

Advanced Registered Nurse Practitioner (ARNP)

Provider Manual



**Iowa Department
of Human Services**



Iowa
Department
of Human
Services

Provider

**Advanced Registered Nurse
Practitioner (ARNP)**

Page

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CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. CONDITIONS OF PARTICIPATION

An advanced registered nurse practitioner (referred to as "ARNP") is defined by Iowa Board of Nursing rules at 655 Iowa Administrative Code (IAC) Chapter 7 as being

"prepared for an advanced role by virtue of additional knowledge and skills gained through a formal advanced practice education program of nursing in a specialty area approved by the board. In the advanced role, the nurse practices nursing assessment, intervention, and management within the boundaries of the nurse-patient relationship.

"Advanced nursing practice occurs in a variety of settings, within an interdisciplinary health care team, which provide for consultation, collaborative management, or referral. The ARNP may perform selected medically delegated functions when a collaborative practice agreement exists."

To be eligible to participate in the Medicaid program, an ARNP in Iowa must both:

- ◆ Be licensed by the state of Iowa as an ARNP, and
- ◆ Possess evidence of certification in a recognized specialty area, as defined in applicable Board of Nursing rules.

The Medicaid program covers all types of ARNPs, in compliance with Iowa Code section 249A.4(7). These include:

- ◆ Certified clinical nurse specialist, an ARNP prepared at the master's level who possesses evidence of current advanced level certification as a clinical specialist in an area of nursing practice.
- ◆ Certified nurse-midwife, an ARNP educated in the disciplines of nursing and midwifery who is authorized to manage the care of normal newborns and women, antepartally, intrapartally, postpartally or gynecologically.
- ◆ Certified nurse practitioner, an ARNP educated in the disciplines of nursing who has advanced knowledge of nursing, physical and psychosocial assessment, appropriate interventions, and management of health care.
- ◆ Certified registered nurse anesthetist (CRNA), an ARNP educated in the disciplines of nursing and anesthesia who possesses evidence of current advanced level certification or recertification.



Of the ARNP specialties able to enroll, only CRNAs have additional specific coverage provisions. For all other types of ARNPs able to enroll, the general provisions indicated in this manual apply.

In addition to being licensed by the state in which the CRNA practices, a CRNA must meet the following requirements:

- ◆ Is currently certified by the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists, or
- ◆ Has graduated in the past 18 months from a nurse anesthesia program that meets the Standards on Accreditation of Nurse Anesthesia Educational Programs and is awaiting initial certification.

ARNPs in other states are eligible to participate if they are licensed in that state and are certified by that state in a practice area recognized by the Iowa Board of Nursing.

B. COVERAGE OF SERVICES

Payment will be approved through the Medicaid program for services provided by ARNPs within their licensure and scope of practice, pursuant to Board of Nursing rules and definitions, including medically delegated functions under a collaborative practice agreement.

“Collaborative practice agreement” means an ARNP and physician practicing together within the framework of their respective professional scopes of practice. This collaborative agreement reflects both independent and cooperative decision-making and is based on the preparation and ability of each practitioner.

Payment will be approved for all reasonable and necessary medical services and supplies, subject to the exclusions and limitations set forth in the following sections.

No payment will be made for services of a private-duty nurse.



1. Ambulance Services

Payment will be approved through the Medicaid program for ambulance service, providing the use of any other method of transportation is medically contraindicated by the member's condition. The member must be transported to the nearest hospital with appropriate facilities, from one hospital to another, or to a skilled nursing facility or licensed nursing home.

If the member who has been transferred to a hospital with appropriate facilities is subsequently taken to another hospital in the same locality, payment for the second trip will be approved only if there is a valid reason for transporting the member (as opposed to the member's personal preference). Example: The member requires inpatient hospital services that were not available at the first hospital.

a. Medical Necessity

The Iowa Medicaid Enterprise (IME) Medical Services Unit is responsible for determining that ambulance service was medically necessary and that the condition of the member precluded any other method of transportation.

The IME relies on information from an ARNP, physician, or hospital to determine if the member's condition requires ambulance transportation. Therefore, all claims related to treatment provided in connection with ambulance transportation should contain sufficient information about the member's diagnosis and medical condition to substantiate the need for ambulance services.

The IME can generally pay claims without confirmation from the provider or the medical facility when:

- ◆ The member is admitted as a hospital inpatient.
- ◆ There is an emergency, such as a result of an accident, injury, or acute illness.
- ◆ Information submitted with the claim clearly indicates that ambulance service was necessary, showing diagnosis and treatment of the condition that gave rise to the need for ambulance service.



The IME **cannot** presume medical necessity for ambulance service in the following cases:

- ◆ The member is ambulatory;
- ◆ The member is not admitted as a hospital inpatient (except in accident cases);
- ◆ The member is transported regularly to the hospital outpatient department for continuing treatment and is regularly returned home;
- ◆ The member is transported between the hospital outpatient department and a nursing home where the member is living.

In these and similar cases, the Medical Services Unit may find it necessary to request information from the ambulance company (which may in turn request it from the ARNP or the hospital) to determine medical necessity and whether payment of a claim should be approved.

Please assist the IME in supplying this information, when requested, to determine if Medicaid can cover ambulance.

b. Non-Covered Services

Payment will not be approved for the following:

- ◆ Transportation of a member from home or a nursing home to a provider's office or clinic (free-standing or hospital-based), or back, unless the transportation is required for specialized treatment available at that location.
- ◆ Transportation of a member from home or a nursing home to the outpatient department of a hospital, unless the trip was an emergency or otherwise medically necessary.
- ◆ Transportation from one private home to another.
- ◆ Transportation of a member to University Hospitals in Iowa City, unless the University Hospitals is the nearest hospital with facilities necessary to the care of the member.
- ◆ Transportation to obtain the services of a specific provider.



2. Family Planning Services

Covered family planning services include the following:

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

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

3. Foot Care

Payment will be made for removal of warts.

Routine foot care is not covered, unless the member has a complicating systemic disease that makes rendering of this routine service by a nonprofessional hazardous. Routine foot care includes:

- ◆ The cutting or removal of corns or calluses,
- ◆ The trimming of nails,
- ◆ Other hygienic or preventative maintenance care in the realm of self-care, such as cleaning and soaking the feet,
- ◆ The use of skin creams to maintain skin tone of both ambulatory and bedfast patients,
- ◆ Application of topical medicine, and
- ◆ Any services performed in the absence of localized injury, illness, or symptoms involving the foot.

Cutting or removal of corns, calluses, or nails is not considered routine care when this care does present a hazard to the member because:

- ◆ There is a systemic disease such as diabetes mellitus, or
- ◆ Other conditions have resulted in circulatory embarrassment or areas of desensitization in the legs or feet.



When such services have been rendered, Item 19 of the CMS-1500 claim form must identify and describe the complicating systemic disease that makes rendition of the routine service by a nonprofessional hazardous.

4. Injected Medication

a. Covered Services

Payment will be approved for injections provided they are reasonable, necessary, and related to the diagnosis and treatment of an illness or injury or are for purposes of immunization. The following information must be provided when billing for injections:

- ◆ Brand name of drug and manufacturer
- ◆ Strength of drug
- ◆ Amount administered
- ◆ Charge for each injection

When the strength and dosage information is not provided, claims will be denied. (This information is not needed if it is specified in the HCPC code.)

b. Non-Covered or Limited Services

For injections related to diagnosis or treatment of illness or injury, the following specific exclusions are applicable:

- ◆ **Injections not indicated for treatment of a particular condition.** Payment will not be approved for injections when they are considered by standards of medical practice not to be specific or effective treatment for the particular condition for which they are administered.

The Vitamin B-12 injection is an example. Medical practice generally calls for use of this injection when various physiological mechanisms produce a vitamin deficiency. Use of Vitamin B-12 in treating any unrelated condition will result in a disallowance.

- ◆ **Injections not for a particular illness.** Payment will not be approved for an injection if administered for a reason other than the treatment of a particular condition, illness or injury. **NOTE:** The physician or ARNP must obtain prior approval before employing an amphetamine or legend vitamin by injection.



- ◆ **Method of injection not indicated.** Payment will not be approved when injection is not an indicated method of administration according to accepted standards of medical practice.
- ◆ **Allergenic extract injection.** Claims from suppliers of allergenic extract materials provided the member for self-administration will be allowed according to coverage limits in effect for this service.
- ◆ **Excessive injections.** Basic standards of medical practice provide guidance as to the frequency and duration of injections. These vary and depend upon the required level of care for a particular condition. The circumstances must be noted on the claim before additional payment can be approved.

When excessive injections appear, representing a departure from accepted standards of medical practice, the entire charge for injections given in excess of these standards will be excluded. For example, such an action might occur when Vitamin B-12 injections are given for pernicious anemia more frequently than the accepted intervals.

If an injection is determined to fall outside of what is medically reasonable or necessary, the entire charge (i.e., for both the drug and its administration) will be excluded from payment. Therefore, if a charge is made for an office visit primarily for the purpose of administering drugs, it will be disallowed along with the non-covered injections.

5. Interpreter Services

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

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

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

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



a. Documentation of the Service

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

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

b. Qualifications

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

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

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

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

6. Prenatal Risk Assessment

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



To determine risk for pregnant Medicaid members upon entry into care, complete the [Medicaid Prenatal Risk Assessment, Form 470-2942](#).

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

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

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

Click [here](#) to access the map showing locations of maternal health agencies.

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

a. Enhanced Services

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

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



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

The enhanced services include:

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

(1) Health Education

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

- ◆ High-risk medical conditions related to pregnancy, such as pre-eclampsia, preterm labor, vaginal bleeding, gestational diabetes, chronic urinary conditions, genetic disorders, and anemia
- ◆ Chronic medical conditions, such as diabetes, epilepsy, cardiac disease, sickle cell disease, and hypertension
- ◆ Other medical conditions, such as HIV, hepatitis, and sexually transmitted diseases
- ◆ Smoking cessation. Refer to Quitline Iowa at (800) 784-8669, or on the web at <https://www.quitnow.net/iowa/>
- ◆ Alcohol use
- ◆ Drug use
- ◆ Education on environmental and occupational hazards
- ◆ High-risk sexual behavior



Referrals may be made for:

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

(2) Nutrition Services

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

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

- ◆ Initial assessment of nutritional risk based on height, current and pre-pregnancy weight status, laboratory data, clinical data, and self-reported dietary information. Discuss the member's attitude about breastfeeding.
- ◆ At least one follow-up nutritional assessment, as evidenced by dietary information, adequacy of weight gain, measures to assess uterine and fetal growth, laboratory data, and clinical data.
- ◆ Development of an individualized nutritional care plan.
- ◆ Referral to food assistance programs, if indicated.



Nutritional interventions include:

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

(3) Psychosocial Services

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

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

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



b. Risk Factors Related to History

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

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

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

c. Risk Factors Related to Current Pregnancy

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

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

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

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



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

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

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

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

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

7. Prescription of Drugs

Payment will be made for drugs when prescribed by a legally qualified practitioner. Payment will be made for drugs dispensed by a practitioner only if there is no licensed retail pharmacy in the community where the practitioner's office is located.

For physician-administered (i.e., injectable) drugs, provide the NDC number when billing for such injected drugs. Claims will be denied when the NDC number information is not provided. Claims will be paid only for injections that are rebatable. Click [here](#) to view the list of drugs with rebates.

Please consult the [Prescribed Drugs Manual](#) for details of Medicaid coverage of drugs.



a. Drugs Requiring Prior Authorization

Drug products designated on the Preferred Drug List as “P” (preferred) or “R” (recommended) do not require prior authorization unless the drug has a number in the comments column to indicate a prior authorization is required, as defined on the first page of the Iowa Medicaid Preferred Drug List.

A preferred drug with conditions has “preferred” agents but must meet certain medical criteria and guidelines that coincide with current prior authorization guidelines.

Drug products designated “N” (nonpreferred) on the Preferred Drug List require prior authorization, with the primary criteria being failure on the preferred agents rather than clinical guidelines.

See www.iowamedicaidpdl.com for the current designations.

Drug products within a therapeutic class that are not selected as preferred will be denied for payment unless the prescriber obtains prior authorization. Payment for drugs requiring a prior authorization will be made only when:

- ◆ The drugs are prescribed for treatment of one or more conditions set forth for each, and
- ◆ The Iowa Medicaid prior authorization criteria have been met, and
- ◆ Approval is obtained through the prior authorization process.

EXCEPTION: In the event of an emergency when the prescriber cannot submit a prior authorization request, the pharmacist may dispense a 72-hour supply of the drug and reimbursement will be made.

The specific criteria for approval of a prior authorization request are available in chart format on the website www.iowamedicaidpdl.com. The prior authorization criteria are also defined in the [Prescribed Drugs Manual: Prior Authorization Requirements](#).

The IME Drug Prior Authorization Unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity.



b. Legend Drugs and Devices

Payment will be made for drugs and devices (e.g., diaphragms) requiring a prescription **by law** with the following exceptions:

- ◆ Drugs marketed by manufacturers that do not have a signed Medicaid rebate agreement. Click [here](#) for additional information.
- ◆ Drugs prescribed for a use other than the drug's medically accepted use.
- ◆ Drugs used to cause anorexia or weight gain. (EXCEPTION: Payment will be made for lipase inhibitor drugs for weight loss with prior authorization.)
- ◆ Drugs used for cosmetic purposes or hair growth.
- ◆ Drugs used to promote smoking cessation. (EXCEPTION: Payment will be made for generic bupropion sustained-release products that are FDA approved for smoking cessation, for nonprescription nicotine patch and gum with prior authorization, and for varenicline with a prior authorization.)
- ◆ Covered outpatient drugs for which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or the manufacturer's designee.
- ◆ Drugs classified as less than effective by the Centers for Medicare and Medicaid Services.
- ◆ Drugs that require a prior authorization as specified under Authorization.
- ◆ Drugs used for fertility purposes.
- ◆ Drugs used for the treatment of sexual or erectile dysfunction.

Payment will also be made for insulin on a legally qualified practitioner's prescription, although a prescription is not legally required.



c. **Non-Covered or Limited Services - Injections**

For injections related to diagnosis or treatment of illness or injury, the following specific exclusions are applicable:

- ◆ **Injections not indicated for treatment of a particular condition.** Payment will not be approved for injections when they are considered by standards of medical practice not to be specific or effective treatment for the particular condition for which they are administered.

The Vitamin B-12 injection is an example. Medical practice generally calls for use of this injection when various physiological mechanisms produce a vitamin deficiency. Use of Vitamin B-12 in treating any unrelated condition will result in a disallowance.

- ◆ **Injections not for a particular illness.** Payment will not be approved for an injection if administered for a reason other than the treatment of a particular condition, illness, or injury. **NOTE:** The physician must obtain prior approval before employing an amphetamine or legend vitamin by injection.
- ◆ **Method of injection not indicated.** Payment will not be approved when injection is not an indicated method of administration according to accepted standards of medical practice.
- ◆ **Allergenic extract injection.** Claims from suppliers of allergenic extract materials provided the member for self-administration will be allowed according to coverage limits in effect for this service.
- ◆ **Excessive injections.** Basic standards of medical practice provide guidance as to the frequency and duration of injections. These vary and depend upon the required level of care for a particular condition. The circumstances must be noted on the claim before additional payment can be approved.

When excessive injections appear, representing a departure from accepted standards of medical practice, the entire charge for injections given in excess of these standards will be excluded. For example, such an action might occur when Vitamin B-12 injections are given for pernicious anemia more frequently than the accepted intervals.



If an injection is determined to fall outside of what is medically reasonable or necessary, the entire charge (i.e., for both the drug and its administration) will be excluded from payment. Therefore, if a charge is made for an office visit primarily for administering drugs, it will be disallowed along with the non-covered injections.

d. Nonprescription Drugs

Payment for nonprescription drugs will be made in the same manner as for prescription drugs, except that a maximum allowable cost (MAC) is established at the median of the average wholesale prices of the chemically equivalent products available. No exceptions for reimbursement for higher cost products will be approved.

For more information on covered nonprescription drugs and current maximum allowable costs, see the Chapter III. [Prescribed Drugs Manual: COVERAGE OF SERVICES, Nonprescription Drugs.](#)

8. Prescription of Medical Supplies and Equipment

a. Medical Supplies

Most medical and sickroom supplies are covered when ordered by a practitioner and supplied by a medical item supplier for a specific rather than an incidental use. Certain items require specific documentation from the practitioner to substantiate medical necessity before reimbursement can be made to the dealer for the items.

No payment will be made for medical supplies for a member receiving care in a Medicare-certified skilled nursing facility. For a member receiving care in a nursing facility or intermediate care facility for the mentally retarded, payment will be approved only for the following (when prescribed by the practitioner):

- ◆ Colostomy and ileostomy appliances
- ◆ Colostomy and ileostomy care dressings, liquid adhesive, and adhesive tape
- ◆ Disposable irrigation trays or sets (sterile)
- ◆ Disposable catheterization trays or sets (sterile)



- ◆ Catheters (indwelling Foley)
- ◆ Disposable saline enemas (sodium phosphate type, for example)
- ◆ Diabetic supplies (needles and syringes, disposable or reusable; test-tape, Clinitest tablets, and Clinistix)
- ◆ Nutritional supplements and supplies (when approved)

b. Nutritional Supplements

For enteral products and supplies, the dispensing provider must submit claims to the IME with form 470-0829, *Request for Prior Authorization*. Prior authorization is no longer required for parenteral therapy. Click [here](#) to access the form online.

For nutritional supplements and supplies for administering the nutritional supplements, the practitioner must prescribe the item and document the medical necessity.

Prescription or nonprescription nutritional supplements shall be approved for payment for a member who needs the supplement due to a specifically diagnosed disease or digestive disorder that prevents the member from obtaining the necessary nutritional value from usual foods and cannot be managed by avoidance of certain food products.

The information submitted must identify other methods attempted to support the member's nutritional needs. The documentation indicating the member's condition must be sufficient to meet the above requirements.

When nutritional supplements are approved, reasonable supplies to administer nutritional supplements are also covered.

This policy applies to members in their own homes or in a nursing facility, since the items in this section are also considered prosthetic devices.

NOTE: Some members require supplementation of their daily protein and calorie intake. Nutritional supplements are often given as a medicine between meals to boost protein or calorie intake. Medicaid does not cover nutritional supplementation.



c. **Orthopedic Shoes, Appliances, and Prosthetic Devices**

Payment will be made to medical appliance and orthopedic shoe dealers for items on the written prescription of the practitioner. Several items of medical equipment require specific documentation from the practitioner to substantiate medical necessity before reimbursement can be made to the dealer for the items. (Diagnosis of flat feet is not acceptable.)

Payment will also be made to shoe repair shops performing modifications on orthopedic shoes when the practitioner prescribes such modifications in writing. The prescription must include:

- ◆ The member's diagnosis and prognosis (for custom-made shoes only).
- ◆ The reason the item is required.
- ◆ An estimate (in months) of the duration of the need.
- ◆ A specific description of any special features to be included (e.g., padding, wedging, metatarsal bars, build-up soles or heels).

Payment will be made to the practitioner for the examination, including required tests, to establish the need for orthopedic shoes. Tennis shoes are covered only when required for participation in school sport activities.

Medical supplies payable to a practitioner are limited to those incidents to a practitioner's service and for which the member cannot be expected to leave the practitioner's office and go to a supplier.

No payment will be approved for walkers, wheelchairs, special beds, or other sickroom equipment for members receiving care in a nursing facility.



9. Routine Physical Examination

A routine physical examination is one performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury.

a. Examination for Adults

Adult members may receive an annual preventative physical examination. This examination should be unrelated to a specific disease, injury, illness, or complaint. Use diagnosis code **V70.0** or **V70.9** consistent with the coding conventions described in the most current version of the International Classification of Diseases (ICD). Additional diagnoses can be listed as secondary.

To bill this service, bill the appropriate evaluation and management procedure code from CPT along with **V70.0** or **V70.9** primary diagnosis. All diagnosis pointers on the claim should point to the primary diagnosis.

Laboratory services are covered as appropriate for an initial preventative examination and should also be billed using V70.0 or V70.9 as the primary diagnosis. Additional treatment resulting from the annual examination (if necessary) should be billed with diagnosis codes appropriate for those conditions.

b. Examination for Children

Federal Medicaid requirements place special emphasis on early and periodic screening and diagnosis for children to ascertain physical and mental defects and provide treatment for conditions discovered. See [CONTENT OF WELL CHILD EXAMINATION](#) for more information.

When billing routine examinations for children:

- ◆ Use diagnosis code V20.2 for members aged 0-18.
- ◆ Use diagnosis code V70.5 for members aged 19 or 20.



10. Services of Auxiliary Personnel

Payment will be approved to the employing practitioner for services rendered by auxiliary personnel when:

- ◆ The services are performed incident to the ARNP's professional services; and
- ◆ The auxiliary personnel are employed by the ARNP and are working under the ARNP's direct personal supervision.

Auxiliary personnel of an ARNP could be nurses, other (employed) ARNPs, social workers, or other similar practitioners. An auxiliary person is considered an employee of the ARNP if the following conditions are met:

- ◆ The ARNP is able to control when, where, and how the work is done. This control need not actually be exercised by the ARNP.
- ◆ The ARNP sets work standards.
- ◆ The ARNP establishes job descriptions.
- ◆ The ARNP withholds taxes from the wages of the auxiliary personnel.

In the office, "direct personal supervision" means the employing ARNP must:

- ◆ Be present in the same office suite, not necessarily the same room, and
- ◆ Be available to provide immediate assistance and direction.

Outside the office, such as in a member's home, a hospital, an emergency room, or a nursing facility, "direct personal supervision" means the ARNP must be present in the same room as the auxiliary person.

NOTE: All types of ARNPs recognized by the Iowa Board of Nursing and certified as such under the Iowa law are exempt from the requirement for direct personal supervision.

Any ARNP who is employed by another ARNP and is rendering services independent of the employing ARNP may render service in the office setting, a hospital, or a nursing facility without supervision by the employing ARNP.

However, to the extent the employing ARNP has a supervisory relationship over the employed ARNP, the employing ARNP must still be available by telephone to provide supervision and direction as needed.



“Services incident to the professional service of the ARNP” means the service provided by the auxiliary person must be related to the ARNP’s professional service to the member. If the ARNP has not or will not perform a personal professional service to the member, the clinical records must document that the ARNP has assigned the member’s treatment to the auxiliary person.

Licensed dietitians employed by or under contract with ARNPs may provide nutritional counseling services to members aged 20 or under. Payment will be made to the employing ARNP.

In all cases, claims for services rendered by the employed auxiliary personnel incident to the employing ARNP’s professional service must be submitted in the name and under the provider number of the employing ARNP. Payment will be made to the employing ARNP.

11. Transportation to Receive Medical Care

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

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

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

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



C. SURGICAL PROCEDURES

1. Pre-Procedure Review

Surgical procedures affect health care expenditures significantly. To ensure that procedures are medically necessary, the IME Medical Services conducts a pre-procedure review program for the Medicaid program. This program entails reviewing selected high-quantity procedures when they are performed on an inpatient basis, in the outpatient unit of a hospital, or in a free-standing surgical unit.

Pre-procedure review is performed for all heart, lung, liver, stem cell, pancreas, and bone marrow transplants and for all bariatric procedures, as identified on the pre-procedure review list. Reviews are performed for members with traditional Medicaid and MediPASS coverage.

The following sections explain:

- ◆ [What procedures are reviewed](#)
- ◆ [How reviews are conducted](#)
- ◆ [What happens if the review is not obtained until after the member is discharged](#)

a. Procedures Subject to Review

The following is a list of the surgical procedures that are subject to pre-procedure review. Procedures for which approval must be obtained are listed with CPT and ICD-9 codes.

	Hospital Use Only: ICD-9	Physician and Ambulatory Surgical Center Use Only: CPT-4
Bone marrow transplant	41.00 41.01 41.02 41.03	38240 38241
Stem cell transplant	41.04 41.05 41.06 41.07 41.08 41.09	38240 38241



	Hospital Use Only: ICD-9	Physician and Ambulatory Surgical Center Use Only: CPT-4
Heart transplant	37.51	33945
Liver transplant auxiliary	50.51	47135
Other transplant of liver	50.59	47135 47136
Lung transplant:	33.50	32851
◆ Unilateral transplant	33.51	32852
◆ Bilateral transplant	33.52	32853 32854
Pancreas	52.80 52.82	48160 48554
Combined heart/lung	33.6	33935
Laparoscopic bariatric procedures	43.82 44.38 44.68 44.95	43644 43645 43770 43772 43773 43774 43775
Bariatric procedures, other than laparoscopic	43.89 44.31 44.39 44.69 45.51 45.91	43842 43843 43845 43846 43847
Bariatric procedures, revisions/removals	44.5 44.96 44.97 44.98	43771 43772 43774 43848 43860 43865 43886 43887 43888



b. Review Process

The following review process applies to all pre-procedure review activities. Pre-procedure review is conducted to evaluate the appropriateness of the procedures identified on the pre-procedure review list. Requests for review of these elective procedures must be submitted in writing to:

Iowa Medicaid Enterprise
Attn: Medical Prior Authorization
PO Box 36478
Des Moines, IA 50315

The request must provide the following information from the physician or ARNP, on which IME Medical Services will base its decision:

- ◆ Procedure planned
- ◆ Proposed admission date
- ◆ Proposed date of procedure
- ◆ Hospital or location of intended procedure
- ◆ Member's name and address
- ◆ Member's age
- ◆ Member's Medicaid identification number
- ◆ Attending physician's name
- ◆ Tentative diagnosis
- ◆ Orders
- ◆ History and chief complaint (include symptoms and duration of problem)
- ◆ Other medical history or problem
- ◆ Preadmission treatment
- ◆ Outpatient studies performed
- ◆ Medication

Pre-procedure review is conducted using criteria that have been developed by the applicable physician specialties. Questionable cases are referred to a physician reviewer for a determination of the medical necessity of the procedure. Denial letters are issued if the procedure is determined not to be medically necessary or other applicable coverage criteria are not met.



The IME provides validation numbers on all approved pre-procedure reviews. The validation number must be listed on the claim in the appropriate field. Claims sent to the IME without a validation prior authorization number will be denied. The hospital, physician, or ARNP must notify the IME and request a retrospective review to determine the appropriateness of the procedure before receiving payment.

A sample of cases reviewed on a pre-procedure basis is selected for retrospective review. The information provided during the pre-procedure review is validated during the retrospective review process. A denial may be issued if the information provided during precertification review is not supported by medical record documentation.

c. Procedure Review Obtained Following Discharge

If the provider discovers that pre-procedure review was not obtained with the IME before or immediately following the procedure and the member was discharged, the provider must request the IME review to determine the appropriateness of the procedure before receiving payment.

In addition, the hospital must send a copy of the complete medical record with the completed form to the IME for a retrospective review. Hospital staff is reminded to identify the type of procedure review that is being requested (e.g., gastric stapling review).

2. Anesthesia Services

Payment for the services of a qualified CRNA may be made:

- ◆ To the CRNA who furnishes anesthesia services or
- ◆ To a practitioner or group practice (anesthesiology) with which the CRNA has an employment or contractual relationship.

When a CRNA practices and bills independent of any affiliation with a physician or physician group, payment will be made for the full scope of Medicaid-reimbursable anesthesia services authorized for CRNAs by state law and regulations.

Note also specific conditions for CRNA services under sections [CONDITIONS OF PARTICIPATION](#) and [BASIS OF PAYMENT](#).



3. Abortion

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

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



a. *Certification Regarding Abortion, 470-0836*

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

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

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

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

All abortion claims must be billed with the appropriate ICD-9 diagnosis and procedure code indicating the abortion on the hospital claim and the appropriate ICD-9 diagnosis and CPT abortion procedure code on the practitioner claim.

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

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



b. Covered Services Associated with Non-Covered Abortions

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

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

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

c. Non-Covered Services

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

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



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

4. Hysterectomies

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

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

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

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

(Date)

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

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

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



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

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

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

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

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

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

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

5. Sterilizations

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

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

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



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

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

An “institutionalized” person is a person who is:

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

The same revision of federal regulations provide that payment may be made through the Medicaid program for the sterilization of a member aged 21 or over when the consent form is signed, who is mentally competent and not institutionalized in accordance with the above definitions under certain conditions.

a. Requirements

The following conditions must be met:

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

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



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

The informed consent shall not be obtained while the member to be sterilized is:

- In labor or childbirth,
- Seeking to obtain or obtaining an abortion, or
- Under the influence of alcohol or other substance that affects the member's state of awareness.

The elements of explanation which must be provided are:

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

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

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

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



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

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

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

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

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

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

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

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

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



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

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

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

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

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

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



D. CONTENT OF WELL CHILD EXAMINATION

A well child examination must include at least the following:

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

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



1. History and Guidance

a. Comprehensive Health and Developmental History

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

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

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

b. Developmental Screening

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

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



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

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

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

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

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

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



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

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

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

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

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

For further information on developmental screening, see:

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



c. Health Education/Anticipatory Guidance

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

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

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

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

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

Suggested Health Education Topics: Birth - 18 Months

Oral Health

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



Injury Prevention

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

Mental Health

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

Nutrition

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



Other Preventive Measures

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

Suggested Health Education Topics: 2 – 5 Years

Oral Health

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

Injury Prevention

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



Mental Health

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

Nutrition

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

Other Preventive Measures

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

Suggested Health Education Topics: 6 – 12 Years

Oral Health

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



Injury Prevention

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

Mental Health

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

Nutrition

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

Other Preventive Measures

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



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

Oral Health

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

Development

- ◆ Normal biopsychosocial changes of adolescence

Gender Specific Health

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

Health Member Issues

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



Injury Prevention

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

Nutrition

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

Personal Behavior and Relationships

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



Substance Use

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

Other Prevention Measures

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

d. Mental Health Assessment

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

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



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

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

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

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



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

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

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

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

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

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

2. Laboratory Tests

a. Cervical Papanicolaou (PAP) Smear

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

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

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

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



b. Chlamydia Test

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

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

c. Gonorrhea Test

Testing for gonorrhea may be done on persons with:

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

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

d. Hemoglobin and Hematocrit

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

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



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

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

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

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

Fifth Percent Criteria for Children

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

Female (non-pregnant)

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

Male

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

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



e. Hemoglobinopathy Screening

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

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

f. Lead Testing

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

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

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

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

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



g. Newborn Screening

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

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

h. Tuberculin Testing

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

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

3. Physical Examination

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

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



a. Blood Pressure

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

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

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

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

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

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

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

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



b. Growth Measurements

(1) Body Mass Index

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

1. Convert any fractions to decimals.

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

2. Insert the values into the formula:

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

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

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

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

(2) Height

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

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

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



(3) Plotting Measurements

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

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

Example:

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

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

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

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

Common errors result from:

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



(4) Recumbent Length

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

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

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

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

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

(6) Weight

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

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



c. Head Circumference

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

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

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

d. Oral Health Screening

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

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

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



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



4. Other Services

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

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

a. Immunization

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

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

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

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

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

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

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



Provide the recommended childhood immunization schedule for the United States for January-December of the current year. The recommended childhood and adolescent immunization schedule can be assessed on the following websites:

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

b. Hearing

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

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

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

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

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

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



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

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

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

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



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

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

c. **Nutritional Status**

To assess nutritional status, include:

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



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

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

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

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

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

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

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



d. Vision

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

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

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

E. BASIS OF PAYMENT

Payment is made directly to enrolled advanced registered nurse-practitioners practicing in a recognized specialty area. The basis of payment is a fixed fee. The lower of the billed charges or the fixed fee is paid.

The basis of payment for CRNA services is a fee schedule based on the HCPCS codes, with base units as established by the Centers for Medicare and Medicaid Services for the Medicare program.

For CRNAs who do not receive medical direction from an anesthesiologist, the CRNA services are reimbursed on the basis of 80 percent of the amount that would be payable to an anesthesiologist for the same surgical procedure. Use the modifier of QZ along with the appropriate anesthesia CPT code.

When the CRNA receives medical direction from an anesthesiologist who is not the CRNA's employer, reimbursement is made on the basis of 60 percent of the amount that would be payable to an anesthesiologist for the same surgical procedure. Use the modifier of QX along with the appropriate anesthesia CPT code.

When the CRNA is employed by the anesthesiologist, the anesthesiologist shall submit the claim under the anesthesiologist's provider number. The entire payment will be made to the anesthesiologist.



For medical direction to be reimbursable to the anesthesiologist, the anesthesiologist must be physically present in the operating suite. (Note the use of "operating suite" and not "operating room.")

Time is billed by minute. Please note the total number of minutes in field 24G on the CMS-1500 claim form.

F. PROCEDURE CODES AND NOMENCLATURE

Medicaid recognizes Medicare's National Level II Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes. However, all HCPCS and CPT codes are not covered.

Click [here](#) to view the fee schedule for ARNPs online.

Providers who do not have Internet access can obtain a copy upon request from the IME.

It is the provider's responsibility to select the code that best describes the item dispensed. Claims submitted without a procedure code will be denied. Refer coverage questions to the IME.

Iowa uses the HCFA Common Procedure Coding System (HCPCS). HCPCS codes are divided into three levels.

- ◆ Level 1 is the current CPT-4 codes.
- ◆ Level 2 codes are specifically designed regional five-digit codes beginning with letters A through V, approved by the federal Centers for Medicare and Medicaid Services.
- ◆ Level 3 codes are specifically designed local codes beginning with letters W through Z.

Note that most Level 3 codes (i.e. "local" codes) have been cross-walked to either CPT or Level 2 codes, pursuant to requirements of the Health Insurance Premium and Portability Act (HIPAA) of 1996. The only Level 3 "local" codes that now remain are those that would be considered an "atypical" service by CMS, whose standard for such is:

- ◆ Not rendered by a traditional health care provider,
- ◆ Not a typical health care service, and
- ◆ Not a service normally payable by other health insurance plans or programs.



Claims submitted without a procedure code and appropriate ICD-9-CM diagnosis code will be denied.

After consultation with the Board of Nursing and the professional organizations associated with advanced registered nurse practitioners, the Department has established advanced registered nurse practitioner payment provisions as follows:

Procedure Codes

Advanced registered nurse practitioners are able to bill for services with the appropriate procedure and diagnosis codes described above, consistent with their licensure, scope of practice, specialty area, and the service being rendered. CRNAs should use standard applicable CPT procedure codes for anesthesia procedures they perform.

G. BILLING POLICIES AND CLAIM FORM INSTRUCTIONS

Claims for Advanced Registered Nurse Practitioners are billed on federal form CMS-1500, *Health Insurance Claim Form*.

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

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

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

The Billing Manual can be located online at:

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