Medicaid Enterprise

Iowa Department of Human Services

Screening Center Provider Manual

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CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. ELIGIBILITY OF SCREENING CENTERS

Agencies wishing to participate as health screening centers in the Medicaid program should direct their request for vendor number to the Iowa Medicaid Enterprise (IME) Provider Services Unit. In order to be accepted for participation, each screening center must meet quality standards and continuity of care consistent with guidelines established by the Iowa Department of Public Health.

B. COVERAGE OF SERVICES

1. Screening Examinations

Screening centers will be paid for health screening examinations for Medicaid members who are 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.

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.

To view RC-0080, *Screening Components by Age*, on line, click here.

2. Nutritional Counseling

Screening centers are eligible for reimbursement of nutritional counseling (medical nutritional therapy) services provided by licensed dietitians who are employed by or have contracts with the screening center 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, and major changes in weight-to-height percentile or BMI for the child's age.
- **Inadequate dietary intake**. Examples include formula intolerance, food allergy, limited variety of foods, limited food resources, and poor appetite.
- **Infant feeding problems**. Examples include poor suck or swallow, breastfeeding difficulties, lack of developmental feeding progress, inappropriate kinds or amounts of feeding offered, and limited information or skills of caregiver.
- **Chronic disease requiring nutritional intervention**. Examples include congenital heart disease, pulmonary disease, renal disease, cystic fibrosis, metabolic disorder, diabetes, and gastrointestinal disease.
- **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.

Families that 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.

3. Care Coordination

This service is reimbursed by the Iowa Department of Public Health through a contract with the Department of Human Services.

NOTE: CMS policy states, "payments for allowable Medicaid services must not duplicate payments that have been, or should have been, included as part of a **direct** medical service…. Activities that are considered integral to, or an extension of, the specified covered service are included in the rate set for the direct service, therefore they should not be claimed as another service. For example, when an agency provides a medical service, the practitioner should not bill separately for the cost of a referral. These activities are properly paid for as part of the medical service."

If the family needs a service that is not covered by Medicaid, make a good-faith effort to locate providers who will furnish those services.

4. Interpreter Services

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

5. Transportation

To help ensure that members have access to medical care, the Department provides reimbursement for transportation to necessary medical care, dental care, and mental health care.

- **Local transportation**: Under the EPSDT "Care for Kids" program, local (in town) transportation is available for screening, diagnosis, and treatment. The transportation service is covered through agencies designated by the Department of Public Health. Screening centers are responsible for linking families with local transportation resources.
- **Out-of-town transportation**: Families seeking medical care for their children outside their own community should contact the local Department of Human Services caseworker to reimburse out-of-town transportation.

  Payment is limited to situations when it is necessary for the member to travel outside the community to receive needed medical care, or when the member lives in a rural area, to travel to the nearest community to receive care.

  Payment for out of town transportation is limited to the nearest source of adequate and appropriate care. The member is reimbursed only for the distance to the nearest doctor, dentist, or other provider who can provide the necessary service.

  In the event that specialty care is needed, the member will be reimbursed by the Department only for the distance to the nearest available specialist or hospital, unless the attending physician indicates that, in view of the diagnosis and condition of the member, a more distant specialist or hospital is the only appropriate source of care.

When there is a nearer specialist of the same type or a nearer hospital, the local office may contact the referring provider to verify the necessity of referral to the more distant physician or hospital in order to document the necessity of reimbursing the member for the greater distance.

This policy is not intended to limit the free choice the member has concerning the practitioner from whom the member wishes to receive service. However, because of limited funds in the Medicaid program, a payment can be made for transportation only the nearest source of necessary care.

C. CONTENT OF SCREENING EXAMINATION

A screening 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.
  - Rapid urine screening.
  - 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.

1. History and Guidance

a. Comprehensive Health and Developmental History

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

Take 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 client's history of illnesses, diseases, allergies, and accidents.
- Information about the client's social or physical environment that may affect the client's overall health.
- Information on current medications or adverse reaction/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, and
- Social and emotional behavior.

In screening children from birth to six years of age, it is recommended that you select recognized instruments. 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 you 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. A surveillance tool for children from birth through age five, the *Iowa Child Health and Developmental Record* (CHDR), is available at http://www.iowaepsdt.org/.

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:

- The Care for Kids Provider web site at: http://www.iowaepsdt.org/;
- The Developmental Behavioral Online site of the American Academy of Pediatrics at: http://www.dbpeds.org/;
- The Assuring Better Child Development and Health (ABCD) Electronic Resource Center of the National Academy for State Health Policy at: www.abcdresources.org;
- The Commonwealth Fund's Child Development and Preventive Care web site at: http://www.commonwealthfund.org/programs/programs_list.htm?attrib_id=9134; or
- The National Center of Home Initiatives for Children with Special Needs web site of the American Academy of Pediatrics at: http://www.medicalhomeinfo.org/screening/index.html

c. 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 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, Second Edition, 1992.

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., 1988, 1999).
- Tools that screen for specific problems, symptoms, and disorders, such as the *Conners' 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.

To view the *Pediatric Symptom Checklist*, see http://www.brightfutures.org/mentalhealth/pdf/professionals/ped_symptom_chklst.pdf

d. 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 *2000 Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, Second 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 http://www.ncemch.org/.

View this list as a guideline only. It does not require the inclusion of topics that are inappropriate for the child or limit topics that are appropriate for the child.

Suggested Health Education Topics: Birth - 18 Months

Oral Health

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

Injury Prevention

Infant/child CPR
Child care options
Child safety seat restraint
Child safety seats
Importance of protective helmets
Electric outlets
Animals/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	Effects of passive smoking
Bowel patterns	Fever
Care of respiratory infections	Hiccoughs
Crying or colic	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"	Appropriate use of bottle and breast feeding
Teething and tooth eruption	Use of sippy cup
Importance of baby teeth	Use of sugary medications
Regular dental visits	Early childhood carries, gingivitis
Non-nutritive sucking (thumb, finger and pacifier)	Dental injury prevention
Feeding and snacking habits: exposure to carbohydrates and sugars	Fluoride exposure: toothpaste, water, topical fluoride and supplements
	Sealants on deciduous molars and permanent six-year molars

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

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

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

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

Suggested Health Education Topics: 6 - 12 Years

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

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

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

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

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

Suggested Health Education Topics: Adolescent (13 - 21 Years)

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

Development
Normal biopsychosocial changes of adolescence

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

Health Consumer Issues	
Selection and purchase of health devices or items	Selection and use of health services

Injury Prevention	
ATV safety	Overexposure to sun
CPR and first aid training	ROPS (roll over protective structure)
Dangers of farm ponds and creeks	Seat belt usage
Falls	Helmet usage
Firearm safety, hunting practices	Smoke detector
Gun and hunter safety	Sports recreation, workshop laboratory, job, or home injury prevention
Handling agricultural chemicals	Tanning practices
Hearing conservation	Violent behavior
Machinery safety	Water safety
Motorized vehicle safety (ATV, moped, motorcycle, car, and trucks)	High noise levels
Nutrition	
Body image, weight issues	Food fads, snacks, fast foods
Caloric requirements by age and gender	Selection of fitness program by need, age, and gender
Balanced diet to meet needs of growth	Special diets
Exercise, sports, and fitness	
Personal Behavior and Relationships	
Communication skills	Community involvement
Dating relationships	Relationships with adults and peers
Decision making	Self esteem building
Seeking help if feeling angry, depressed, hopeless	Stress management and reduction
	Personal responsibility
Substance Use	
Alcohol and drug cessation	Riding with intoxicated driver
Counseling or referral for chemical abuse	Sharing of drug paraphernalia
	Steroid or steroid-like use
Driving under the influence	Tobacco cessation
HIV counseling and referral	
Other Preventive Measures	
Adequate sleep	Safety regarding strangers
Clothing	Age-appropriate sexuality education
Exercise	Social skills
Hygiene	Preparation of girls for menarche
Importance of preventative health visits	Sports
	Stress
Smoke-free environments	TV viewing

2. 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. Growth Measurements

- **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 1/8th inch.
- **Height:** Measure children over 2 years of age using a standing height board or stadiometer. Read and record the measurement to the nearest 1/8th inch.

  If the child is two years old or older and less than 31 1/2 inches tall, the height measurement does not fit on the 2 - 20 year old chart. Therefore, you must measure the child's recumbent length and plot the length on the Birth - 36 month growth chart.

  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.

- **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.

- **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
     41 ½ inches = 41.5 inches

  2. Insert the values into the formula:

     [weight (1b) / height (in) / height (in)] X 703 = BMI

     Example: (37.25 lb / 41.5 in / 41.5 in) X 703 = 15.2

  A reference table can also be used to calculate BMI. This table can be downloaded from the Centers for Disease Control and Prevention web site at www.cdc.gov/growthcharts.

  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.

- **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 of calculating child's age:

	Year		Month		Day			
Date of visit	~~93~~	92	~~7~~	~~6~~	18	~~15~~	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 the birth date from the clinic visit date. You may borrow 30 days from the month column or 12 months from 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.

♦ **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/year for ages 3 to 10 years.
  - A change in weight/height percentile rank of 25 or more.
  - Sudden weight gain or loss.
  - More than two standard deviations below or above the mean for the child's height.

b. Head Circumference

Measure the head circumference at each visit until the child is two years old. Measure with a nonstretchable 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 5th percentile.
- Reflecting a major change in percentile levels from one measurement to the next or over time.

c. Blood Pressure

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

Recently the National Health, Lung and Blood Institute published new blood pressure standards for children and adolescents. The new 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 Tables 1 and 2.

To use these tables, you need to 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.

Table 1. Blood Pressure Levels for Boys Aged 1 to 17 Years by Percentile of Height

Boys		Systolic BP (mm Hg) by percentile of height*							Diastolic BP (mm Hg) by percentile of height*						
Age	Percentile	5%	10%	25%	50%	75%	90%	95%	5%	10%	25%	50%	75%	90%	95%
1 yr	90th	94	95	97	98	100`	102	102	50	51	52	53	54	54	55
	95th	98	99	101	102	104	106	106	55	55	56	57	58	59	59
2 yr	90th	98	99	100	102	104	105	106	55	55	56	57	58	59	59
	95th	101	102	104	106	108	109	110	59	59	60	61	62	63	63
3 yr	90th	100	101	103	105	107	108	109	59	59	60	61	62	63	63
	95th	104	105	107	109	111	112	113	63	63	64	65	66	67	67
4 yr	90th	102	103	105	107	109	110	111	62	62	63	64	65	66	66
	95th	106	107	109	111	113	114	115	66	67	67	68	69	70	71
5 yr	90th	104	105	106	108	110	112	112	65	65	66	67	68	69	69
	95th	108	109	110	112	114	115	116	69	70	70	71	72	73	74
6 yr	90th	105	106	108	110	111	113	114	67	68	69	70	70	71	72
	95th	109	110	112	114	115	117	117	72	72	73	74	75	76	76
7 yr	90th	106	107	109	111	113	114	115	69	70	71	72	72	73	74
	95th	110	111	113	115	116	118	119	74	74	75	76	77	78	78
8 yr	90th	107	108	110	112	114	115	116	71	71	72	73	74	75	75
	95th	111	112	114	116	118	119	120	75	76	76	77	78	79	80
9 yr	90th	109	110	112	113	115	117	117	72	73	73	74	75	76	77
	95th	113	114	116	117	119	121	121	76	77	78	79	80	80	81
10 yr	90th	110	112	113	115	117	118	119	73	74	74	75	76	77	78
	95th	114	115	117	119	121	122	123	77	78	79	80	80	81	82
11 yr	90th	112	113	115	117	119	120	121	74	74	75	76	77	78	78
	95th	116	117	119	121	123	124	125	78	79	79	80	81	82	83
12 yr	90th	115	116	117	119	121	123	123	75	75	76	77	78	78	79
	95th	119	120	121	123	125	126	127	79	79	80	81	82	83	83
13 yr	90th	117	118	120	122	124	125	126	75	76	76	77	78	79	80
	95th	121	122	124	126	128	129	130	79	80	81	82	83	83	84
14 yr	90th	120	121	123	125	126	128	128	76	76	77	78	79	80	80
	95th	124	125	127	128	130	132	132	80	81	81	82	83	84	85
15 yr	90h	123	124	125	127	129	131	131	77	77	78	79	80	81	81
	95th	127	128	129	131	133	134	135	81	82	83	83	84	85	86
16 yr	90th	125	126	128	130	132	133	134	79	79	80	81	82	82	83
	95th	129	130	132	134	136	137	138	83	83	84	85	86	87	87
17 yr	90th	128	129	131	133	134	136	136	81	81	82	83	84	85	85
	95th	132	133	135	136	138	140	140	85	85	86	87	88	89	89

* Height percentile determined by standard growth curves. Diastolic BP determined by disappearance of Korokoff's sounds (K5), Source: National Heart, Lung and Blood Institute: Update on the 1997 Task Force Report on High Blood Pressure in Children and Adolescents, A Working Group Report from the National High Blood Pressure Education Program, Pediatrics Vol. 98 No.4 October 1996.

Table II. Blood Pressure Levels for Girls Aged 1 to 17 Years by Percentile of Height

GIRLS		Systolic BP (mm Hg) by percentile of height*							Diastolic BP (mm Hg) by percentile of height*						
Age	Percentile	5%	10%	25%	50%	75%	90%	95%	5%	10%	25%	50%	75%	90%	95%
1 yr	90th	97	98	99	100	102	103	104	53	53	53	54	55	56	56
	95th	101	102	103	104	105	107	107	57	57	57	58	59	60	60
2 yr	90th	99	99	100	102	103	104	105	57	57	58	58	59	60	61
	95th	102	103	104	105	107	108	109	61	61	62	62	63	64	65
3 yr	90th	100	100	102	103	104	105	106	61	61	61	62	63	63	64
	95th	104	104	105	107	108	109	110	65	65	65	66	67	67	68
4 yr	90th	101	102	103	104	106	107	108	63	63	64	65	65	66	67
	95th	105	106	107	108	109	111	111	67	67	68	69	69	70	71
5 yr	90th	103	103	104	106	107	108	109	65	66	66	67	68	68	69
	95th	107	107	108	110	111	112	113	69	70	70	71	72	72	73
6 yr	90th	104	105	106	107	109	110	111	67	67	68	69	69	70	71
	95th	108	109	110	111	112	114	114	71	71	72	73	73	74	75
7 yr	90th	106	107	108	109	110	112	112	69	69	69	70	71	72	72
	95th	110	110	112	113	114	115	116	73	73	73	74	75	76	76
8 yr	90th	108	109	110	111	112	113	114	70	70	71	71	72	73	74
	95th	112	112	113	115	116	117	118	74	74	75	75	76	77	78
9 yr	90th	110	110	112	113	114	115	116	71	72	72	73	74	74	75
	95th	114	114	115	117	118	119	120	75	76	76	77	78	78	79
10 yr	90th	112	112	114	115	116	117	118	73	73	73	74	75	76	76
	95th	116	116	117	119	120	121	122	77	77	77	78	79	80	80
11 yr	90th	114	114	116	117	118	119	120	74	74	75	75	76	77	77
	95th	118	118	119	121	122	123	124	78	78	79	79	80	81	81
12 yr	90th	116	116	118	119	120	121	122	75	75	76	76	77	78	78
	95th	120	120	121	123	124	125	126	79	79	80	80	81	82	82
13 yr	90th	118	118	119	121	122	123	124	76	76	77	78	78	79	80
	95th	121	122	123	125	126	127	128	80	80	81	82	82	83	84
14 yr	90th	119	120	121	122	124	125	126	77	77	78	79	79	80	81
	95th	123	124	125	126	128	129	130	81	81	82	83	83	84	85
15 yr	90h	121	121	122	124	125	126	127	78	78	79	79	80	81	82
	95th	124	125	126	128	129	130	131	82	82	83	83	84	85	86
16 yr	90th	122	122	123	125	126	127	128	79	79	79	80	81	82	82
	95th	125	126	127	128	130	131	132	83	83	83	84	85	86	86
17 yr	90th	122	123	124	125	126	128	128	79	79	79	80	81	82	82
	95th	126	126	127	129	130	131	132	83	83	83	84	85	86	86

* Height percentile determined by standard growth curves. Diastolic BP determined by disappearance of Korokoff's sounds (K5), Source: National Heart, Lung and Blood Institute: Update on the 1997 Task Force Report on High Blood Pressure in Children and Adolescents, A Working Group Report from the National High Blood Pressure Education Program, Pediatrics Vol. 98 No.4 October 1996.

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.

- 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 other 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; and
- Difficulty chewing.

3. Laboratory Tests

a. 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% 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.

b. Urinalysis

Depending on the success in obtaining a voided urine specimen, urinalysis is suggested:

- At 5 years
- Once from 11 through 20 years, preferable at 14 years

Use a dipstick that shows at least pH, glucose, protein, blood, and nitrates. Referral criteria should include:

- PH below 5 or above 9
- Glycosuria
- 2+ protein
- Positive nitrates
- Trace or greater blood

c. Newborn Screening

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

- Congenital adrenal hyperplasia
- Galactosemia
- Hemoglobinopathies
- Hypothyroidism
- Phenylketonuria (PKU)
- Medium chain acyl Co-A dehydrogenase (MCAD) deficiency
- Biotinidase deficiency
- Hearing
- Cystic fibrosis
- Any other amino acid, organic acid, and fatty oxidation disorders detectable by tandem mass spectrometry

A current list of the screening panel can be found at: http://www.idph.state.ia.us/genetics

d. 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.

e. 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).

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 1-800-972-2026.

(1) Determining Risk Through Asking Questions

Beginning with the age of 12 months, ask the following questions for all children at each office visit to determine each child's risk for lead poisoning:

- Has your child ever lived in or regularly visited a house built before 1960 (including home, child care center, baby-sitter, relatives' home)?
- Have you noticed any peeling or chipping paint in or around the pre-1960 house that your child lives in or regularly visits?

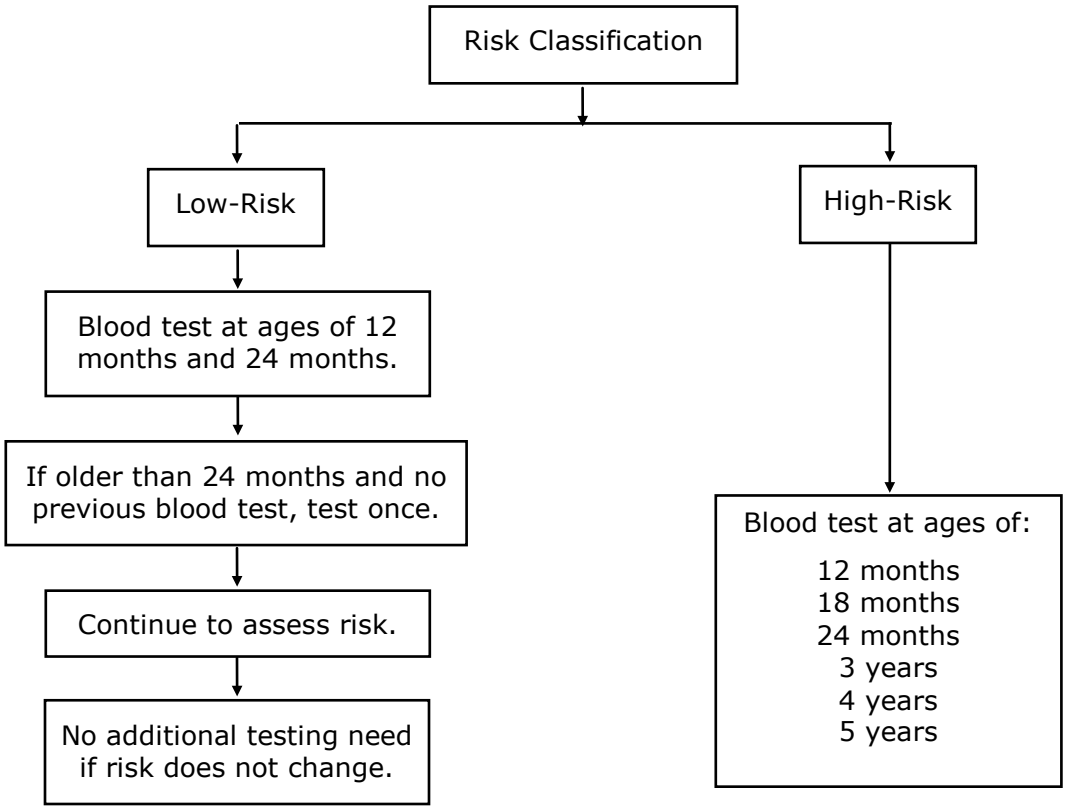
- Is the pre-1960 home that your child lives in or regularly visits being remodeled or renovated by:
  - Stripping, sanding, or scraping paint on the inside or outside of the house.
  - Removing walls or tearing out lath and plaster.
- Does your child eat non-food items, such as dirt?
- Have any of your other children or their playmates had elevated lead levels ≥ 15 µg/dL?
- Does your child live with or frequently encounter an adult who works with lead on the job or in a hobby?

  (Examples: painter, welder, foundry worker, old home renovator, shooting range worker, battery plant worker, battery recycling worker, ceramic worker, stained glass worker, sheet metal worker, plumber.)
- Does your child live near a battery plant, battery recycling plant, or lead smelter?
- Do you give your child any home or folk remedies? (Examples: Azarcon, Greta, Pay-loo-ah)
- Does your child eat candy that comes from Mexico or is purchased from a Mexican grocery store?
- Has you child ever lived in Mexico, Central America, or South America or visited one of these areas for a period longer than two months?

If the answer to **any** of these questions is yes, the child is considered to be at high risk for lead poisoning and must be tested according to the high-risk screening schedule.

If the parent does not know the answer, it must be assumed to be yes. If the answer to all of the questions is no, the child is considered to be at low risk for lead poisoning and must be tested according to the low-risk testing schedule.

(2) Basic Lead Testing Chart (Based on Risk and Age)



NOTE: If you see children at different ages than these, you can change these schedules to correspond with the ages when you do see children. However, the first test should not be done before 12 months unless the child is at extremely high risk for lead poisoning.

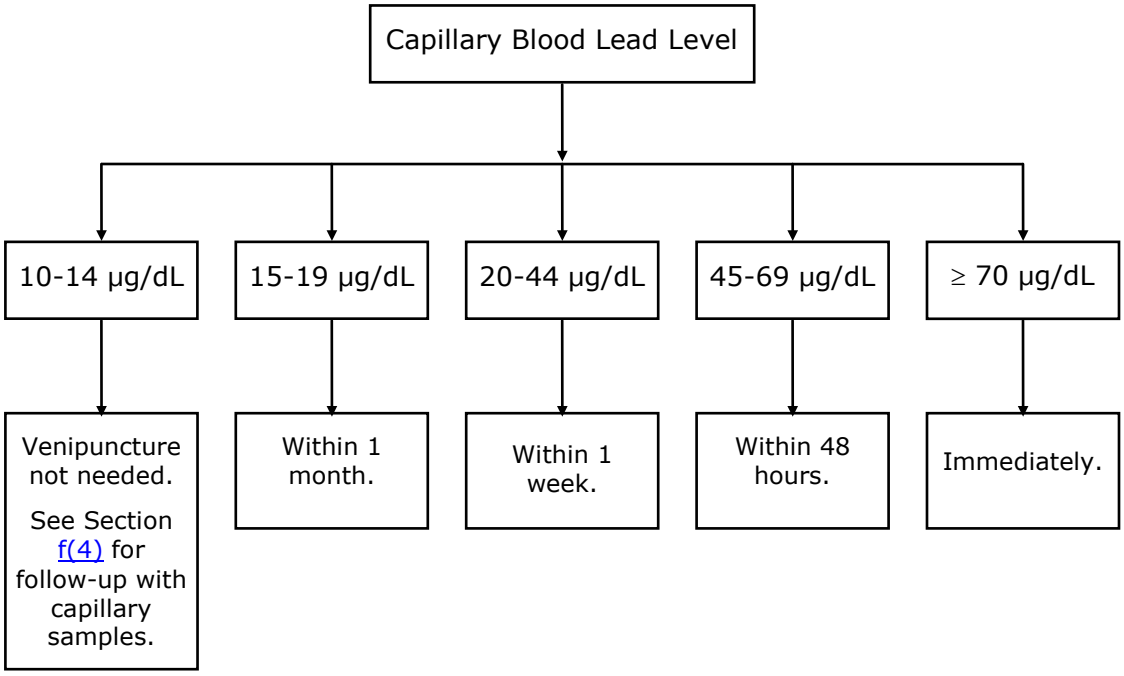
If capillary samples are used, see next page for follow-up of any level ≥ 10 µg/dL.

If venous samples are used, see Follow-up of Elevated Blood Lead Levels (10-14 µg/dL), Follow-up of Elevated Venous Blood Leads (15-19 µg/dL), and Follow-up of Elevated Venous Levels (≥ 20 µg/dL) for follow-up of any level ≥ 10 µg/dL.

Source: Iowa Department of Public Health (IDPH), *Statewide Plan for Childhood Blood Lead Testing* (January 2004).

(3) Schedule for Obtaining Confirmatory Venipunctures

Children who have blood lead levels ≥ 15 µg/dL on a capillary sample should have these levels confirmed on venous samples according to the timetables below.



If venous level < 9 µg/dL, return to regular blood lead testing schedule.

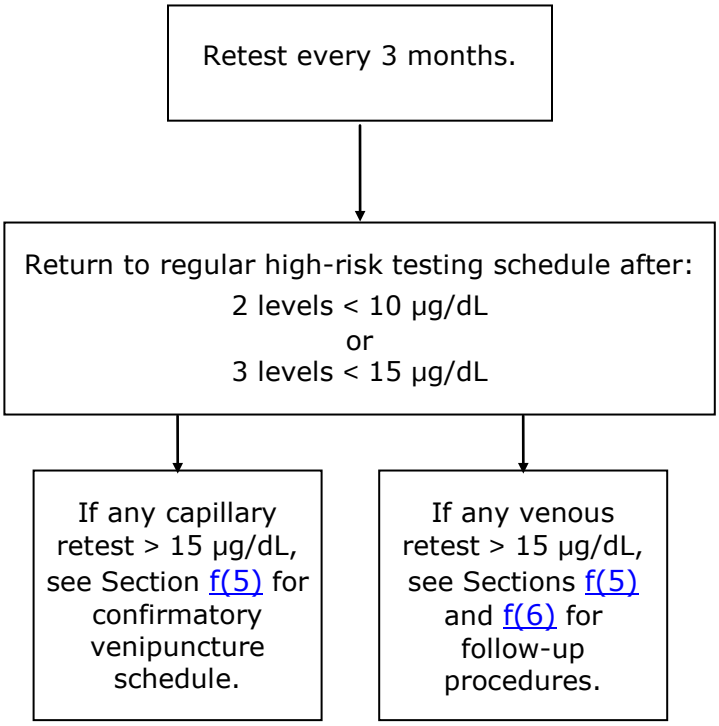
If venous level 10-14 µg/dL, see Follow-up of Elevated Blood Lead Levels (10-14 µg/dL).

If venous level 15-19 µg/dL, see Follow-up of Elevated Venous Blood Leads (15-19 µg/dL).

If venous level ≥ 20 µg/dL, see Follow-up of Elevated Venous Levels (≥ 20 µg/dL).

Source: Iowa Department of Public Health (IDPH), *Statewide Plan for Childhood Blood Lead Testing* (January 2004).

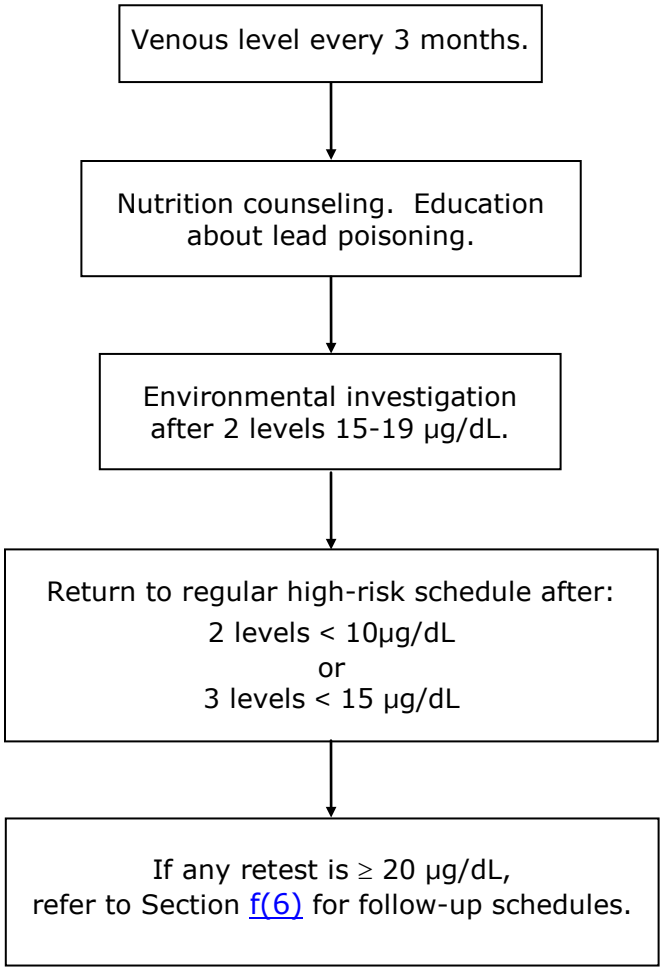
(4) Follow-up of Elevated Blood Lead Levels (10-14 µg/dL)



Source: Iowa Department of Public Health (IDPH), *Statewide Plan for Childhood Blood Lead Testing* (January 2004).

(5) Follow-up of Elevated Venous Blood Leads (15-19 µg/dL)

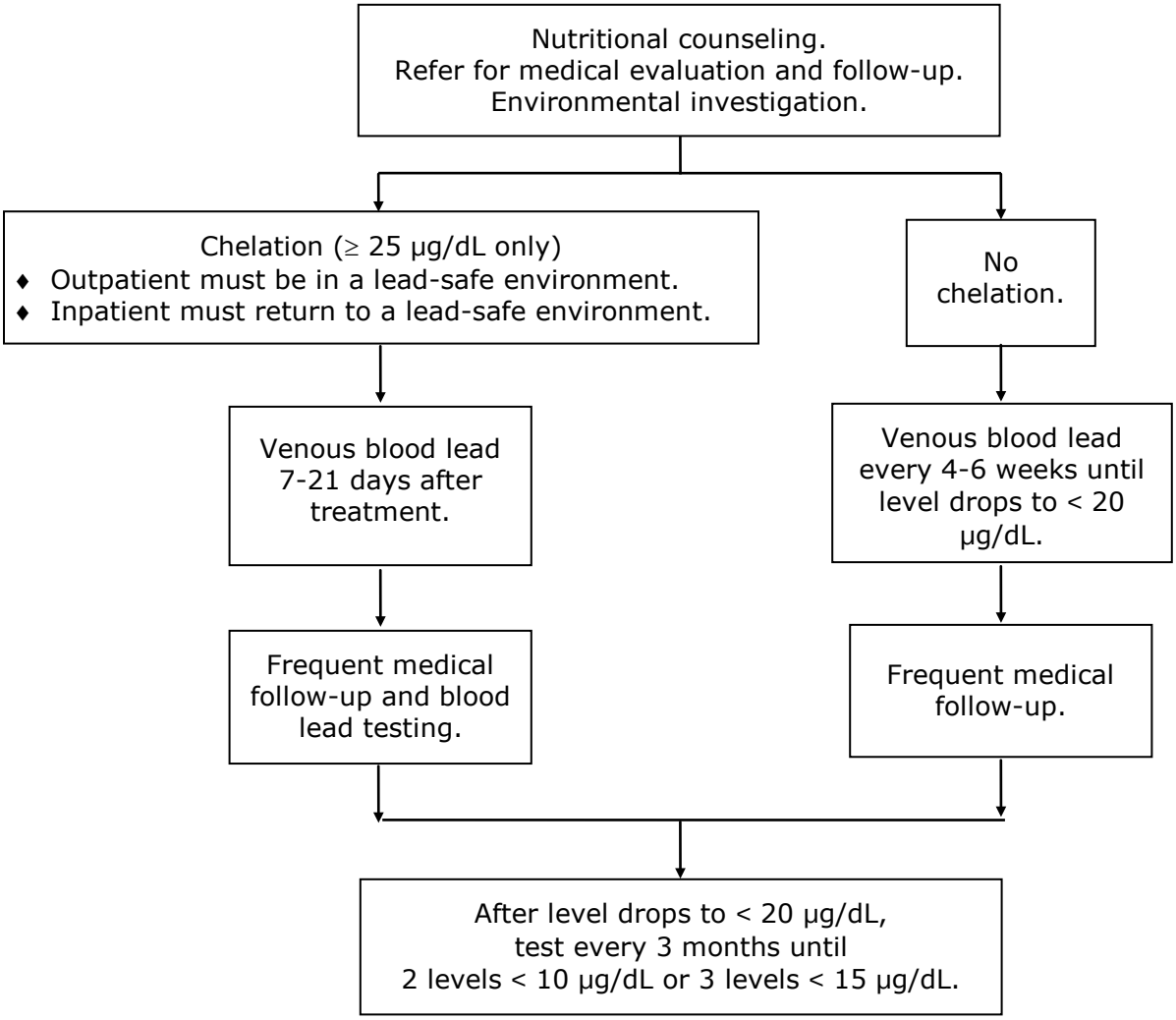
All children who have had venous levels ≥ 15 µg/dL are considered "high" risk regardless of initial risk assessment.



See Timelines for Medical and Nutritional Follow-up and Timelines for Environmental Follow-up for time frames for referrals.

Source: Iowa Department of Public Health (IDPH), *Statewide Plan for Childhood Blood Lead Testing* (January 2004).

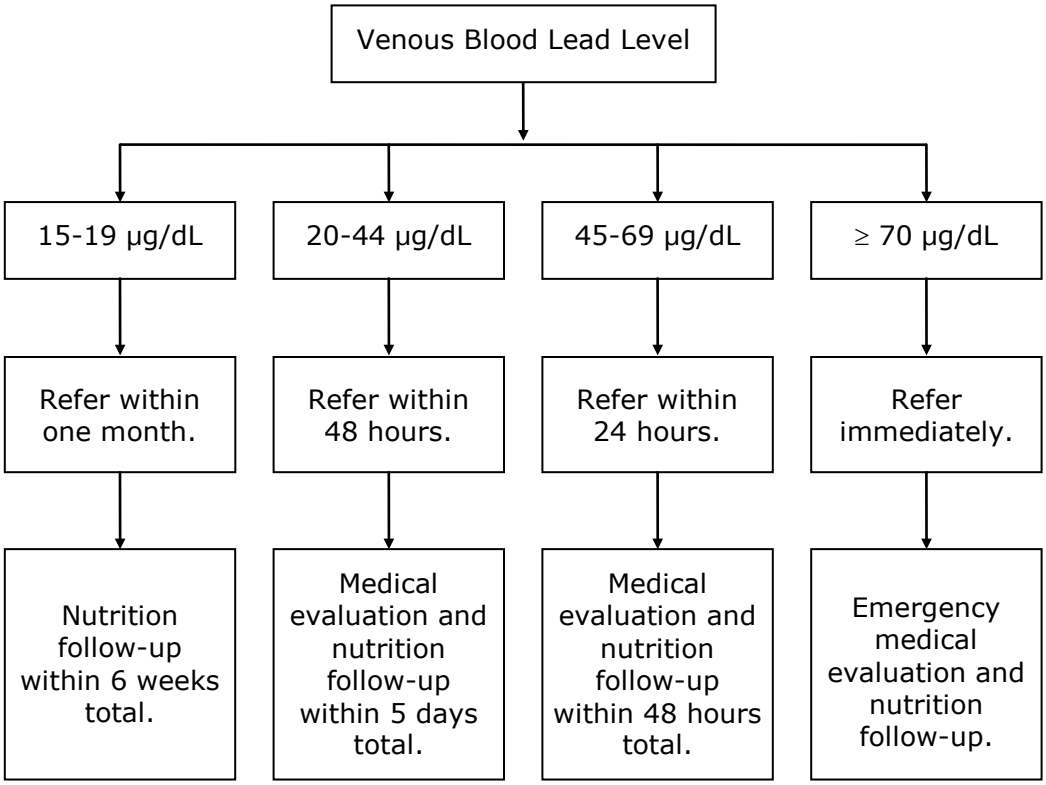
(6) Follow-up of Elevated Venous Levels (≥ 20 µg/dL)



See Timelines for Medical and Nutritional Follow-up and Timelines for Environmental Follow-up for time frames for referrals.

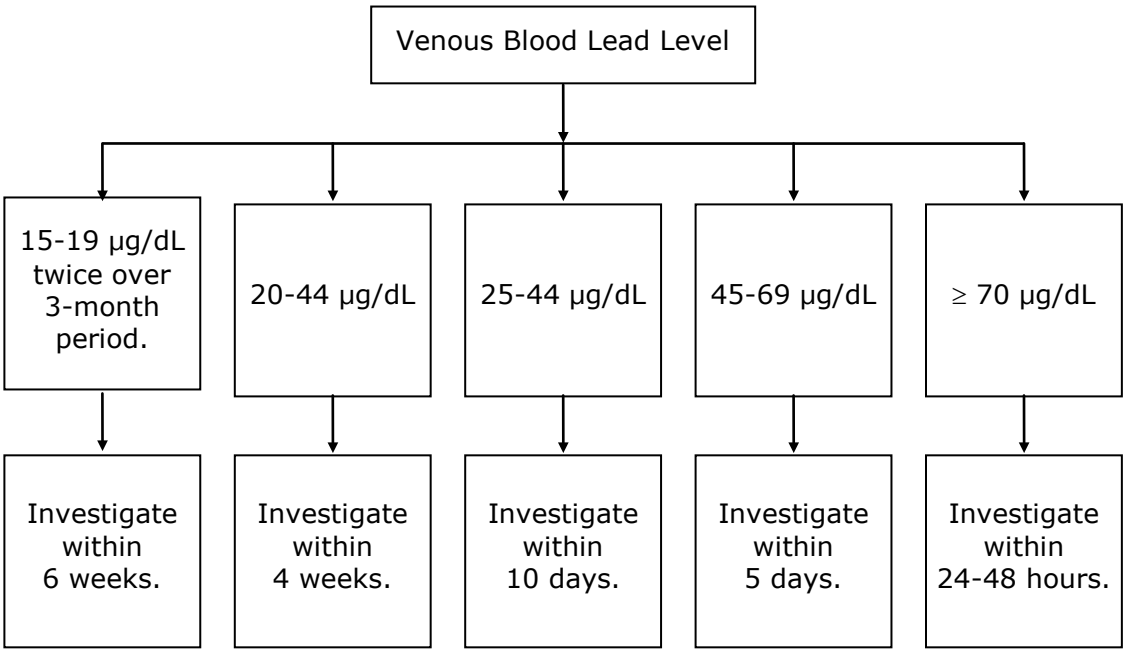
Source: Iowa Department of Public Health (IDPH), *Statewide Plan for Childhood Blood Lead Testing* (January 2004).

(7) Timelines for Medical and Nutritional Follow-up



Source: Iowa Department of Public Health (IDPH), *Statewide Plan for Childhood Blood Lead Testing* (January 2004).

(8) Timelines for Environmental Follow-up



Source: Iowa Department of Public Health (IDPH), *Statewide Plan for Childhood Blood Lead Testing* (January 2004).

g. 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, and
- Have multiple partners.

Sexually active females should receive family planning counseling, including pap smears, self breast examinations, and education on prevention of sexually transmitted diseases.

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.

h. 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 sexually transmitted diseases.

i. 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 STD, also provide:

- Education on prevention of sexually transmitted diseases.
- Education on the importance of contraception to prevent pregnancy.

4. Other Services

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

- Immunizations
- Assessment of nutritional status
- Vision screening
- Hearing screening

a. Immunization

In an effort to improve immunization practice, the health objectives for the nation call for a minimum of 90% 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.) You can obtain information about immunizations by contacting 1-800-232-4636 or 1-800-831-6293.

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. http://www.cdc.gov/vaccines/pubs/ACIP-list.htm

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 (http://www.cdc.gov/vaccines/recs/vac-admin/). The revised standards 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. These recommendations are approved by:

- The Advisory Committee on Immunization Practices (ACIP).
- The American Academy of Pediatrics.
- The American Academy of Family Physicians.

The recommended childhood and adolescent immunization schedule can be accessed on the following web sites: http://www.cdc.gov/vaccines, www.aap.org, or www.aafp.org.

b. 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 on 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 µg/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, gastrointestinal 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

	FEMALE		MALE	
Age	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, binging 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: *Report of the Expert Panel on Blood Cholesterol Levels in Children and Adolescents*. U.S. Department of Health and Human Services, September 1991.

c. 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.

(1) Birth To Age Three

Eye evaluations of infants and children birth to age three years should include:

- Ocular history.
- Vision assessment.
- External inspection of the eyes and lids.
- Ocular motility assessment.
- Pupil examination.
- Red reflex examination.

(2) At Three Years and Older

In addition to all the eye evaluations listed for infants and young children, two additional measures should be included. Beginning as early as age 2½ to 3 years, children should receive objective vision testing using picture cards. (See the following chart for suggested tests.)

Three-year-old-children who are uncooperative when tested should be retested four to six months later. Make a referral for an eye examination if the test cannot be completed on the second attempt. The referral should be to an optometrist or ophthalmologist who is experienced in treating children.

In addition to visual acuity testing, children four years old may cooperate by fixating on a toy while the ophthalmoscope is used to evaluate the optic nerve and posterior eye structures.

(3) At Five Years and Older

Children five years and older should receive all the previously described eye examinations and screening described for younger children.

During the preschool years, muscle imbalance testing is very important. The guidelines above suggest assessing muscle imbalance by use of the corneal light reflex test, unilateral cover test at near and far distance, and random-dot-E test for depth perception.

As the child reaches school age, refractive errors that may require eyeglasses for correction become important. The most common refractive error is hyperopia or far-sightedness. Hyperopia can cause problems in performing close work. Therefore, referral to an eye care specialist is recommended. Uncorrected hyperopia is very common in learning-related vision problems.

In addition, the following behaviors may be indicative of myopia:

- Tendency to squint.
- Holding toys or books close to the eyes.
- Difficulty recognizing faces at a distance.
- Failure to pass a school vision screening.
- Complaint that the classroom blackboard has become difficult to see.

Source: Hagan JF, Shaw JS, Duncan PM, eds. 2008, *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, Third Edition. Elk Grove Village, IL: American Academy of Pediatrics, page 231.

VISION SCREENING GUIDELINES		
Function: Recommended Tests	Referral Criteria	Comments
Distance visual acuity: ♦ Snellen chart ♦ Tumbling E ♦ HOTV test ♦ Picture tests: • Allen cards • LH symbols	**Ages 3-5 years:** 1. <4 of 6 correct on 20 ft line with either eye tested at 10 ft monocularly (i.e., <10/20 or 20/40) or 2. Two-line difference between eyes, even within the passing range (i.e., 10/12.5 and 10/20 or 20/25 and 20/40) **Ages 6 years and older:** 1. <4 of 6 correct on 15 ft line with either eye tested at 10 ft monocularly (i.e., <10/15 or 20/30) 2. Two-line difference between eyes, even within the passing range (i.e., 10/10 and 10/15 or 20/20 and 20/30)	1. Tests are listed in decreasing order of cognitive difficulty. Use the highest test that the child is capable of performing. In general, the tumbling E or the HOTV test should be used for ages 3-5 years and Snellen letters or numbers for ages 6 years and older. 2. Testing distance of 10 ft is recommended for all visual acuity tests. 3. A line of figures is preferred over single figures. 4. The nontested eye should be covered by an occluder held by the examiner or by an adhesive occluder patch applied to eye. The examiner must ensure that it is not possible to peek with the nontested eye.

Function: Recommended Tests	Referral Criteria	Comments
Ocular alignment:		
♦ Corneal light reflex test		
♦ Simultaneous red reflex test (Bruckner)		
♦ Cross cover test at 10 ft or 3 m	Any eye movement	
♦ Random-dot-E stereo test at 40 cm (630 s of arc)	<4 of 6 correct	

Source: American Academy of Pediatrics Committee on Practice and Ambulatory Medicine; Section on Ophthalmology, American Association of Certified Orthoptists; American Association for Pediatric Ophthalmology and Strabismus; and American Academy of Ophthalmology. Eye examination in infants, children, and young adults by pediatricians. ***Pediatrics***, 2003; 111:902-907, (page 902)

d. Hearing

Each child up to age 3 should have an objective hearing screen or documented parent refusal. Objective screening of hearing for all neonates is now recommended by the Joint Committee on Infant Hearing. See www.jcih.org/posstatements.htm.

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 3 months.

All infants with confirmed hearing loss should receive intervention services before 6 months of age.

For information on audiologists in your area, see the early hearing detection and intervention system (EDHI) website, www.idph.state.ia.us/iaehdi/default.asp or call 1-800-383-3826.

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.

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 5 days, or any of the following regardless of length of stay:
  - ECMO,*
  - Assisted ventilation,
  - Hyperbilirubinemia requiring exchange transfusion, and
  - 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 all., 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 finding, 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 include 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).

See Appendix D, *Hearing Screening Bright Futures, Guidelines for Health Supervision of Infants, Children, and Adolescents*, Second Edition, for additional information. www.brightfutures.org

D. BASIS OF PAYMENT FOR SERVICES

Payment to a screening center for services is on a fee-for-service basis. Submit all the actual costs of the screening examination, lab tests, and immunizations.

Bill all procedures in whole units of service. For most codes, 15 minute equals one unit. Round remainders of seven minutes or less down to the lower unit and remainders of more than seven minutes up to the next unit.

E. RECORDS

The documentation for each "patient encounter" shall include the following (when appropriate):

- Complaint and symptoms; history; examination findings; diagnostic test results; assessment, clinical impression or diagnosis; plan for care; date; and identity of the observer.
- Specific procedures or treatments performed.
- Medications or other supplies.
- Patient's progress, response to and changes in treatment, and revision of diagnosis.
- Information necessary to support each item of service reported on the Medicaid claim form.
  - Date of service.
  - Place of service.
  - Name of member.
  - Name of provider agency and person providing the service.
  - Nature, content, or units of service. Maintain a record of the time to support the units on the claim form. (Time must include AM/PM.)

Documentation of medical transportation services shall include the following:

- Date of service
- Member's name
- Address of where recipient was picked up
- Destination (medical provider's name and address)
- Invoice of cost
- Mileage if the transportation is paid per mile

Providers of service shall maintain fiscal records in support of each item of service for which a charge is made to the program. The fiscal record does not constitute a clinical record.

Failure to maintain supporting fiscal and clinical records may result in claim denials or recoupment of Medicaid payment.

As a condition of accepting Medicaid payment for services, providers are required to provide the Iowa Medicaid program access to client medical records when requested. Providers shall make the medical and fiscal records available to the Department or its duly authorized representative on request.

F. PROCEDURE CODES AND NOMENCLATURE

Iowa uses the CMS Health Care Procedures Coding System (HCPCS). Bill the screening examination using the appropriate preventive office CPT code. Claims submitted without a CPT code, modifier code, and an ICD-9 diagnosis code will be denied.

New Patient

99381 **Initial preventive medicine** evaluation and management of an individual including a comprehensive history, a comprehensive examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate laboratory/diagnostic procedures, new patient; infant (age under 1 year)

99382 Early childhood (age 1 through 4 years)

99383 Late childhood (age 5 through 11 years)

99384 Adolescent (age 12 through 17 years)

99385 18-20 years

Established Patient

99391 **Periodic preventive medicine** reevaluation and management of an individual including a comprehensive history, a comprehensive examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate laboratory/diagnostic procedures, established patient; infant (age under 1 year)

99392 Early childhood (age 1 through 4 years)

99393 Late childhood (age 5 through 11 years)

99394 Adolescent (age 12 through 17 years)

99395 18-20 years

Use the following modifier if applicable:

Modifier	Description
U1	Indicate a referral for treatment

If a follow-up visit is scheduled after the preventive visit, use the following codes and an appropriate ICD-9 code.

99211 Office or other outpatient visit for the evaluation and management of an established patient.

99401 Preventive medicine counseling or risk factor reduction interventions provided to an individual (separate procedure); approximately 15 minutes.

99402 Preventive medicine counseling or risk factor reduction interventions provided to an individual (separate procedure); approximately 30 minutes.

1. Home Visits

Code	Description
S9123	Nursing visit in the home, per hour
S9127	Social work visit in the home (encounter code)

Use the appropriate ICD-9 diagnosis code.

2. Interpretation Services

Code	Description	Unit
T1013	Sign language or oral interpretative services	15 minute unit
T1013 UC	Telephonic oral interpretive services	1 minute unit

3. Nutritional Counseling

Payment for nutritional counseling services will be made using the following codes:

Code	Description
97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes.
97803	Reassessment and intervention, individual, face-to-face with the patient, each 15 minutes

In the diagnosis area of the claim form, use the diagnosis appropriate for the condition being treated.

4. Testing

Bill specific laboratory and testing services as follows:

Code	Description
36416	Collection of capillary blood specimen (e.g. finger, heel, ear stick) (Cannot be used in conjunction with 99000.)
36415	Collection of venous blood by venipuncture (Cannot be used in conjunction with 99000)
96110	Developmental testing, limited, with interpretation and report
99000	Handling or conveyance of specimen for transfer to a lab (Cannot be used with 36415/36416)
85014	Hematocrit
85018	Hemoglobin
83655	Lead

Code	Description
92555	Speech audiometry (threshold only)
86580	Tuberculosis, intradermal
81002	Urinalysis
99173	Visual acuity (will not be paid if used with the preventive visit code)

5. Immunizations

Providers must provide immunizations under the Vaccines for Children Program (VFC). When a child receives a vaccine outside of the VFC schedule, Medicaid will provide reimbursement.

You must provide Medicaid immunizations under the Vaccines for Children Program (VFC). Vaccines available through the VFC program are found at http://www.idph.state.ia.us/adper/vaccines_for_children.asp or at 1-800-831-6293. The charges in box 24F should be "0" for the vaccine. Charge your usual and customary charge for the administration.

Code	Description
90460	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component
90461	Each additional vaccine/toxoid component (List separately in addition to code for primary procedure.) (Use 90460 for each vaccine administered. For vaccines with multiple components (combination vaccines), report 90460 in conjunction with 90461 for each additional component in a given vaccine.)
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid) (Do not report 90471 in conjunction with 90473.)
90472	Each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure.) (Use 90472 in conjunction with 90471 or 90473.)
90473	Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid) (Do not report 90473 in conjunction with 90471.)
90474	Each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure.) (Use 90474 in conjunction with 90471 or 90473.)

6. Local Transportation

Only agencies designated by the Iowa Department of Public Health can bill for transportation services. In the diagnosis area of the claim form, use diagnosis code V68.9.

Code	Description	Unit
A0110	Non-emergency transportation and bus, intrastate or interstate carrier	Per round trip
A0100	Non-emergency transportation taxi--intracity	Per round trip
A0130	Non-emergency transportation; wheelchair van	Per round trip
A0090	Non-emergency transportation per mile-volunteer interested individual, neighbor	Per mile
A0120	Non-emergency transportation mini-bus, mountain area transports, other non-profit transportation systems	Per round trip
A0170	Transportation, parking fees, tolls, other	

7. Oral Health Services

In the diagnosis area of the claim form, use diagnosis code 528.9. Use a DA modifier with oral health codes identified below.

Code	Mod	Procedure	Comment
D0120	DA	Screening evaluation	Once every six months
D0145	DA	Oral evaluation for patient under age three and counseling with primary caregiver	Once every six months
D0150	DA	Initial screening evaluation	One time per patient (Also allowed when provider has not seen patient within three years)
D0270		Bitewing, single film *	Once every 12 months
D0272		Bitewing, two films *	Once every 12 months
D0274		Bitewing, four films *	Once every 12 months
D1110		Adult prophylaxis (Age 13 and older)	Once every six months
D1120		Child prophylaxis (Age 12 and younger)	Once every six months
D1206		Topical fluoride varnish	Three times per year
D1310		Nutritional counseling for the control and prevention of oral disease	15-minute unit once every six months
D1330		Oral hygiene instruction	15-minute unit once every six months
D1351		Sealant, per tooth	One time per tooth (Replacement sealants may be covered when record documents medical necessity

* Before radiographs are taken, standing orders must be in place with a specific dentist who will read the radiographs, provide an examination, and establish a treatment plan.

8. Other

Code	Procedure	Comment
T1001	Nursing assessment/evaluation	15-minute unit

G. CLAIM FORM

Bill for screening examinations on the *Health Insurance Claim Form*, CMS-1500. To view a sample of this form on line, click here.

1. Instructions for Completing the CMS-1500 Claim Form

The table below follows the CMS-1500 claim form by field number and name, and gives a brief description of the information to be entered and whether providing information in that field is required, optional, or conditional of the individual member's situation.

For electronic media claim (EMC) submitters, refer also to your EMC specifications for claim completion instructions.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
1.	CHECK ONE	**REQUIRED.** Check the applicable program block.
1a.	INSURED'S ID NUMBER	**REQUIRED.** Enter the Medicaid member's Medicaid number, found on the *Medical Assistance Eligibility Card*. The Medicaid "member" is defined as a recipient of services who has Iowa Medicaid coverage. The Medicaid number consists of seven digits followed by a letter, e.g., 1234567A. Verify eligibility by visiting the web portal or by calling the Eligibility Verification System (ELVS) at 800-338-7752 or 515-323-9639, local in the Des Moines area. To establish a web portal account, call 800-967-7902.
2.	PATIENT'S NAME	**REQUIRED.** Enter the last name, first name, and middle initial of the Medicaid member.
3.	PATIENT'S BIRTHDATE	**OPTIONAL.** Enter the Medicaid member's birth month, day, year, and sex. Completing this field may expedite processing of your claim.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
4.	INSURED'S NAME	**OPTIONAL.** For Medicaid purposes, the "insured" is always the same as the patient. For Iowa Medicaid purposes, the member receiving services is always the "insured." If the member is covered through other insurance, the policyholder is the "other insured."
5.	PATIENT'S ADDRESS	**OPTIONAL.** Enter the address and phone number of the patient, if available.
6.	PATIENT RELATIONSHIP TO INSURED	**OPTIONAL.** For Medicaid purposes, the "insured" is always the same as the patient.
7.	INSURED'S ADDRESS	**OPTIONAL.** For Medicaid purposes, the "insured" is always the same as the patient.
8.	PATIENT STATUS	**REQUIRED, IF KNOWN.** Check boxes corresponding to the patient's current marital and occupational status.
9a-d.	OTHER INSURED'S NAME	**SITUATIONAL.** Required if the Medicaid member is covered under other additional insurance. Enter the name of the policyholder of that insurance, as well as the policy or group number, the employer or school name under which coverage is offered, and the name of the plan or program. If 11d is "yes," these boxes must be completed.
10.	IS PATIENT'S CONDITION RELATED TO	**REQUIRED, IF KNOWN.** Check the applicable box to indicate whether or not treatment billed on this claim is for a condition that is somehow work-related or accident-related. If the patient's condition is related to employment or an accident, and other insurance has denied payment, complete 11d, marking the "yes" and "no" boxes.
10d.	RESERVED FOR LOCAL USE	**OPTIONAL.** No entry required.
11a-c.	INSURED'S POLICY GROUP OR FECA NUMBER	**OPTIONAL.** For Medicaid purposes, the "insured" is always the same as the patient.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
11d.	IS THERE ANOTHER HEALTH BENEFIT PLAN?	**REQUIRED.** If the Medicaid member has other insurance, check "yes" and enter the payment amount in field 29. If "yes," then boxes 9a-9d must be completed. If there is no other insurance, check "no." If you have received a denial of payment from another insurance, check **both** "yes" and "no" to indicate that there is other insurance, but that the benefits were denied. Proof of denials must be included in the patient record. Request this information from the member. You may also determine if other insurance exists by visiting the web portal or by calling the Eligibility Verification System (ELVS) at 800-338-7752 or 515-323-9639, local in the Des Moines area. To establish a web portal account, call 800-967-7902. NOTE: Auditing will be performed on a random basis to ensure correct billing.
12.	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	**OPTIONAL.** No entry required.
13.	INSURED OR AUTHORIZED PERSON'S SIGNATURE	**OPTIONAL.** No entry required.
14.	DATE OF CURRENT ILLNESS, INJURY, PREGNANCY	**SITUATIONAL.** Enter the date of the onset of treatment as month, day, and year. For pregnancy, use the date of the last menstrual period (LMP) as the first date. This field is not required for preventative care.
15.	IF THE PATIENT HAS HAD SAME OR SIMILAR ILLNESS…	**SITUATIONAL.** Chiropractors must enter the current X-ray as month, day, and year. For all others, no entry is required.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
16.	DATES PATIENT UNABLE TO WORK...	**OPTIONAL.** No entry required.
17.	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	**CONDITIONAL.** Required if the referring provider is not enrolled as an Iowa Medicaid provider. "Referring provider" is defined as the health care provider that directed the patient to your office.
17a.		**LEAVE BLANK.** The claim will be returned if any information is entered in this field.
17b.	NPI	**SITUATIONAL.** If the patient is a MediPASS member and the MediPASS provider authorized service, enter the 10-digit national provider identifier (NPI) of the referring provider. If this claim is for consultation, independent lab, or DME, enter the NPI of the referring or prescribing provider. If the patient is on lock-in and the lock-in provider authorized the service, enter that provider's NPI.
18.	HOSPITALIZATION DATES RELATED TO...	**OPTIONAL.** No entry required.
19.	RESERVED FOR LOCAL USE	**OPTIONAL.** No entry required. Note that pregnancy is now indicated with a pregnancy diagnosis code in box 21. If you are unable to use a pregnancy diagnosis code in any of the fields in box 21, write in this box, "Y – Pregnant."
20.	OUTSIDE LAB	**OPTIONAL.** No entry required.
21.	DIAGNOSIS OR NATURE OF ILLNESS	**REQUIRED.** Indicate the applicable ICD-9-CM diagnosis codes in order of importance (1-primary, 2-secondary, 3-tertiary, and 4-quaternary), to a maximum of four diagnoses. Do **not** enter descriptions If the patient is pregnant, one of the diagnosis codes must indicate pregnancy. The pregnancy diagnosis codes are as follows: 640 through 648, 670 through 677, V22, V23

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
22.	MEDICAID RESUBMISSION CODE…	This field will be required at a future date. Instructions will be provided before the requirement is implemented.
23.	PRIOR AUTHORIZATION NUMBER	**SITUATIONAL.** If there is a prior authorization, enter the prior authorization number. Obtain this number from the prior authorization form.
24. A	DATE(S) OF SERVICE/NDC TOP SHADED PORTION LOWER PORTION	**SITUATIONAL.** Required for provider-administered drugs. Enter qualifier "N4" followed by the NDC for the drug referenced in 24d (HCPCs). No spaces or symbols should be used in reporting this information. **REQUIRED** Enter the month, day, and year under both the "From" and "To" categories for each procedure, service or supply. If the "From-To" dates span more than one calendar month, enter each month on a separate line. Because eligibility is approved on a month-by-month basis, spanning or overlapping billing months could cause the entire claim to be denied.
24. B	PLACE OF SERVICE	**REQUIRED.** Using the chart below, enter the number corresponding to the place service was provided. Do not use alphabetic characters. 11 Office 12 Home 21 Inpatient hospital 22 Outpatient hospital 23 Emergency room – hospital 24 Ambulatory surgical center 25 Birthing center 26 Military treatment facility 31 Skilled nursing 32 Nursing facility 33 Custodial care facility 34 Hospice 41 Ambulance – land 42 Ambulance – air or water

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
		51 Inpatient psychiatric facility 52 Psychiatric facility – partial hospitalization 53 Community mental health center 54 Intermediate care facility/mentally retarded 55 Residential substance abuse treatment facility 56 Psychiatric residential treatment center 61 Comprehensive inpatient rehabilitation facility 62 Comprehensive outpatient rehabilitation facility 65 End-stage renal disease treatment 71 State or local public health clinic 72 Rural health clinic 81 Independent laboratory 99 Other unlisted facility
24. C	EMG	**OPTIONAL.** No entry required.
24. D	PROCEDURES, SERVICES OR SUPPLIES	**REQUIRED.** Enter the codes for each of the dates of service. **Do not** list services for which no fees were charged. Do **not** enter the description. Enter the procedures, services, or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) code or valid Current Procedural Terminology (CPT) codes. When applicable, show the HCPCS code modifiers with the HCPCS code.
24. E	DIAGNOSIS POINTER	**REQUIRED.** Indicate the corresponding diagnosis code from field 21 by entering the number of its position, e.g., 3. **Do not** write the actual diagnosis code in this field. Doing so will cause the claim to deny. There is a maximum of four diagnosis codes per claim.
24. F	$ CHARGES	**REQUIRED.** Enter the usual and customary charge for each line item. This is defined as the provider's customary charges to the public for the services.
24. G	DAYS OR UNITS	**REQUIRED.** Enter the number of times this procedure was performed or number of supply items dispensed. If the procedure code specifies the number of units, then enter "1." When billing general anesthesia, the units of service must reflect the total **minutes** of general anesthesia.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
24. H	EPSDT/FAMILY PLANNING	**SITUATIONAL.** Enter "F" if the service on this claim line is for family planning. Enter "E" if the services on this claim line are the result of an EPSDT Care for Kids screening.
24. I	ID QUAL.	**LEAVE BLANK.** The claim will be returned if any information is entered in this field.
24. J	RENDERING PROVIDER ID # TOP SHADED PORTION LOWER PORTION	**LEAVE BLANK** **REQUIRED.** Enter the NPI of the provider rendering the service when the NPI given in field 33a does not identify the treating provider.
25.	FEDERAL TAX ID NUMBER	**OPTIONAL.** No entry required.
26.	PATIENT'S ACCOUNT NUMBER	**FOR PROVIDER USE.** Enter the account number you have assigned to the patient. This field is limited to 10 alphabetical or numeric characters.
27.	ACCEPT ASSIGNMENT?	**OPTIONAL.** No entry required.
28.	TOTAL CLAIM CHARGE	**REQUIRED.** Enter the total of the line-item charges. If more than one claim form is used to bill services performed, each claim form must be separately totaled. Do not carry over any charges to another claim form.
29.	AMOUNT PAID	**SITUATIONAL.** Enter only the amount paid by other insurance. Do not list member copayments, Medicare payments, or previous Medicaid payments on this claim. Do not submit this claim until you receive a payment or denial from the other carrier. Proof of denial must be kept in the patient record.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
30.	BALANCE DUE	**REQUIRED.** Enter the amount of total charges less the amount entered in field 29.
31.	SIGNATURE OF PHYSICIAN OR SUPPLIER	**REQUIRED.** Enter the signature of either the provider or the provider's authorized representative and the original filing date. The signatory must be someone who can legally attest to the service provided and can bind the organization to the declarations on the back of the claim form. If the signature is computer-generated block letters, the signature must be initialed. A signature stamp may be used.
32.	SERVICE FACILITY LOCATION INFORMATION	**OPTIONAL.** Enter the name and address associated with the rendering provider.
32a.	NPI	**OPTIONAL.** Enter the NPI of the facility where services were rendered.
32b.		**LEAVE BLANK.** The claim will be returned if any information is entered in this field.
33.	BILLING PROVIDER INFO AND PHONE #	**REQUIRED.** Enter the complete name and address of the billing provider. The "billing provider" is defined as the provider that is requesting to be paid for the services rendered. The address **must** contain the ZIP code associated with the billing provider's NPI. NOTE: The ZIP code must match the ZIP code confirmed during NPI verification. To view the confirmed ZIP code, access imeservices.org.
33a.	NPI	**REQUIRED.** Enter the ten-digit NPI of the billing provider.
33b.		**REQUIRED.** Enter qualifier "ZZ" followed by the taxonomy code of the billing provider. No spaces or symbols should be used. The taxonomy code must match the taxonomy code confirmed during NPI verification. To view the confirmed taxonomy code, access imeservices.org.

2. Claim Attachment Control, Form 470-3969

If you want to submit electronically a claim that requires an attachment, you must submit the attachment on paper using the following procedure:

- **Staple** the additional information to form 470-3969, *Claim Attachment Control*. (To view a sample of this form on line, click here.)
- Complete the "attachment control number" with the same number submitted on the electronic claim. IME will accept up to 20 characters (letters or digits) in this number. If you do not know the attachment control number for the claim, please contact the person in your facility responsible for electronic claims billing.
- **Do not** attach a paper claim.
- Mail the *Claim Attachment Control* with attachments to:

  Iowa Medicaid Enterprise
  PO Box 150001
  Des Moines, IA 50315

Once IME receives the paper attachment, it will manually be matched up to the electronic claim using the attachment control number and then processed.

H. REMITTANCE ADVICE

1. Remittance Advice Explanation

To simplify your accounts receivable reconciliation and posting functions, you will receive a comprehensive *Remittance Advice* with each Medicaid payment. The *Remittance Advice* is also available on magnetic computer tape for automated account receivable posting.

The *Remittance Advice* is separated into categories indicating the status of those claims listed below. Categories of the *Remittance Advice* include paid, denied, and suspended claims.

- **Paid** indicates all processed claims, credits and adjustments for which there is full or partial reimbursement.

- **Denied** represents all processed claims for which no reimbursement is made.
- **Suspended** reflects claims which are currently in process pending resolution of one or more issues (member eligibility determination, reduction of charges, third party benefit determination, etc.).

Suspended claims may or may not print depending on which option was specified on the Medicaid Provider Application at the time of enrollment. You chose one of the following:

- Print suspended claims only once.
- Print all suspended claims until paid or denied.
- Do not print suspended claims.

Note that claim credits or recoupments (reversed) appear as regular claims with the exception that the transaction control number contains a "1" in the twelfth position and reimbursement appears as a negative amount.

An adjustment to a previously paid claim produces two transactions on the *Remittance Advice*. The first appears as a credit to negate the claim; the second is the replacement or adjusted claim, containing a "2" in the twelfth position of the transaction control number.

If the total of the credit amounts exceeds that of reimbursement made, the resulting difference (amount of credit – the amount of reimbursement) is carried forward and no check is issued. Subsequent reimbursement will be applied to the credit balance, as well, until the credit balance is exhausted.

An example of the *Remittance Advice* and a detailed field-by-field description of each informational line follow. It is important to study these examples to gain a thorough understanding of each element as each *Remittance Advice* contains important information about claims and expected reimbursement.

Regardless of one's understanding of the *Remittance Advice*, it is sometimes necessary to contact the IME Provider Services Unit with questions. When doing so, keep the *Remittance Advice* handy and refer to the transaction control number of the particular claim. This will result in timely, accurate information about the claim in question.

2. Remittance Advice Samples and Field Descriptions

Two different remittance advice formats may be issued, depending on whether the claims are for members and items that are also covered by Medicare Part B.

To view a sample of the standard RA-1500 remittance advice on line, click here. The fields are described as follows:

	Field Name	Field Description
A	R.A. No.	*Remittance Advice* number
B	Warrant Number	Check number (usually zeros). Contact IME for check number.
C	Provider Name	Name of the pay-to provider as registered with IME
D	Provider Address	Address registered with IME
E	Important IME Information	Reminders and updates from IME
F	Run Date	Date the *Remittance Advice* was created
G	Date Paid	Date the *Remittance Advice* and check were released
H	Prov. Number	National provider identifier (NPI) of the billing (pay-to) provider
I	Page	Page number
J	Number of Claims	Number of claims processed for each defined status
K	Billed Amount of All Claims	Total dollar amount of claims billed for each defined status
L	Subtotal Amount Paid	Amount paid for each defined status
M	Amount of Deposit	Total check amount for claims paid on this *Remittance Advice*
N	EOB Code	Explanation of benefits (EOB) code or denial code
O	EOB Description	Description of the denial EOB
P	Number of Claims Posting EOB	Number of claims that denied for the EOB code described
Q	Number of Claims	Total number of claims within same claim type or status

	Field Name	Field Description
R	Total Billed Amt.	Total billed amount of all claims within same claim type or status
S	Total Other Sources	Total third-party insurance payments within same claim type or status
T	Total Paid by Mcaid	Total dollar amount paid within same claim type or status
X	Copay Amt.	Total copayment amount within same claim type or status

1	Patient Name	Last, first name or initial of the member as shown on the Medical Assistance Eligibility Card
2	Recip ID	Member identification number (7 digits+letter)
3	Trans-Control-Number	17-digit transaction control number assigned to each claim
4	Billed Amt.	Total billed amount on claim
5	Other Sources	Total "other sources" on claim (for example: TPL, spenddown)
6	Paid by Mcaid	Total amount paid by Iowa Medicaid on claim
7	Copay Amt.	Total member copayment on claim
8	Med Rcd Num	Medical record number or patient account number
9	EOB	Explanation of benefits denial reason code if entire claim denied (Full description of denial can be found on the last page of the *Remittance Advice* statement.)
10	Line	Claim line number
11	Svc-Date	Date of service
12	Proc/Mods	CPT or HCPCS code and modifier billed
13	Units	Number of units billed
14	Billed Amt.	Billed amount on this line
15	Paid by Mcaid	Amount paid by Medicaid on this line
16	Copay Amt.	Copayment amount on this line
17	Perf. Prov.	Treating provider national provider identifier (NPI) number

	Field Name	Field Description
18	S	Source of payment. Allowed charge source codes are as follows: A Anesthesia B Billed charge C Percentage of charges D Inpatient per diem rate E EAC priced plus dispense fee F Fee schedule G FMAC priced plus dispense fee H Encounter rate I Prior authorization rate K Denied L Maximum suspend ceiling M Manually priced N Provider charge rate O Professional component P Group therapy Q EPSDT total over 17 R EPSDT total under 18 S EPSDT partial over 17 SP Not yet priced T EPSDT partial under 18 U Gynecology fee V Obstetrics fee W Child fee X Medicare or coinsurance deductibles Y Immunization replacement Z Batch bill APG 0 APG 1 No payment APG 3 HMO/PHP rate 4 System parameter rate 5 Statewide per diem 6 DRG auth or new 7 Inlier/outlier adjust 8 DRG ADR inlier 9 DRG ADR
19	EOB	Explanation of benefits denial reason code

To view a sample of the Medicare Part B crossover remittance advice format on line, click here. The fields are described as follows:

	Field Name	**Field Description**
A	R.A. No.	*Remittance Advice* number
B	Warrant Number	Check number (usually zeros). Contact IME for check number.
C	Provider Name	Name of the pay-to provider as registered with IME
D	Provider Address	Address registered with IME
E	Important IME Information	Reminders and updates from IME
F	Run Date	Date the *Remittance Advice* was created
G	Date Paid	Date the *Remittance Advice* and check were released
H	Prov. Number	National provider identifier (NPI) of the billing (pay-to) provider
I	Page	Page number
J	Number of Claims	Number of claims processed for each defined status
K	Billed Amount of All Claims	Total dollar amount of claims billed for each defined status
L	Subtotal Amount Paid	Amount paid for each defined status
M	Amount of Deposit	Total check amount for claims paid on this *Remittance Advice*
N	EOB Code	Explanation of benefits (EOB) code or denial code
O	EOB Description	Description of the denial EOB
P	Number of Claims Posting EOB	Number of claims that denied for the EOB code described
Q	Number of Claims	Total number of claims within same claim type or status
R	Mcare Paid Amt	Total Medicare payment within same claim type or status
S	Mcare Apprd	Total Medicare approved within same claim type or status

	Field Name	Field Description
T	Deductible	Total deductible amount within same claim type or status
U	Coins. Amt.	Total coinsurance amount within same claim type or status
V	Copay	Total copayment amount within same claim type or status
X	Mcaid Paid Amt	Total Medicaid payment within same claim type or status

1	Patient	Name of the member as shown on the Medical Assistance Eligibility Card (last name and first initial)
2	Recipient Ident Num	Member identification number (7 digits+letter)
3	Trans-Control-Number	17-digit transaction control number assigned to each claim
4	Mcare Paid Amt	Total paid by Medicare on claim
5	Mcare Apprd	Total amount Medicare approved
6	Deductible	Total Medicare deductible on claim
7	Coins Amt.	Total Medicare coinsurance on claim
8	Copay	Total Iowa Medicaid copayment on claim
9	Mcaid Paid Amt	Total amount paid by Medicaid on claim
10	Med Rcd Num	Medical record number OR patient account number
11	Line	Line number
12	Svc-Date	Date of service on line
13	Proc Mods	CPT or HCPCS code and modifier billed
14	Units	Number of units billed
15	Mcare Paid Amt	Medicare paid amount on line item
16	Mcare Apprd	Medicare approved amount on line item
17	Deductible	Medicare deductible amount on line item
18	Coins. Amt.	Medicare coinsurance amount on line item
19	Copay	Iowa Medicaid copayment on line item
20	Mcaid Paid Amt	Total amount paid by Medicaid on line

	Field Name	Field Description
21	S	Source of payment. Allowed charge source codes are as follows: A Anesthesia B Billed charge C Percentage of charges D Inpatient per diem rate E EAC priced plus dispense fee F Fee schedule G FMAC priced plus dispense fee H Encounter rate I Prior authorization rate K Denied L Maximum suspend ceiling M Manually priced N Provider charge rate O Professional component P Group therapy Q EPSDT total over 17 R EPSDT total under 18 S EPSDT partial over 17 SP Not yet priced T EPSDT partial under 18 U Gynecology fee V Obstetrics fee W Child fee X Medicare or coinsurance deductibles Y Immunization replacement Z Batch bill APG 0 APG 1 No payment APG 3 HMO/PHP rate 4 System parameter rate 5 Statewide per diem 6 DRG auth or new 7 Inlier/outlier adjust 8 DRG ADR inlier 9 DRG ADR
22	EOB	Explanation of benefits denial reason code. A full description of denial can be found on the last page of the *Remittance Advice* statement.