EPSDT – PCS REIMBURSEMENT

All claims for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) – Personal Care Services (PCS) shall be filed by electronic claims submission 837P or on the CMS 1500 claim form. Providers must utilize the Health Insurance Portability and Accountability Act (HIPAA) compliant billing procedure code and modifier. Refer to Appendix E for information about procedure code, unit of service and the current reimbursement rate. EPSDT – PCS shall be paid the lesser of billed charges or the maximum unit rate set by the Bureau of Health Services Financing (BHSF).

Current procedure codes must be used to identify services. Time units shall be those defined by the current procedure code, not including travel time. The entire time submitted must be spent providing services to the beneficiary. Units of service approved shall be based on the physical or cognitive limitations of the beneficiary and medical necessity for the covered services in the EPSDT-PCS program.
The claim submission date cannot precede the date the service was rendered.

If the claim for EPSDT – PCS is submitted without the prior authorization number, the claim will automatically deny with the error code "191" (Procedure Requires Prior Authorization (PA)).

If the dates of services on the claim are not within the dates in the PA, the claim will be denied with error code "193" (Date on Claim Not Covered by PA).

If an incorrect number of units are billed, the claim will be denied with error code "194" (Claim Exceeds PA Limits).

Hours may not be "saved" to be used later or in excess of the number of hours specified in the approval letter.

Hardcopy claims must be mailed to the fiscal intermediary. (See Appendix H for contact information).