

Provider Agreement



Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) Services:

I, the undersigned participating physician/provider, agree to adhere to the American Academy of Pediatrics (AAP) Bright Futures periodicity schedule for physical, mental, psychosocial and/or behavioral health, vision, hearing, adolescent and developmental screenings when conducting EPSDT screenings.

SECTION A. Provider Agreement:

I agree to:

1. Perform appropriate components of EPSDT screenings in adherence with the current AAP Bright Futures periodicity schedule.
2. Refer EPSDT-eligible beneficiaries to other Division of Medicaid (DOM) enrolled licensed practitioners, of the beneficiary's choice, for services necessary to correct or ameliorate physical, mental, psychosocial and/or behavioral health conditions discovered by the screening services, whether or not such services are covered under DOM State Plan.
3. Seek reimbursement only for EPSDT screening(s) if the EPSDT screening(s) have been provided in accordance with DOM policies and the AAP Bright Futures' periodicity schedule.
4. Permit the provider's name to be listed as an EPSDT screening provider with the DOM program and consent to inclusion on a provider list made available to DOM Regional Office staff for selection by eligible beneficiaries.
5. Document in the medical record the specific age appropriate screening requirements in accordance with the AAP Bright Futures periodicity schedule and as outlined in Miss. Admin Code Part 223, Rule 1.6: Documentation Requirements for EPSDT Screenings.
6. Follow-up on all referred cases and document whether or not the initial referral visit was kept by the beneficiary.

SECTION B. Screening Requirements:

EPSDT screenings must include:

1. An initial or established age appropriate medical screening which must include, at a minimum:
 - ✓ A comprehensive health and developmental history including assessment of both physical and mental health development,
 - ✓ A comprehensive unclothed physical exam,
 - ✓ Appropriate immunizations according to the Advisory Committee for Immunization Practices (ACIP) and specific to age and health history*
 - ✓ Laboratory tests adhering to the AAP Bright Futures periodicity schedule,
 - ✓ Sexual development and sexuality screening adhering to the AAP Bright Futures periodicity schedule, and
 - ✓ Health education, including anticipatory guidance
2. Adolescent counseling and risk factor reduction intervention to include diagnosis with referral to a DOM enrolled provider for diagnosis and treatment for defects discovered.
3. Developmental screening or surveillance to include diagnosis with referral to a DOM provider for diagnosis and treatment for defects discovered.
4. Psychosocial/behavioral assessment to include referral to a DOM provider for diagnosis and treatment for defects discovered.
5. Vision screening at a minimum to include diagnosis with referral to a DOM optometry or ophthalmology provider for diagnosis and treatment for defects in vision, including eyeglasses.
6. Hearing screening at a minimum to include diagnosis with referral to a DOM audiologist, otologist, otolaryngologist or other physician hearing specialists for diagnosis and treatment for defects in hearing

including hearing aids.

7. Dental screening at a minimum to include diagnosis with referral to a DOM dental provider for beneficiaries at or the eruption of the first tooth or by twelve (12) months of age for diagnosis and referral to a dentist for treatment and relief of pain and infections, restoration of teeth and maintenance of dental health.

*DOM does not enroll providers in the VFC Program. To enroll in the VFC program, please contact the Mississippi Department of Health Immunizations at 1-601-576-7751.

<p>Provider's Printed Name: _____ Date signed: _____</p> <p>Provider's Signature (Original signature of the provider is required): _____</p> <p>DOM Provider Identification (ID): _____</p> <p>CLIA Number: _____ NPI Number: _____</p> <p>Group Affiliation for Screening Purposes & Group DOM Provider Identification (ID): _____</p> <p>Physical Street Address: (Indicate address applicable to site where screenings will be provided)</p> <p>_____</p> <p>City: _____ State: _____ Zip Code: _____</p> <p>Phone Number: _____</p>
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Send the completed and signed EPSDT Provider Agreement to:

Mailing address:

Division of Medicaid – Office of Medical Services
550 High Street, Suite 1000
Jackson, MS 39201

Or via

Fax: 601-359-6147