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Medicaid Appendix

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FEDERALLY QUALIFIED HEALTH CENTER MANUAL TRANSMITTAL NO. 14-1

ISSUED BY: Iowa Medicaid Enterprise

SUBJECT: **FEDERALLY QUALIFIED HEALTH CENTER**, Title page, revised; Table of Contents (page 1), new; Chapter III, *Provider-Specific Policies*, Title page, new; Table of Contents (pages 1 and 2), new; pages 1 and 63, new; and the following forms:

470-0836	<i>Certification Regarding Abortion</i> , unchanged
RC-0080	<i>Screening Components by Age</i> , new
470-2942	<i>Medicaid Prenatal Risk Assessment</i> , revised
470-0835	<i>Consent for Sterilization</i> , revised
470-0835S	<i>Consent for Sterilization (Spanish)</i> , revised
470-3495	<i>Managed Care Wraparound Payment Request</i> , revised
470-5210	<i>Dental Wellness Plan Wraparound Payment Request</i> , new
470-5211	<i>Iowa Marketplace Choice Wraparound Payment Request</i> , new

Summary

The **FEDERALLY QUALIFIED HEALTH CENTER MANUAL** is revised to:

- ◆ Reformat and revise the chapters on coverage and limitations and billing and payment to reflect the implementation of the Iowa Medicaid Enterprise and the reorganization of the Medicaid "All Providers" manual chapters. This includes:
 - Removing Chapter E. Information on coverage and limitations is now included in Chapter III. *Provider-Specific Policies*.
 - Removing Chapter F. Billing and payment information and forms are now included in Chapter IV. *Billing Iowa Medicaid*.
- ◆ Align with current policies, procedures, and terminology.
- ◆ Ensure that current contact information is provided.
- ◆ Within the manual, the form samples have been removed from the numbered pages and connected to the on-line manual through hypertext links. This will make sure that the most recent version of the form is accessible.

Date Effective

Upon receipt.

Material Superseded

This material replaces the entire Chapter E and Chapter F from the **FEDERALLY QUALIFIED HEALTH CENTER MANUAL**, which includes the following:

<u>Page</u>	<u>Date</u>
Title page	Undated
Contents (pages 4 and 5)	July 1, 2003
Contents (page 6)	November 1, 2001
Chapter E	
1-4	August 1, 1995
5	January 1, 1997
6	March 1, 1999
7, 8, 8a	July 1, 2003
9	November 1, 2001
10	July 1, 2003
11, 12 (470-2942)	5/03
13, 14	August 1, 1995
14a, 14b, 15, 16, 16a, 16b	November 1, 2001
16c, 16d (470-0836)	7/11
16e-16h	February 1, 1999
16i (470-0835)	7/03
16j (470-0835S)	7/03
16k, 16l, 17	February 1, 1999
18	July 1, 2003
19-22	August 1, 1995
23-25 (470-3165)	8/95
26-28	January 1, 1997
29-31	August 1, 1995
32-36	July 1, 2003
39, 40	May 1, 1997
41, 42	July 1, 2003
43	November 1, 2001
44, 45	July 1, 2003
46	November 1, 2001
47, 48	November 1, 1998
49	January 1, 1997
50-54	July 1, 2003
55	January 1, 1997
56	August 1, 1995
57-72	July 1, 2003

Chapter F

1, 2	November 1, 1998
3 (470-0829)	4/98
5, 6	July 1, 2003
6a (470-3970)	7/03
6b, 7-10	July 1, 2003
11-13	November 1, 1998
14	July 1, 2003
15, 16 (HCFA-1500)	12/90
16a (470-3969)	7/03
17, 18	November 1, 1998
19 (Remittance Advice)	6/12/97
21-25	November 1, 1998
27 (470-3495)	6/03
28	July 1, 2003
29 (470-3744)	10/02
31 (470-0040)	10/02

Additional Information

The updated provider manual containing the revised pages can be found at:
<http://dhs.iowa.gov/sites/default/files/fedqhc.pdf>

If any portion of this manual is not clear, please contact the Iowa Medicaid Enterprise Provider Services Unit at 800-338-7909 or locally (in Des Moines) at 515-256-4609, or email at imeproviderservices@dhs.state.ia.us.

Federally Qualified Health Center (FQHC)

Provider Manual





Iowa
Department
of Human
Services

Provider
**Federally Qualified Health Center
(FQHC)**

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Date
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CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. ELIGIBILITY OF FEDERALLY QUALIFIED HEALTH CENTER

Federally qualified health centers (FQHC) are eligible to participate in the Medicaid program providing the Health Care Financing Administration has notified the Iowa Medicaid Enterprise (IME) of their eligibility as allowed by Section 6404(b) of Public Law 101-239.

B. CONTENT OF WELL CHILD EXAMINATION

A well child examination must include at least the following:

- ◆ Comprehensive health and developmental history, including an assessment of both physical and mental health development. This includes:
 - A developmental assessment.
 - An assessment of nutritional status.
- ◆ A comprehensive unclothed physical examination. This includes:
 - Physical growth.
 - A physical inspection, including ear, nose, mouth, throat, teeth, and all organ systems, such as pulmonary, cardiac, and gastrointestinal.
- ◆ Appropriate immunizations according to age and health history as recommended by the Iowa Department of Public Health.
- ◆ Health education, including anticipatory guidance.
- ◆ Hearing and vision screening.
- ◆ Appropriate laboratory tests. These shall include:
 - Hematocrit or hemoglobin
 - Lead toxicity screening for all children ages 12 to 72 months
 - Tuberculin test, when appropriate
 - Hemoglobinopathy, when appropriate
 - Serology, when appropriate
- ◆ Oral health assessment with dental referral for children over age 12 months and older based on risk assessment.

Click [here](#) to view the Iowa Early and Periodic Screening, Diagnosis, and Treatment program (EPSDT) Care for Kids Health Maintenance Recommendations for additional details.



1. History and Guidance

a. Comprehensive Health and Developmental History

A comprehensive health and developmental history is a profile of the member's medical history. It includes an assessment of both physical and mental health development. Take the member's medical history from the member, if age-appropriate, or from a parent, guardian, or responsible adult who is familiar with the member's history.

Complete or update a comprehensive health and developmental history at every initial or periodic EPSDT screening visit. Include the following:

- ◆ Identification of specific concerns
- ◆ Family history of illnesses
- ◆ The member's history of illnesses, diseases, allergies, and accidents
- ◆ Information about the member's social or physical environment that may affect the member's overall health
- ◆ Information on current medications or adverse reaction or responses due to medications
- ◆ Immunization history
- ◆ Developmental history to determine whether development falls within a normal range of achievement according to age group and cultural background
- ◆ Identification of health resources currently used

b. Developmental Screening

Screening is a "brief assessment procedure designed to identify children who should receive more intensive diagnosis or assessment." The primary purpose of developmental screening is to identify children who may need more comprehensive evaluation.

The use of validated screening tools improves detection of problems at the earliest possible age. Each developmental screening instrument is accompanied by an interpretation and report (e.g., a score or designation as normal or abnormal). Any interventions or referrals based on abnormal findings should be documented as well.



Developmental screening for young children should include the following four areas:

- ◆ Speech and language
- ◆ Fine and gross motor skills
- ◆ Cognitive skills
- ◆ Social and emotional behavior

In screening children from birth to six years of age, it is recommended that recognized instruments are selected. The best instruments have good psychometric properties, including adequate sensitivity, specificity, validity, and reliability, and have been standardized on diverse populations.

Parents report instruments such as the *Parents' Evaluation of Developmental Status (PEDS)*, *Ages and Stages Questionnaires*, and the *Child Development Review* have excellent psychometric properties and require a minimum of time.

No list of specific instruments is required for identifying developmental problems of older children and adolescents. However, the following principles should be considered in developmental screening:

- ◆ Collect information on the child's or adolescent's usual functioning, as reported by the child, parents, teacher, health professional or other familiar person.
- ◆ Incorporate and review this information in conjunction with other information gathered during the physical examination.
- ◆ Make an objective professional judgment as to whether the child is within the expected ranges. Review the developmental progress of the child as a component of overall health and well-being, given the child's age and culture.
- ◆ Screening should be culturally sensitive and valid. Do not dismiss or excuse potential problems improperly based on culturally appropriate behavior. Do not initiate referrals improperly for factors associated with cultural heritage.
- ◆ Screening should not result in a label or premature diagnosis being assigned to a child. Report only that a condition was referred or that diagnostic treatment services are needed. Results of initial screening should not be accepted as conclusions and do not represent diagnosis.



When the provider or the parent has concerns or questions regarding the functioning of the child in relation to expected ranges of activities after screening, make referral for developmental assessment by professionals trained in the use of more elaborate instruments and structured tests.

Developmental surveillance is different than developmental testing. Developmental surveillance is a flexible, continuous process in which knowledgeable professionals perform skilled observations of children during the provision of health care.

Developmental surveillance is an important technique, which includes questions about the development as a part of the general developmental survey or history. It is not a “test” as such, and is not billable as a developmental screen.

Health care providers often use age-appropriate developmental checklists to record milestones during preventative care visits as part of developmental surveillance. Click [here](#) to view the surveillance tool for children, with the *Iowa Child Health and Developmental Record (CHDR)*.

The adolescent population presents a different developmental challenge. Many of the more readily apparent developmental problems should have been identified and be under treatment. Focus screening on such areas of special concern as potential presence of learning disabilities, peer relations, psychological or psychiatric problems, and vocational skills.

For further information on developmental screening, see:

- ◆ [Care for Kids Provider website](#)
- ◆ [Developmental Behavioral Online website of the American Academy of Pediatrics](#)
- ◆ [Assuring Better Child Development and Health \(ABCD\) Electronic Resource Center of the National Academy for State Health Policy](#)
- ◆ [Commonwealth Fund’s Child Development and Preventative Care website](#)
- ◆ [National Center of Home Initiatives for Children with Special Needs website of the American Academy of Pediatrics](#)



c. **Health Education/Anticipatory Guidance**

Health education that includes anticipatory guidance is an essential component of screening services. Provide it to parents and youth (if age-appropriate) at each screening visit. Design it to:

- ◆ Assist the parents and youth in understanding what to expect in terms of the child's development.
- ◆ Provide information about the benefits of healthy lifestyles and practices as well as injury and disease prevention.

Health education must be age-appropriate, culturally competent, and geared to the particular child's medical, developmental, dental, and social circumstances. Four lists of age-related topics recommended for discussion at screenings are included below.

Anticipatory guidance and health education recommended topics are included in the *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, Third Edition, Arlington, VA. This publication is available from the National Center for Education in Maternal and Child Health (703) 356-1964, (888) 434-4MCH, or click [here](#) to view the website.

These lists are guidelines only. They do not require the inclusion of topics that are inappropriate for the child nor limit topics that are appropriate for the child.

Suggested Health Education Topics: Birth - 18 Months

Oral Health

- ◆ Appropriate use of bottle and breast feeding
- ◆ Fluoride exposure: toothpaste, water, topical fluoride, and supplements
- ◆ Infant oral care: cleaning teeth and gums
- ◆ Early childhood caries
- ◆ Transmission of oral bacteria
- ◆ Non-nutritive sucking (thumb, finger, and pacifier)
- ◆ Teething and tooth eruption
- ◆ First dental visit by age one
- ◆ Feeding and snacking habits: exposure to carbohydrates and sugars
- ◆ Use of cup and sippy cup



Injury Prevention

- ◆ Infant and child CPR
- ◆ Child care options
- ◆ Child safety seat restraint
- ◆ Child safety seats
- ◆ Importance of protective helmets
- ◆ Electric outlets
- ◆ Animals and pets
- ◆ Hot water heater temperature
- ◆ Ingestants, pieces of toys, popcorn, peanuts, hot dogs, powder, plastic bags
- ◆ Exposure to sun and heat
- ◆ Safety locks
- ◆ Lock up chemicals
- ◆ Restricted play areas on the farm
- ◆ Smoke detectors
- ◆ Stairway gates, walkers, cribs
- ◆ Syrup of ipecac, poison control
- ◆ Emergency telephone numbers
- ◆ Water precautions: buckets, tubs, small pools

Mental Health

- ◆ Adjustment to new baby
- ◆ Balancing home, work, and school
- ◆ Caretakers' expectations of infant development
- ◆ Responding to infant distress
- ◆ Baby self-regulation
- ◆ Child care
- ◆ Sibling rivalry
- ◆ Support from spouse and friends
- ◆ Recognizing unique temperament
- ◆ Creating stimulating learning environments
- ◆ Fostering baby caregiver attachment

Nutrition

- ◆ Bottle propping
- ◆ Breast or formula feeding to 1 year
- ◆ Burping
- ◆ Fluid needs
- ◆ Introduction of solid foods at 4-6 months
- ◆ Managing meal time behavior
- ◆ Self-feeding
- ◆ Snacks
- ◆ Weaning



Other Preventive Measures

- ◆ Back sleeping
- ◆ Bowel patterns
- ◆ Care of respiratory infections
- ◆ Crying or colic
- ◆ Effects of passive smoking
- ◆ Fever
- ◆ Hiccoughs
- ◆ Importance of well-child visits

Suggested Health Education Topics: 2 – 5 Years

Oral Health

- ◆ Oral care: parental tooth brushing and flossing when the teeth touch, monthly “lift the lip”
- ◆ Teething and tooth eruption
- ◆ Importance of baby teeth
- ◆ Regular dental visits
- ◆ Non-nutritive sucking (thumb, finger, and pacifier)
- ◆ Feeding and snacking habits: exposure to carbohydrates and sugars
- ◆ Appropriate use of bottle and breast feeding
- ◆ Use of sippy cup
- ◆ Use of sugary medications
- ◆ Early childhood carries, gingivitis
- ◆ Dental injury prevention
- ◆ Fluoride exposure: toothpaste, water, topical fluoride, and supplements
- ◆ Sealants on deciduous molars and permanent six-year molars

Injury Prevention

- ◆ CPR training
- ◆ Booster car seat
- ◆ Burns and fire
- ◆ Farm hazards: manure pits, livestock, corn cribs, grain auger, and grain bins
- ◆ Dangers of accessible chemicals
- ◆ Importance of protective helmets
- ◆ Machinery safety
- ◆ No extra riders on tractor
- ◆ Play equipment
- ◆ Purchase of bicycles
- ◆ Put up warning signs
- ◆ Restricted play areas
- ◆ Street danger
- ◆ Teach child how to get help
- ◆ Toys
- ◆ Tricycles
- ◆ Walking to school
- ◆ Water safety
- ◆ Gun storage



Mental Health

- ◆ Adjustment to increasing activity of child
- ◆ Balancing home, work, and school
- ◆ Helping children feel competent
- ◆ Child care
- ◆ Sibling rivalry
- ◆ Managing emotions

Nutrition

- ◆ Appropriate growth pattern
- ◆ Appropriate intake for age
- ◆ Control issues over food
- ◆ Managing meal-time behavior
- ◆ Physical activity
- ◆ Snacks

Other Preventive Measures

- ◆ Adequate sleep
- ◆ Care of illness
- ◆ Clothing
- ◆ Common habits
- ◆ Importance of preventative health visits
- ◆ Safety rules regarding strangers
- ◆ TV watching
- ◆ Age-appropriate sexuality education
- ◆ School readiness
- ◆ Toilet training
- ◆ Smoke-free environments
- ◆ Social skills

Suggested Health Education Topics: 6 – 12 Years

Oral Health

- ◆ Fluoride exposure: toothpaste, water, topical fluoride, and supplements
- ◆ Oral care: supervised tooth brushing and flossing
- ◆ Gingivitis and tooth decay
- ◆ Non-nutritive sucking (thumb, finger, and pacifier)
- ◆ Permanent tooth eruption
- ◆ Regular dental visits
- ◆ Dental referral: orthodontist
- ◆ Diet and snacking habits: exposure to carbohydrates, sugars, and pop, diet/snack habits and sports drinks
- ◆ Dental injury prevention: mouth guards for sports
- ◆ Sealants on deciduous molars and permanent 6- and 12-year molars
- ◆ Smoking and smokeless tobacco



Injury Prevention

- ◆ Bicycle (helmet) safety
- ◆ Car safety
- ◆ CPR training
- ◆ Dangers of ponds and creeks
- ◆ Electric fences
- ◆ Farm hazards: corn cribs, grain auger, gravity flow wagon, livestock
- ◆ Fire safety
- ◆ Gun and hunter safety
- ◆ Emergency telephone numbers
- ◆ Machinery safety
- ◆ Mowing safety
- ◆ Self-protection tips
- ◆ Sports safety
- ◆ Street safety
- ◆ Tractor safety training
- ◆ Water safety
- ◆ High noise levels

Mental Health

- ◆ Discipline
- ◆ Emotional, physical, and sexual development
- ◆ Handling conflict
- ◆ Positive family problem solving
- ◆ Developing self esteem
- ◆ Nurturing friendships
- ◆ Peer pressure and adjustment
- ◆ School-related concerns
- ◆ Sibling rivalry

Nutrition

- ◆ Appropriate intake for age
- ◆ Breakfast
- ◆ Child involvement with food decisions
- ◆ Food groups
- ◆ Inappropriate dietary behavior
- ◆ Managing meal time behavior
- ◆ Peer influence
- ◆ Physical activity
- ◆ Snacks

Other Preventive Measures

- ◆ Adequate sleep
- ◆ Clothing
- ◆ Exercise
- ◆ Hygiene
- ◆ Importance of preventative health visits
- ◆ Smoke-free environments
- ◆ Safety regarding strangers
- ◆ Age-appropriate sexuality education
- ◆ Social skills
- ◆ Preparation of girls for menarche
- ◆ Sports
- ◆ Stress
- ◆ TV viewing



Suggested Health Education Topics: 13 – 21 Years

Oral Health

- ◆ Fluoride exposure: toothpaste, water, and topical fluoride
- ◆ Daily oral care: tooth brushing and flossing
- ◆ Gingivitis, periodontal disease, and tooth decay
- ◆ Permanent tooth eruption
- ◆ Regular dental visits
- ◆ Dental referral: orthodontist and oral surgeon for third molars
- ◆ Diet and snacking habits: exposure to carbohydrates, sugars, sports drinks, and pop
- ◆ Dental injury prevention: Mouth guards for sports
- ◆ Sealants on premolars and permanent 6- and 12-year molars
- ◆ Smoking and smokeless tobacco
- ◆ Drug use (methamphetamines)
- ◆ Oral piercing

Development

- ◆ Normal biopsychosocial changes of adolescence

Gender Specific Health

- ◆ Abstinence education
- ◆ Contraception, condom use
- ◆ HIV counseling or referral
- ◆ Self-breast exam
- ◆ Self-testicular exam
- ◆ Sexual abuse, date rape
- ◆ Gender-specific sexual development
- ◆ Sexual orientation
- ◆ Sexual responsibility, decision making
- ◆ Sexually transmitted diseases
- ◆ Unintended pregnancy

Health Member Issues

- ◆ Selection and purchase of health devices or items
- ◆ Selection and use of health services



Injury Prevention

- ◆ CPR and first aid training
- ◆ Dangers of farm ponds and creeks
- ◆ Falls
- ◆ Firearm safety, hunting practices
- ◆ Gun and hunter safety
- ◆ Handling agricultural chemicals
- ◆ Hearing conservation
- ◆ Machinery safety
- ◆ Motorized vehicle safety (ATV, moped, motorcycle, car, and trucks)
- ◆ Overexposure to sun
- ◆ ROPS (roll over protective structure)
- ◆ Seat belt usage
- ◆ Helmet usage
- ◆ Smoke detector
- ◆ Sports recreation, workshop laboratory, job, or home injury prevention
- ◆ Tanning practices
- ◆ Violent behavior
- ◆ Water safety
- ◆ High noise levels

Nutrition

- ◆ Body image, weight issues
- ◆ Caloric requirements by age and gender
- ◆ Balanced diet to meet needs of growth
- ◆ Exercise, sports, and fitness
- ◆ Food fads, snacks, fast foods
- ◆ Selection of fitness program by need, age, and gender
- ◆ Special diets

Personal Behavior and Relationships

- ◆ Communication skills
- ◆ Dating relationships
- ◆ Decision making
- ◆ Seeking help if feeling angry, depressed, hopeless
- ◆ Community involvement
- ◆ Relationships with adults and peers
- ◆ Self-esteem building
- ◆ Stress management and reduction
- ◆ Personal responsibility



Substance Use

- ◆ Alcohol and drug cessation
- ◆ Counseling or referral for chemical abuse
- ◆ Driving under the influence
- ◆ HIV counseling and referral
- ◆ Riding with intoxicated driver
- ◆ Sharing of drug paraphernalia
- ◆ Steroid or steroid-like use
- ◆ Tobacco cessation

Other Prevention Measures

- ◆ Adequate sleep
- ◆ Clothing
- ◆ Exercise
- ◆ Hygiene
- ◆ Importance of preventative health visits
- ◆ Smoke-free environments
- ◆ Safety regarding strangers
- ◆ Age-appropriate sexuality education
- ◆ Social skills
- ◆ Preparation of girls for menarche
- ◆ Sports
- ◆ Stress
- ◆ TV viewing

d. Mental Health Assessment

Mental health assessment should capture important and relevant information about the child as a person. It may include a psychosocial history such as:

- ◆ The child's **life-style**, home situation, and "significant others."
- ◆ A **typical day**: How the child spends the time from getting up to going to bed.
- ◆ **Religious and health beliefs** of the family relevant to perceptions of wellness, illness, and treatment, and the child's outlook on the future.
- ◆ **Sleep**: Amount and patterns during day and at night; bedtime routines; type and location of bed; and nightmare, terrors, and somnambulating.
- ◆ **Toileting**: Methods of training used, when bladder and bowel control attained, occurrence of accidents or of enuresis or encopresis, and parental attitudes.



- ◆ **Speech:** Hesitation, stuttering, baby talk, lisping, and estimate of number of words in vocabulary.
- ◆ **Habits:** Bed rocking, head banging, tics, thumb sucking, pica, ritualistic behavior, and use of tobacco, alcohol, or drugs.
- ◆ **Discipline:** Parental assessment of child's temperament and response to discipline, methods used and their success or failure, negativism, temper tantrums, withdraw, and aggressive behavior.
- ◆ **Schooling:** Experience with day care, nursery school, and kindergarten; age and adjustment on entry; current parental and child satisfaction; academic achievement; and school's concerns.
- ◆ **Sexuality:** Relations with members of the opposite sex; inquisitiveness regarding conception, pregnancy, and girl-boy differences; parental responses to child's questions and the sex education parents have offered regarding masturbation, menstruation, nocturnal emissions, development of secondary sexual characteristics, and sexual urges; and dating patterns.
- ◆ **Personality:** Degree of independence; relationship with parents, siblings, and peers; group and independent activities and interests, congeniality; special friends (real or imaginary); major assets and skills; and self-image.

Source: Boyle Jr., W.E. and Hoekelman, R.A. *The Pediatric History*, In Hoekelman, R.A. ed. Primary Pediatric Care, Fourth Edition, 2001.

Clinical screening tools can increase the identification of psychosocial problems and mental disorders in primary care settings. Moreover, such tools can provide an important framework for discussing psychosocial issues with families. These screening tools can be grouped into three general categories:

- ◆ Broad psychosocial tools that assess:
 - Overall functioning, family history, and environmental factors;
 - Deal with a wide range of psychosocial problems; and
 - Identify various issues for discussion with the child or adolescent and family.

An example of this type of tool is the *Pediatric Intake Form*, which can be used to assess such issues as parental depression and substance use, gun availability, and domestic violence (Kemper and Kelleher, 1996a, 1996b).



- ◆ Tools that provide a general screen for psychosocial problems or risk in children and adolescents, such as the *Pediatric Symptom Checklist* (Jellinek et al., 1998, 1999).
- ◆ Tools that screen for specific problems, symptoms, and disorders, such as the *Conner's Rating Scales for ADHD* (Conners, 1997) and the *Children's Depression Inventory* (Kovacs, 1992).

Often a broader measure such as the *Pediatric Symptom Checklist* is used first, followed by a more specific tool focused on the predominant symptoms for those that screen positive on the broader measure.

Some of the more specific tools may not be readily available to primary care health professionals or may require specialized training.

Source: Jellinek M, Patel BP, Froehle MC, eds. 2002. *Bright Futures in Practice: Mental Health – Volume I. Practice Guide*. Arlington, VA: National Center for Education in Maternal and Child Health.

Click [here](#) to view the *Pediatric Symptom Checklist*.

2. Laboratory Tests

a. Cervical Papanicolaou (PAP) Smear

Regular cervical Papanicolaou (PAP) smears are recommended for all females who are sexually active or whose sexual history is thought to be unreliable at age 18. High-risk for cancer in situ are those who:

- ◆ Begin sexual activity in early teen years
- ◆ Have multiple partners

Sexually active females should receive family planning counseling, including PAP smears, self-breast examinations, and education on prevention of sexually-transmitted infections (STI).

Make a referral for further evaluation, diagnosis, or treatment when the smear demonstrates an abnormality. If first smear is unsatisfactory, repeat as soon as possible.



b. Chlamydia Test

Routine testing of sexually active women for chlamydia trachomatis is recommended for asymptomatic persons at high risk for infection (e.g., age less than 25, multiple sexual partners with multiple sexual contacts). For recent sexual partners of persons with positive tests for STI, also provide:

- ◆ Education on prevention of STI
- ◆ Education on the importance of contraception to prevent pregnancy

c. Gonorrhea Test

Testing for gonorrhea may be done on persons with:

- ◆ Multiple sexual partners or a sexual partner with multiple contacts
- ◆ Sexual contacts with a person with culture-proven gonorrhea
- ◆ A history of repeated episodes of gonorrhea

Discuss how to use contraceptives and make them available. Offer education on prevention of STIs.

d. Hemoglobin and Hematocrit

One hematocrit or hemoglobin determination is suggested by the American Academy of Pediatrics during the first year, and in each of the following intervals:

- ◆ 9-12 months, if any of the following risk factors are present:
 - Qualify for EPSDT Care for Kids
 - Low socioeconomic status
 - Birth weight under 1500 grams
 - Whole milk given before 6 months of age (not recommended)
 - Low-iron formula given (not recommended)
- ◆ 11-20 years. Annual screening for females, if any of the following factors are present:
 - Qualify for EPSDT Care for Kids
 - Moderate to heavy menses
 - Chronic weight loss
 - Nutrition deficit
 - Athletic activity



A test for anemia may be performed at any age if there is:

- ◆ Medical indication noted in the physical examination
- ◆ Nutritional history of inadequate iron in the diet
- ◆ History of blood loss
- ◆ Family history of anemia

All children whose hemoglobin or hematocrit is less than the fifth percentile are considered at risk for developing anemia.

Children under five years of age with incomes under 185 percent of poverty and hemoglobin or hematocrit below the fifth percentile qualify for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

Fifth Percent Criteria for Children

Age/Years	Hematocrit	Hemoglobin
6 months up to 2 years	32.9	11.0
2 up to 5 years	33.0	11.1
5 up to 8 years	34.5	11.5
8 up to 12 years	35.4	11.9

Female (non-pregnant)

12 up to 15 years	35.5	11.8
15 up to 18 years	35.9	12.0
18 up to 21 years	35.7	12.0

Male

12 up to 15 years	37.3	12.5
15 up to 18 years	39.7	13.3
18 up to 21 years	39.9	13.5

Source: "Recommendations to Prevent and Control Iron Deficiency in the United States," *Morbidity and Mortality Weekly Report*, April 3, 1998; Vol. 47, No. RR-3, pages 1-29.



e. **Hemoglobinopathy Screening**

Screen infants not born in Iowa and children of Caribbean, Latin American, Asian, Mediterranean, and African descent who were born before February 1988 for hemoglobin disorders. Identification of carrier status before conception permits genetic counseling and availability of diagnostic testing in the event of pregnancy.

The Hemoglobinopathy Screening and Comprehensive Care Program at the University of Iowa offers testing for a small fee. Call (319) 356-1400 for information.

f. **Lead Testing**

Perform blood lead testing for lead toxicity on children aged 12 to 72 months of age. The goal of all lead poisoning prevention activities is to reduce children's blood lead levels below 10 µg/dL.

Do not use erythrocyte protoporphyrin (EP) as a screening tool for lead poisoning, because it is not sensitive enough to identify children with blood lead levels below 25 µg/dL.

Initial screening may be done using a capillary specimen if procedures are followed to prevent the contamination of the sample. Consider an elevated blood level from a capillary test presumptive. Confirm it with a venous blood specimen.

For more information or assistance on lead testing, screening, or case management, contact the Bureau of Lead Poisoning Prevention, Iowa Department of Public Health, (515) 281-3479 or (800) 972-2026.

Click [here](#) to access the Iowa Childhood Lead Poisoning Risk Questionnaire. Use this questionnaire to decide whether to use the high risk or low risk blood lead testing schedule, or use the high risk testing schedule for all children. Do **not** assume that all children are at low risk. The lead testing and follow up protocols are also located at this link.



g. Newborn Screening

Confirm during the infant's first visit that newborn screening was done. In Iowa newborn screening is mandatory for the conditions on the screening panel.

Click [here](#) to view a current list of the screening panel.

h. Tuberculin Testing

The American Academy of Pediatrics Committee on Infectious Disease recommends annual tuberculin skin testing in high-risk children.

High-risk children include those in households where tuberculosis is common (e.g., from Asia, Africa, Central America, the Pacific Islands, or the Caribbean; migrant workers; residents of correctional institutions and homeless shelters; and homes of IV drug users, alcoholics, HIV positives, and prostitutes).

3. Physical Examination

Perform a comprehensive unclothed physical examination at each screening visit. It should include, but is not limited to, the following:

- ◆ General appearance
- ◆ Assessment of all body systems
- ◆ Height and weight
- ◆ Head circumference through 2 years of age
- ◆ Blood pressure starting at 3 years of age
- ◆ Palpation of femoral and brachial (or radial) pulses
- ◆ Breast inspection and palpation for age-appropriate females, including breast self-examination instructions and health education
- ◆ Pelvic examination, recommended for women 18 years old and older, if sexually active or having significant menstrual problems
- ◆ Testicular examination, include age-appropriate self-examination instructions and health education



a. Blood Pressure

Blood pressure measurement is a routine part of the physical examination at three years of age and older. During infancy, conduct a blood pressure only if other physical findings suggest it may be needed.

The National Health, Lung and Blood Institute published blood pressure standards for children and adolescents. The standards are based on height as well as age and gender for children and adolescents from one through 17 years old.

This is a change from the past when height and weight were both thought to be correlates of blood pressure. Height was determined by the investigators to be a better correlate for children and teenagers because of the prevalence of obesity in young people in this country. The standards appear in the Blood Pressure Tables for Children and Adolescents. See below.

To use the tables, measure each child and plot the height on a standard growth chart. Measure the child's systolic and diastolic blood pressure and compare them to the numbers provided in the tables for blood pressure for height, age, and sex.

The National Heart, Lung and Blood Institute recommends using the disappearance of Korotkoff's (K5) to determine diastolic blood pressure in children and adolescents.

The interpretation of children and adolescents blood pressure measurements for height, age, and gender are as follows:

- ◆ Readings below the 90th percentile are considered normotensive.
- ◆ Reading between the 90th and 95th percentile are high normal and warrant further observation and identification of risk factors.
- ◆ Readings of either systolic or diastolic at or above the 95th percentiles indicate the child may be hypertensive. Repeated measurements are indicated.

Click [here](#) to access Blood Pressure Tables for Children and Adolescents provided by the National Heart, Lung and Blood Institute.



b. Growth Measurements

(1) Body Mass Index

Body Mass Index (BMI) is the recommended parameter for monitoring the growth of children 24 months and older. BMI can be determined using a handheld calculator. The steps for calculating BMI using pounds and inches are listed below.

1. Convert any fractions to decimals.

Examples: 37 pounds 4 ounces = 37.25 pounds
41½ inches = 41.5 inches

2. Insert the values into the formula:

$[\text{weight (lb.)} / \text{height (in.)} / \text{height (in.)}] \times 703 = \text{BMI}$

Example: $(37.25 \text{ lb.} / 41.5 \text{ in.} / 41.5 \text{ in.}) \times 703 = 15.2$

A reference table can also be used to calculate BMI. Click [here](#) to download the table from the Centers for Disease Control and Prevention.

For children, BMI values are plotted against age. If the BMI-for-age is less than or equal to the 5th percentile, the child is considered underweight. If the BMI-for-age is between the 85th and 94th percentiles, the child is considered to be at risk for overweight. Children with a BMI equal to or greater than the 95th percentile are considered overweight.

(2) Height

Measure children over 2 years of age using a standing height board or stadiometer.

If the child is two years old or older and less than 31½ inches tall, the height measurement does not fit on the 2-20 year old chart. Therefore, measure the child's recumbent length and plot the length on the Birth-36 month growth chart. Read and record the measurement to the nearest 1/8 inch.

Never use measuring rods attached to scales, because the surface on which the child stands is not stable, and the measuring rod's hinge tends to become loose, causing inaccurate readings.



(3) Plotting Measurements

Record measurements as soon as they are taken to reduce errors.

Plot weight and height against age and weight against height on the Center for Disease Control and Prevention (CDC) growth chart for the children under 2 years of age. For children 2-20 years, plot weight and height against age and BMI against age on the appropriate growth chart.

Example:

	Year	Month	Day	
Date of visit	93 92	7 6 18	45 45	July 15, 1993
Birth date	-91	-10	-28	October 28, 1991
Age	1	8	17	= 20 months, 17 days or 21 months

Borrow 30 days for the 7 in the month column to make the day column 45 and the month column 6.

Borrow 12 months for 93 in the year column so that the top number in the month column is now 18.

Calculate the age to the nearest month. (Round to the next month if over 15 days.) Subtract birth date from the clinic visit date. It is allowable to borrow 30 days from the months column or 12 months for the year column when subtracting.

Common errors result from:

- ◆ Unbalanced scales,
- ◆ Failure to remove shoes and heavy clothing,
- ◆ Use of an inappropriate chart for recording the results, and
- ◆ Uncooperative children.



(4) Recumbent Length

Measure the length of infants and children up to two years of age on a horizontal length board with a fixed headboard and sliding footboard securely attached at right angles to the measuring surface. Read and record the measurement to the nearest 1/8 inch.

(5) Referral and Follow-up of Growth in Infants and Children

Nutrition. See criteria in [Nutritional Status](#).

Medical. Most children follow the usual patterns of growth, but a small but significant number of children have growth patterns that cross percentile lines in infancy, familial short stature, constitutional growth delay, and familial tall stature. Some warning signs of growth abnormalities are as follows:

- ◆ Growth of less than 2 inches per year for ages 3 to 10 years
- ◆ A greater than 25 percent change in weight/height percentile rank
- ◆ Sudden weight gain or loss
- ◆ More than two standard deviations below or above the mean for height

(6) Weight

Use a balance beam scale with non-detachable weights. Calibrate the scale once a year. Infants can be measured on either a specially designed infant scale or in a cradle on the adult scale.

Weigh infants and children with a minimal amount of clothing. Read and record to the nearest ounce for infants and quarter of a pound for children and youth.



c. **Head Circumference**

Measure the head circumference at each visit until the child is two years old. Measure with a non-stretchable tape measure firmly placed from the maximal occipital prominence around to the area just above the eyebrow. Plot the results on the Center for Disease and Prevention (CDC) growth chart.

Further evaluation is needed if the CDC growth grid reveals a measurement:

- ◆ Above the 95th percentile.
- ◆ Below the 5th percentile.
- ◆ Reflecting a major change in percentile levels from one measurement to the next or over time.

d. **Oral Health Screening**

The purpose of the oral health screening is to identify dental anomalies or diseases, such as dental caries (decay), soft tissue lesions, gum disease, or developmental problems and to ensure that preventive oral health education is provided to the parents or guardians.

Unlike other health needs, dental problems are so prevalent that most children will need diagnostic evaluation by age 12 months. An oral screening includes a medical and dental history and an oral evaluation. Each component of the oral screening listed below must be documented in the child's record:

- ◆ Complete or update the dental history:
 - Current or recent dental problems, including pain or mouth injuries
 - Name of dentist
 - Date of child's last dental visit or length of time since last dental visit
- ◆ Medical and dental history:
 - Current or recent medical conditions
 - Current medications used
 - Allergies



- Name of child's physician and dentist
- Frequency of dental visits
- Use of fluoride by child (source of water, use of fluoridated toothpaste or fluoride products)
- Current or recent dental problems or injuries, including parental concerns
- Home care (frequency of brushing, flossing, or other oral hygiene practices)
- Exposure to sugar, carbohydrates (snacking and feeding habits, use of sugary medications)
- ◆ Oral evaluation
 - Hard tissue:
 - Suspected decay
 - Demineralized areas (white spots)
 - Visible plaque
 - Enamel defects
 - Sealants
 - Decay history (fillings, crowns)
 - Stained fissures
 - Trauma or injury
 - Soft tissue:
 - Gum redness or bleeding
 - Swelling or lumps
 - Trauma or injury
- ◆ Provide age-appropriate oral health education to the parent or guardian. Education should be based on the findings of the oral health screening.
- ◆ Refer children to a dentist for:
 - Complete dental examination annually by 12 months and periodic exams semiannually based on risk assessment
 - Obvious or suspected dental caries
 - Pain or injury to the oral tissue
 - Difficulty chewing



4. Other Services

Other services that must be included in the screening examination are:

- ◆ [Immunizations](#)
- ◆ [Hearing screening](#)
- ◆ [Assessment of nutritional status](#)
- ◆ [Vision screening](#)

a. Immunization

In an effort to improve immunization practice, the health objectives for the nation call for a minimum of 90 percent of children to have recommended immunizations by their second birthday.

Standards published by the National Vaccine Advisory Committee in February 2002 reflect changes and challenges in vaccine delivery.

Every time children are seen, screen their immunization status and administer appropriate vaccines. (See [ACIP Recommendations Immunization Schedule](#).) Information about immunizations may be obtained by contacting the CDC at (800) 232-4636 or the Iowa Immunization Program at (800) 831-6293.

Many opportunities to immunize children are missed due to lack of knowledge about true contraindications, such as erroneously considering mild illness a contraindication. See [Contraindications and Precaution for Immunization](#) for a guide to contraindications to immunization.

When multiple vaccines are needed, administer vaccines simultaneously to decrease the number of children lost to follow-up. Do this particularly in high-risk populations who tend to be transient and noncompliant with recommendations for routine health maintenance visits.

Under the leadership of National Vaccine Advisory Committee (NVAC), standards were recently revised. Click [here](#) to view the revised standards which focus on:

- ◆ Making vaccines easily accessible
- ◆ Effectively communicating vaccination information
- ◆ Implementing strategies to improve vaccination rates
- ◆ Developing community partnerships to reach target patient populations



Provide the recommended childhood immunization schedule for the United States for January-December of the current year.

The recommended childhood and adolescent immunization schedule can be assessed on the following websites:

- ◆ [Centers for Disease Control and Prevention: Vaccines and Immunizations](#)
- ◆ [American Academy of Pediatrics](#)
- ◆ [American Academy of Family Physicians](#)

b. Hearing

Objective screening of hearing for all neonates is now recommended by the Joint Committee on Infant Hearing. Click [here](#) to view recommendations.

Objective hearing screening should be performed on all infants before age one month. Newborn infants who have not had an objective hearing test should be referred to an audiologist who specializes in infant screening using one of the latest audiology screening technologies.

Infants who do not pass the initial hearing screen and the subsequent rescreening should have appropriate audiology and medical evaluations to confirm the presence of hearing loss before three months.

All infants with confirmed hearing loss should receive intervention services before six months of age.

For information on nearby audiologists, see the early hearing detection and intervention system (EDHI) website, click [here](#) or call (888) 425-4371.

An objective hearing screening should be performed on all infants and toddlers who do not have a documented objective newborn hearing screening or documented parental refusal. This screening should be conducted by a qualified screener during well-child health screening appointments according to the periodicity schedule.



An objective hearing screening performed on newborns and infants will detect congenital hearing loss, but will not identify those children with late onset hearing loss. In order to be alert to late onset hearing loss, health providers should also monitor developmental milestones, auditory and speech skills, middle ear status, and should consider parental concerns.

A child of any age who has not had objective hearing screening should be referred for audiology evaluation to rule out congenital hearing loss.

The following risk indicators are associated with either congenital or delayed-onset hearing loss. Heightened surveillance of all children with risk indicators is recommended. Risk indicators marked with an asterisk are greater concern for delayed-onset hearing loss.

- ◆ Caregiver concern* regarding hearing, speech, language, or developmental delay (Roizen, 1999).
- ◆ Family history* of permanent childhood hearing loss (Cone-Wesson et al., 2000; Morton & Nance, 2006).
- ◆ Neonatal intensive care of more than five days or any of the following regardless of length of stay:
 - Extracorporeal Membrane Oxygenation (ECMO)*
 - Assisted ventilation
 - Hyperbilirubinemia requiring exchange transfusion
 - Exposure to ototoxic medications (gentamycin and tobramycin) or loop diuretics (furosemide/lasix)(Fligor et al., 2005; Roizen, 2003)
- ◆ In-utero infections, such as CMV,* herpes, rubella, syphilis, and toxoplasmosis (Fligor et al., 2005; Fowler et al., 1992; Madden et al., 2005; Nance et al., 2006; Pass et al., 2006; Rivera et al., 2002).
- ◆ Craniofacial anomalies, including those involving the pinna, ear canal, ear tags, ear pits, and temporal bone anomalies (Cone-Wesson et al., 2000).
- ◆ Physical findings, such as white forelock, associated with a syndrome known to include a sensorineural or permanent conductive hearing loss (Cone-Wesson et al., 2000).



- ◆ Syndromes associated with hearing loss or progressive or late-onset hearing loss, * such as neurofibromatosis, osteopetrosis, and Usher syndrome (Roizen, 2003). Other frequently identified syndromes including Waardenburg, Alport, Pendred and Jervell and Lange-Nielson (Nance, 2003).
- ◆ Neurodegenerative disorders, * such as Hunter syndrome, or sensory motor neuropathies, such as Friedreich ataxia and Charcot-Marie-Tooth syndrome (Roizen, 2003).
- ◆ Culture-positive postnatal infections associated with sensorineural hearing loss, * including confirmed bacterial and viral (especially herpes viruses and varicella) meningitis (Arditi et al., 1998; Bess, 1982; Biernath et al., 2006; Roizen, 2003).
- ◆ Head trauma, especially basal skull/temporal bone fracture * requiring hospitalization (Lew et al., 2004; Vartialnen et al., 1985; Zimmerman et al., 1993).
- ◆ Chemotherapy * (Bertolini et al., 2004).

Source: [*Hearing Screening Bright Futures, Guidelines for Health Supervision of Infants, Children, and Adolescents, Third Edition.*](#)

c. **Nutritional Status**

To assess nutritional status, include:

- ◆ Accurate measurements of height and weight.
- ◆ A laboratory test to screen for iron deficiency anemia (see Hgb/Hct procedures under [Hemoglobin and Hematocrit](#) for suggested screening ages).
- ◆ Questions about dietary practices to identify:
 - Diets that are deficient or excessive in one or more nutrients.
 - Food allergy, intolerance, or aversion.
 - Inappropriate dietary alterations.
 - Unusual eating habits (such as extended use of bottle feedings, pica, or abnormal behaviors intended to change body weight).
- ◆ Complete physical examination, including dental, with special attention to such general features as pallor, apathy, and irritability.



- ◆ If feasible, cholesterol measurement for children over two years of age who have increased risk for cardiovascular disease according to the following criteria:
 - Parents or grandparent, at 55 years of age or less, underwent diagnostic coronary arteriography and was found to have coronary atherosclerosis or suffered a documented myocardial infarction, peripheral vascular disease, cerebrovascular disease, or sudden cardiac death.
 - A parent who has been found to have high blood cholesterol (240 mg/dL or higher).

(1) Medical Evaluation Indicated (0-12 months)

Use the following criteria for referring an infant for further medical evaluation due to nutrition status:

- ◆ Measurements
 - Weight/height < 5th percentile or > 95th percentile (NCHS charts)
 - Weight/age < 5th percentile
 - Major change in weight/height percentile rank (a 25 percentile or greater shift in ranking)
 - Flat growth curve (two months without an increase in weight/age of an infant below the 90th percentile weight/age)
- ◆ Laboratory tests
 - < Hct 32.9%
 - < Hgb 11 gm/dL (6-12 months)
 - ≥ 15 $\mu\text{g/dL}$ blood lead level
- ◆ Health problems
 - Metabolic disorder
 - Chronic disease requiring a special diet
 - Physical handicap or developmental delay that may alter nutritional status
- ◆ Physical examination: Abnormality of any of the following which indicates poor nutrition: hair, skin or nails, eyes, teeth or gums, disorders of the thyroid or parotid glands, gastro-intestinal disorders, neurological disorders, or skeletal disorders



(2) Medical Evaluation Indicated (1-10 years)

Use these criteria for referring a child for further medical evaluation of nutrition status:

◆ Measurements

- Weight/length < 5th percentile or > 95th percentile for 12-23 months
- BMI for age < 5th percentile or > 95th percentile for 24 months and older
- Weight/age < 5th percentile
- Major change in weight/height percentile rank (a 25 percentile or greater shift in ranking)
- Flat growth curve:

Age	Indicator
12 to 36 months	Two months without an increase in weight per age of a child below the 90th percentile weight per age.
3 to 10 years	Six months without an increase in weight per age of a child below the 90th percentile weight per age.

◆ Laboratory tests

Age	HCT %	HGB gm/dL
1 up to 2 years	32.9	11.0
2 up to 5 years	33.0	11.1
5 up to 8 years	34.5	11.4
8 up to 10 years	35.4	11.9

◆ Health problems

- Chronic disease requiring a special diet
- Metabolic disorder
- Family history of hyperlipidemias
- Physical handicap or developmental delay that may alter nutritional status

- ◆ Physical examination: Abnormality of any of the following which indicates poor nutrition: hair, skin or nails, eyes, teeth or gums, disorders of the thyroid or parotid glands, gastrointestinal disorders, neurological disorders, or skeletal disorders



(3) Medical Evaluation Indicated (11-21 years)

Use these criteria for referring adolescents for further medical evaluation of nutritional status:

◆ Laboratory tests

Age	Female		Male	
	HCT %	HGB gm/dL	HCT %	HGB gm/dL
11 up to 12	35.4	11.9	35.4	11.9
12 up to 15	35.7	11.8	37.3	12.5
15 up to 18	35.9	12.0	39.7	13.3
18 up to 21	35.7	12.0	39.9	13.6

◆ Health problems

- Chronic disease requiring a special diet
- Physical handicap or developmental delay that may alter nutritional status
- Metabolic disorder
- Substance use or abuse
- Family history of hyperlipidemias
- Any behaviors intended to change body weight, such as self-induced vomiting, bingeing and purging, use of laxatives or diet pills, skipping meals on a regular basis, excessive exercise
- Physical examination. Abnormality of any of the following which indicates poor nutrition: hair, skin or nails, eyes, teeth or gums, disorders of the thyroid or parotid glands, gastrointestinal disorders, neurological disorders, or skeletal disorders

Source: *Expert Panel on Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents.* U.S. Department of Health and Human Services, October 2012.



d. Vision

Examination of the eyes should begin in the newborn period and should be done at all well infant and well child visits. Comprehensive examination of children is recommended as a part of the regular plan for continuing care beginning at three years of age.

At each visit, obtain a history to elicit from parents evidence of any visual difficulties. During the newborn period, infants who may be at risk for eye problems include those who are premature (e.g., retinopathy of prematurity) and those with family history of congenital cataracts, retinoblastoma, and metabolic and genetic diseases.

Click [here](#) to view the full scope of pediatric vision screening as stated by the American Academy of Ophthalmology Pediatric Ophthalmology/Strabismus Panel.

C. COVERAGE OF SERVICES

The following services are reimbursable as FQHC services. All services provided as part of the FQHC encounter must be provided within the scope of practice of the health professional rendering the service.

Except for other ambulatory services, services must be within the Medicaid coverage limits for as defined in [PHYSICIANS SERVICES](#) manual.

Coverage includes any other ambulatory services offered by the center that are otherwise covered by the IME and are provided within the limits on coverage for that service.

FQHC services are provided to members who are patients of the center. Therefore, these services are reimbursable when furnished to a member at the center, at a hospital or other medical facility, or at the member's place of residence, when the physician is compensated for the services by the center.



1. Abortions

Legislation enacted by the Iowa General Assembly restricts payment for abortions through the Medicaid program to the following situations:

- ◆ The attending provider certifies in writing, on the basis of professional judgment, that continuing the pregnancy would endanger the life of the pregnant woman. Federal funding is available in these situations only if the woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed.
- ◆ The attending provider certifies in writing, on the basis of professional judgment, that the fetus is physically deformed, mentally deficient, or afflicted with a congenital illness and states the medical indications for determining the fetal condition.
- ◆ The pregnancy is the result of rape that:
 - Was reported to a law enforcement agency or public or private health agency, which may include a family physician, and
 - Was reported within 45 days of the date of the incident, and
 - The report contains the name, address, and signature of the person making the report. An official of the agency must so certify in writing.
- ◆ The pregnancy is the result of incest that:
 - Was reported to a law enforcement agency or public or private health agency, which may include a family physician, and
 - Was reported within 150 days of the incident, and
 - The report contains the name, address, and signature of the person making the report. An official of the agency or physician must so certify in writing.



a. *Certification Regarding Abortion, Form 470-0836*

A copy of the form *Certification Regarding Abortion*, form 470-0836, must be attached to the physician's claim if payment is to be made for an abortion. Click [here](#) to view the form online. Payment cannot be made to the attending physician, to other physicians assisting in the abortion, to the anesthetist, or to the hospital or ambulatory surgical center if the required certification is not submitted with the claim for payment.

In case of a pregnancy resulting from rape or incest, a certification from a law enforcement agency, public or private health agency, or family physician is required as set forth above. It is the responsibility of the member, someone acting in her behalf, or the attending physician to obtain the necessary certification from the agency involved. Form 470-0836 is also to be used for this purpose.

It is the responsibility of the physician to make a copy of form 470-0836 available to the hospital, other physicians, certified registered nurse anesthetists, anesthetists, or ambulatory surgical centers billing for the service. This will facilitate payment to the hospital and other physicians on abortion claims.

Treatment is required for a spontaneous abortion or miscarriage where all the products of conception are not expelled.

All abortion claims must be billed with the appropriate diagnosis and procedure code indicating the abortion on the hospital claim and the appropriate diagnosis and CPT abortion procedure code on the practitioner claim.

The reason for the abortion must be identified on the *Certification Regarding Abortion* form. This form must be attached to the claim for payment, along with the following documentation:

- ◆ The operative report
- ◆ The pathology report
- ◆ Lab reports
- ◆ The ultrasound report
- ◆ The physician's progress notes
- ◆ Other documents that support the diagnosis identified on the claim

Iowa Department of Human Services
Certification Regarding Abortion



CERTIFY TO ONE OF THE FOLLOWING:

I certify that on the basis of my professional judgment:

Life of the Mother.

(Name and address of the mother)
suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused or arising from the pregnancy itself, that would place her in danger of death unless an abortion is performed, or,

Fetus Deformed. The fetus carried by

(Name and address of the mother)
is physically deformed, mentally deficient, or afflicted with a congenital illness based on:

(Medical indications)

Rape

I, _____, of _____
(Name of official) (Name of agency)
received a signed form from _____
(Name and address of person reporting)
stating that _____
(Name and address of the mother)
was the victim of an incident of rape. The incident took place on _____
(Date)
and the incident was reported on _____. The report included the name,
(Date)
address and signature of the person making the report.

Incest

I, _____, of _____
(Name of official) (Name of agency)
received a signed form from _____
(Name and address of person reporting)
stating that _____
(Name and address of the mother)
was the victim of an incest incident. The incident took place on _____
(Date)
and the incident was reported on _____. The report included the name,
(Date)
address and signature of the person making the report.

I further certify that the mother has been given the opportunity to view an ultrasound image of the fetus as part of the standard care before an abortion is performed, and the mother has been provided information regarding the options relative to a pregnancy including continuing the pregnancy to term and retaining parental rights following the child's birth, continuing the pregnancy to term and placing the child for adoption, and terminating the pregnancy.

Signature of attending provider	Date
Signature of official of law enforcement, public or private health agency which may include a family physician	Date

Conditions for Medicaid Payment for Abortions

Legislation enacted by the Iowa General Assembly restricts payment for abortions through the Medicaid program to the following situations:

1. The attending provider certifies in writing that continuing the pregnancy would endanger the life of the pregnant woman. Federal funding is available in these situations only if the woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed.
2. The attending provider certifies in writing on the basis of the provider's professional judgment that the fetus is physically deformed, mentally deficient or afflicted with a congenital illness and states the medical indications for determining the fetal condition.
3. The pregnancy is the result of rape, that incident was reported to a law enforcement agency or public or private health agency, which may include a family physician, within 45 days of the date of the incident, and that report contains the name, address and signature of the person making the report. An official of the agency must so certify in writing.
4. The pregnancy is the result of incest, that incident was reported to a law enforcement agency or public or private health agency, which may include a family physician, within 150 days of the incident, and that report contains the name, address and signature of the person making the report. An official of the agency or physician must so certify in writing.

A copy of the form, *Certification Regarding Abortion (470-0836)*, must be attached to any Medicaid claim associated with the abortion. **Payment will not be made to the attending provider or to other providers assisting in the abortion or to the hospital if the required certification is not submitted by the provider with the claim for payment.** It is the responsibility of the attending provider to make a copy of the certification available to the hospital and other providers billing for the services associated with the abortion.

In the case of pregnancy resulting from rape or incest, a certification from a law enforcement agency, public or private health agency, or family physician is required as set forth above. The member, someone acting in her behalf, or the attending provider is responsible for obtaining the necessary certification from the agency involved. The form, *Certification Regarding Abortion (470-0836)*, is to be used for this purpose. It is also the responsibility of the provider to make a copy of the certification available to the hospital and any other provider billing for the service. This will facilitate payment to the hospitals and other providers on abortion claims.



b. Covered Services Associated with Non-Covered Abortions

The following services are covered even if performed in connection with an abortion that is not covered:

- ◆ Services that would have been performed on a pregnant woman regardless of whether she was seeking an abortion, including:
 - Pregnancy tests.
 - Tests to identify sexually transmitted diseases (e.g., chlamydia, gonorrhea, syphilis).
 - Laboratory tests routinely performed on a pregnant member, such as Pap smear and urinalysis, hemoglobin, hematocrit, rubella titre, hepatitis B, and blood typing.
- ◆ Charges for all services, tests, and procedures performed post abortion for complications of a non-covered therapeutic abortion, including:
 - Charges for services following a septic abortion.
 - Charges for a hospital stay beyond the normal length of stay for abortions.

NOTE: Family planning or sterilization services must not be billed on the same claim with an abortion service. These services must be billed separately.

c. Non-Covered Services

The following abortion-related services are **not** allowed when the abortion is not covered by federal or state criteria:

- ◆ Physician and surgical charges for performing the abortion. These charges include the usual, uncomplicated preoperative and postoperative care and visits related to performing the abortion.
- ◆ Hospital or clinic charges associated with the abortion. This includes:
 - The facility fee for use of the operating room.
 - Supplies and drugs necessary to perform the abortion.
- ◆ Charges associated with routine, uncomplicated preoperative and postoperative visits by the member.



- ◆ Physician charges for administering the anesthesia necessary to induce or perform an abortion.
- ◆ Charges for laboratory tests performed before performing the non-covered abortion to determine the anesthetic or surgical risk of the member (e.g., CBC, electrolytes, blood typing).
- ◆ Drug charges for medication usually provided to or prescribed for a member who undergoes an uncomplicated abortion. This includes:
 - Routinely provided oral analgesics.
 - Antibiotics to prevent septic complication of abortion and Rho-GAM (an immune globulin administered to RH-negative women who have an abortion).
- ◆ Charges for histo-pathological tests performed routinely on the extracted fetus or abortion contents.
- ◆ Uterine ultrasounds performed immediately following an abortion.

2. Care for Kids Screening Examinations

FQHC services will be paid for health screening examinations provided to Medicaid-eligible persons under 21 years of age.

The recommended schedule for health, vision, and hearing screening is as follows:

Child's Age	Number of Screenings Recommended	Recommended Ages for Screening
0 to 12 months	7	2-3 days,* 1, 2, 4, 6, 9, and 12 months
13 to 24 months	3	15, 18, and 24 months
3 to 6 years	4	3, 4, 5, and 6 years
7 to 20 years	7	8, 10, 12, 14, 16, 18, and 20 years
* For newborns discharged in 24 hours or less after delivery.		

The periodicity schedule provides a minimum basis for follow-up examinations at critical points in a child's life. Families who accept screening will receive a notice that screening is due 60 days before the recommended ages for screening. New eligibles will receive a notice that screening is due immediately and then notified according to the recommended ages.

Screening Components by Age

Age	Infancy						Early Childhood						Middle Childhood				Adolescence				
	nb 1	by 1 m	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	3 yr	4 yr	5 yr	6 yr	8 yr	10 yr	12 yr	14 yr	16 yr	18 yr	20+ yr
HISTORY																					
Initial/Interval	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
PHYSICAL EXAM	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
MEASUREMENTS																					
Height/Weight	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Head Circumference	★	★	★	★	★	★	★	★	★												
Weight for Length	★	★	★	★	★	★	★	★	★												
Body Mass Index										★	★	★	★	★	★	★	★	★	★	★	★
Blood Pressure	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	★	★	★	★	★	★	★	★	★	★	★
NUTRITION ASSESS/EDUCATION	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
ORAL HEALTH²																					
Oral Health Assessment	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dental Referral							★		★	Every six months											
SENSORY SCREENING																					
Vision	RA	RA	RA	RA	RA	RA	RA	RA	RA	O	O	O	O	O	O	O	O	RA	O	RA	O
Hearing	O	RA	RA	RA	RA	RA	RA	RA	RA	RA	O						RA	RA	RA	O	RA
DEVELOPMENTAL/ BEHAVIORAL ASSESSMENT³																					
Developmental Screening						★			★	★											
Autism Screening								★	★												
Developmental Surveillance	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Psychosocial/Behav. Assess.	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Alcohol and Drug Use Assess.																	RA	RA	RA	RA	RA
PROCEDURES																					
Hgb/Hct	⊕																⊕				
Urinalysis													★								
Metabolic screening ⁵																					
Lead Screening						RA	RA	★or RA	RA	★or RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
Tuberculin Test		RA			RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
Dyslipidemia Screening										RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	★
STI Screening																	RA	RA	RA	RA	RA
Cervical Dysplasia Screening-																	RA	RA	RA	RA	RA

KEY: ★ To be performed ⊕ Perform test once during indicated time period
 ○ Objective, by a standard testing method RA Risk assessment to be performed, with appropriate action to follow if positive

Continued on next page.

HEMOGLOBINOPATHY	Only once (newborn screen) and offered to adolescents at risk.
TUBERCULIN TEST	Tuberculosis testing per recommendations of the Committee on Infectious Diseases, published in the current edition of <i>Red Book: Report of the Committee on Infectious Diseases</i> . Testing should be done on recognition of high-risk factors.
LEAD	Starting at 12 months, assess risk for high dose exposure.
GYNECOLOGIC TESTING	Pap smear for females who are sexually active or (if the sexual history is thought to be unreliable) age 18 or older. Pregnancy testing should be done when indicated by the history.
STI	All sexually active patients should be screened for sexually transmitted infections (STIs)
ANTICIPATORY GUIDANCE	Refer to the specific guidance by age as listed in Bright Futures Guidelines. (Hagan JF, Shaw JS, Duncan PM, eds. <i>Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents</i> . 3 rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008)

- ¹ Every infant should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital, to include evaluation for feeding and jaundice. Breastfeeding infants should receive formal breastfeeding evaluation, encouragement, and instruction as recommended in AAP statement “Breastfeeding and the Use of Human Milk” (2005) [URL: <http://aappolicy.aappublications.org/cgi/content/full/pediatrics;115/2/496>]. For newborns discharged in less than 48 hours after delivery, the infant must be examined within 48 hours of discharge per AAP statement “Hospital Stay for Healthy Term Newborns” (2004) [URL: <http://aappolicy.aappublications.org/cgi/content/full/pediatrics;113/5/1434>].
- ² The oral health assessment should include dental history, recent problems, pain, or injury and visual inspection of the oral cavity. Referral to a dentist should be at 12 months, 24 months, and then every 6 months, unless more frequent dental visits are recommended.
- ³ At each visit, age-appropriate physical examination is essential, with infant totally unclothed, older child undressed and suitably draped.
- ⁴ An immunization review should be performed at each screening, with immunizations being administered at appropriate ages, or as needed.
- ⁵ The Iowa Newborn Screening program tests every baby born in Iowa for the following disorders: hypothyroidism, galactosemia, phenylketonuria, hemoglobinopathies, congenital adrenal hyperplasia, medium chain acyl Co-A dehydrogenase (MCAD) deficiency, biotinidase deficiency, hearing, cystic fibrosis, and any other amino acid, organic acid, and fatty oxidation disorders detectable by tandem mass spectrometry.



Interperiodic screening, diagnosis, and treatment allow the flexibility necessary to strengthen the preventative nature of the program. Interperiodic screens may be obtained as required by foster care, educational standards, or when requested for a child.

These recommendations for preventive health care of children and youth represent a guide for the care of well children who receive competent parenting, who have not manifested any important health problems, and who are growing and developing satisfactorily. Other circumstances may indicate the need for additional visits or procedures.

If children or youth come under care for the first time at any point on the schedule, or if any of the items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest time.

Click [here](#) to view RC-0080, *Screening Components by Age*, online.

3. Family Planning Services

Family planning services include the following:

- ◆ Examination and tests which are necessary before prescribing family planning services. (Please indicate in the description area of the claim form service that is related to family planning.)
- ◆ Contraceptive services, including counseling services related to contraceptive method choice.
- ◆ Supplies for family planning, including such items as pharmaceuticals, an IUD, a diaphragm, or a basal thermometer.

Special Payment Method for FQHCs and RHCs

FQHCs and RHCs may provide these family planning waiver services to eligible members. **NOTE:** Payment for these family planning services will be based on the physician fee schedule for the CPT codes eligible for reimbursement. RHCs and FQHCs may **NOT** bill an encounter (procedure code T1015) for these services. To receive payment:

- ◆ The claim submitted by the FQHC or RHC must have the eligible CPT code (i.e., for the covered family planning waiver service) and the supporting eligible (i.e., family planning) diagnosis code.
- ◆ See [Informational Letter 483](#) for a list of covered CPT codes and covered prescription and over the counter drugs.



- ◆ When the claim is submitted, the payment system will verify that the member is eligible for this limited benefit package.
- ◆ The payment will then be made according to the physician fee schedule, for the appropriate family planning waiver service CPT code.

These IFPN visits and payments may not be used in calculations to establish the FQHC's or RHC's encounter rate for subsequent payment years. These visits may not be counted as Medicaid visits and the revenue must be treated as any other private or commercial insurance payment.

Direct family planning services receive additional federal funds. Therefore, it is important to indicate family planning services on the claim form by adding the modifier "FP" after the procedure code.

4. Hysterectomies

Payment will be made only for a medically necessary hysterectomy that is performed for a purpose other than sterilization and only when one or more of the following conditions are met:

- ◆ A member or her representative has signed an acknowledgment that she has been informed orally and in writing from the person authorized to perform the hysterectomy that the hysterectomy will make the member permanently incapable of reproducing.

This statement may be added to either the surgery consent form, written on the claim form, or on a separate sheet of paper. The person who receives the explanation must sign the statement. The following language is satisfactory for such a statement:

"Before the surgery, I received a complete explanation of the effects of this surgery, including the fact that it will result in sterilization.

(Date)

(Signature of member or person acting on her behalf)"

The vehicle for transmitting the acknowledgement that the member received the explanation before the surgery should **not** be the *Consent for Sterilization*, form 470-0835 or 470-0835S.

This statement must be submitted to the IME with the related Medicaid claims.



- ◆ The member was already sterile before the hysterectomy. The physician must certify in writing that the member was already sterile at the time of the hysterectomy and must state the cause of the sterility. The following language is satisfactory for such a statement:

"Before the surgery, this patient was sterile and the cause of that sterility was _____.
(Physician's signature) (Date)"

This statement may be added to either the surgery consent form, written on the claim form, or a separate sheet of paper. A physician must sign any document stating the cause of sterility. This includes a history and physical, operative report, or claim form.

The statement must be submitted to the IME with the related Medicaid claims.

- ◆ The hysterectomy was performed as the result of a life-threatening emergency in which the physician determined that prior acknowledgment was not possible. The physician must include a description of the nature of the emergency.

If the physician certifies that the hysterectomy was performed for a life-threatening emergency and includes a description of the nature of the emergency, the claim will be reviewed on an individual basis. Payment will be permitted only in extreme emergencies.

- ◆ Where the member is about to undergo abdominal exploratory surgery or a biopsy, and removal of the uterus could be a potential consequence of the surgery, the member should be informed of this possibility and given an opportunity to acknowledge in writing the receipt of this information. This includes C-sections when there is a reasonable expectation a hysterectomy will be performed, such as in the event of an acreta.

5. Immunizations

Pneumococcal and influenza vaccines and their administration are covered.

Providers must provide immunizations under the Vaccines for Children Program (VFC). Vaccines available through the VFC program are:

- ◆ Diphtheria and tetanus toxoids (DT vaccine)
- ◆ Diphtheria, tetanus toxoids, and acellular pertussis (DTAP)



- ◆ Diphtheria, tetanus toxoids, and acellular pertussis, (DTAP) Hepatitis B, poliovirus (IPV) vaccine
- ◆ Diphtheria, tetanus toxoid, and acellular pertussis, (DTAP) hemophilus influenza B (Hib) vaccine
- ◆ Hemophilus influenza B (HIB)
- ◆ Hemophilus influenza B (Hib) HbOC conjugate (four-dose schedule)
- ◆ Hemophilus influenza B (Hib) PRP-D conjugate (booster only)
- ◆ Hemophilus influenza B (Hib) PRP-OMP conjugate (three-dose schedule)
- ◆ Hepatitis B vaccine (HEP)
- ◆ Influenza vaccine, 6-35 months
- ◆ Influenza vaccine, three years and older
- ◆ Measles, mumps, and rubella virus vaccine (MMR), live
- ◆ Poliovirus vaccine (IPV)
- ◆ Pneumococcal conjugate, for children under five
- ◆ Tetanus and diphtheria toxoids absorbed, for people aged seven or over (TD)
- ◆ Varicella

6. Interpreter Services

Interpretative services may be covered, whether done orally or through sign language. Interpreters must provide only interpretation services for the agency. The services must facilitate access to Medicaid covered services.

In order for interpretation services to be covered by Iowa Medicaid, the services must meet the following criteria:

- ◆ Provided by interpreters who provide only interpretive services
- ◆ Interpreters may be employed or contracted by the billing provider
- ◆ The interpretive services must facilitate access to Medicaid covered services



Providers may only bill for these services if offered in conjunction with an otherwise Medicaid covered service. Medical staff that are bilingual are not reimbursed for the interpretation but only for their medical services.

a. Documentation of the Service

The billing provider must document in the member's record the:

- ◆ Interpreter's name or company,
- ◆ Date and time of the interpretation,
- ◆ Service duration (time in and time out), and
- ◆ Cost of providing the service.

b. Qualifications

It is the responsibility of the billing provider to determine the interpreter's competency. Sign language interpreters should be licensed pursuant to 645 Iowa Administrative Code (IAC) 361. Oral interpreters should be guided by the standards developed by the [National Council on Interpreting in Health Care](#).

Following is the instruction for billing interpretive services when that service is provided by an outside commercial translation service:

- ◆ Bill code T1013
 - For telephonic interpretive services use modifier "UC" to indicate that the payment should be made at a per-minute unit.
 - The lack of the UC modifier will indicate that the charge is being made for the 15 minute face-to-face unit.
- ◆ Enter the number of minutes actually used for the provision of the service. The 15 minute unit should be rounded up if the service is provided for 8 minutes or more.

NOTE: Because the same code is being used but a conditional modifier may be necessary, any claim where the UC modifier is **NOT** used and the units exceed 24 will be paid at 24 units.



7. Nutrition Counseling

Providers are eligible for reimbursement of nutritional counseling (medical nutritional therapy) services provided by licensed dietitians who are employed by or have contracts with the provider when a nutritional problem or a condition of such severity exists that nutritional counseling beyond that normally expected as part of the standard medical management is warranted.

Medical conditions that can be referred to a licensed dietitian include the following:

◆ Inadequate or excessive growth

Examples include:

- Failure to thrive,
- Undesired weight loss,
- Underweight,
- Excessive increase in weight relative to linear growth,
- Major changes in weight-to-height percentile or BMI for the child's age;
- Excessive appetite, or
- Hyperphagia.

◆ Inadequate dietary intake

Examples include:

- Formula intolerance,
- Food allergy,
- Limited variety of foods,
- Limited food resources, and
- Poor appetite.

◆ Infant or child feeding problems

Examples include:

- Poor suck or swallow,
- Breastfeeding difficulties,
- Lack of developmental feeding progress,
- Inappropriate kinds or amounts of feeding offered,
- Limited information or skills of caregiver,
- Food aversions enteral or parenteral feeding, and
- Delayed oral motor skills.



◆ **Chronic disease requiring nutritional intervention**

Examples include:

- Congenital heart disease,
- Pulmonary disease,
- Renal disease,
- Cystic fibrosis,
- Metabolic disorder,
- Diabetes,
- Gastrointestinal disease, and
- Any other genetic disorders requiring nutritional intervention.

◆ **Medical conditions requiring nutritional intervention**

Examples include:

- Iron deficiency anemia,
- High serum lead level,
- Familial hyperlipidemia,
- Hyperlipidemia, and
- Pregnancy.

◆ **Developmental disability**

Examples include:

- Increased risk of altered energy and nutrient needs,
- Oral-motor or behavioral feeding difficulties,
- Medication-nutrient interaction, and
- Tube feedings.

◆ **Psychosocial factors**

Examples include behaviors suggesting an eating disorder. Children with an eating disorder should also be referred to community resources and to their primary care provider for evaluation and treatment.

This is not an all-inclusive list. Other diagnoses may be appropriate and warrant referral to a licensed dietitian.



Individual Nutrition Evaluation and Assessment

Initial evaluations and follow-up assessments document the process of comprehensive data collection, child and family observation, and analysis to determine a child's nutritional status in order to develop a plan of care. The evaluation is based on:

- ◆ Informed clinical opinion through objective food record review,
- ◆ Evaluation of the child's pattern of growth, and
- ◆ Evaluation of area of concern based on the evaluation tool used and medical nutritional therapy.

Families who are eligible for nutritional counseling through the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) must provide a statement that the need for nutritional counseling exceeds the services available through WIC. Maintain a copy of the statement in the child's record.

8. Physician Services

Services performed by a physician at the center are covered FQHC services. They are reimbursable only to the center.

Covered services performed by a physician outside the center, including services to members in an inpatient hospital, are also covered FQHC services if the physician is compensated for the services by the center.

If the physician is not compensated, according to a written agreement between the physician and the center, the covered physician services provided outside the center are reimbursable to the physician on the basis of a fee schedule.

Services and supplies incident to a physician's professional services are covered and reimbursable as FQHC services if the service or supply is:

- ◆ Of the type commonly furnished in a physician's office.
- ◆ Of a type commonly rendered either without charge or included in the FQHC's bill.
- ◆ Furnished as an incidental although integral part of a physician's professional services.

Risk Factor Definition
AB 1st trimester: More than three spontaneous or induced abortions at less than 13 weeks gestation. (Do not include ectopic pregnancies.)
AB 2nd trimester: Spontaneous or induced abortion between 12 and 19 weeks gestation.
Uterine anomaly: Bicornate, T-shaped, or septate uterus, etc.
Dental visit: Routine preventive dental care; not visit for emergency extraction, mouth trauma.
DES exposure: Exposure to diethylstilbesterol in utero. Patient who has anomalies associated with diethylstilbesterol receives points for this item and uterine anomaly.
Hx PTL: Spontaneous preterm labor during any previous pregnancies (whether or not resulting in preterm birth) or preterm delivery.
Hx pyelonephritis: One or more episodes of pyelonephritis in past medical history.
Illicit drug use: Any street drug use during this pregnancy, e.g., speed, marijuana, cocaine, heroin (includes methadone), huffing, or the recreational use of Rx or OTC drugs.
Alcohol use: Consumption of 6 or more glasses of beer or wine per week or 4 or more mixed drinks per week. Includes any binge drinking.
Initial prenatal visit: First prenatal visit at or after 16 weeks gestation.
Poor social situation: Personal or family history of abuse, incarceration, homelessness, unstable housing, psychiatric disorder, child custody loss, cultural barriers, low cognitive functioning, mental retardation, negative attitude toward pregnancy, exposure to hazardous/toxic agents, inadequate support system, low self esteem.
Employment: Light work = part time or sedentary work or school Heavy work = work involving strenuous physical effort, standing, or continuous nervous tension, such as, nurses, sales staff, cleaning staff, baby-sitters, laborers
Bacteriuria: Any symptomatic or asymptomatic urinary tract infection, i.e., 100,000 colonies in urinalysis.
Pyelonephritis: Diagnosed pyelonephritis in the current pregnancy. (Give points for pyelonephritis only, not both pyelonephritis and bacteriuria.)
Bleeding after 12th week: Vaginal bleeding or spotting after 12 weeks of gestation of any amount, duration, or frequency which is not obviously due to cervical contact.
Dilation (Internal os): Cervical dilation of the internal os of one cm or more at 34 weeks gestation.
Uterine irritability: Uterine contractions of 5 contractions in one hour perceived by patient or documented by provider without cervical change at less than 34 weeks.
Surgery: Any abdominal surgery performed at 18 weeks or more of gestation or cervical cerclage at any time in this pregnancy.
Hypertension: Two measurements showing an increase of systolic pressure of 30 mgHg above baseline, an increase in diastolic pressure of 15 mgHg above baseline, or both.

Nutritional Risk Factor Assessment and Definitions
Instructions: Check nutrition counseling if any of the factors below indicate nutritional risk.
Anemia: Hgb < 11 or Hct < 33 (weeks 1-13 and weeks 27-40+) Hgb < 10.5 or Hct < 32 (weeks 14-26)
Inappropriate nutrition practices:
<ul style="list-style-type: none"> ◆ Consuming potentially harmful dietary supplements (includes excessive doses and those that may be toxic or harmful in other ways) ◆ Consumes diet very low in calories or essential nutrients (includes vegan diet defined as consuming only fruits, vegetables, and grains; macrobiotic diet; food faddism; and impaired calorie intake or nutrient absorption following bariatric surgery) ◆ Pica ◆ Inadequate iron supplementation (< 30 mg/day) ◆ Consuming foods potentially contaminated with pathogenic bacteria (raw seafood, meat, poultry, and eggs or any foods containing these products; raw sprouts; undercooked meat, poultry, and eggs; unpasteurized milk or foods containing it; soft cheeses such as feta, Brie, Camembert, blue-veined and Mexican-style cheese; unpasteurized fruit or vegetable juices; and hot dogs and luncheon meats unless reheated until steaming hot)

Examples of additional risk factors:	
Medical	<ul style="list-style-type: none"> ◆ Autoimmune disease ◆ Current eating disorder, fasting, skipping meals ◆ Diabetes ◆ Febrile illness ◆ Gestational diabetes ◆ Heart disease ◆ History of gastric bypass ◆ HIV ◆ Hyperemesis ◆ Psychiatric disorder ◆ Renal disease ◆ Seizure disorders ◆ Thyroid disease ◆ Type I diabetes
OB History	<ul style="list-style-type: none"> ◆ Caesarean section ◆ Infertility ◆ Perinatal loss
Psychosocial	<ul style="list-style-type: none"> ◆ Ambivalent, denying, or rejecting of this pregnancy ◆ Child care stress ◆ Cultural or communication barriers ◆ History of mental illness ◆ Not compliant with visit or healthy pregnancy behaviors (or not expected to be compliant without additional intervention) ◆ Teen pregnancy



- ◆ Furnished under the direct personal supervision of a physician.
- ◆ In the case of a service, furnished by a member of the center's health care staff who is an employee of the center.
- ◆ In the case of drugs and biologicals, furnished incident to the physician's professional service and not able to be self-administered.

9. Prenatal Risk Assessment

The Iowa Departments of Human Services and Public Health have jointly developed the *Medicaid Prenatal Risk Assessment* to help the clinician determine which pregnant members are in need of supplementary services to complement and support routine medical prenatal care.

To determine risk for pregnant Medicaid members upon entry into care, complete the *Medicaid Prenatal Risk Assessment*, form 470-2942. Click [here](#) to view the form online.

The form categorizes prenatal risk factors and assigns a score value related to the seriousness of the risk. In individual cases, the clinician may determine that the value the form assigns is not appropriate and based on professional judgment may choose a lesser value.

To determine a woman's risk status during the current pregnancy, add the total score value on the left side and either column B1 (initial visit score value) or column B2 (re-screen visit between 24-28 weeks gestation score value) to obtain the total score. A total score of 10 meets the criteria for high risk on this assessment.

When a high-risk pregnancy is reflected, inform the woman and refer her to an Iowa Department of Public Health maternal health agency or provide enhanced services. (See [Enhanced Services](#).) If referring the member to a maternal health agency, with the member's permission, provide a copy of the *Medicaid Prenatal Risk Assessment* to the agency providing enhanced services and keep a copy in the member's medical records. Click [here](#) to access the map showing locations of maternal health agencies.

When a low-risk pregnancy is reflected, complete a second determination at approximately 28 weeks of care or when an increase in the pregnant woman's risk status is indicated.



a. Enhanced Services

Additional services are available to women determined to have high-risk pregnancies. The services included in the Medicaid enhanced services for pregnant women are recommended in a 1989 report of the United States Public Health Services Expert Panel on the Content of Prenatal Care, *Caring for the Future: The Content of Prenatal Care*.

National studies have shown that low-income women who receive these services along with medical prenatal care have better birth outcomes. This package of services is aimed at promoting improved birth outcomes for Medicaid-eligible pregnant women in Iowa.

Maternal health centers that provide enhanced services work with physicians to provide services to high-risk pregnant women. This process allows members determined to be at high risk to access additional services that Medicaid does not provide under other circumstances. It is expected that the primary medical care provider will continue to provide the medical care.

Enhanced services include:

- ◆ [Health Education](#)
- ◆ [Nutrition Services](#)
- ◆ [Psychosocial Services](#)

(1) Health Education

A registered nurse shall provide health education services. In addition to the education services listed earlier, education on the following topics should be provided as appropriate:

- ◆ High-risk medical conditions related to pregnancy, such as pre-eclampsia, preterm labor, vaginal bleeding, gestational diabetes, chronic urinary conditions, genetic disorders, and anemia
- ◆ Chronic medical conditions, such as diabetes, epilepsy, cardiac disease, sickle-cell disease, and hypertension
- ◆ Other medical conditions, such as HIV, hepatitis, and sexually transmitted diseases



- ◆ Smoking cessation. Refer to Quitline Iowa at (800) 784-8669, or on the web at <https://www.quitnow.net/iowa/>
- ◆ Alcohol use
- ◆ Drug use
- ◆ Education on environmental and occupational hazards
- ◆ High-risk sexual behavior

Referrals may be made for:

- ◆ Tobacco cessation counseling or treatment for alcohol or illegal drug.
- ◆ Psychosocial services for:
 - Parenting issues or unstable home situations,
 - Stress management,
 - Relationship issues,
 - Financial stress,
 - Domestic violence,
 - Communication skills and resources,
 - Depression, or
 - Self-esteem.

(2) Nutrition Services

Need must be identified and documented for nutrition needs and service provision if the member is enrolled in WIC. Services provided if enrolled in WIC must be above and beyond what WIC provides. Services must be provided one-on-one based on needs assessment and not provided as part of a group class.

A licensed dietitian shall provide nutrition services. Nutrition assessment and counseling shall include:

- ◆ Initial assessment of nutritional risk based on height, current and prepregnancy weight status, laboratory data, clinical data, and self-reported dietary information. Discuss the member's attitude about breastfeeding.
- ◆ At least one follow-up nutritional assessment, as evidenced by dietary information, adequacy of weight gain, measures to assess uterine and fetal growth, laboratory data, and clinical data.



- ◆ Development of an individualized nutritional care plan.
- ◆ Referral to food assistance programs, if indicated.

Nutritional interventions include:

- ◆ Nutritional requirements of pregnancy as linked to fetal growth and development.
- ◆ Recommended dietary allowances for pregnancy.
- ◆ Appropriate weight gain.
- ◆ Vitamin and iron supplements.
- ◆ Information to make an informed infant feeding decision.
- ◆ Education to prepare for the proposed feeding method and the support services available for the mother.
- ◆ Infant nutritional needs and feeding practices.

(3) Psychosocial Services

Psychosocial assessment and counseling shall involve a psychosocial needs assessment of the mother outlining a profile that includes:

- ◆ Demographic factors.
- ◆ Mental and physical health history and concerns.
- ◆ Adjustment to pregnancy and future parenting.
- ◆ Environmental needs.
- ◆ A profile of the mother's family composition, patterns of functioning, and support systems.
- ◆ An assessment-based plan of care.
- ◆ Risk tracking.
- ◆ Counseling and anticipatory guidance as appropriate.
- ◆ Referral and follow-up services.

Psychosocial services shall be provided by a registered nurse or a person with at least a bachelor's degree in social work, counseling, sociology, psychology, family and community service, health or human development, health education, or individual and family studies.



b. Risk Factors Related to History

The left side of the *Medicaid Prenatal Risk Assessment* includes medical, dental, historical, environmental, or situational risk factors. A description of many of the risk factors is located on the back of the form. Included are abortions (AB) first trimester, AB second trimester, uterine anomaly, history of pyelonephritis, illicit drug use, and poor social situation.

Assign cigarette use and smoking a point value if the person smokes one cigarette or more per day. If secondary smoke is a risk factor, indicate it under "Other."

Indicate the risk factor "Last pregnancy within 1 year," when the member has been pregnant within 12 months of the beginning of the present pregnancy.

c. Risk Factors Related to Current Pregnancy

The right side of the form includes risk factors related to the current pregnancy. These factors are more likely to change during the pregnancy. They may be present during the initial visit or may not appear until the mid to last trimester. For this reason these risk factors may be assessed twice during the pregnancy on the form.

A definition of the following risk factors is located on the back of the form:

- ◆ Bacteriuria
- ◆ Pyelonephritis
- ◆ Bleeding after the twelfth week
- ◆ Dilation
- ◆ Uterine irritability
- ◆ Surgery
- ◆ Hypertension

Depression is the most common complication of pregnancy. It is under recognized and has an impact on pregnancy since it may lead to poor self-care including not following through with health care recommendations. Untreated depression has been associated with unfavorable health behaviors in pregnancy and subsequent fetal growth restrictions, preterm delivery, placental abruption, or newborn irritability.



Using the following two questions to screen for depression may be as effective as more lengthy tools.

- ◆ Over the past two weeks, have you ever felt down, depressed, or hopeless?
- ◆ Over the past two weeks, have you felt little interest or pleasure in doing things?

A positive response to either question suggests the need for further assessment. A positive response to either of these questions is sufficient to make a referral for enhanced services.

Use the "Other" box to indicate other risk factors present in the pregnancy, but not reflected in the earlier sections. Examples of other risk factors are listed on the back of the form. These are common examples only and are not meant to be a comprehensive list.

Source: *Psychosocial Risk Factors: Prenatal Screening and Interventions*, ACOG Committee Opinion No. 343, American College of Obstetricians and Gynecologists, Obstet Gynecol 2006, 108.469-77.

10. Sterilizations

Federal regulations provide that payment shall not be made through the Medicaid program for sterilization of a person under the age of 21 at the time of consent or who is legally mentally incompetent or institutionalized.

"Sterilization" means any medical procedure, treatment, or operation for the purpose of rendering an individual incapable of reproducing which is not:

- ◆ A necessary part of the treatment of an existing illness, or
- ◆ Medically indicated as an accompaniment to an operation of the genital urinary tract.

For purpose of this definition, mental illness or intellectual disability is not considered an illness or injury.

A "legally mentally incompetent" person is one who has been declared mentally incompetent by a federal, state, or local court for any purpose, unless the court declares the person competent for purposes which include the ability to consent to sterilization.



An “institutionalized” person is a person who is:

- ◆ Involuntarily confined or detained under a civil or criminal statute in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness, or
- ◆ Confined under voluntary commitment in a mental hospital or facility for the care and treatment of mental illness.

The same revision of federal regulations provide that payment may be made through the Medicaid program for the sterilization of a person aged 21 or over when the consent form is signed, who is mentally competent and non-institutionalized in accordance with the above definitions under certain conditions.

a. Requirements

The following conditions must be met:

- ◆ The member to be sterilized must voluntarily request the services.
- ◆ The member to be sterilized must be advised that the member is free to withhold or withdraw consent to the procedure at any time before the sterilization without prejudicing the member’s future care or loss of other project or program benefits to which the member might otherwise be entitled.
- ◆ The member to be sterilized must be given an explanation of the procedures to be performed by a knowledgeable informant upon whom the member can base the consent for sterilization. An “informed consent” is required.

“Informed consent” means the voluntary knowing assent from the member on whom the sterilization is to be performed after the member has been given a complete explanation of what is involved and has signed a written document to that effect.

If the member is blind, deaf, or does not understand the language used to provide the explanation, an interpreter must be provided. The member to be sterilized may be accompanied by a witness of the member’s choice.

The informed consent shall not be obtained while the member to be sterilized is in labor or childbirth, seeking to obtain or obtaining an abortion, or under the influence of alcohol or other substance that affects the member’s state of awareness.



The elements of explanation which must be provided are:

- A thorough explanation of the procedures to be followed and the benefits to be expected.
- A description of the attendant discomforts and risks, including the possible effects of the anesthetic to be used.
- Counseling concerning alternative methods of family planning and the effect and impact of the proposed sterilization, including the fact that it must be considered to be an irreversible procedure.
- An offer to answer any inquiries concerning the proposed procedure.

The member must give "informed consent" at least 30 days but not more than 180 days before the sterilization is performed except when emergency abdominal surgery or premature delivery occurs.

For an exception to be approved when emergency abdominal surgery occurs, at least 72 hours must have elapsed after consent was obtained.

For an exception to be approved when a premature delivery occurs, at least 72 hours must have elapsed after the informed consent was obtained, and the documentation must also indicate that the expected delivery date was at least 30 days after the informed consent was signed.

b. *Consent for Sterilization, Form 470-0835 or 470-0835S*

The "informed consent" shall be obtained on form 470-0835, *Consent for Sterilization*, or the Spanish version, form 470-0835S, *Formulario de Consentimiento Requerido*. The individual must be 21 years of age or older at the time of consent. An equivalent Medicaid form from another state is accepted.

Click [here](#) to view the English consent form online.

Click [here](#) to view the Spanish consent form online.

CONSENT FOR STERILIZATION

NOTICE: Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving federal funds.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from _____ . When I first asked for the _____ *doctor or clinic* information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving federal funds, such as FIP or Medicaid that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children or father children.

I was told about temporary methods of birth control that are available and could be provided to me that would allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____ .

The discomforts, risks, and benefits with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____ *month* _____ *day* _____ *year* .

I _____ , hereby consent of my own free will to be sterilized by _____ , by a method called _____ *doctor* .

My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

- Representatives of the Department of Health and Human Services or
- Employees of programs or projects funded by that Department , but only for the purpose of determining if federal laws were observed.

I have received a copy of this form.

Signature	Month	Day	Year
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The following race and ethnicity information is requested, but is not required:
Race and ethnicity designation (please check):

- White (not of Hispanic origin) Asian or Pacific Islander
 Black (not of Hispanic origin) American Indian or Alaska Native
 Hispanic

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the person to be sterilized:

I have translated the information and advice presented orally to the person to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

Interpreter	Date
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STATEMENT OF PERSON OBTAINING CONSENT

Before _____ *name of person* signed the consent form, I explained to him/her the nature of the sterilization operation, _____ , the fact that it is intended to be a final and irreversible procedure and the discomforts, risks, and benefits associated with it.

I counseled the person to be sterilized that alternative methods of birth control are available that are temporary. I explained that sterilization is different because it is permanent.

I informed the person to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by federal funds.

To the best of my knowledge and belief, the person to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

Signature of person obtaining consent	Date
Facility	
Address	

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon _____ *name of person to be sterilized* on _____ *date of sterilization operation* .

I explained to him/her the nature of the sterilization operation _____ , the fact that it is intended to be a _____ *specify type of operation* .

final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the person to be sterilized that alternative methods of birth control are available that are temporary. I explained that sterilization is different because it is permanent.

I informed the person to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by federal funds.

To the best of my knowledge and belief, the person to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the person's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least 30 days have passed between the date of the person's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the person's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

Premature delivery; person's expected date of delivery _____

Emergency abdominal surgery: (describe circumstances): _____

Physician	Date
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FORMULARIO DE CONSENTIMIENTO REQUERIDO

NOTA: Si en cualquier momento decide no hacerse esterilizar ello no resultara en que se le retiren o retengan cualquiera de los beneficios proporcionados por programas o proyectos que reciben fondos del gobierno federal.

CONSENTIMIENTO PARA LA ESTERILIZACIÓN

He pedido y recibido información sobre la esterilización de _____ . Cuando me informé al respecto, _____
(*doctor o clínica*)

se me dijo que la decisión de hacerme esterilizar es absolutamente mía. Me han informado que, si así lo deseo, puedo decidir no hacerme esterilizar. Si decido no hacerme esterilizar, esta decisión no afectará mis derechos a cuidados o tratamiento futuros. No perderé ninguno de los beneficios de programas que reciben fondos federales, como por ejemplo FIP o Medicaid que esté recibiendo en la actualidad o que pueda recibir en el futuro.

Entiendo que la esterilización se considera permanente e irrevocable. He decidido que no quiero quedar embarazada, tener hijos o procrear hijos.

Se me ha informado acerca de los métodos anticonceptivos que están disponibles y que se me podrán proporcionar, los que si me permitirán tener un hijo o procrear un hijo en el futuro. He rechazado estas alternativas y he elegido el ser esterilizado(a).

Entiendo que será esterilizado(a) por medio de una operación conocida bajo el nombre de _____. Los inconvenientes, riesgos y beneficios asociados con esta operación me han sido explicados. Todas mis preguntas han sido contestadas en forma satisfactoria.

Entiendo que la operación no se hará hasta por lo menos 30 días después de haber firmado este consentimiento. Entiendo que puedo cambiar de opinión en cualquier momento y que mi decisión de no hacerme esterilizar no resultará en que se me retiren cualquiera de los beneficios o servicios médicos proporcionados por fondos federales.

Tengo por lo menos 21 años de edad y nací el _____ día _____ mes _____ año.

Yo, _____, por la presente consiento por mi propia voluntad a que me esterilice _____, por el método conocido como _____
(*doctor*)

Mi consentimiento se vence a los 180 días de la fecha de mi firma.

También consiento a que este formulario y otros antecedentes médicos sean puestos a la disposición de:

- Representantes del Departamento de Salud, Educación y Bienestar (Department of Health, Education and Welfare) o
- Empleados de programas o proyectos que operan con fondos de ese departamento, pero solamente para determinar si se han cumplido las leyes federales.

He recibido una copia de este formulario.

<i>firma</i>	<i>mes</i>	<i>día</i>	<i>año</i>
--------------	------------	------------	------------

Se le pide que proporcione la siguiente información, pero esto no es obligatorio:

Raza y Designación Étnica (haga una marca):

- Negro (no de origen hispano) Indio Norteamericano o Nativo de Alaska
 Hispano
 Asiático o de Islas del Pacífico Blanco (no de origen hispano)

DECLARACION DEL INTERPRETE

Si se proporciona un intérprete para asistir a la persona a ser esterilizada:

He traducido la información y consejos incluidos dados en forma oral por la persona que obtiene este consentimiento, a la persona a ser esterilizada. También le he leído el formulario de consentimiento en el idioma _____ y le he explicado su contenido.

Según mi mejor entender esta persona ha comprendido esta explicación.

<i>intérprete</i>	<i>fecha</i>
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DECLARACION DE LA PERSONA QUE OBTIENE ESTE CONSENTIMIENTO

Antes de que _____ firmara este
nombre de la persona

formulario de consentimiento, le he explicado la naturaleza de la operación para la esterilización llamada _____, y el hecho de que se trata de un procedimiento final e irrevocable, habiéndole explicado también los inconvenientes, riesgos y beneficios que la acompañan.

Advertí a la persona a ser esterilizada que existen métodos anticonceptivos alternos, que son temporarios. Le expliqué que la esterilización es diferente porque es permanente.

He informado a la persona a ser esterilizada que puede retirar su consentimiento en cualquier momento y que no perderá ninguno de los servicios de salud o cualquier otro beneficio proporcionado con fondos federales.

De acuerdo a mi mejor entender, la persona a ser esterilizada tiene por lo menos 21 años de edad y parece tener capacidad mental suficiente. Esta persona ha solicitado en forma voluntaria, con pleno conocimiento de lo que implica, que la esterilicen y parece comprender la naturaleza y consecuencias del procedimiento.

<i>firma de la persona que obtiene el consentimiento</i>	<i>fecha</i>
<i>establecimiento</i>	
<i>dirección</i>	

DECLARACION DEL MEDICO

Poco antes de efectuar la operación para la esterilización de _____ el _____
nombre de la persona a ser esterilizada *fecha de la operación*

le expliqué la naturaleza de la operación llamada _____
tipo de operación

así como el hecho de que es un procedimiento final e irrevocable, así como los inconvenientes, riesgos y beneficios derivados del mismo.

He advertido a la persona a ser esterilizada que existen métodos anticonceptivos que son temporarios. Le he explicado que la esterilización es diferente, porque es permanente.

He informado a la persona a ser esterilizada que su consentimiento puede ser retirado en cualquier momento y que por ello no perderá ninguno de los cuidados médicos o beneficios proporcionados por fondos federales.

A mi mejor entender, la persona a ser esterilizada tiene por lo menos 21 años de edad y tiene la suficiente capacidad mental. Ha pedido voluntariamente y con pleno conocimiento el ser esterilizado(a) y parece comprender la naturaleza y consecuencias del procedimiento.

(Instrucciones para el uso de párrafos finales alternos: Utilice el primer párrafo que sigue, excepto en casos de parto prematuro o cirugía abdominal de emergencia, en que la esterilización se efectúa menos de 30 días después de la fecha de la firma del formulario de consentimiento. En dichos casos, deberá usarse el segundo párrafo de los que siguen. Tache el párrafo que no utilice.)

(1) Por lo menos treinta días han transcurrido entre la fecha en que la persona firmó el formulario de consentimiento y la fecha en que se efectuó la operación de esterilización.

(2) Esta esterilización fue efectuada menos de 30 días pero mas de 72 horas después de haber firmado la persona el formulario de consentimiento, debido a las circunstancias siguientes (haga una marca donde corresponda y de la información requerida):

- Parto prematuro
 Fecha en que debiera haber ocurrido el parto: _____
 Cirugía abdominal de emergencia: (describa las circunstancias) _____

<i>médico</i>	<i>fecha</i>
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Consent forms may be requested by contacting IME Provider Services at (800) 338-7909 or locally in Des Moines at (515) 256-4609. To request forms by mail, complete the *Iowa Medicaid Provider Form Request*, form 470-4166, and send to the following address:

Iowa Medicaid Enterprise
Form Requests
PO Box 36450
Des Moines, IA 50315

Click [here](#) to view the form online.

The physician's copy of the consent must be completely executed in all aspects (no substitute form is accepted) according to the above directions and attached to the claim in order to receive payment.

When a claim for physician's services for sterilization is denied either due to the failure to have the consent form signed at least 30 days and not more than 180 days before the date service is provided, or failure to use the official consent form, 470-0835 or 470-0835S, any claim submitted by the ambulatory surgical center, hospital, anesthesiologists, assistant surgeon, or associated providers for the same operation or procedure will also be denied.

It is the responsibility of the ambulatory surgical center, hospital, and other providers associated with the sterilization services to obtain a photocopy of the completed consent form which must be attached to their claim when submitted to the IME for payment.

All names, signatures, and dates on the consent form must be fully, accurately, and legibly completed. The only exceptions to this requirement are that:

- ◆ The "Interpreter's Statement" is completed only if an interpreter is actually provided to assist the individual to be sterilized.
- ◆ The information requested pertaining to race ethnicity designation is to be supplied voluntarily on the part of the member, but is not required.



It is the responsibility of the provider obtaining the consent form to verify that the member requesting the sterilization is at least 21 years of age on the date that the member signs the form. If there is any question pertaining to the true age of the member, the member's birthdate must be verified.

The "Statement of Person Obtaining Consent" may be completed by any qualified professional capable of clearly explaining all aspects of sterilization and alternate methods of birth control which are available to the member.

The "Physician's Statement" must be completed fully and signed by the **physician performing the sterilization** and dated when signed. It is important that one of the paragraphs at the bottom of this statement, which is not used, be crossed out as per instructions.

Since the physician performing the sterilization will be the last person to sign the consent form, the physician should provide a photocopy of the fully completed consent form to every other Medicaid provider involved in the sterilization for which a claim will be submitted; i.e., ambulatory surgical center, hospital, anesthetist, assistant surgeons, etc.

It is the responsibility of all other providers associated with the sterilization to obtain a photocopy of the fully completed consent form from the physician performing the sterilization, to be attached to the provider claim which is submitted to the IME for payment.

The only signatures which should be on the completed consent form are those of the member, interpreter (if interpreter services were provided), the provider obtaining the consent form, and the physician performing the sterilization.

11. Transportation Services to Receive Medical Care

To help ensure that Medicaid members have access to medical care within the scope of the program, the Department will arrange non-emergency medical transportation (NEMT) or reimburse the member under certain conditions for transportation costs to receive necessary medical care. This will be facilitated through the broker designated by the Department.



When a member needs transportation or reimbursement for transportation, the member must contact the broker 72 business hours in advance for approval and scheduling. Modes of transportation may include:

- ◆ Bus tokens,
- ◆ Volunteer services,
- ◆ Mileage reimbursement, or
- ◆ Other forms of public transportation.

The IME has contracted NEMT services through TMS Management Group, Inc. For information about the broker's policies and processes, please visit their website: <http://tmsmanagementgroup.com/index.php/iowa-medicaid-net-program/>.

12. Vision Services

Vision services include:

- ◆ Identification of the range, nature, and degree of vision loss.
- ◆ Consultation with a child and parents concerning the child's vision loss and appropriate selection, fitting or adaptation of vision aids.
- ◆ Evaluation of the effectiveness of a vision aid.
- ◆ Orientation and mobility services.

Medicaid covers the following services when they are in the child's Individual Family Service Plan (IFSP) or are linked to a service in the IFSP:

- ◆ [Vision Screening](#)
- ◆ [Vision Assessment](#)
- ◆ [Services to an Individual or Group](#)
- ◆ [Contracted Vision Services](#)
- ◆ [Orientation and Mobility Services](#)

For services to be covered, they must be provided by personnel who are licensed or certified to provide vision services.



a. Vision Screening

Screening is the process of assessing vision through direct observation in order to identify problems and determine if further assessment is needed.

Documentation is required if the child is referred for evaluation or treatment services identified through the screening. Document referrals when they are made.

b. Vision Assessment

Assessment refers to the process of collecting data for the purpose of making treatment decisions. These decisions may require:

- ◆ Determining the need, nature, frequency, and duration of treatment.
- ◆ Determining the need for coordination with other providers.
- ◆ Documenting these activities.

c. Services to an Individual or Group

Individual intervention is designed to enhance vision or orientation and mobility skills of an individual.

Group services involve two or more persons and are designed to enhance vision or orientation and mobility skills of the group.

The role of consultation is monitoring, supervising, teaching, and training professionals, paraprofessionals, and parents in the home or community environment. Consultation includes:

- ◆ Providing general information about a child's condition.
- ◆ Teaching specific skills necessary to meet a child's needs.
- ◆ Developing, maintaining, and demonstrating use of adaptive or assistive devices for a specific child.
- ◆ Making recommendations to enhance a child's performance.

Early ACCESS service provided to a specific child must be provided in that child's "natural environment" unless the child's goals and outcomes cannot be met in "the home or community setting when children of the same age without disabilities participate." A justification statement must be included on the IFSP if service is provided in another setting.



d. Contracted Vision Services

Contracted service includes vision assessment and direct services for an individual or group that are rendered by a qualified practitioner who is a contractor, rather than an employee, of the agency. The requirements for documentation, records maintenance, and medical necessity remain the same.

e. Orientation and Mobility Services

Orientation and mobility services are services provided to eligible blind or visually impaired children by qualified personnel to enable those children to attain systematic orientation to and safe movement within their environments in the home and community.

The services include teaching the children as appropriate:

- ◆ Spatial and environmental concepts and use of information received by the senses (such as sound, temperature and vibrations) to establish, maintain, or regain orientation and line of travel (e.g., traveling in the direction of the caregiver's voice).
- ◆ Use of the long cane to supplement visual travel skills or as a tool for safely negotiating the environment for children with no available travel vision.
- ◆ Use of remaining vision and distance, low-vision aids and other concepts, techniques, and tools.

13. Services of Other Practitioners

a. Physician Assistants and Nurse Practitioners

Services furnished by physician assistants and nurse practitioners are covered, whether or not the center is under the full-time direction of a physician.

Services and supplies which are furnished incident to physician assistant or nurse practitioner services are also covered as they would otherwise be covered if furnished by or incident to physician services.



Essentially, the services must be of a type that:

- ◆ Would be covered if furnished as incident to a physician's services.
- ◆ Is commonly furnished in a physician's office.
- ◆ Is commonly rendered without charge or included in the center's bill. To be covered under this provision, the services must be furnished by an employee of the center and under the direct supervision of a nurse practitioner, physician assistant, or physician.

b. Psychologists and Social Workers

Services furnished by clinical psychologists and clinical social workers are covered services.

Services and supplies incident to clinical psychologist or clinical social worker services are also covered as they would be covered if furnished by or incident to physician services.

D. BASIS OF PAYMENT

FQHCs are reimbursed for services to Medicaid members based on 100 percent of the costs that are reasonable and related to the cost of furnishing FQHC services.

Reasonable costs are determined by the IME based on the center's cost report, submitted to the IME on the *FQHC Cost Report Form*. Click [here](#) to view the form online. The costs claimed in the approved cost report cannot exceed the reasonable costs as determined by the applicable Medicare cost reimbursement principles.

Until the center submits a cost report, Medicaid will make interim payments to the center. The interim payments will be based on a budgeted or projected average cost per visit, and will be subject to reconciliation after a cost report has been received.

After receiving the center's first cost report, Iowa Medicaid computes the annual allowable Medicaid costs as reported by the center. Iowa Medicaid will make additional payment to the center when the allowable reported annual Medicaid costs exceed the sum of the payments made to the center using the interim rates in effect for the cost reporting period. Payment adjustments will be made within 90 days of Medicaid's receipt of the cost report.

Managed Care Wraparound Payment Request

Federally Qualified Health Centers, Rural Health Clinics

Quarterly HMO Reconciliation Worksheet

(Due 30 days from end of previous quarter)

Name of Federally Qualified Health Center or Rural Health Clinic

Return to: Iowa Medicaid Enterprise
Provider Cost Audit Unit
P.O. Box 36450
Des Moines, IA 50315
Fax: (515) 725-1353

Reconciliation Quarter Ending

1	2	3	4	5	6
# Medicaid HMO Encounters or Visits	Expected HMO Payments	Subcapitation Payments	Estimated HMO Payments to Be Received	Medicaid Regular Encounter or per Visit Payments	Difference Reimbursable to FQHC or RHC

- 1) Enter the number of daily encounters or visits for Medicaid members receiving HMO benefits. These encounters must follow the encounter rules as indicated in the Federally Qualified Health Center Provider Manual, Section VI, procedure codes and nomenclature, or rules for counting visits as indicated in the Rural Health Clinic Provider Manual, Section XX, procedure codes and billing.
- 2) List all dollar amounts normally expected to be received by the federally qualified health center or rural health clinic from the HMO for the services provided in #1. [Note: These amounts exclude any subcapitation arrangements to the federally qualified health center or rural health clinic.] If any payments are made over and above the general capitation payments, these must be included here.
- 3) List all dollar amounts of contractual, risk-based capitation payments made on behalf of the HMO (for Iowa Medicaid members) for the provision of care that is NOT separately reimbursed either by encounter, visit, or fee schedule.
- 4) Add together the total amounts from Columns 2 and 3.
- 5) Multiply the actual Medicaid encounter rate or per-visit interim rate times the number of encounters or visits reported in Column 1.
- 6) Subtract Column 5 from Column 4. This amount represents the wraparound payment that the Medicaid program will reimburse to the federally qualified health center or rural health clinic for the reconciliation quarter indicated.

I attest that this information is correct and complete to the best of my knowledge and that the calculations are supported by records maintained at our facility. Any adjustments or amendments to this report will be made within seven days of the original submission of this document.

Signature

Date

Title of Submitter



The center must reimburse Medicaid when its allowable reported payments are less than the sum of the payments made to the center using the initial interim rate for the cost reporting period. Adjustments owed to Medicaid must be made within 90 days following Iowa Medicaid's notice to the center of the amount due.

After the center submits a cost report which is accepted by Iowa Medicaid, the interim rate may be adjusted, if necessary, subject to reconciliation at the end of the cost reporting period.

After receiving the center's annual cost report, Iowa Medicaid computes the annual allowable Medicaid costs as reported by the center. Iowa Medicaid will make additional payment to the center when the allowable reported annual Medicaid costs exceed the sum of the payments made to the center under the interim rate for the cost reporting period. Payment adjustments will be made within 90 days of Medicaid's receipt of the cost report.

The center must reimburse Medicaid when its allowable reported payments are less than the sum of the payments made to the center under the interim rate for the cost reporting period. Adjustments owed to Medicaid must be made within 90 days following Iowa Medicaid's notice to the center of the amount due.

1. HMO Wraparound Services

When a center provides services under contract to a managed care organization, the managed care organization must pay the center no less than the amount it would pay for the services if furnished by a provider other than an FQHC. The Department will supplement the payment from the managed care organization to provide reasonable cost reimbursement, as specified by Medicare cost reimbursement principles.

Centers must use form 470-3495, *Managed Care Wraparound Payment Request*, to document Medicaid encounters and differences in payments by the managed care organization and the regular Medicaid encounter payment. Click [here](#) to view the form online.



2. *Dental Wellness Plan Wraparound Payment Request, Form 470-5210*

The Dental Wellness Plan, announced in [Informational Letter 1353](#), begins May 1, 2014. The Dental Wellness Plan uses a new, commercial plan framework and will offer dental benefits to the Iowa Health and Wellness Plan membership.

When an FQHC provides dental services under contract to the commercial plan, the commercial plan must pay the FQHC no less than the amount it would pay for the same services if furnished by another provider. The Department will supplement the payment of the commercial plan to provide reasonable cost reimbursement, as specified by Medicare cost reimbursement principles.

The *Dental Wellness Plan Wraparound Payment Request*, form 470-5210, is to be used to document Medicaid encounters and differences in payments by the commercial plan and the regular Medicaid encounter payment. Click [here](#) to view the form online. The form should be submitted within 30 days of the end of the quarter and should include an excel spreadsheet with the following information:

- ◆ Patient name
- ◆ Patient Medicaid state identification number
- ◆ Date of service
- ◆ Dental code billed
- ◆ Billed amount
- ◆ Amount paid by dental plan administrator

3. *Iowa Marketplace Choice Wraparound Payment Request, Form 470-5211*

When an FQHC provides services under contract to a Qualified Health Plan (QHP), the QHP must pay the FQHC no less than the amount it would pay for the same services if furnished by another provider. The Department will supplement the payment from the QHP to provide reasonable cost reimbursement, as specified by Medicare cost reimbursement principles.

The *Iowa Marketplace Choice Wraparound Payment Request*, form 470-5211, shall be used to document Medicaid encounters and differences in payments by the QHP and the regular Medicaid encounter payment. Click [here](#) to view form 470-5211 online.



Dental Wellness Plan Wraparound Payment Request

Federally Qualified Health Center
Quarterly Reconciliation Worksheet
(Due 30 days from end of previous quarter)

Name of Federally Qualified Health Center:

Reconciliation Quarter Ending:

1	2	3	4	5	6
# of Medicaid Dental Wellness Plan Encounters or Visits	Expected Plan Payments	Subcapitation Payments	Estimated Payments to Be Received	Medicaid Regular Encounter or per Visit Payments	Difference Reimbursable to FQHC

1. Enter the number of daily encounters or visits for Medicaid members receiving Dental Wellness Plan benefits. These encounters must follow the encounter rules as indicated in the Federally Qualified Health Center Provider Manual, Chapter E, Section V, Procedure Codes and Nomenclature, or rules for counting visits as indicated in the Rural Health Clinic Provider Manual Chapter III, Section E, Procedure Codes and Billing.
2. List all dollar amounts normally expected to be received by the federally qualified health center or rural health clinic from the plan for the services provided in box 1. (Note: These amounts exclude any subcapitation arrangements to the federally qualified health center or rural health clinic.) If any payments are made over and above the general capitation payments, these must be included here.
3. List all dollar amounts of contractual, risk based capitation payments made on behalf of the plan (for Delta Wellness members) for the provision of care that is NOT separately reimbursed either by encounter, visit, or fee schedule.
4. Add together the total amounts from boxes 2 and 3.
5. Multiply the actual Medicaid encounter rate or per-visit interim times the number of encounters or visits reported in box 1.
6. Subtract box 5 from box 4. This amount represents the wraparound payment that the Medicaid program will reimburse to the federally qualified health center or rural health clinic for the reconciliation quarter indicated.

I attest that this information is correct and complete to the best of my knowledge and that the calculations are supported by records maintained at our facility. Any adjustments or amendments to this report will be made within seven days of the original submission of this document.

Signature:

Date:

Return to: Iowa Medicaid Enterprise – Provider Cost Audit Unit, PO Box 36450, Des Moines, IA 50315, or Fax: (515) 725-1353



Iowa Market Place Choice Wraparound Payment Request

Federally Qualified Health Centers, Rural Health Clinics

Quarterly Reconciliation Worksheet

(Due 30 days from end of previous quarter)

Name of Federally Qualified Health Center:

Reconciliation Quarter Ending:

1	2	3	4	5	6
# of Medicaid Dental Wellness Plan Encounters or Visits	Expected Plan Payments	Subcapitation Payments	Estimated Payments to Be Received	Medicaid Regular Encounter or per Visit Payments	Difference Reimbursable to FQHC

1. Enter the number of daily encounters or visits for Medicaid members receiving Marketplace Choice Plan benefits. These encounters must follow the encounter rules as indicated in the Federally Qualified Health Center Provider Manual, Chapter E, Section V, procedure codes and nomenclature, or rules for counting visits as indicated in the Rural Health Clinic Provider Manual Chapter III, Section E, procedure codes and billing.
2. List all dollar amounts normally expected to be received by the federally qualified health center or rural health clinic from the plan for the services provided in box 1. (Note: These amounts exclude any subcapitation arrangements to the federally qualified health center or rural health clinic.) If any payments are made over and above the general capitation payments, these must be included here.
3. List all dollar amounts of contractual, risk based capitation payments made on behalf of the plan (for Delta Wellness members) for the provision of care that is NOT separately reimbursed either by encounter, visit, or fee schedule.
4. Add together the total amounts from boxes 2 and 3.
5. Multiply the actual Medicaid encounter rate or per-visit interim times the number of encounters or visits reported in box 1.
6. Subtract box 5 from box 4. This amount represents the wraparound payment that the Medicaid program will reimburse to the federally qualified health center or rural health clinic for the reconciliation quarter indicated.

I attest that this information is correct and complete to the best of my knowledge and that the calculations are supported by records maintained at our facility. Any adjustments or amendments to this report will be made within seven days of the original submission of this document.

Signature:

Date:

Return to: Iowa Medicaid Enterprise – Provider Cost Audit Unit, PO Box 36450, Des Moines, IA 50315, or Fax: (515) 725-1353



E. PROCEDURE CODES AND NOMENCLATURE

Only one face-to-face encounter between a member and the center health professional can be billed per day, even though the member may encounter the professional more than once or may encounter more than one professional.

Any necessary services should be provided during one encounter whenever possible. When there is a need for services to be unbundled that would normally be provided during one encounter medical necessity must be documented and maintained in the record.

An exception to this is when the member suffers illness or injury requiring additional diagnosis or treatment after the first encounter on a particular day. In that situation, another encounter is reimbursable. Refer those claims to IME Provider Services for special handling.

T1015 must be used for all FQHC medical service encounters, regardless of the underlying services that are provided in any given encounter. The T1015 encounter code must always be billed on the first claim line. The encounter rate paid to each FQHC is to be "all-inclusive" of any and all services rendered for a given date of service and member. This requirement is not applicable to services rendered to Iowa Family Planning Network (IFPN) members.

The applicable encounter code should be submitted on the first claim line, with any and all subsequent claim lines containing the applicable specific procedure codes for actual services rendered as "informational only" and billed at \$0.00. No other procedure code is intended to be payable to FQHCs, RHCs or IHS providers. Claims submitted without the specific procedures identified on the subsequent lines will be denied. The IME requires prior authorization for certain procedures and will begin editing to confirm an authorization has been obtained for services where a prior authorization is required.



The applicable modifiers are:

<u>Modifier</u>	<u>Description</u>
U1	Care for Kids screen with referral for treatment
U6	EPSDT "Care for Kids" screen
EP	Services provided as a result of the findings from a Care for Kids (EPSDT) screening examination
FP	Service related to family planning
U3	Medical expense services, e.g., those related to mental health diagnoses not covered by the Iowa Plan for Behavioral Health (Iowa Plan)
32	Annual routine physical required for RCF resident

1. Dental Services

Dental services provided at a FQHC and an IHS must be billed on the *Dental Claim Form*, ADA 2012. Procedure code D9999 must always be billed on the first line of the claim form, or the claim will deny. Changes to the Medicaid claims payment system have been made that will generate reimbursement for the encounter. Do not use procedure code T1015 on the dental claim form.

All other dental procedures provided during the encounter should be billed on the subsequent claim lines. Area of oral activity, tooth number and surface should also be entered, if applicable. Enter "0.00" in the fee area for each procedure provided.

Dental services performed by FQHCs that require prior authorization (PA) should have the PA number appended to the claim.

2. EPSDT "Care for Kids Services"

To bill EPSDT screening services for the preventive health visit, use the encounter code with the appropriate diagnosis code and modifier.

To bill EPSDT care coordination services, use code T1016 instead of the encounter code with the diagnosis code of V68.9 for agencies designated by the Department of Public Health.



To bill EPSDT informing services, use the encounter code with the CI modifier and diagnosis code of V68.9 for agencies designated by the Department of Public Health.

Agencies designated by the Iowa Department of Public Health can bill for local medical transportation for children age 20 and under. To bill medical transportation service, use code A0100 and diagnosis code of V68.9.

F. BILLING POLICIES AND CLAIM FORM INSTRUCTIONS

Claims for Federally Qualified Health Centers are billed on federal form CMS-1500, *Health Insurance Claim Form*.

Click [here](#) to view a sample of the CMS-1500.

Click [here](#) to view billing instructions for the CMS-1500.

Refer to Chapter IV. *Billing Iowa Medicaid* for claim form instructions, all billing procedures, and a guide to reading the Iowa Medicaid Remittance Advice statement.

The Billing Manual can be located online at:

<http://dhs.iowa.gov/sites/default/files/all-iv.pdf>