Services Covered Under Preventive and Well Visits, Professional

Purpose

This policy is intended to ensure correct provider reimbursement and serves only as a general resource regarding Molina Healthcare's reimbursement policy for the services described in this policy. It is not intended to address every aspect of a reimbursement situation, nor is it intended to impact care decisions. This policy was developed using nationally accepted industry standards and coding principles. In a conflict, federal and state guidelines, as applicable, and the member's benefit plans supersede the information in this policy. Also, to the extent of conflicts between this policy and the provider contract language, the Provider contract language will prevail. Coverage may be mandated by applicable legal requirements of a State, the Federal government or the Centers for Medicare and Medicaid Services (CMS). References included were accurate at the time of policy approval. If there is a state exception, please refer to the state exception table listed below.

Policy Overview

This policy applies to all Molina lines of business and is specifically for preventive services and wellness visits submitted on the CMS-1500 form or its electronic equivalent, the 837P. This policy provides coding and billing guidance and identifies the services covered under the applicable CPT and HCPCS codes.

Preventive services and wellness visits are based on a combination of five sources, which include:

- Services rated "A" or "B" by the U.S. Preventive Services Task Force (USPSTF)
- Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP)
- Women's preventive health per Health Resources and Services Administration (HRSA) guidelines
- The AAP's Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents, 4th Edition
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) programs

Preventive Medicine Services (CPT codes 99381–99387, 99391–99397, and HCPCS codes G0402, G0438, and G0439) are comprehensive in nature. These services reflect an age and gender appropriate history and examination and include counseling, anticipatory guidance, and risk factor reduction interventions. Preventive services are not problem focused, and the patient does not present with a chief medical complaint.

During a preventive service or wellness visit, a comprehensive patient history and medical examination are conducted. This includes a detailed review of systems, an extensive personal, family, and social history, and a thorough assessment of relevant risk factors.

Preventive Medicine Services include components that are not separately reimbursable when performed on the same date of service. These components are considered inherent to the preventive visit. These include:

- Screening services
- Counseling services
- Prolonged services
- Medical nutrition therapy services

Reimbursement Guidelines

The terms "preventive service" and "wellness visit" are used interchangeably within the healthcare industry and throughout this document.

Provider Types Who Render Preventive Services or Wellness Visits

Preventive services are provided by primary care physicians, nurse practitioners, physician assistants or registered nurses. Primary

care doctors include internal medicine physicians, family medicine physicians, geriatric medicine physicians and pediatricians.

Preventive Medicine Service and Problem Oriented E/M Service

When a preventive medicine CPT or HCPCS code and a problem oriented Evaluation and Management (E/M) service are provided during the same visit:

- The preventive medicine service is reimbursed at 100% of the allowable contracted rate.
- The problem oriented E/M service is reimbursed at 50% of the allowable contracted rate when modifier 25 is appended.
- If the problem oriented service is minimal or modifier 25 is not appended, the E/M service is not separately reimbursed.

This reduction accounts for overlapping practice expense components already included in the preventive service.

During an annual preventive exam, it is standard to check the status of chronic conditions and refill ongoing prescriptions. These actions do not justify billing a separate problem-oriented Evaluation and Management (E/M) service.

If a chronic condition is not well controlled, and treatment adjustments are necessary, such as altering medication dosages or changing to a different medication, this may justify billing for a distinct problem-oriented E/M service code in addition to the preventive exam code. In such instances, the level of work performed and documented exceeds the usual scope of an annual preventive exam. When this occurs, modifier 25 is appended to the problem-oriented E/M service code.

EPSDT

EPSDT is exclusively a Medicaid benefit. EPSDT services cover children and adolescents up to (but not including) age 21. EPSDT visits may require specific modifiers (such as the EP modifier) or specific billing rules depending on the state Medicaid agency.

Medicaid and Marketplace

In cases where the patient is not covered by Medicare, the appropriate range of CPT codes should be used for wellness visits or preventive services.

CPT Code	Definition
99381	Initial comprehensive preventive medicine evaluation and management of an individual, including an age and gender appropriate history, examination, counseling, anticipatory guidance, risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient, infant (age younger than one year).
99382	New patient, early childhood (age 1 through 4 years old)
99383	New patient, late childhood (age 5 through 11 years old)
99384	New patient, age 12 through 17 years old.
99385	New patient, age 18 through 39 years old.
99386	New patient, age 40 through 64 years old.
99387	New patient, 65 + years old.
99391	Initial comprehensive preventive medicine evaluation and management of an individual, including an age and gender appropriate history, examination, counseling, anticipatory guidance, risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient, infant (age younger than one year).
99392	Established patient, early childhood (age 1 through 4 years old).
99393	Established patient, late childhood (age 5 through 11 years old).
99394	Established patient, age 12 through 17 years old.
99395	Established patient, age 18 through 39 years old.
99396	Established patient, age 40 through 64 years old.
99397	Established patient, 65 + years old.

- Vaccines provided during preventive visits may require separate CPT/HCPCS codes.

- HCPCS code S0302 is a supplemental code documenting that the provider completed all required EPSDT components for that particular visit for a child or adolescent enrolled in Medicaid. HCPCS code S0302 does not replace the preventive visit code — it is billed in addition to the preventive visit code when required by a state Medicaid agency. Some state Medicaid agencies reimburse S0302, but many do not.

Use the following ICD-10-CM diagnosis codes with the above CPT codes for wellness visits or preventive services for non-Medicare

patients.

ICD-10-CM	Definition
Z00.110	Health examination for newborns under 8 days old
Z00.111	Health examination for newborn 8 to 28 days old
Z00.121	Encounter for routine child health examination (29 days through 17 years) with abnormal findings.
Z00.129	Encounter for routine child health examination (29 days through 17 years) without abnormal findings.
Z00.00	Encounter for general adult medical examination (18 years old and higher) without abnormal findings.
Z00.01	Encounter for general adult medical examination (18 years old and higher) with abnormal findings.
Z23	Encounter for Immunization. This diagnosis code can be used for both children and adults. Z23 may be used as a secondary diagnosis code, to be used after primary diagnosis code Z00.110, Z00.111, Z00121, Z00.129, Z00.00 or Z00.01.
Sick Visit DX Code	If a sick visit is performed at the same time as the preventive service or wellness visit, then list the appropriate sick visit diagnosis code in the second or third position on the encounter form or claim form.

Medicare

The Centers for Medicare and Medicaid Services (CMS) designates specific HCPCS procedure codes (G0402, G0438, G0439) for Medicare patients receiving an annual preventive service or wellness visit. CPT codes 99387 or 99397 cannot be billed for Medicare beneficiaries over the age of 65.

For Medicare beneficiaries under 65 years old who have Medicaid as secondary insurance, code ranges 99381–99397 cannot be used. Instead, codes G0402, G0438, or G0439 must be used.

Selecting the appropriate Medicare HCPCS code for a preventive service or wellness visit depends on whether the beneficiary is a new Medicare enrollee and whether they have received any preventive or wellness visit within the previous 12 months.

HCPCS Code	HCPCS Code Definition
G0402	Initial preventive physical examination (IPPE); face to face visit. This service is limited to a new Medicare beneficiary during the first 12 months of Medicare Part B enrollment. The IPPE, billed with G0402, is a one time benefit and does not include a personalized prevention plan of service (PPPS). A beneficiary who receives an IPPE remains eligible for an Initial Annual Wellness Visit (G0438) once **12 months have passed** since the IPPE. For example, if a Medicare beneficiary has an IPPE (G0402) at month 6 of Part B, that same Medicare beneficiary can still get G0438 **but no earlier than month 18** (12 months after the IPPE, and >12 months after Part B start).
G0438	Initial Annual Wellness Visit; includes a personalized prevention plan of service (PPPS). The Medicare beneficiary must have been enrolled in Medicare Part B for **more than 12 months** and must **not** have received an IPPE (G0402) or any Annual Wellness Visit (G0438 or G0439) **within the previous 12 months. G0438 is a once per lifetime benefit** for each beneficiary. A beneficiary who previously received an IPPE (G0402) may still receive G0438, provided the required **12-month interval** has elapsed. See example provided for G0402.
G0439	An annual wellness visit includes a personalized prevention plan of service (PPPS), subsequent visit. G0439 can only be used after 12 months have passed since G0438 was first used for the patient. Medicare Part B patients are eligible for G0439 once every 12 months.

To better understand coverage guidelines, limitations, and medical necessity criteria for Medicare patients, please consult the reference document: Medicare Wellness Visits | CMS .

Additionally, the following ICD-10-CM diagnosis codes should be used alongside one of the Medicare HCPCS procedure codes listed above when indicating a wellness visit or preventive service.

ICD-10-CM	Description
Z00.00	Encounter for general adult medical examination without abnormal findings.
Z00.01	Encounter for general adult medical examination with abnormal findings.
Z23	Encounter for Immunization. This diagnosis code can be used for both children and adults. Z23 may be used as a secondary diagnosis code, to be used after primary diagnosis code Z00.00 or Z00.01.

Services Covered Under Preventive Services and Well Visits

The purpose of this section is to detail the preventive medical services included in 99381 – 99387, 99391 – 99397, G0402, G0438, and G0439.

Well Baby Visits (Birth to 2 Years): CPT codes 99381, 99382, 99391, 99392

- Physical Exam: Weight, length, head circumference, examination of various body parts and systems.
- Counseling and Guidance: Immunizations, safety, health, nutrition, developmental milestones.
- Screening Services: Hearing, vision, PKU, hemoglobin, sickle-cell disease, fluoride supplementation.

Well Child Visits (3 to 10 Years): CPT codes 99382 – 99383, 99392 – 99393

- Physical Exam: Height, weight, BMI, vision and hearing screening, blood pressure, review of various systems.
- Counseling and Guidance: Immunizations, safety, health, nutrition, developmental milestones, screenings.
- Screening Services: Vision, obesity screening for children 6+.

Well Child Visits (11 to 18 Years): CPT codes 99383 – 99385, 99393 – 99395

- Physical Exam: Height, weight, BMI, vision and hearing screening, blood pressure, review of various systems.
- Counseling and Guidance: Immunizations, injury prevention, nutrition, tobacco/alcohol/drug avoidance, healthy weight, physical activity, mental health, dental health, sexual health, STD screenings.
- Risk Factors: Depression, eating disorders, abuse, learning disabilities, hypertension, hyperlipidemia, coronary heart disease.
- Screening Services: Depression, obesity, HIV, Chlamydia.

Adult Visits (19 to 39 Years): CPT codes 99385 or 99395

- Physical Exam: Height, weight, BMI, blood pressure, breast exam, depression screening, review of various systems.
- Counseling and Guidance: Annual immunizations, healthy weight, physical activity, nutrition, injury prevention, tobacco/alcohol/drug avoidance, mental health, dental health, sexual health, family planning/contraception.
- Screening Services: Cholesterol, chlamydia, cervical cancer, pap smear, HIV testing.

Adult Visits (40 to 64 Years): CPT codes 99386 or 99396

- Physical Exam: Height, weight, BMI, blood pressure, breast exam, depression screening, review of various systems.
- Counseling and Guidance: Annual immunizations, shingles vaccine, healthy weight, physical activity, nutrition, injury prevention, tobacco/alcohol/drug avoidance, mental health, dental health, sexual health, family planning/contraception.
- Screening Services: Cholesterol, diabetes, colorectal cancer, HIV testing.
- For Women: Breast cancer, cervical cancer screenings.
- For Men: Prostate cancer screening starting at 50.

Adult Visits (65+ Years): HCPCS codes G0402, G0438, G0439 (Medicare) or CPT codes 99387, 99397 (Medicaid and Marketplace)

- Physical Exam: Height, weight, BMI, blood pressure, breast exam, depression and hearing screening, review of various systems.
- Counseling and Guidance: Annual immunizations, shingles and pneumococcal vaccines, healthy weight, physical activity, nutrition, injury prevention, tobacco/alcohol/drug avoidance, mental health, dental health, sexual behavior, fall prevention.
- Screening Services: Cholesterol, diabetes, colorectal cancer.
- For Women: Breast cancer, cervical cancer, osteoporosis screenings from 65.
- For Men: Prostate cancer, aortic aneurysm screening (one-time for men 65-75 with smoking history).

Not all codes are covered by all jurisdictions. Please consult local fee schedules for coverage determinations.

Supplemental Information

Definitions

Term	Definition
AAP Bright Futures Guidelines	The Bright Futures Guidelines are developed by the American Academy of Pediatrics (AAP) to provide evidence informed recommendations for the preventive care of infants, children, and adolescents. The guidelines outline age specific schedules for well child visits and include recommendations for physical examinations, developmental and behavioral screenings, immunizations, anticipatory guidance, and risk assessments. Bright Futures serves as the national standard for pediatric preventive care and forms the basis for EPSDT screening requirements in Medicaid programs.
ACIP	The Advisory Committee on Immunization Practices. The Advisory Committee on Immunization Practices (ACIP) is a federal advisory committee within the Centers for Disease Control and Prevention (CDC). ACIP reviews scientific evidence and issues national recommendations on vaccine use, including the U.S. immunization schedules for children and adults.
CMS	The Centers for Medicare & Medicaid Services. It is a federal agency within the United States Department of Health and Human Services that administers the Medicare program and works in partnership with state governments to administer Medicaid, the Children's Health Insurance Program (CHIP), and health insurance portability standards.
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment. EPSDT is a federally mandated Medicaid benefit established under Section 1905(r) of the Social Security Act. Its purpose is to ensure that Medicaid eligible individuals under age 21 receive comprehensive and preventive health services. EPSDT requires states to provide periodic well child screenings, vision, dental, and hearing services, as well as any medically necessary diagnostic and treatment services identified during a screening, even if the service is not covered under the state's Medicaid plan. States may require specific modifiers, billing rules, or add on codes (such as S0302) to document completion of EPSDT components.
HRSA	The Health Resources and Services Administration. Women's Preventive Services Guidelines are issued by the Health Resources and Services Administration (HRSA), an agency within the U.S. Department of Health and Human Services (HHS). HRSA develops these guidelines to identify evidence based preventive services that support women's health across the lifespan. The guidelines outline required coverage for services such as well woman visits, contraceptive care, breastfeeding support, screening for interpersonal and domestic violence, and other key preventive interventions.
PKU	PKU (phenylketonuria) is an inherited metabolic disorder in which the newborn cannot properly break down phenylalanine. Because untreated PKU can cause serious developmental harm, PKU screening is mandated in newborn screening panels nationwide.
USPSTF	The U.S. Preventive Services Task Force. The U.S. Preventive Services Task Force is an independent panel of experts supported by the Agency for Healthcare Research and Quality (AHRQ) within the Department of Health and Human Services (HHS). The USPSTF's role is to review scientific evidence and issue recommendations on clinical preventive services, including screenings, counseling, and preventive medications.

State Exceptions

State	Exception
Arizona	• EPSDT visits are all-inclusive visits. Only those services specifically identified below as a separately billable service may be billed separately or in addition to the EPSDT visit code 99381-99385, and 99391-99395. Services are billed on the date performed. • Separately billable services during an EPSDT preventive visit: 96127, 99408, 99409, 96160, 96161, 96110, T2101, 90460, 90480, 90622, 90611, 90714, 90715, 90702, G0312, G0313, G0314, G0315, S3620, 86592, 86593, 86780, 99188, and 99177.
California	• Use CPT codes 99385 or 99395 for recipients who are 18 to 20 years of age. • For certain services performed at a preventive service exam, use modifier 33. Modifier 33 is a CPT modifier that indicates a covered preventive service following USPSTF guidelines. The modifier is applied when the USPSTF has given the service an A or B rating. Please see References section for more information.
Connecticut	• **CPT Code 99459** – CPT 99459 is an add-on pelvic examination code reported with illness-related or preventive E/M services. It represents practice expense only, covering supplies (e.g., disposable or sterilized speculum) and limited staff time (e.g., room setup or chaperone time). • **Effective 1/1/2024** – Connecticut Medicare and Marketplace – For these lines of business, Molina

	Healthcare considers CPT 99459 included in the reimbursement for the Preventive Medicine Service or illness related E/M service performed on the same date. CPT 99459 is not separately reimbursed.
Georgia	• If a significant abnormality or preexisting problem requires additional work beyond the preventive visit (99381–99385, 99391–99395), report the appropriate problem-oriented E/M code (99202–99205, 99211–99215) with both modifiers EP and 25.
Illnois	• A preventive medicine CPT code and an office or other outpatient evaluation and management CPT code during the same session are not separately reimbursable. The practitioner should submit the single evaluation and management service code that best describes the actual services rendered. • When preventive services are provided as a part of a problem-focused visit, the office or other outpatient evaluation and management procedure code is to be used instead of the preventive medicine code. Such a visit is subject to cost sharing.
Idaho	• Physical exams for life activities such as sports participation, camp attendance, employment, driving licensure, admission to an educational institution, military recruitment, insurance coverage, paternity determination, adoption, immigration, or marriage are not considered medically necessary and are not covered by Idaho Medicaid. Non-covered physicals may be rendered as incidental to a Medicaid-covered service, but only the Medicaid-covered service is reimbursable. No additional payment will be made for the physical exam.
Iowa	• Physical examinations performed for the purpose of prescribing birth control medications or devices may include a physical exam, pelvic exam, and any diagnostic procedures (e.g., Pap smear) deemed medically necessary by the provider. For members age 20 and under, append the EP modifier. This service does not replace a comprehensive Care for Kids examination. • For children preventive services or wellness visits, services that must be included in the screening examination are: Immunizations; Hearing screening; Assessment of nutritional status; Vision screening.

Massachusetts	• If an EPSDT child wellness visit is performed by non-independent nurse practitioner, non-independent nurse midwife, or physician assistant employed by a MassHealth-enrolled physician, then certain modifiers must be used on codes 99381 – 99385 or 99391 – 99395:
	  ○ SA - A non-independent nurse practitioner who is employed by a physician.
	  ○ SB - A non-independent nurse midwife who is employed by a physician.
	  ○ HN - Bachelor's degree level (Use to indicate the physician assistant.)
	• For an EPSDT child preventive service, additional preventive services performed outside of 99381 – 99385 or 99391 – 99395, the first claim line must list 99381 – 99385 or 99391 – 99395, the second claim line must list S0302, and then the third claim line must list the CPT code or HCPCS code for the additional preventive service.
	• For a sick visit performed during a preventive service, the first claim line must list 99381 – 99385 or 99391– 99395, the second claim line must list S0302. Use the diagnosis code appropriate for the condition for which the child was treated.
	• For EPSDT child preventive services, the following preventive services are payable in addition to 99381-99385, or 99391-99395, along with the code S0302:
	  ○ 81000, 81002, 84703, 85013, 85014, 85018, 86580, 87081, 87210, 92551, 92552, 92587, 96110, 96127, and 99173. Note that this is not an exhaustive list and that there are additional codes that may be billed that are not listed.

Michigan	• Use modifier 33 when a service that is not inherently preventive is performed for a USPSTF A or B rated preventive purpose or other mandated preventive service. ○ For example, a diagnostic colonoscopy code such as 45378 may be billed with modifier 33 when the procedure is performed for a preventive screening purpose under USPSTF A rated colorectal cancer guidelines. In this situation, modifier 33 identifies the service as preventive even though the code itself is not inherently preventive. • Do not append modifier 33 to codes that are already designated as preventive.
Nevada	• Preventive health services not cataloged or that do not have a current status as either an A or B recommendation by the USPSTF are not covered. • School Based Health Centers (SBHCs) can provide primary and preventive medical services to Medicaid and Nevada Check Up recipients.
South Carolina	• The following services are not covered under EPSDT: Sports, camp or college physical examination. • Well-care visits conducted via telehealth must be billed with the appropriate EPSDT code and a GT modifier. Providers rendering services to children 24 months or younger must follow the American Academy of Pediatrics (AAP) recommendations to deliver the visit in person whenever possible. A justification as to why the visit could not be performed in person must be documented in the patient's health record. • South Carolina Medicaid policy allows providers to bill an EPSDT well-child screening on the same day as a sick visit.

	• South Carolina Medicaid reimburses for preventive health services for men and women (adults) as recommended by the USPSTF A and B recommendations.

Texas	• Modifier AM, SA, TD, or U7 must be submitted with the THSteps (the Texas EPSDT program) medical checkups procedure code to indicate the practitioner who performed the unclothed physical examination during the medical checkup.
	  ○ AM Physician, team member service
	  ○ SA Nurse practitioner rendering service in collaboration with a physician
	  ○ TD Registered nurse
	  ○ U7 Physician assistant
	• THSteps (the Texas EPSDT program) medical checkups performed in an FQHC or RHC setting are paid an all-inclusive rate per encounter, which includes immunizations, developmental screening, autism screening, mental health screening for adolescents, postpartum depression screening, TST, blood lead test, and OEFV.
	• When submitting claims for THSteps checkups and services, RHC providers must use the national POS code 72.
	• FQHC providers must use modifier EP in addition to the modifiers used to identify who performed the medical checkup.
	• In accordance with the federal rules for RHCs and FQHCs, an RN in an RHC or FQHC may not perform THSteps checkups independently of a physician's interactions with the client.
	• THSteps (the Texas EPSDT program): When a new patient checkup is billed for the same date of service as a new patient acute care visit, both new patient services may be reimbursed when billed by the same provider or provider group if no other acute care visits or preventive care medical checkups have been billed in the past three years.
	• THSteps (the Texas EPSDT program): Providers must use modifier 25 to describe circumstances in which an acute care E/M visit was provided at the same time as a checkup. Providers must submit modifier 25 with the E/M procedure code when the rendered services are distinct and provided for a different diagnosis.
	• The client's medical record must contain documentation that the separate identifiable service(s) were medically necessary and include a diagnosis in addition to Z0000, Z0001, Z00110, Z00111, Z00121 or Z00129 and treatment.
	• THSteps (the Texas EPSDT program): checkups billed as a synchronous audiovisual or synchronous telephone (audio-only) checkup (procedure codes 99381, 99391, 99382, or 99392) for children who are 24 months of age or younger will be denied.
	• For claims that are submitted with an immunization administration procedure code and a preventive E/M visit, providers may append modifier 25 to the preventive E/M visit procedure code to identify a significant, separately identifiable E/M service that was rendered by the same provider on the same day as the immunization administration.
	• Adhere to Texas Health Steps Periodicity Schedule for guidelines and exemptions for wellness visits.

Washington	• When a condition is treated during a well child checkup, bill the problem oriented E/M with modifier 25 and the correct diagnosis code. Submit the treatment code(s) and the EPSDT well child service code on separate claims. • There are specific criteria to bill EPSDT preventive visits for 19 and 20 year olds. See References below.
Wisconsin	• Preventive medicine services are those office visits that relate to preventive medicine E&M (evaluation and management) of infants, children, adolescents, and adults. Wisconsin Medicaid reimburses a maximum of one comprehensive, routine physical examination per calendar year per member. • Members may use this examination to fulfill employment, school entrance, or sports participation requirements.

Documentation History

Type	Date	Action
Initial Cration Date	06/28/2025	New Policy
Revised Date	07/28/2025	Policy Number 241 Added
Revised Date	08/10/2025	Updated Template
Revised Date	08/19/2025	Updated Initial Creation Date
Revised Date	09/22/2025	Updated Template to Molina Organic
Revised Date	01/13/2026	Combined with CCI policy Preventive Medicine and Screening

References

This policy was developed using:

- CMS
- State Medicaid Regulatory Guidance
- State Contracts

Reference	Link
AAPC	Recommended Ways to document and Report a Preventative Visit
US Preventative Services	A&B Recommendations
CDC	Immunization Schedules
HRSA	Women's Preventative Services Guidelines
CMS	Medicare Claim Manual Ch 12
CMS	Medicare Claim Manual Ch 18
CMS	Medicare Wellness Visits | CMS
CMS	MM13548 - HCPCS Billing Codes & Advance Beneficiary Notice of Non-coverage Requirements
Arizona	AMPM 430 EPSDT Service Codes
California	Preventative Services Pg 21
Connecticut	Preventative Health Services
Florida	Medicaid Well Child Visits
Georgia	Health Check
Georgia AAP	Medicaid | Georgia Chapter American Academy of Pediatrics
Idaho	EPSDT
Illinois	Preventative Services for Adults and Children
Illinois	Illinois Modifiers DHFS
Iowa	Physician Services Provider Manual
Kentucky	EPSDT Screenings PT 45
Massachusetts	EPSDT and PPHSD Services Billing Guidelines
Michigan	Medicaid Provider Manual
Mississippi	Managed Care Provider Webinar
Nebraska	Nebraska DHHS
Nevada	Provider Fact Sheet - Healthy Kids Program
Nevada	School Based Health Centers and EPSDT Services
New Mexico	Keeping Kids Healthy
New York	EPSDT/CTHP Provider Manual
Ohio	Rule 5160-1-16 Preventive Services
Ohio	EP Modifier for EPSDT Services
South Carolina	Physicians Services Provider Manual | SCDHHS
Texas	Texas Medicaid Provider Manual
Utah	Utah Medicaid Physician Services Manual
Washington	Provider billing guides and fee schedules | Physician-related Professional Services Manual
Washington	Provider billing guides and fee schedules | Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Manual
Wisconsin	Provider Handbook (EPSDT)

*__CODING DISCLAIMER.__ Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.