EPSDT

Reimbursement Policy ID: RPC.0094.2400

Recent review date: 06/2026

Next review date: 07/2027

Select Health of South Carolina reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. Select Health of South Carolina may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program, mandated by the Centers for Medicare and Medicaid Services (CMS) for children younger than 21 (twenty-one) years who are enrolled in Medicaid, includes preventive and comprehensive health care services, and is designed to guarantee access to age-appropriate screening, preventive care, and treatment for children and adolescents.

Exceptions

N/A

Reimbursement Guidelines

EPSDT is made up of the following comprehensive services that are intended to find and prevent health issues:

- Screening services
  - Health and developmental history
  - Physical exam
  - Immunizations
  - Laboratory tests
  - Health education
- Vision services
- Dental services
- Hearing services
- Other necessary health care services (if coverable under the Federal Medicaid program and are found to be medically necessary to treat, correct, or reduce illnesses and conditions discovered)
- Diagnostic services, if identified by a screening examination
- Treatment for any identified physical and mental illnesses or conditions

The American Academy of Pediatrics (AAP) Preventive Pediatric Health Care Periodicity Schedule is included as part of this Reimbursement Policy. The link to the schedule is listed in the 'Edit Source' section of this policy.

The appropriate preventive medicine CPT codes, diagnosis codes and EPSDT referral indicators (if indicated following the preventive visit) must be included on the claim. Claims missing this information will be denied**.**

Acceptable preventative diagnosis codes are:

Diagnosis Codes	**Code Description**
Z00.110	health exam under 8 days
Z00.111	health exam 8-28 days
Z00.121	routine exam with abnormal findings
Z00.129	routine exam without abnormal findings (Adult 18-20)
Z00.01	routine exam with abnormal findings (Adult 18-20)

Include additional diagnosis code(s) for any abnormal finding.

Acceptable CPT codes for preventable visits are:

CPT Codes	**Code Description**
New Patient	
99460	Newborn Care (during admission)
99381	Age < 1 year
99382	Age 1-4 years
99383	Age 5-11 years
99384	Age 12-17 years
99385	Age 18-20 years
Established Patient	
99463	Newborn (same day discharge)
99391	Age < 1 year
99392	Age 1-4 years

99393	Age 5-11 years
99394	Age 12-17 years
99385	Age 18-20 years

Acceptable Referral Indicator modifiers are:

Referral Indicators	Indicator Description
YM	Medical Referral
YD	Dental Referral
YV	Vision Referral
YH	Hearing Referral
YB	Behavioral Health Referral
YO	Other Referral

Definitions

N/A

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. Centers for Medicare and Medicaid Services (CMS).
V. https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf
VI. https://www.selecthealthofsc.com/pdf/provider/provider-manual.pdf
VII. South Carolina Medicaid Fee Schedule(s).

Attachments

N/A

Associated Policies

N/A

Policy History

06/2026	Reimbursement Policy Committee Approval
05/2026	Annual Review • Converted codes lists to tables
06/2025	Minor updates to formatting and syntax
05/2025	Reimbursement Policy Committee Approval
04/2025	Revised preamble
04/2024	Revised preamble
08/2023	Removal of policy implemented by Select Health of South Carolina from Policy History section
01/2023	Template Revised • Revised preamble • Removal of Applicable Claim Types table • Coding section renamed to Reimbursement Guidelines

	• Added Associated Policies section