on immunization practices of the centers for disease control and prevention, found at http://www.cdc.gov/vaccines/hcp/acip-recs/index.html;

(ii) For other screening services, at ages and intervals in accordance with the bright futures guidelines; and

(iii) For all screening services, at such other intervals indicated as medically necessary to determine the existence of physical or mental illnesses or conditions.

(2) Vision services.

(a) Healthchek vision services include but are not limited to diagnosis and treatment for defects in vision, including eyeglasses.

(b) Healthchek vision services are covered at the following frequency:

(i) At intervals that meet reasonable standards of medical practice in accordance with the bright futures guidelines; and

(ii) At such other intervals indicated as medically necessary to determine the existence of a suspected illness or condition.

(3) Dental services.

(a) Healthchek dental services include but are not limited to relief of pain and infections, restoration of teeth, and maintenance of dental health.

(b) Healthchek dental services are covered at the following frequency:

(i) For individuals six years of age or younger, at intervals that meet reasonable standards of dental practice in accordance with the bright futures guidelines;

(ii) For individuals older than six and younger than twenty-one years of age, at least once every one hundred eighty days; and

(iii) For all individuals younger than twenty-one years of age, at such other intervals indicated as medically necessary to determine the existence of a suspected illness or condition.

(4) Hearing services.

(a) Healthchek hearing services include but are not limited to diagnosis and treatment for defects in hearing, including hearing aids.

(b) Healthchek hearing services are covered at the following frequency:

(i) At intervals that meet reasonable standards of medical practice in accordance with the bright futures guidelines; and

(ii) At such other intervals indicated as medically necessary to determine the existence of a suspected illness or condition.

(5) All medically necessary services and items set forth in agency 5160 of the Administrative Code.

(6) All medically necessary screenings, health care, diagnostic services, treatment, and other measures described in 42 U.S.C. 1396d(a) (as in effect 10/2017) to correct or ameliorate defects and physical and mental illnesses and conditions, regardless of whether such measures are addressed in agency 5160 of the Administrative Code.

(D) Additional provisions.

(1) Coverage limits that have been established may be exceeded, with prior authorization, for medically necessary services rendered to medicaid-eligible individuals younger than twenty-one years of age.

(2) Separate payment may be made for additional medically necessary services rendered during, as part of, or as a result of a screening visit. Payment may be made to a provider for necessary follow-up services rendered at the time of the screening visit if the provider is qualified to perform them.

(3) When a screening examination indicates the need for further evaluation of a child's health, the child should be appropriately referred without delay for diagnosis and necessary treatment.

Replaces: Part of 5160-14-01, part of 5160-14-03, part of 5160-14-04, part of 5160-14-09

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5164.02
Prior Effective Dates:	04/07/1977, 11/01/1985, 09/01/1987, 02/17/1991, 04/01/1992 (Emer), 07/01/1992, 01/15/1995, 01/04/2000 (Emer), 03/20/2000, 08/01/2001, 07/01/2003, 07/01/2006, 02/14/2011

5160-14-01 **Relocated provisions concerning EPSDT services.**

Policy provisions concerning early and periodic screening, diagnostic, and treatment (EPSDT) services are set forth in rule 5160-1-14 of the Administrative Code.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5164.02

TO BE RESCINDED

5160-14-01 **Healthchek: early and periodic screening, diagnostic and treatment (EPSDT) mandatory services for medicaid recipients under twenty-one years of age.**

(A) Definitions. The following definitions apply to Chapter 5101:3-14 of the Administrative Code:

(1) "Current procedural terminology" (CPT) has the same meaning as in Chapter 5101:3-1 of the Administrative Code.

(2) "Healthchek" is Ohio's early and periodic screening, diagnostic and treatment (EPSDT) benefit for all medicaid recipients under twenty-one years of age.

(3) "Healthchek services," also known as "EPSDT services," has the same meaning as in rule 5101:1-38-05 of the Administrative Code.

(4) "Medically necessary services" has the same meaning as in rule 5101:3-1-01 of the Administrative Code.

(5) "Prior authorization" for a member of a medicaid managed care plan is the process established by the medicaid managed care plan as required by rule 5101:3-26-05.1 of the Administrative Code. For all other medicaid recipients, prior authorization is the process outlined in rule 5101:3-1-31 of the Administrative Code.

(6) "Screening" means the identification of individuals at risk of health problems. Results of a screening do not represent a diagnosis, but rather may indicate the need for referral to an appropriate resource for additional evaluation, diagnosis, treatment, or other follow-up when concerns or questions remain as a result of the screening.

(B) Subject to the limitations of 42 U.S.C. 1396d(r) (1/1/2011), healthchek requires the coverage of the following screening services, described in Chapter 5101:3-14 of the Administrative Code:

(1) A comprehensive health and developmental history (including assessment of both physical and mental health development);

(2) A comprehensive unclothed physical examination;

(3) Appropriate immunizations;

(4) Appropriate vision testing;

(5) Appropriate laboratory tests; and

(6) Appropriate dental screenings.

(C) Healthchek requires coverage of all mandatory and optional medically necessary services (including treatment) and items listed in 42 U.S.C. 1396d(a) (1/1/2011) to correct or ameliorate defects and physical and mental illness and conditions discovered by a screening service described in paragraph (B) of this rule. Such services and items, if approved through prior authorization, include those services and items listed at 42 U.S.C. 1396d(a) (1/1/2011) that are in excess of state medicaid plan limits applicable to adults. Nothing in Chapter 5101:3-14 requires healthchek to cover services or items that are not listed in 42 U.S.C. 1396d(a) (1/1/2011).

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5162.03, 5164.02
Prior Effective Dates:	04/07/1977, 09/01/1987, 02/17/1991, 08/01/2001, 07/01/2006, 02/14/2011

TO BE RESCINDED

5160-14-02 **Healthchek: eligible providers of early and periodic screening, diagnosis, and treatment (EPSDT) services.**

(A) Healthchek (EPSDT) screening services, composed of the components described in rule 5101:3-14-03 of the Administrative Code, shall be provided by the following eligible providers:

(1) Eligible providers of physician services, in accordance with Chapter 5101:3-4 of the Administrative Code may provide physician services; and

(2) Advanced practice nurses (APNs) may also provide healthchek (EPSDT) screening services, in accordance with Chapter 5101:3-8 of the Administrative Code.

(B) Healthchek (EPSDT) diagnosis and treatment services, composed of the components described in rule 5101:3-14-05 of the Administrative Code, may be provided by the following eligible providers:

(1) Eligible providers of vision services as defined in Chapter 5101:3-6 of the Administrative Code may provide vision services;

(2) Eligible providers of dental services as defined in Chapter 5101:3-5 of the Administrative Code may provide dental services;

(3) Eligible providers of physician or clinic services as defined in Chapters 5101:3-4 and 5101:3-13 of the Administrative Code may provide hearing services; and

(4) Other medically necessary health care, diagnostic, or treatment services that are covered under the medicaid program may be provided by eligible medicaid providers.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5162.03, 5164.02
Prior Effective Dates:	04/07/1977, 09/01/1987, 02/17/1991, 08/01/2001, 07/01/2006

TO BE RESCINDED

5160-14-03 Healthchek: early and periodic screening, diagnosis, and treatment (EPSDT) screening visits.

This rule describes the screening components that the healthchek (EPSDT) provider shall complete and document as part of initial and periodic healthchek (EPSDT) screening visits, unless the individual or the individual's parent or guardian, refuses the components. The provider shall document such a refusal.

(A) Definitions.

(1) For the purposes of Chapter 5101:3-14 of the Administrative Code, "screening" is defined as the identification of individuals at risk of health problems. Results of a screening do not represent a diagnosis, but rather, indicate need for referral to an appropriate resource for additional evaluation, diagnosis, treatment, or other follow-up when concerns or questions remain as a result of the screening.

(2) For the purposes of Chapter 5101:3-14 of the Administrative Code, "CPT" (current procedural terminology) is defined in rule 5101:3-1-19.3 of the Administrative Code.

(B) Screening frequencies and indication of need for further evaluation.

(1) Screening components of the healthchek (EPSDT) visit shall be provided to individuals at ages and at frequencies in accordance with American academy of pediatrics recommendations for preventative pediatric health care (March, 2000), www.aap.org.

(2) Healthchek (EPSDT) screening providers shall coordinate with public and private resources to eliminate duplicative screening and ensure comprehensive screening, evaluation, diagnosis, and treatment.

(3) When a healthchek (EPSDT) screening visit indicates the need for further evaluation of an individual's health, the provider shall, without delay, make a referral for evaluation, diagnosis, and/or treatment. For individuals enrolled in the medicaid managed care program (MCP), the healthchek (EPSDT) provider shall utilize referral requirements specified in rule 5101:3-26-05.1 of the Administrative Code in satisfying the referral requirements for healthchek (EPSDT) services as defined in Chapter 5101:3-14 of the Administrative Code.

(C) Comprehensive health and developmental history.

(1) A "comprehensive health and developmental history" is a profile of the individual's medical history and includes a review of both physical and mental health development. The provider shall obtain the individual's medical history from the individual (if age appropriate), the individual's parent, or a responsible adult who is familiar with the individual's history.

(2) The provider shall obtain or update the comprehensive health and developmental history at each initial and periodic healthchek (EPSDT) screening visit. The comprehensive health and developmental history shall include at a minimum:

(a) Current complaints/concerns;

(b) The individual's and family's history of illnesses, diseases, and allergies;

(c) Current medications and adverse effects to medications;

(d) The individual's social or physical environment that may affect the individual's overall health; and

(e) For adolescents, the individual's sexual activity and contraceptive methods.

(D) The provider shall perform a comprehensive unclothed physical examination during each initial and periodic screening visit. The examination shall include at a minimum:

(1) Measurements of height and weight, including comparisons of age-appropriate percentiles;

(2) Blood pressure, as age-appropriate;

(3) Head circumference, including percentiles, as age-appropriate;

(4) Examination of head, ears, eyes, nose, and throat; respiratory, cardiovascular, gastrointestinal, reproductive, musculoskeletal and neurological systems;

(5) For age-appropriate females, a breast inspection and palpation, and instructions

in breast self-examination;

(6) For age-appropriate males, testicular examination, and instructions in self-examination of the testes; and

(7) A pelvic examination may be provided for age-appropriate females as part of the healthchek (EPSDT) screening visit, when medically indicated. Pelvic examinations are considered part of the comprehensive unclothed physical examinations and are not reimbursed separately.

(E) Developmental screening (including physical and mental health development).

(1) The provider shall perform or update the developmental screening at each initial and periodic screening visit. The developmental screening shall include an age-appropriate developmental history and a screening of the individual's motor, speech, mental, and social development.

(2) Formal developmental tests that are performed during the screening visit will be reimbursed in addition to the healthchek (EPSDT) screening visit as described in rule 5101:3-14-04 of the Administrative Code.

(3) When the screening of the individual's mental health indicates the need for diagnostic and/or therapeutic mental health services, the services are covered and reimbursed separately in accordance with Chapters 5101:3-4 (physician services), 5101:3-8 (limited practitioner services), and 5101:3-27 (community mental health agency services) of the Administrative Code. Drug and alcohol rehabilitation shall be covered and reimbursed separately in accordance with Chapter 5101:3-30 (alcohol and drug addiction services) of the Administrative Code.

(F) Nutritional screening.

The provider shall perform a screening of the individual's nutritional status as part of the basic examination component of each initial and periodic healthchek (EPSDT) screening visit through questions about dietary practices, measurements of height and weight (in accordance with paragraph (D) of this rule), laboratory testing (if medically indicated, in accordance with paragraphs (J) and (K) of this rule), a complete physical examination in accordance with paragraph (D) of this rule), and a dental screening (in accordance with paragraph (L) of this rule).

(G) Vision screening.

(1) The provider shall perform a vision screening as part of each initial and periodic healthchek (EPSDT) screening visit using the following criteria:

(a) Individuals ages birth to three years shall be screened by reviewing the individual's medical history for risk factors and by performing an external (gross) observation and (internal) ophthalmoscopy.

(b) Individuals ages three and older are required to be screened by:

(i) External (gross) observation and (internal) ophthalmoscopy;

(ii) Visual acuity test (e.g., Titmus, Snellen, Lea, or Tumbling E);

(iii) Ocular muscle balance test, administered at distance and near; and,

(iv) Stereopsis test (e.g., random dot E).

(2) A vision screening is considered part of the comprehensive healthchek (EPSDT) visit and is not reimbursed separately.

(3) When the vision screening indicates a potential visual problem or when a parent, teacher, professional, or responsible adult suspects that the individual has a vision problem, the provider shall, without delay, make a referral for the individual to an ophthalmologist or an optometrist for evaluation, diagnosis, and/or treatment.

(H) Hearing screening.

(1) The provider shall perform a hearing screening during each initial and periodic healthchek (EPSDT) screening visit using the following criteria:

(a) Individuals ages one to three years shall be screened by:

(i) Reviewing the individual's history for risk factors or symptoms indicative of hearing problems; and

(ii) Observing the child for, and questioning the parents about, physical behaviors or speech development that may suggest a hearing impairment.

(b) Individuals ages three and older shall be screened by:

(i) Using manually administered, individual pure-tone, air conduction equipment, if the provider has the equipment available; or

(ii) .When pure-tone equipment is not available, providers are encouraged to refer children to another provider for a pure-tone test.

(2) If pure-tone equipment is used or other covered hearing services are provided, the service shall be separately reimbursed to the provider who performs the procedure as described in rule 5101:3-14-04 of the Administrative Code.

(3) When the hearing screening indicates a hearing impairment or a parent, teacher, professional, or other responsible adult reports that the child may have a hearing problem, the provider shall, without delay, make a referral for the child to a health care provider who specializes in the evaluation, diagnosis, and treatment of hearing problems and is eligible to provide the service under the medicaid program.

(I) Immunization screening.

(1) The provider shall perform an immunization screening as part of the basic examination component of each initial and periodic screening visit and shall include a history of past immunizations.

(2) If, at the time of screening, an immunization is needed, the provider shall provide the immunization or refer the individual for the appropriate immunization unless the immunization is medically contraindicated. If medically contraindicated, the immunization shall be rescheduled as appropriate.

(3) The provider shall use the standard immunization schedule in accordance with rule 5101:3-4-12 of the Administrative Code.

(4) Immunizations shall be reimbursed separately as described in rule 5101:3-14-04 of the Administrative Code.

(J) Lead toxicity screening.

(1) The centers for medicare and medicaid services (CMS) and centers for disease control and prevention (CDC) require the following lead screening:

(a) All children must receive a blood lead screening test at twelve months and twenty-four months of age;

(b) Children between the ages of thirty-six months and seventy-two months of age shall receive a blood lead screening test if they have not been previously screened for lead poisoning.

(c) A blood lead screening test shall be used when screening.

(i) Blood lead screening tests are covered whenever medically indicated.

(ii) The test methodology used for the required blood lead screening test shall have the sensitivity to detect blood lead levels of ten micrograms per deciliter or lower.

(iii) The erythrocyte protoporphyrin test does not meet this standard and is not acceptable as a blood lead screening test. The erythrocyte protoporphyrin test may be used to diagnose other conditions such as iron deficiency.

(d) Children of any age may be screened.

(K) Laboratory tests.

(1) Based on the individual's medical and nutritional history, age, physical condition, ethnic background, and home environment, the primary health care provider shall determine and order the appropriate laboratory procedures.

(2) Reimbursement is available to a physician or clinic if the laboratory procedures are actually performed in the physician's office or clinic and the physician's office or clinic meets the requirements set forth in Chapter 5101:3-11 of the Administrative Code. Specimens that are sent to an outside laboratory for analysis must be billed by the laboratory that actually performs the procedure.

(3) These laboratory procedures shall include, but are not limited to, the following:

(a) Blood lead screening test, in accordance with paragraph (J) of this rule and rule 3701-82-02 of the Administrative Code.

(b) Hemoglobin and/or hematocrit.

Anemia is a common condition reported during the healthchek (EPSDT) screening visit. At a minimum, a hematocrit and/or hemoglobin is recommended on all premature and low birth weight infants during the first six months of life. If medical indications are noted in the physical examination, a test for anemia may be performed at any age. Such medical indications include a history of inadequate iron in the diet, a history of blood loss, family history of anemia, or pallor.

(c) Sickle cell test.

It is recommended that a test for sickle cell and/or other hemoglobinopathies be performed at least once on all children of African-American, Greek, Italian, Arabian, Egyptian, Turkish, or Asiatic Indian descent. If it cannot be determined that a child has been tested previously, a test for the sickle cell or other hemoglobinopathies should be performed.

(d) Pap smears and tests for sexually transmitted infections.

Pap smears are recommended for all females age eighteen or older. Sexually active adolescents should be tested regardless of age. Tests for sexually transmitted infections are covered if medically indicated. Individuals shall be informed about all tests performed, given results of each test and provided health education regarding sexually transmitted infections, in accordance with paragraph (M) of this rule.

(e) Tuberculin test.

(i) A tuberculin test shall be performed on all individuals who:

(a) Are suspected of having a mycobacterial infection;

(b) Have a known history or exposure to active tuberculosis (TB);

(c) Are immigrants from high prevalence areas of TB;

(d) Are from areas of high endemic rates of TB; or

(e) Are members of families or social groups with an increased incidence of the disease.

(ii) If an individual does not meet at least one of the conditions listed in paragraph (K)(3)(e)(i) of this rule, TB testing is optional.

(iii) The tuberculin test shall be reimbursed in accordance with rule 5101:3-14-04 of the Administrative Code.

(f) Other laboratory screens as medically necessary.

(L) Dental screening.

(1) For children from birth through the age of two years, the provider shall perform a dental screening as part of the basic examination component of each initial and periodic screening visit, and shall include, at a minimum:

(a) A screening of the growth and development of the dentition and adjacent dento-facial structure and an oral inspection for dental caries shall be performed. Individuals shall be provided health education regarding early childhood caries prevention in accordance with paragraph (M) of this rule.

(b) When a dental screening and oral inspection indicates the need for further evaluation, the provider shall, without delay, make a referral to a dentist or, in accordance with rule 5101:1-38-05 of the Administrative Code, to the county department of job and family services (CDJFS) for a referral to a dentist, for evaluation, diagnosis, and/or treatment.

(c) Diagnostic and preventive dental examinations shall be provided to individuals at ages and at frequencies in accordance with American academy of pediatrics recommendations for preventative pediatric health care. Providers are encouraged to refer children, beginning at age two years to a dentist or the CDJFS for a referral to a dentist.

(2) For children ages three years through twenty, the provider shall perform a dental screening during each initial and periodic screening visit, and shall include, at a minimum:

(a) Providers of the healthchek (ESPDT) screening visits shall provide individuals ages three years and older with referrals to a dentist or to the CDJFS if the individual has not been seen by a dentist or dental hygienist under the supervision of a dentist during the last six months.

(b) Physicians are encouraged to emphasize the importance of preventive dental health care available under the medicaid program. Providers should explain that cleanings, examinations, and fluoride treatments are covered every six months. Dental sealants are covered for permanent first molars for children under age nine and for permanent second molars for individuals under age eighteen.

(M) Health education, counseling, anticipatory guidance, and risk factor reduction interventions.

(1) Health education, including counseling, anticipatory guidance, and risk factor reduction intervention, is a required component of each healthchek (EPSDT) screening visit. Health education should be designed to assist parents and individuals in understanding what to expect in terms of the individual's development and to provide information about the benefits of healthy lifestyles and practices, and disease prevention.

(2) Providers should encourage parents and individuals participating in the program to take advantage of screening services, dental services, vision services, and hearing services covered under medicaid.

(3) Health education and counseling is part of each initial and periodic healthchek (EPSDT) visit. Additional health education codes and counseling will not be reimbursed on the same date of service as a healthchek (EPSDT) visit.

(4) The preventive counseling code/anticipatory guidance shall be billed only when counseling/anticipatory guidance is provided at an encounter separate from the healthchek (EPSDT) screening visit.

(N) When a healthchek (EPSDT) screening visit indicates the need for further evaluation of an individual's health, the provider shall, without delay, make a referral for evaluation, diagnosis, and/or treatment. Evaluation, diagnosis, and/or treatment may be provided at the time of the healthchek (EPSDT) screening visit if the health care professional is qualified to provide the services.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5162.03, 5164.02
Prior Effective Dates:	04/07/1977, 09/01/1987, 01/15/1990, 02/17/1991, 04/01/1992 (Emer), 07/01/1992, 01/15/1995, 01/04/2000 (Emer), 03/20/2000, 08/01/2001, 07/01/2006

TO BE RESCINDED

5160-14-04 **Healthchek: reimbursement of early and periodic screening, diagnosis, and treatment (EPSDT) services.**

(A) Healthchek (EPSDT) service codes.

(1) Healthchek (EPSDT) screening visits shall be billed using the appropriate preventive medicine services code, reflecting a comprehensive preventive medicine evaluation and management, focusing on age and gender appropriate history, examination, anticipatory guidance, and risk factor reduction interventions. For new patients, codes are 99381 to 99385; for established patients, codes are 99391 through 99395.

(2) Providers of healthchek (EPSDT) screening visits shall include the following information when billing the department based on the date of service and type of claim submission.

(a) For dates of service prior to October 16, 2003 or the effective date of electronic data interchange transactions (e.g. the 837 professional transaction), indicate that the service is part of the healthchek (EPSDT) program by placing:

(i) An "E" in item 24h on the paper claim form or in the same block on an electronic claim, indicating that a healthchek (EPSDT) visit was provided and no follow-up services were required; or

(ii) An "R" in item 24h on the paper claim form or in the same block on an electronic claim, indicating that a healthchek (EPSDT) visit was provided, follow-up is required, and a referral was made.

(b) For dates of service October 16, 2003 and after or the effective date of electronic data interchange transactions (e.g. the 837 professional transaction) and based on the type of claim submission, follow these instructions:

(i) When billing electronically using the 837 professional claim transaction, use the EPSDT referral feature in the 2300 claim information loop to indicate that the healthchek (EPSDT) referral was made by placing a "Y" in the "Yes/No" condition or response code data element and complete the condition indicator data

element in the healthchek (EPSDT) referral feature area.

(ii) When using a paper claim form, follow the instructions provided in paragraphs (A)(2)(a)(i) and (A)(2)(a)(ii) of this rule, which require that item 24h on the paper claim form be completed.

(B) Reimbursement for diagnostic and treatment services.

(1) In addition to the healthchek (EPSDT) screening services, the department will reimburse providers for the following services provided during, or as part of, the healthchek (EPSDT) screening visit.

(a) Specimen collection and laboratory services in accordance with Chapter 5101:3-11 of the Administrative Code, although specimens sent to an outside laboratory for analysis must be billed by the laboratory that actually performs the procedure;

(b) Immunizations in accordance with rule 5101:3-4-12 of the Administrative Code;

(c) Formal developmental tests;

(d) Pure-tone audiometry and other formal hearing tests using calibrated electronic equipment;

(e) Tuberculin tests; and

(f) Other covered physician services in accordance with Chapter 5101:3-4 of the Administrative Code.

(2) Interperiodic examinations, vision, hearing, and dental services that are medically necessary to determine the existence of suspected physical or mental illnesses or conditions are covered under medicaid and may be billed in accordance with Chapters 5101:3-4, 5101:3-5, and 5101:3-6 of the Administrative Code.

(3) The services listed in paragraph (B)(1) of this rule are services that may be performed on the same day as the healthchek (EPSDT) screening visit or at another time as medically indicated or as necessary from a scheduling standpoint (e.g., a patient requires that an immunization service be administered in three months from the date of the screening service).

(a) These services may be provided by the provider who performed the healthchek (EPSDT) screening service or by another eligible provider under medicaid.

(b) Only the provider who performed the service may bill for the service.

(4) To receive separate reimbursement for these services, the provider must bill the department by itemizing the appropriate code in accordance with rule 5101:3-1-60 of the Administrative Code.

(C) Prior authorization and claim submission requirements for healthchek (EPSDT) services provided through the medicaid managed care program (MCP) are specified in rule 5101:3-26-05.1 of the Administrative Code.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5162.03, 5164.02
Prior Effective Dates:	04/07/1977, 09/01/1987, 02/17/1991, 04/01/1992 (Emer), 07/01/1992, 08/01/2001, 07/01/2003, 07/01/2006

TO BE RESCINDED

5160-14-05 **Healthchek: covered diagnostic and treatment services under early and periodic screening, diagnosis, and treatment (EPSDT).**

When a screening examination indicates the need for further evaluation of an individual's health, the provider shall make a referral for diagnosis and treatment without delay, and follow-up to make sure that the individual receives a complete diagnostic evaluation. Evaluation, diagnosis, and/or treatment may be provided at the time of the healthchek (EPSDT) screening visit if the health care professional is qualified to provide the services. Rule 5101:3-1-60 of the Administrative Code lists coverage of other codes that may be billed when services are provided as part of further evaluation, diagnosis, or treatment following a healthchek (EPSDT) screening visit.

(A) Vision services.

(1) The department covers vision services for the diagnosis and treatment of vision problems. The scope of vision services covered under the medicaid program are described in Chapter 5101:3-6 of the Administrative Code.

(2) The minimum periodicity schedule for vision screenings for individuals under twenty-one years of age is defined in accordance with rule 5101:3-14-03 of the Administrative Code.

(3) In addition to the vision screenings performed during the healthchek (EPSDT) screening visit, the department covers vision examinations of all levels (minimal through comprehensive) performed by eligible providers of vision services in accordance with Chapter 5101:3-6 of the Administrative Code.

(B) Hearing services.

(1) The department covers hearing services for the diagnosis and treatment of hearing problems. The scope of hearing services covered under the medicaid program includes hearing aids, which are covered as a medical supplier service in accordance with Chapter 5101:3-10 of the Administrative Code.

(2) The minimum periodicity schedule for hearing screenings for individuals under twenty-one years of age is defined in accordance with rule 5101:3-14-03 of the Administrative Code.

(3) In addition to the hearing screenings performed during the healthchek (EPSDT) screening visit, the department covers hearing screenings and other hearing services (including hearing aids) performed by eligible providers of hearing services.

(C) Dental services.

(1) The department covers dental services for the diagnosis and treatment of dental problems for individuals under age twenty-one. The scope of dental services covered under the medicaid program are described in Chapter 5101:3-5 of the Administrative Code.

(2) The department covers one diagnostic and preventive dental examination every six months. The minimum periodicity schedule for dental services for individuals under twenty-one years of age is defined in accordance with rule 5101:3-14-04 of the Administrative Code.

(3) Diagnostic and preventive dental examinations shall be provided to individuals at ages and at frequencies in accordance with American academy of pediatrics recommendations for preventative pediatric health care (March 2003), www.aap.org. Providers are encouraged to refer children, beginning at the age of two years to a dentist or to the county department of job and family services (CDJFS) for a referral to a dentist.

(4) Dental diagnostic and treatment services are covered for individuals under the age of twenty-one, at as early an age as necessary, needed for relief of pain and infections, restoration of teeth, and maintenance of dental health as described in Chapter 5101:3-14-05 of the Administrative Code.

(5) Methods will be employed by the department to encourage dental examinations:

(a) Providers of healthchek (EPSDT) screening shall provide individuals ages three years and older with referrals to a dentist or to the (CDJFS) if the individual has not been seen during the last six months by a dentist or a dental hygienist under the supervision of a dentist; and

(b) The CDJFS shall notify medicaid eligible individuals under the age of twenty-one at least once a year that it is time for a dental examination in accordance with the minimal periodicity schedule for dental services.

(D) Interperiodic examinations, vision, hearing, and dental services that are medically

necessary to determine the existence of suspected physical or mental illnesses or conditions are covered under medicaid and may be billed in accordance with Chapters 5101:3-4, 5101:3-5, and 5101:3-6 of the Administrative Code.

(E) Diagnostic and treatment services for individuals under age twenty-one are covered under the medicaid program when the services are medically necessary, as defined in rule 5101:3-1-01 of the Administrative Code, to treat or ameliorate a defect, physical or mental illness, or condition. Covered diagnostic and treatment services for individuals under age twenty-one include:

(1) Diagnostic and treatment services within the coverage and limitations set forth in Chapters 5101:3-1 to 5101:3-22, 5101:3-24 to 5101:3-30, and 5101:3-56 of the Administrative Code; and,

(2) Diagnostic and treatment services beyond the coverage and limitations set forth in Chapters 5101:3-1 to 5101:3-22, 5101:3-24 to 5101:3-30, and 5101:3-56 of the Administrative Code that are:

(a) Prior authorized by the department in accordance with rule 5101:3-1-31 of the Administrative Code, and when provided through the medicaid managed care program (MCP), in accordance with rule 5101:3-26-05.1 of the Administrative Code; and,

(b) Available in accordance with federal EPSDT requirements found at 42 U.S.C. 1396d(a) as amended.

(F) Additional services not usually covered under the medicaid program may be available in an institutional setting or through a home and community-based services (HCBS) waiver.

(G) Habilitation services are not covered and are not authorized under EPSDT on Ohio medicaid's state plan except when provided in an intermediate care facility for persons with mental retardation (ICF/MR). Habilitation services may also be provided to enrollees of ICF/MR based waivers if the habilitation service is a service covered by the waiver and if the service is medically necessary for the waiver enrollee.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5162.03, 5164.02
Prior Effective Dates:	02/17/1991, 08/01/2001, 07/01/2006

TO BE RESCINDED

5160-14-09 **Healthchek: environmental investigation for elevated blood levels under early and periodic screening, diagnosis, and treatment (EPSDT) services environmental investigation.**

(A) Definitions.

(1) "Public health lead investigation" means, in accordance with rule 3701-30-01 of the Administrative Code, an investigation conducted by a public health lead investigator in accordance with rule 3701-30-07 of the Administrative Code.

(2) "Public health lead risk assessment" means, in accordance with rule 3701-30-01 of the Administrative Code, a lead risk assessment conducted by a public health lead investigator in accordance with rule 3701-30-08 of the Administrative Code.

(B) An "environmental assessment" is a public health lead investigation performed by the Ohio department of health in accordance with Chapter 3742. of the Revised Code.

(C) Environmental assessments will be reimbursed by the department provided all the following requirements are met:

(1) The individual is under age twenty-one.

(2) The individual's blood lead level indicates poisoning, as determined using standards set by the centers for disease control and prevention (CDC).

(3) The assessment is conducted by the Ohio department of health.

(4) The rate of reimbursement has been negotiated and mutually agreed upon by the Ohio department of health and the Ohio department of job and family services. The rate shall be based on the costs of providing assessment services to eligible medicaid recipients as incurred by the Ohio department of health.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5162.03, 5164.02
Prior Effective Dates:	11/01/1985, 08/01/2001, 07/01/2006