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June 15, 2007

ACS M07-09

MEMORANDUM

TO: Physicians and Nurse Practitioners

FROM: Lois Lee, Acting Med-QUEST Division Administrator

SUBJECT: EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) FORMS AND PROCEDURES

Effective July 1, 2007, the Med-QUEST Division (MQD) of the Department of Human Services (DHS) is requiring that all Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) exams and catch-up/follow-up visits be reported using the new "Hawaii Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) Exam" forms (DHS Forms 8015, 8015A, and 8016). (Forms and instructions are attached.)

Because QUEST plans and the Medicaid fee-for-service (FFS) program share the same providers, we felt that it was very important that the reporting of EPSDT exams and the processes for the use and submittal of the EPSDT forms be standardized. Additionally, by standardizing the reporting of findings on the EPSDT exam, the form enables the QUEST plans and DHS to:

- Provide physicians with a clear understanding of the required components of the EPSDT exam;
- Formalize the distinction between screening and surveillance;
- Obtain information on the screenings and immunizations received by a child at various ages whether or not the child has had physician and/or QUEST plan changes; and
- Better understand the health and health care needs of children covered by Medicaid/QUEST.

GENERAL GUIDELINES FOR THE USE OF THE FORMS

- The purpose of the DHS 8015 is to improve the quality of the EPSDT exams and to gather data relevant to understanding the health status of EPSDT eligibles.
- Thus, the DHS 8015 is designed to enable QUEST plans and the MQD help providers to better understand and perform the components of the EPSDT exam and to assist the providers in

obtaining services needed to improve the health status of EPSDT eligible individuals under their care.

- The MQD and QUEST plans agree that the completed and signed EPSDT exam form submitted to the QUEST plan by a provider who is a participating primary care provider (PCP) in the QUEST plan's network or is an active Medicaid provider (for EPSDT eligible individuals covered by the Medicaid FFS program) fulfills the State's auditing requirement for compliance with an EPSDT comprehensive periodic screening visit.

- If maintained in the child's medical record, the completed and signed yellow copy(ies) of the DHS 8015 and, (if used to provide additional information), the optional DHS 8015A, and the DHS 8016 (EPSDT Immunization Catch-up and Follow-up) may be used as the progress notes for the visit.

- Since the MQD and QUEST plans will be accepting the EPSDT exam forms as meeting the State's auditing requirement and as the progress notes for the visit, the EPSDT exam forms MUST BE SIGNED BY THE PHYSICIAN performing the examination or supervising the immunization and screenings. The forms cannot be signed by the provider's staff.

- Results of screenings tests and immunizations reported on the DHS 8015 and/or the DHS 8016 as being performed must be kept in the child's medical record.

- The DHS 8015 and DHS 8016 are designed for providers to enter information related to abnormal finding and/or concerns and to request assistance. Thus, in most cases, it is not necessary for a provider to enter negative or normal findings. By completing and signing the form, the provider is indicating that the appropriate history, physical examination, surveillance, screening(s), diagnosis(ses), treatment, and immunizations were performed.

- The EPSDT exam is a comprehensive exam and viewed as a global service. Therefore, the treatment of any medical conditions discovered during the EPSDT exam is included in the exam.

REQUIREMENTS FOR THE COMPLETION OF THE FORM

- The DHS 8015, 8015A, and 8016 forms must be completed in BLUE or BLACK ink.

- Before detaching the claim/encounter copy from the yellow (provider) copy, please verify that the information you entered has been transferred to the yellow (provider) copy.

- If the age of the child on the date of the examination is NOT at the specific age listed, select the age arrange immediately below the age of the child—Example: The child is eight (8) months old, select the six (6) months exam and not the nine (9) months exam.

- Four (4) leading zeros have been entered for the recipient identification (ID) number. If the ID number has more that six (6) digits (other than zero), write the first digit of the ID number directly after the fourth zero. Example:

Medicaid/QUEST I.D. is 0001234567: Please enter:

0	0	0	1	2	3	4	5	6	7

- The name and National Provider Identifier (NPI) number of the physician who performed the EPSDT assessment must be entered. Do NOT enter the name of the clinic or the clinic's NPI number. As mentioned previously, the examining physician must sign the form.

PROCESSES FOR OBTAINING AND SUBMITTING THE FORMS

- Forms for children in the Medicaid FFS program may be obtained from ACS at (808) 952-5570.

- The forms are in duplicate. The original forms (red ink) should be submitted to ACS as claim/encounter attachments. The original form is designed to be optically scanned. The copies (black ink, yellow paper) are provider copies and should be kept in the individual EPSDT eligible's medical record. The provider must attach the completed and signed forms to CMS 1500 claims and mail them to:

ACS
P.O. Box 1220
Honolulu, Hawaii 96807-1220

- Providers interested in submitting the 8015, 8015A, and 8016 electronically should contact ACS at (808) 952-5570. Specifications for electronic submittal are being worked on by the MQD, ACS, and QUEST plans.

ASSISTING THE EXAMINING PHYSICIAN

Both the DHS 8015 and DHS 8016 are designed for the MQD to respond to the examining provider's request for assistance. For the MQD, care coordination assistance will be provided by Community Case Management Corporation (CCMC). CCMC currently coordinates inter-island travel for Medicaid recipients and assists Medicaid recipients and QUEST members to access dental services. When the examining physician indicates that assistance is needed, CCMC will contact the physician and work with the physician and family to provide the specific assistance the physician has identified as being needed.

CCMC can be contacted as follows:

Telephone Number: 792-1052
Fax Number: 792-1098

REIMBURSEMENT FOR COMPREHENSIVE EPSDT EXAMS AND CATCH-UP/FOLLOW UP VISITS

- Effective July 1, 2007, the MQD has decided to increase the rate of reimbursement for comprehensive EPSDT exams performed on Medicaid FFS recipients from $95.00 to $120.00. The EPSDT reimbursement will apply under the following conditions:

1. The DHS 8015 is completed, appropriately signed, and attached to the 1500 claim. If the optional DHS 8015A is used to report additional findings, it also must be submitted.

2. No other claim for an evaluation and management (E & M) service (99201-99255; 99304-99499) is submitted on the same day by the same provider. The EPSDT exam includes diagnosis of abnormal conditions and appropriate treatment rendered by the EPSDT examining provider on the day of the EPSDT examination. (Example: Otitis media found during an EPSDT exam should be submitted with the appropriate EPSDT code; a separate claim line for an office visit for the diagnosis and treatment of otitis media should NOT be submitted.)

3. The DHS 8015 and if used, the DHS 8015A, must be attached to the 1500 claim form. At the present time, there is no mechanism for the electronic submittal of the DHS 8015, 8015A, and 8016. Thus, exhanced reimbursement for EPSDT comprehensive exams cannot be extended unless the 1500 claim form and appropriate EPSDT form(s) are submitted manually.

4. One of the following codes with the specific modifier (EP) must be used.

Code	Modifier	Brief Description	Usage
New Patient			
99381	EP	Initial comprehensive preventive medicine evaluation and management; infant less than 1 year of age.	Initial EPSDT exam for a well infant, an infant with an acute illness, or an infant who is a child with special health care needs (CSHCN); less than 1 year of age. No other E & M service can be billed for the same date of service.
99382	EP	Initial comprehensive preventive medicine evaluation and management; age 1 through 4.	Initial EPSDT exam for a well child, a child with an acute illness, or a CSHCN; age 1 through 4. No other E & M service can be billed for the same date of service.
99383	EP	Initial comprehensive preventive medicine evaluation and management; age 5 through 11.	Initial EPSDT exam for a well child, a child with an acute illness, or a CSHCN; age 5 through 11. No other E & M service can be billed for the same date of service.
99384	EP	Initial comprehensive preventive medicine evaluation and management; age 12 through 17.	Initial EPSDT exam for a well child, a child with an acute illness, or a CSHCN; age 12 through 17. No other E & M. No other E & M service can be billed for the same date of service.
99385	EP	Initial comprehensive preventive medicine evaluation and management; age 18 through 39.	Initial EPSDT exam for a well youth, a youth with an acute illness, or a CSHCN; age 18 through 20. No other E & M service can be billed for the same date of service.

Established Patient		Brief Description	Usage
99391	EP	Periodic comprehensive preventive medicine evaluation and management; infant less than 1 year of age.	Periodic EPSDT exam for a well infant, an infant with an acute illness, or an infant who is a child with special health care needs (CSHCN); less than 1 year of age. No other E & M service can be billed for the same date of service.
99392	EP	Periodic comprehensive preventive medicine evaluation and management; age 1 through 4.	Periodic EPSDT exam for a well child, a child with an acute illness, or a CSHCN; age 1 through 4. No other E & M service can be billed for the same date of service.
99393	EP	Periodic comprehensive preventive medicine evaluation and management; age 5 through 11.	Periodic EPSDT exam for a well child, a child with an acute illness, or a CSHCN; age 5 through 11. No other E & M service can be billed for the same date of service.
99394	EP	Periodic comprehensive preventive medicine evaluation and management; age 12 through 17.	Periodic EPSDT exam for a well child, a child with an acute illness, or a CSHCN; age 12 through 17. No other E & M service can be billed for the same date of service.
99395	EP	Periodic comprehensive preventive medicine evaluation and management; age 18 through 39.	Periodic EPSDT exam for a well youth, a youth with an acute illness, or a CSHCN; age 18 through 20. No other E & M service can be billed for the same date of service.
99232	EP	Subsequent hospital care.	Initial or periodic EPSDT exam for infant/child/youth performed during an inpatient acute hospital stay. At the time of evaluation, the infant, child, or youth may be well, have an acute illness, or be a CSHCN. No other E & M service can be billed for the same date of service.
99308	EP	Subsequent nursing facility care.	Initial or periodic EPSDT exam for infant/child/youth performed during a nursing facility stay. At the time of evaluation, the infant, child, or youth may be well, have an acute illness, or be a CSHCN. No other E & M service can be billed for the same date of service.

99348	EP	Established Patient, Home Visit.	Initial or periodic EPSDT exam for infant/child/youth performed in the child's home. At the time of evaluation, the infant, child, or youth may be well, have an acute illness, or be a CSHCN. No other E & M service can be billed for the same date of service. The child must be homebound/bedbound for medically appropriate reason(s) and the physician must be able to provide all age appropriate screening and surveillance in the home setting.
99431	EP	History and Examination of the normal newborn infant.	Initial EPSDT exam of a normal infant one month or less of age in the hospital or birthing room. At the time of evaluation, the infant may be well, have an acute illness, or be a CSHCN. No other E & M service can be billed for the same date of service.
99432	EP	Normal newborn care in other than hospital or birthing room.	Initial EPSDT exam of a normal infant one month or less of age in a setting other than the hospital or birthing room. At the time of evaluation, the infant may be well, have an acute illness, or be a CSHCN. No other E & M service can be billed for the same date of service.

- Effective July 1, 2007, the MQD has decided to increase the rate of reimbursement for EPSDT catch-up immunizations given to Medicaid FFS recipients to $30.00. Additionally, the MQD has decided to extend this rate to visits for "follow-up" on referrals and screenings. Thus, if a screening was attempted but could not be completed or was deferred on the date of the EPSDT comprehensive exam, the catch-up or follow-up would be reimbursed if performed at a later date. The EPSDT catch-up/follow-up reimbursement will apply under the following conditions:

  1. The DHS 8016 is completed, appropriately signed and attached to the 1500 claim.

  2. No more than two (2) follow-up visits for screening attempts will be allowed—Example: If on the dates of the first and second follow-up visit for an audiogram, the child was unable to comply, the provider should note this on the DHS 8016 forms and the visits will be reimbursed. However, if the child is unable to comply after the second visit, the provider should not schedule a third follow-up visit for the audiogram. Instead, the audiogram should be attempted at the next EPSDT comprehensive visit.

  3. The DHS 8016 must be attached to the 1500 claim form. At the present time, there is no mechanism for the electronic submittal of the DHS 8015, 8015A, and 8016. Thus, exhanced

reimbursement for EPSDT catch-up/follow-up exams cannot be extended unless the 1500 claim form and appropriate EPSDT form(s) are submitted manually.

4. One of the following codes with the specific modifier (EP) must be used.

Code	Modifier	Brief Description	Usage
99211	EP	Established Patient, office or outpatient evaluation and management that may not require the presence of a physician.	Immunization catch-up, repeat screening(s), and/or screening(s) not performed during an EPSDT exam visit that do NOT require the presence of the physician.
99212	EP	Established Patient, office or outpatient evaluation and management, physician performed.	Immunization catch-up, repeat screening(s), screening(s) not performed during an EPSDT exam visit, follow-up of a referral and/or follow-up on a diagnosis or treatment that require a face-to-face assessment by the physician.

- If an E & M service on a follow-up visit requires more than a problem focused history and examination and straightforward decision making, the codes 99213 to 99215 with an EP modifier should be used. Medical records must justify this level of E & M service. Please attach the DHS 8016 to the claim. These visits will be reimbursed at the following rates:

Code	Modifier	Rate
99213	EP	36.31
99214	EP	56.46
99215	EP	83.57

For questions or clarification on the contents of this memorandum, please contact ACS at (808) 952-5570.

Attachments

Hawaii Early And Periodic, Screening, Diagnosis, and Treatment (EPSDT) Exam

PATIENT INFORMATION

Health Plan						Island of Residence						Indicate the EPSDT periodic screening age being reported																				Type	
AC	HQ	KQ	SU	MA	OT	HI	KA	LA	MA	MO	OA	14d	30d	2m	4m	6m	9m	12m	15m	18m	2y	3y	4y	5y	6y	7y	8y	10y	12y	14y	16y	18y	20y	NEW	EST
O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O

Today's Date (MMDDYY)	Name (Last, First, Middle Initial)	Medicaid/QUEST ID	Birthdate (MMDDYY)	M	F
		0 0 0 0		O	O

HISTORY FOR INFANTS (FIRST YEAR OF LIFE)

APGAR	BIRTH WEIGHT - g	Mother's Medicaid/QUEST ID#	#

List any birth/newborn complications, including abnormal NB Screens, significant illnesses, injuries, surgery, and hospitalizations. (*APGAR, Birth Weight* are *optional after 1 year of age*)

HISTORY FOR CHILDREN OLDER THAN 1 YEAR OF AGE: List below any significant illnesses, injuries, surgery, hospitalization, or applicable family history

MEASUREMENTS

Temperature-C or F	Blood Pressure	Height-cm	Weight-kg	BMI	Head Circ-cm	Allergies	Medications
.	/		.		.	O	O
						List:	

PHYSICAL EXAMINATION normal except as noted

SURVEILLANCE normal except as noted

Vision/Hearing/Dental/Oral/ Developmental and Behavioral, Lead Risk Assessment, Health Education, Counseling & Age Appropriate Anticipatory Guidance

List all abnormal findings and/or concerns noted in Measurements, the Physical Exam, Surveillance and/or Screening (Also list other screening tools used). *Use this space for additional comments on history*

SCREENING done today	Y	N
Snellen/Allen 3y, 4y, 5y, 6y, 8y, 10y, 12y, 15y, 18y, 20y	O	O
Audio (20-25 db screen) 4y - 6y	O	O
Blood Lead Level 9m – 12m, 2y	O	O
Hgb/Hct 9m – 12m, Females 12y – 14y	O	O
PPD 12m, 2-6y, 12-14 y	O	O
Dev: PEDS/ASQ 9m, 12m, 18m, 24 m, 2y, 3y, 4y, 5y	O	O
Other Dev/Beh – List	O	O

DIAGNOSIS/STATUS

O Well child	O Acute Illness	O CSHCN	List ICD-9 Codes of CSHCN
List Acute Illness(es):			. . .

REFERRALS MADE TODAY O Y – Indicate below O N

Print names of specialists to whom referrals were made today

O H-KISS	O DDD	O Cardiology	O Neurology	O Ophthalmology			
O PHN	O Child Welfare	O Psychiatry or Psychology	O Otolaryngology	O Nephrology			
O CAMHD	O DOE	O Orthopedics	O Gastroenterology	O Urology			
O Developmental/Behavioral		O Dentistry	O Other(s)–list				

CARE COORDINATION ASSISTANCE NEEDED O Y – Indicate below O N List additional information or other assistance needed

O Arranging transportation		O	Managing medical condition and/or medications
O Scheduling/Keeping appointments		O	Coordinating multiple appointments
O Obtaining dental care		O	Obtaining specialty services
O Obtaining foreign/sign language translation		O	Other
O	Written plan of care (POC) has been given to the family	O	Family needs assistance in following the POC

If assistance is needed, please provide parent's/ caregiver's telephone no. to facilitate coordination -

IMMUNIZATIONS GIVEN TODAY AND STATUS O Y – Indicate below O N

O HepB	O DTaP	O IPV	O Hib	O Rotav	O PCV	O MMR					
O Influenza	O Varicella	O HPV	O MCV4/MPSV4	O Tdap	O HepA	O Other(s)					
List Other(s)				O Immunizations up to date		O Catch up scheduled					

PROVIDER INFORMATION: By signing below, I attest that the services indicated above were performed today by me or my staff under my supervision.

PCP Y	PCP N	Provider Name (Print)	Signature	73. NPI #	Phone #
O	O				-

FORM INSTRUCTIONS
DHS 8015 (07/07)
Hawaii Early And Periodic, Screening, Diagnosis, and Treatment (EPSDT) Exam

PURPOSE:

The purpose of the DHS 8015 is to improve the quality of care provided to Medicaid recipients and QUEST members under age twenty-one (21) years of age. The form facilitates the process for PCPs to request and obtain assistance in care coordination and management from the Medicaid agency and QUEST plans to assist in providing comprehensive care within the Medical Home. Additionally, the form enables the Department and QUEST plans to do the following:

- Provide PCPs with a clear understanding of the required components of the EPSDT exam
- Formalize the distinction between screening and surveillance
- Obtain information on the screenings and immunizations received by a child at various ages whether or not the child has had PCP and/or QUEST plan changes
- Better understand the health and health care needs of children covered by Medicaid/QUEST.

GENERAL DIRECTIONS:

- Complete the form using BLACK or BLUE ink
- When a bubble (O) is indicated, fill in the bubble using BLACK or BLUE ink. Do not √ (check), × (cross), I (draw a line through one or more bubbles)
- If the age of the patient on the date of the exam is NOT at the specific age listed in the column titled "Indicate the EPSDT periodic screening age being reported," select the age range immediately below the age of the child—ex. The child is 8 months old, select the 6 months, not the 9 months exam.
- The form is designed for providers to enter information related to abnormal findings and/or concerns. Thus, if the child has no allergies, is not taking any medications and the physical examination, surveillance, and screening(s) are normal, by completing, signing, and submitting the form, the provider is reporting that the EPSDT comprehensive exam was performed and was within normal limits. Therefore, it is not necessary for the provider to write further explanation.

PATIENT INFORMATION:

Fill in the bubble below the appropriate choice or enter information in the prescribed format

Health Plan	**AC** Aloha Care	**HQ** HMSA-QUEST	**KQ** Kaiser Quest	**SU** Summerlin	**MA** Medicaid Fee-for-Service	**OT** Other
Island of Residence	**HI** Hawaii	**KA** Kauai	**LA** Lanai	**MA** Maui	**MO** Molokai	**OA** Oahu
Indicate the EPSDT periodic screening age being reported	There are 22 age ranges listed. Fill only 1 bubble. The first bubble should be filled when the child 14 days of age and under. The second bubble for ages 15 to 30 days of age. When the EPSDT exam is performed between the age range indicated, select the age range immediately below the child's age.					
Type	New (patient) is a patient seen for the first time or who HAS NOT received services from the physician or a physician in the same specialty in the same group practice within the past 3 years. Established (patient) is a patient who received services from the physician or a physician in the same specialty in the same group practice in the past 3 years.					
Today's Date (MMDDYY)	Enter the date the EPSDT exam was done in prescribed format					
Name	Enter child's name in prescribed format					
Medicaid/QUEST ID	This is a 10 digit number lead by 4 or 5 zeros. 4 zeros are inputted, you may need to add a zero. DO NOT enter the case #, the SS#, the mother's ID #, etc.					
Birthdate (MMDDYY)	Enter the child's birthdate in prescribed format					
M (Male) F (Female)	Enter the sex of the child					

HISTORY:

Enter information in the prescribed format

HISTORY FOR INFANTS IN THE FIRST YEAR OF LIFE		Enter APGAR score & Birth Weight in grams; these are optional after 1 year of age. Use the block "List any birth/neonatal complications…" to enter any problems in the first year of life.
HISTORY FOR CHILDREN OLDER THAN 1 YEAR OF AGE:		Use the block "List below any significant illness…" to enter pertinent medical and family history. Pertinent problems in the first year of life can be either listed here or in the block above.
Mother's Medicaid/QUEST ID #	#	Enter the mother's 10 digit Medicaid/QUEST ID ONLY for infants under 1 month of age who have NOT been assigned a Medicaid/QUEST ID. In "#", enter A, B, C, etc. for the child when the mother delivered more than one baby.

MEASUREMENTS, PHYSICAL EXAMINATION, SURVEILLANCE, SCREENING: *Enter information in the prescribed format*

Measurements	Temperature—Centigrade or Fahrenheit; height, weight, head circumference in the specified metric units. Consult the EPSDT Periodic Screening Guidelines (reverse side of the PROVIDER copy) for age specific requirements
Physical Examination	An unclothed physical examination must be performed. If normal, no entry is required. Abnormal findings and/or concerns should be listed in the block to the right.
Surveillance	Includes the assessment through physical examination of vision, hearing, dental/oral health, the direct observation and parental reporting of development and behavior, dialogue with the parent on lead risk, counseling and education of the parent and child on health concerns and provision of age appropriate anticipatory guidance. Problems and concerns related to screening should be listed in the block to the right.
Screening	Fill the bubbles Y (yes) or N (no) for specific screening(s) performed today

DIAGNOSIS/STATUS: *Fill in the bubble(s) to the left of the diagnosis. Enter ICD-9 code(s).*

Well child	Fill in the bubble for a child who is growing and developing normally and has no acute or chronic medical problems.
Acute illness	Fill in the bubble for a child who has an acute illness. List the acute illness(es) in the block. ex. enter "otitis media"
CSHCN	Fill in the bubble if you believe that the child being examined is a child with special health care need(s). (If a child with special health care need(s) has an acute illness—both the Acute Illness and the CSHCN bubbles should be filled and the Acute Illness(es) should be listed)
List ICD-9 Codes of CSHCN	The ICD-9 code(s) of the condition(s) you identify as significant, chronic medical conditions should be listed. DO NOT ENTER ICD-9 CODE(S) FOR ACUTE ILLNESS(ES) present on the day of the exam. (ex. do not enter 462—pharyngitis, acute)

REFERRALS MADE TODAY, CARE COORDINATION ASSISTANCE NEEDED, IMMUNIZATIONS GIVEN TODAY AND STATUS: *Enter information in the prescribed format*

REFERRALS MADE TODAY	Fill Y or N; if Y is entered, fill in the bubble to the left of the agency(ies) or specialty(ies) to which you have referred the child. Refer to reverse side of the PROVIDER copy for explanation of abbreviations. Print the names of the specialist(s) to whom referrals were made.
CARE COORDINATION ASSISTANCE NEEDED	Fill Y or N; if Y is entered, fill in the bubble to the left of the service for which assistance is needed. Use the block "List additional information or assistance needed" for clarification or details. If care coordination is needed, please provide the parent's phone number.
IMMUNIZATIONS GIVEN TODAY & STATUS	Fill Y or N; if Y is entered, fill in the bubble to the left of the immunization given. If combinations are used, fill the bubbles that indicate the applicable combination. Enter the names of immunizations given today that are not specifically listed. Fill either the bubble "Immunizations up to date" or the bubble "Catch up scheduled."

PROVIDER INFORMATION: *Enter information in the prescribed format*

PCP	Enter Y if you are the child's PCP (Primary Care Provider) or N if you are not. If the designated PCP is a clinic and you are contracted/employed by the clinic, enter Y.
Provider Name & Signature	Enter the actual name and degree of the provider performing the EPSDT exam—ex. John Smith, M.D. or Jane Smith, D.O. (Do not enter—ABC Clinic). The only acceptable signature is the signature of the named provider.
NPI#	Enter the 10 digit NPI (National Provider Identification) # assigned to the provider performing the EPSDT exam
Phone #	Enter your 7 digit phone number.

By completing and signing the form, the provider attests that the history, physical examination, surveillance, screening(s), diagnosis(ses), treatment, and immunizations were performed by the provider or by the provider's staff under the supervision of the provider.

The completed and signed EPSDT exam submitted by the provider meets the State's auditing requirement for compliance with an EPSDT comprehensive periodic screening visit. If maintained in the child's medical record, it may be used as the progress note for the visit. Results of screenings performed must be kept in the child's medical record.

FILING DIRECTIONS:

- Submit the completed original (red ink) form (CLAIM/ENCOUNTER ATTACHMENT) with your claim/encounter to the specific QUEST plan in which the child is enrolled or to the Medicaid fiscal agent if the child is covered by the fee-for-service Medicaid program
- The PROVIDER COPY (yellow paper in black ink) should be kept in the child's medical record.

Hawai'i Early And Periodic, Screening, Diagnosis, and Treatment (EPSDT) Exam

ADDITIONAL INFORMATION

Today's Date (MMDDYY)	Name (Last, First, Middle Initial)	Provider Name (Print)

Additional information, comments, concerns, and/or clarification pertaining to HISTORY:

Additional information, comments, concerns, and/or clarification pertaining to PHYSICAL EXAMINATION, MEDICATIONS, ALLERGIES

Additional information, comments, concerns, and/or clarification pertaining to SURVEILLANCE, SCREENING, and DIAGNOSIS/STATUS

Additional information, comments, concerns, and/or clarification pertaining to REFERRALS AND CARE COORDINATION

Additional information, comments, concerns, and/or clarification pertaining to IMMUNZATIONS:

Additional information, comments, concerns, and/or clarification pertaining to OVERALL HEALTH STATUS

FORM INSTRUCTIONS
DHS 8015A (07/07)
HAWAII EARLY AND PERIODIC, SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) EXAM
ADDITIONAL INFORMATION

PURPOSE:

The purpose of the DHS 8015A is to provide a format for providers to report information pertinent to the health of the child receiving an Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) Exam.

GENERAL DIRECTIONS:

Use BLACK or BLUE ink to complete this form
This is an optional form. It is a supplement to the DHS 8015 form--Hawaii Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) Exam and for use when there is insufficient space on the DHS 8015 to report specific issues or concerns.

DIRECTIONS FOR COMPLETION OF SPECIFIC ELEMENTS:

Today's Date	Enter the date the EPSDT exam was done in the prescribed format. It must be the same date entered in "Today's Date (MMDDYY) entered on the DHS 8015
Name (Last, First, Middle Initial)	Print the child's name in prescribed format. This name must be the same as the "Name (Last, First, Middle Initial)" entered on the DHS 8015
Provider Name (Print)	Print the actual name of the provider performing the EPSDT exam. It must be the same as the name entered under "Provider Name (Print)" on the DHS 8015
Additional Information, comments, concerns, and/or clarification pertaining to HISTORY	Enter birth/newborn complications, significant illness, injuries, surgery, hospitalization, or applicable family history if there is not enough space provided for this information on the DHS 8015. If there is insufficient space in the four lines provided in this section, continue comments on the subsequent lines.
Additional Information, comments, concerns, and/or clarification pertaining to PHYSICAL EXAMINATION, MEDICATIONS, ALLERGIES	Enter abnormal findings and/or concerns in Measurements and Physical Exam, Medications, and Allergies if there is not enough space provided for this information on the DHS 8015. If there is insufficient space in the four lines provided in this section, continue comments on the subsequent lines.
Additional Information, comments, concerns, and/or clarification pertaining to SURVEILLANCE, SCREENING, AND DIAGNOSIS/STATUS	Enter abnormal findings and/or concerns in Surveillance, Screening, and Diagnosis/Status or list Other Developmental/Behavioral Screens done, if there is not enough space provided for this information on the DHS 8015. If there is insufficient space in the four lines provided in this section, continue comments on the subsequent lines.
Additional Information, comments, concerns, and/or clarification pertaining to REFERRALS AND CARE COORDINATION	Print names of specialists and/or enter additional information or other assistance needed in care coordination, if there is not enough space provided for this information on the DHS 8015. If there is insufficient space in the four lines provided in this section, continue comments on the subsequent lines.
Additional Information, comments, concerns, and/or clarification pertaining to IMMUNIZATIONS	List other immunizations given or enter additional information or concerns pertaining to immunizations, if there is not enough space provided for this information on the DHS 8015. If there is insufficient space in the four lines provided in this section, continue comments on the subsequent lines.
Additional Information, comments, concerns, and/or clarification pertaining to OVERALL HEALTH STATUS	Enter comments pertaining to overall health status of the child, including social and educational concerns, if not addressed on the DHS 8015 or in previous sections of this form.

FILING DIRECTIONS:

- Submit the completed original (red ink) form (CLAIM/ENCOUNTER ATTACHMENT) attached to the DHS 8015 with your claim/encounter to the specific QUEST plan in which the child is enrolled or to the Medicaid fiscal agent if the child is covered by the fee-for-service Medicaid program
- The PROVIDER COPY (yellow paper in black ink) should be kept in the child's medical record.
- This form is optional. However, if used, it is a supplement to the DHS 8015 and cannot be submitted alone.

Hawaii Early And Periodic Screening, Diagnosis, and Treatment (EPSDT) IMMUNIZATION CATCH-UP & FOLLOW-UP Form

PATIENT INFORMATION

Health Plan						Island of Residence					
AlohaCare	HMSA QUEST	Kaiser QUEST	Summerlin	Medicaid Fee-For Service	Other	Hawaii	Kauai	Lanai	Maui	Molokai	Oahu
O	O	O	O	O	O	O	O	O	O	O	O

Today's Date (MMDDYY)	Name (Last, First, Middle Initial)	Medicaid ID#	Birthdate (MMDDYY)	M	F
		0 0 0 0		O	O

IMMUNIZATIONS GIVEN TODAY O Y- mark below O N

O	HepB (Hepatitis B)	O	DTaP (Diphtheria, Tetanus, Acellular Pertussis)	O	IPV (Inactivated Poliovirus)	O	Hib (Haemophilus Influenza Type B)	O	Rotav (Rotavirus)	O	PCV (Pneumococcal)
O	MMR (Measles, Mumps, Rubella)	O	Tdap (Tetanus, Diphtheria, Acellular Pertussis)	O	Varicella	O	HPV (Human Papillomavirus)	O	MCV4/MPSV4 (Meningococcal)	O	Influenza
O	HepA (Hepatitis A)	O	Other(s)	List other(s)							
O	Up to date	O	Additional catch-up needed	Comments on catch up or immunization status							

SCREENING DONE OR REPEATED TODAY

Screening	Y	N
Snellen/Allen	O	O
Audio (20-25 db screen)	O	O
Blood Lead Level	O	O
Hgb/Hct	O	O
PPD	O	O
Dev: PEDS/ASQ	O	O
Other Dev/Beh - List	O	O

List abnormalities and/or concerns related to the screenings performed today and or abnormalities in Hgb/Hct, PPD, blood lead or screening results not previously noted during an EPSDT exam

FOLLOW-UP ON DIAGNOSIS(SES) AND TREATMENT O Y – indicate below O N

O Well child	O Acute Illness	O CSHCN

List ICD-9 Codes of CSHCN

. . .

If "Y" list condition(s) and/or treatment follow-up provided today and/or new condition(s) identified today

FOLLOW UP AND/OR REFERRALS MADE TODAY O Y – indicate below O N

Agency(ies)	O	O
Specialist(s)	O	O

If "Y" list agency(ies) and specialist(s). For follow-up, list results from previous referral(s)

CARE COORDINATION ASSISTANCE NEEDED O Y – indicate below O N

- O Bringing immunizations up to date
- O Arranging transportation
- O Scheduling/Keeping appointments
- O Obtaining foreign/sign language translation
- O Other

List additional information or other assistance needed

If assistance is needed, please provide parent's/caregiver's telephone no. to facilitate coordination -

PROVIDER INFORMATION: By signing below I attest that the immunizations and screenings indicated above were given today by me or my staff under my supervision

Provider Name (Print)	Signature	NPI #	Phone #
			-

FORM INSTRUCTIONS
DHS 8016 (07/07)
HAWAII EARLY AND PERIODIC, SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)
IMMUNIZATION CATCH-UP AND FOLLOW-UP

PURPOSE:

The purpose of the DHS 8016 is to provide a format for providers to report immunizations that were not administered on the date of an Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) Exam. Also, the form allows providers to report on results of specific screening tests performed or repeated and on follow-up of treatment and referrals.

GENERAL DIRECTIONS:

- Complete the form using BLACK or BLUE ink
- When a bubble (O) is indicated, fill in the bubble using BLACK or BLUE ink. Do not √ (check), × (cross), I (draw a line through one or more bubbles)

PATIENT INFORMATION:

Fill in the bubble below the appropriate choice or enter information in the prescribed format

Health Plan	**AC** AlohaCare	**HQ** HMSA-QUEST	**KQ** Kaiser Quest	**SU** Summerlin	**MA** Medicaid Fee-for-Service	**OT** Other
Island of Residence	**HI** Hawaii	**KA** Kauai	**LA** Lanai	**MA** Maui	**MO** Molokai	**OA** Oahu

Today's Date (MMDDYY)	Enter the date the immunization catch up and/or follow up was done in prescribed format
Name	Enter child's name in prescribed format
Medicaid/QUEST ID	This is a 10 digit number lead by 4 or 5 zeros. 4 zeros are inputted, you may need to add a zero. DO NOT enter the case #, the SS#, the mother's ID #, etc.
Birthdate (MMDDYY)	Enter the child's birthdate in prescribed format
M (Male) F (Female)	Enter the sex of the child

IMMUNIZATION CATCH UP:

Fill in the bubble(s) to the left of the appropriate choice and/or list information

IMMUNIZATIONS GIVEN TODAY	Enter Y (Yes) or N (No); if Y is entered, fill in the bubble to the left of the specific immunization(s) given. If combinations are used, fill the bubbles that indicate the applicable combination. If immunizations, not specifically listed are given, fill the bubble to the left of "Other" and list the immunizations in the block provided Fill in either the bubble to the left of "Up to Date" or "additional catch-up needed." Enter comments on catch-up or immunization status.

FOLLOW-UP TO ITEMS ON THE EPDST EXAM:

Fill in the appropriate bubble(s) or enter information in the block provided

SCREENING PERFORMED OR REPEATED TODAY	Fill in the bubbles, in the column "Y" or "N," to the right of the listed screenings. List abnormalities and/or concerns related to the screenings performed today in the block provided. Also, if Y is entered in "Other Dev/Behav—name", list the name(s) of the other dev/behave screening tool(s).
FOLLOW-UP ON DIAGNOSIS(SES) AND TREATMENT	Enter Y or N; if Y is entered, fill in the bubbles, "Y" or "N" to the right. If Y is entered, list conditions and/or treatment follow-up provided today and/or any new condition(s) identified today. Fill in the bubble to the left of "Well child" for a child who is growing and developing normally and has no acute or chronic medical problems. Fill in the bubble "Acute Illness" for a child who ha an acute illness. List the acute illness in the block to the right. Fill in the bubble "CSHCN" if you believe that the child being examined is a child with special health care need(s). (If a hld with special health care need(s) ha an acute illness—both the Acute Illness and the CSHCN bubbles should be filled. Enter the ICD-9 code(s) if the child has special health care need(s).

REFERRALS MADE TODAY AND/OR FOLLOWED-UP TODAY	Enter Y or N. If Y is entered, list agency(ies) and specialist(s). For follow-ups, list agency(ies) and specialist(s) and results of referral(s).
CARE COORDINATION ASSISTANCE NEEDED	Enter Y or N. If Y is entered, fill in the bubble(s) .to the left of the specific assistance. List additiona information or other assistance needed in the block provided. If assistance is needed, please provide the parents (caregiver's) telephone no. to facilitate coordination

PROVIDER INFORMATION: *Enter information in the prescribed format*

Provider Name & Signature	Enter the actual name and degree of the provider performing the EPSDT exam—ex. John Smith, M.D. or Jane Smith, D.O. (Do not enter—ABC Clinic). The only acceptable signature is the signature of the named provider.
NPI#	Enter the 10 digit NPI (National Provider Identification) # assigned to the provider performing the EPSDT exam
Phone #	Enter your 7 digit phone number.

By completing and signing the form, the provider attests that the immunizations, screening(s), and follow-ups reported on this form were performed by the provider or by the provider's staff under the supervision of the provider.

The completed and signed DHS 8016 submitted by the provider meets the State's auditing requirement for compliance with the reporting of EPSDT catch-up immunizations and follow-up to conditions identified during an EPSDT comprehensive periodic screening visit. If maintained in the child's medical record, it may be used as the progress note for the visit. Results of screening(s) performed must be kept in the child's medical record.

FILING DIRECTIONS:

- Submit the completed original (red ink) form (CLAIM/ENCOUNTER ATTACHMENT) with your claim/encounter to the specific QUEST plan in which the child is enrolled or to the Medicaid fiscal agent if the child is covered by the fee-for-service Medicaid program
- The PROVIDER COPY (yellow paper in black ink) should be kept in the child's medical record.