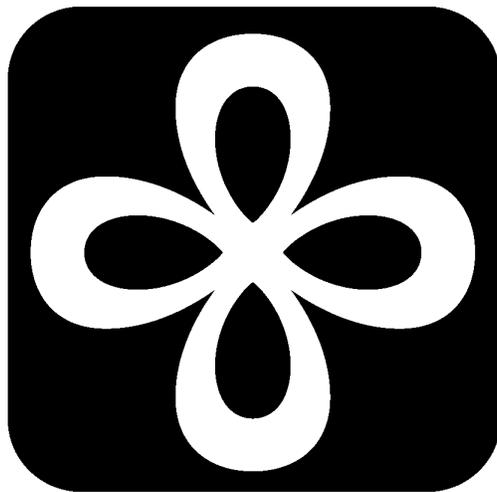


**STATE OF IOWA  
DEPARTMENT OF HUMAN SERVICES**

# **MEDICAID**



**Provider Manual**  
**Federally Qualified Health Center**



**CHAPTER E: COVERAGE AND LIMITATIONS**

Page

- I. ELIGIBILITY OF FEDERALLY QUALIFIED HEALTH CENTERS .....E-1
- II. COVERAGE OF SERVICES.....E-1
  - A. Physician Services .....E-1
  - B. Services of Other Practitioners .....E-2
    - 1. Physician Assistants and Nurse Practitioners .....E-2
    - 2. Psychologists and Social Workers .....E-3
  - C. Care for Kids Screening Examinations.....E-3
  - D. Immunizations.....E-7
  - E. Nutritional Counseling.....E-7
  - F. Family Planning Services .....E-8a
  - G. Obstetrical Services .....E-9
    - 1. Prenatal Risk Assessment .....E-9
    - 2. Facsimile of Form 470-2942, Medicaid Prenatal Risk Assessment ..E-10
    - 3. Enhanced Prenatal Services .....E-13
  - H. Surgery.....E-15
    - 1. Abortions.....E-15
    - 2. Sterilizations .....E-16e
    - 3. Hysterectomies.....E-16k
  - I. Transportation .....E-17
- III. CONTENT OF SCREENING EXAMINATION.....E-18
  - A. History and Guidance .....E-19
    - 1. Comprehensive Health and Developmental History.....E-19
    - 2. Developmental Screening .....E-20
    - 3. Mental Health Assessment.....E-21
    - 4. Health Education/Anticipatory Guidance .....E-26
  - B. Physical Examination.....E-31
    - 1. Growth Measurements .....E-32
    - 2. Head Circumference .....E-34
    - 3. Blood Pressure .....E-34
    - 4. Oral Health Screening.....E-41



	<u>Page</u>
C. Laboratory Tests .....	E-42
1. Hemoglobin and Hematocrit.....	E-42
2. Urinalysis .....	E-44
3. Metabolic Screening .....	E-44
4. Hemoglobinopathy Screening.....	E-44
5. Tuberculin Testing.....	E-45
6. Lead Testing.....	E-45
7. Cervical Papanicolaou (PAP) Smear .....	E-54
8. Gonorrhea Test.....	E-54
9. Chlamydia Test .....	E-54
D. Other Services .....	E-55
1. Immunization .....	E-55
2. Nutritional Status .....	E-61
3. Vision.....	E-65
4. Hearing.....	E-68
IV. BASIS OF PAYMENT FOR SERVICES .....	E-69
V. PROCEDURE CODES.....	E-71
A. Dental Services .....	E-71
B. EPSDT “Care for Kids Services” .....	E-72

**CHAPTER F: BILLING AND PAYMENT**

I. REQUEST FOR PRIOR AUTHORIZATION FORM AND INSTRUCTIONS.....	F-1
A. How to Use .....	F-1
B. Facsimile of Request for Prior Authorization.....	F-1
C. Instructions for Completing Request for Prior Authorization .....	F-1
D. Electronic Prior Authorization Requests .....	F-6b
II. INSTRUCTIONS AND CLAIM FORM.....	F-7
A. Instructions for Completing the Claim Form.....	F-7
B. Facsimile of Claim Form, HCFA-1500 (front and back) .....	F-14
C. Claim Attachment Control, Form 470-3969 .....	F-14
III. REMITTANCE ADVICE AND FIELD DESCRIPTIONS .....	F-17
A. Remittance Advice Explanation .....	F-17
B. Facsimile of Remittance Advice and Detailed Field Descriptions .....	F-18
C. Remittance Advice Field Descriptions .....	F-18



Iowa  
Department  
of  
Human  
Services

CHAPTER SUBJECT:

TABLE OF CONTENTS  
FEDERALLY QUALIFIED  
HEALTH CENTER

PAGE

6

DATE

November 1, 2001

Page

IV.	MANAGED CARE WRAPAROUND PAYMENT REQUEST, EXPLANATION AND INSTRUCTIONS.....	F-23
A.	How to Use .....	F-23
B.	Instructions for Completing Managed Care Wraparound Payment Request.....	F-23
C.	Facsimile of Managed Care Wraparound Payment Request .....	F-25
V.	PROBLEMS WITH SUBMITTED CLAIMS .....	F-28
A.	Facsimile of Provider Inquiry, 470-3744.....	F-28
B.	Facsimile of Credit/Adjustment Request, 470-0040.....	F-28

#### **APPENDIX**

I.	ADDRESSES OF COUNTY HUMAN SERVICES OFFICES .....	1
II.	ADDRESSES OF SOCIAL SECURITY ADMINISTRATION OFFICES.....	9
III.	ADDRESSES OF EPSDT CARE COORDINATION AGENCIES.....	13



## **I. ELIGIBILITY OF FEDERALLY QUALIFIED HEALTH CENTERS**

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

## **II. COVERAGE OF SERVICES**

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

Except for other ambulatory services, services must be within the Medicaid coverage limits for physician services. (Refer to the Physician Services Manual.)

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

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

### **A. Physician Services**

Services performed by a physician at the center are covered as federally qualified health center services. They are reimbursable only to the center.

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

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



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

- ◆ Of a type commonly furnished in a physician's office.
- ◆ Of a type commonly rendered either without charge or included in the federally qualified health center's bill.
- ◆ Furnished as an incidental although integral part of a physician's professional services.
- ◆ Furnished under the direct personal supervision of a physician.
- ◆ In the case of a service, furnished by a member of the center's health care staff who is an employee of the center.
- ◆ In the case of drugs and biologicals, furnished incident to the physician's professional service and not able to be self-administered.

## **B. Services of Other Practitioners**

### **1. Physician Assistants and Nurse Practitioners**

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

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

Essentially, the services must be of a type that:

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



2. Psychologists and Social Workers

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

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

C. Care for Kids Screening Examinations

Federally qualified health center services will be paid for health screening examinations for Medicaid-eligible persons under 21 years of age.

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

<u>Child's Age</u>	<u>Number of Screenings Recommended</u>	<u>Recommended Ages for Screening</u>
0 to 12 months	7	2-3 days,* 1, 2, 4, 6, 9, and 12 months
13 months to 24 months	3	15, 18, and 24 months
3 years to 6 years	4	3, 4, 5, and 6 years
7 years to 20 years	7	8, 10, 12, 14, 16, 18, and 20 years

\* For newborns discharged in 24 hours or less after delivery.

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

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



Iowa  
Department  
of  
Human  
Services

CHAPTER SUBJECT:

COVERAGE AND LIMITATIONS

FEDERALLY QUALIFIED  
HEALTH CENTER

CHAPTER PAGE

E - 4

DATE

August 1, 1995

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

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



Iowa  
Department  
of  
Human  
Services

CHAPTER SUBJECT:

COVERAGE AND LIMITATIONS

FEDERALLY QUALIFIED  
HEALTH CENTER

CHAPTER PAGE

E - 5

DATE

January 1, 1997

## SCREENING COMPONENTS BY AGE

Age	<u>Infancy</u>							<u>Early Childhood</u>					<u>Late Childhood</u>					<u>Adolescence</u>				
	2-3 1 day s	by 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	2 yr	3 yr	4 yr	5 yr	6 yr	8 yr	10 yr	12 yr	14 yr	16 yr	18 yr	20+ yr	
<b>HISTORY</b> Initial/Internal																						
<b>PHYSICAL EXAM</b>																						
<b>MEASUREMENTS</b> Height/Weight Head Circumference Blood Pressure																						
<b>NUTRITION ASSESS/EDUCATION</b>																						
<b>ORAL HEALTH <sup>2</sup></b> Oral Health Assessment Dental Referral																						
<b>SENSORY SCREENING</b> Vision Hearing	S O	S S	S S	S S	S S	S S	S S	S S	S S	S S	S S	O O	O O	O S	O S	S O	O O	O S	S S	O O	O S	
<b>DEVELOPMENTAL AND BEHAVIORAL ASSESSMENT <sup>3</sup></b>																						
<b>IMMUNIZATION <sup>4</sup></b>												★					★					
<b>PROCEDURES</b> Hgb/Hct Urinalysis Metabolic screening <sup>5</sup>																						

**KEY:** ★ To be performed  
S Subjective, by history

★ Perform test once during indicated time period  
O Objective, by a standard testing method

*Continued on next page.*



<b>HEMOGLOBINOPATHY</b>	Only once (newborn screen) and offered to adolescents at risk.
<b>TUBERCULIN TEST</b>	For high-risk groups, annual testing is recommended. These are household members of persons with tuberculosis or others at risk for close contact with the disease: recent immigrants or refugees from countries in which tuberculosis is common (e.g., Asia, Africa, Central and South America, Pacific islands); migrant workers; residents of correctional institutions or homeless shelters; or persons with certain underlying medical disorders.
<b>LEAD</b>	Starting at 12 months, assess risk for high dose exposure.
<b>GYNECOLOGIC TESTING</b>	Pap smear for females who are sexually active or (if the sexual history is thought to be unreliable) age 18 or older. Pregnancy testing should be done when indicated by the history.
<b>STD</b>	When appropriate. (People with a history and risk factors for sexually transmitted diseases should be tested for chlamydia and gonorrhea.)
<b>ANTICIPATORY GUIDANCE</b>	Performed every visit.

- <sup>1</sup> For newborns discharged in 24 hours or less after delivery.
- <sup>2</sup> The oral health assessment should include dental history, recent problems, pain, or injury and visual inspection of the oral cavity. Referral to a dentist should be at 12 months, 24 months, and then every 6 months, unless more frequent dental visits are recommended.
- <sup>3</sup> By history and appropriate physical examination, if suspicious, by specific objective developmental testing.
- <sup>4</sup> An immunization review should be performed at each screening, with immunizations being administered at appropriate ages, or as needed.
- <sup>5</sup> The Iowa Newborn Screening program tests every baby born in Iowa for the following disorders: hypothyroidism, galactosemia, phenylketonuria, hemoglobinopathies, and congenital adrenal hyperplasia.



## D. Immunizations

Pneumococcal and influenza vaccines and their administration are covered.

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

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

## E. Nutritional Counseling

Nutritional counseling services provided by licensed dietitians for recipients age 20 and under are covered when a nutritional problem or condition of such severity exists that nutritional counseling beyond that normally expected as part of the standard medical management is warranted.



Medical conditions that may be appropriate for nutritional counseling include the following:

- ◆ Inadequate or excessive growth. Examples include failure to thrive, undesired weight loss, underweight, major changes in weight-to-height percentile or BMI-for-age.
- ◆ Inadequate dietary intake. Examples include formula intolerance, food allergy, limited variety of foods, limited food resources, poor appetite.
- ◆ Infant feeding problems. Examples include poor suck/swallow, breastfeeding difficulties, lack of developmental feeding progress, inappropriate kinds or amounts of feeding offered, limited information and/or skills of caregiver.
- ◆ Chronic disease requiring nutritional intervention. Examples include congenital heart disease, pulmonary disease, renal disease, cystic fibrosis, metabolic disorder, gastrointestinal disease.
- ◆ Medical conditions requiring nutritional intervention. Examples include iron deficiency anemia, high serum lead level, familial hyperlipidemia, hyperlipidemia, pregnancy.
- ◆ Developmental disability. Examples include increased risk of altered energy and nutrient needs, oral-motor or behavioral feeding difficulties, medication-nutrient interaction, tube feedings.
- ◆ Psychosocial factors. Examples include behaviors suggesting an eating disorder.

This is not an all-inclusive list. Other diagnosis may be appropriate.



Iowa  
Department  
of  
Human  
Services

CHAPTER SUBJECT:

COVERAGE AND LIMITATIONS

FEDERALLY QUALIFIED  
HEALTH CENTER

CHAPTER PAGE

E - 8a

DATE

July 1, 2003

## **F. Family Planning Services**

Family planning services include the following:

- ◆ Examination and tests which are necessary before prescribing family planning services. (Please indicate in the description area of the claim form the service that is related to family planning.)
- ◆ Contraceptive services.
- ◆ Supplies for family planning, including such items as 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 the modifier "FP" after the procedure code.



## G. Obstetrical Services

All Medicaid-eligible pregnant women must have a determination of risk using form 470-2942, *Medicaid Prenatal Risk Assessment*, upon entry into care. When a low-risk pregnancy is reflected, complete a second determination at approximately 28 weeks of care, or when there is an increase in the pregnant woman's risk status.

When a high-risk pregnancy is reflected, inform the woman and provide a referral for enhanced services. See below for a definition of enhanced services and the referral process. Give a copy of the *Medicaid Prenatal Risk Assessment* to the enhanced services agency. Keep a copy in the patient's medical records.

### 1. Prenatal Risk Assessment

Form 470-2942, *Medicaid Prenatal Risk Assessment*, was developed jointly by the Iowa Departments of Human Services and Public Health. It was designed to help the clinician determine which pregnant clients are in need of supplementary services to complement and support routine medical prenatal care.

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 enhanced services along with medical prenatal care have better birth outcomes. This package of services is aimed at promoting better birth outcomes for Medicaid-eligible pregnant women in Iowa.

It is expected that the primary medical care provider will continue to provide the medical care. Maternal health centers that provide enhanced services work with clinicians to provide enhanced services for higher risk pregnant women. This process allows patients who are determined high-risk to access additional services that Medicaid does not provide under other circumstances.



The left side of the *Medicaid Prenatal Risk Assessment* includes risk factors relating to medical, historical, environmental, or situational factors. A description of many of these factors is included on the back of the form. The factors are categorized and the score value is related to the seriousness of the risk (for example, age, education, and prepregnancy weight).

You may determine that the value assigned on the form is not appropriate for this patient and may choose a lesser value.

Give cigarette smoking 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 birth within one year,” when the patient has been pregnant within one year of the beginning of the present pregnancy.

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

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

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

## 2. Facsimile of Form 470-2942, Medicaid Prenatal Risk Assessment

See the following pages for a facsimile of form 470-2942.



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

Nutritional Risk Factor Assessment and Definitions	
<b>Instructions:</b> Check nutrition counseling if any of the factors below indicate nutritional risk.	
<b>Anemia:</b> Hematocrit is < 31 or hemoglobin is < 11.	
<b>Inadequate Food Intake:</b> Determine nutritional risk by diet history (foods typically eaten in a day). Use this risk factor if deficient in two or more groups.	
<u>Food Group</u>	<u>Number Servings Recommended</u>
<b>Milk:</b> (includes milk, cheese, yogurt, cottage cheese, etc.)	3
<b>Meat or Alternates:</b> (includes meats, fish, poultry, eggs, nuts, legumes, peanut butter, etc.)	2-3 (total of 6 oz. per day)
<b>Breads and Cereals:</b> (includes breads, cereal, pasta, rice, etc.)	6-11
<b>Vegetables:</b> (includes broccoli, tomatoes, cabbage, baked potato, carrots, squash, sweet potato, etc.) For <b>Vitamin A</b> include dark green and yellow vegetables.	3-5
<b>Fruits:</b> (includes oranges, grapefruits, melons, berries, apples, grapes, etc.) For <b>Vitamin C</b> include citrus fruit and juices.	2-4

Examples of additional risk factors:	
Medical	<ul style="list-style-type: none"> <li>◆ Thyroid disease</li> <li>◆ Type I diabetes</li> <li>◆ Renal disease</li> <li>◆ Heart disease</li> <li>◆ Diabetes</li> <li>◆ HIV</li> <li>◆ Autoimmune disease</li> <li>◆ Seizure disorders</li> <li>◆ Gestational diabetes</li> <li>◆ Psychiatric disorder</li> </ul>
OB History	<ul style="list-style-type: none"> <li>◆ Infertility</li> <li>◆ Perinatal loss</li> <li>◆ Caesarean section</li> </ul>
Nutrition	<ul style="list-style-type: none"> <li>◆ Diet deficient in two or more food groups</li> <li>◆ Vegan diet (consumes <b>only</b> fruits, vegetables and grains)</li> <li>◆ Pica</li> <li>◆ Current eating disorder</li> <li>◆ Hyperemesis</li> <li>◆ Food faddism</li> <li>◆ Excessive use of supplements</li> </ul>
Psychosocial	<ul style="list-style-type: none"> <li>◆ Teen pregnancy</li> <li>◆ Ambivalent, denying, or rejecting of this pregnancy</li> <li>◆ Not compliant with healthy pregnancy behaviors (or not expected to be compliant without additional intervention)</li> <li>◆ Cultural or language barriers</li> <li>◆ History of mental illness</li> </ul>



### 3. **Enhanced Prenatal Services**

The primary medical care provider will continue to provide the medical care. Maternal health centers that provide enhanced services work with clinicians to provide enhanced services for higher risk pregnant women. This process allows patients who are determined high risk to access additional services that Medicaid does not provide under other circumstances.

Enhanced services include health education nutrition counseling, social services, care coordination, and one postpartum home visit. Enhanced services may be provided by bachelor-degree nutritionists, bachelor-degree social workers, physicians, and registered nurses. Maternal health centers are one provider of enhanced services. Enhanced services are as follows:

#### a. **Care Coordination**

The coordination of comprehensive prenatal services shall be provided by a registered nurse or social worker. It shall include:

- ◆ Developing an individual plan of care based on client's needs.
- ◆ Ensuring that the client receives all components as appropriate: medical, education, nutrition, psychosocial, and postpartum home visit.
- ◆ Risk tracking.

#### b. **Education**

Education services shall be provided by a registered nurse. Education shall include as appropriate, education about:



- ◆ High-risk medical conditions:
  - Related to pregnancy, including PIH, preterm labor, vaginal bleeding, diabetes (gestational and regular), chronic urinary conditions, and genetic disorders.
  - Chronic medical conditions, such as diabetes, epilepsy, cardiac disease, sickle-cell disease, and hypertension.
  - Other medical conditions, such as HIV, hepatitis, and STDs.
  - High-risk sexual behavior.
  - Smoking cessation.
  - Alcohol usage.
  - Drug usage.
  - Environmental and occupational hazards.

Education services may include referral to psychosocial services for high-risk parenting issues, high-risk home situations, stress management, communication skills and resources, and self-esteem.

**c. Nutrition**

Nutrition services shall be provided by a licensed dietitian. Nutrition assessment and counseling shall include:

- ◆ Initial assessment of nutritional risk based on height, current and prepregnancy weight status, laboratory data, clinical data, and self-reported dietary information.
- ◆ Ongoing nutritional assessment (at least once every trimester) 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 intervention:
  - 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 to her.
  - Infant nutritional needs and feeding practices.

**d. Psychosocial Services**

Psychosocial services shall be provided by a social worker. Psychosocial assessment and counseling shall include:

- ◆ A psychosocial assessment including a needs assessment, a profile of client demographic factors, mental and physical health history and concerns, adjustment to pregnancy and future parenting, and environmental needs.
- ◆ A profile of the client's family composition, patterns of functioning and support system.
- ◆ An assessment-based plan of care, risk tracking, counseling and anticipatory guidance as appropriate, and referral and follow-up services.



**e. Postpartum Home Visit**

A follow-up home visit shall be done ideally the first week postpartum, but no later than two weeks postpartum. It should be provided by a registered nurse and shall include:

- ◆ Assessment of mother's health status.
- ◆ Physical and emotional changes postpartum, such as relationships, sexual changes, additional stress, nutritional needs, and physical activity.
- ◆ Family planning.
- ◆ Parenting skills, such as nurturing, meeting infant needs, and bonding.
- ◆ Assessment of infant health.
- ◆ Infant care, including:
  - Feeding and nutritional needs,
  - Breast feeding support,
  - Recognition of illness,
  - Accident prevention, and
  - Immunizations and well child care.
- ◆ Grief support for unhealthy outcome.
- ◆ Parenting a sick or preterm infant.
- ◆ Identification and referral to community resources as needed.



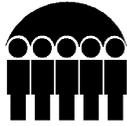
## H. Surgery

### 1. Abortions

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 the fetus is physically deformed, mentally deficient, or afflicted with a congenital illness and states the medical indications for determining the fetal condition.
- ◆ The attending physician certifies in writing on the basis of professional judgment that the life of the pregnant woman would be endangered if the fetus was carried to term.
- ◆ An official of a law enforcement agency or public or private health agency (which may include a family physician), certifies in writing that:
  - The pregnancy is the result of rape that was reported to the agency within 45 days of the date of the incident, and
  - The report contains the name, address, and signature of the person making it.
- ◆ An official of a law enforcement agency or public or private health agency (which may include a family physician) certifies in writing that:
  - The pregnancy resulted from incest that was reported to the agency within 150 days of the incident, and
  - The report contains the name, address, and signature of the person making it.
- ◆ Treatment is required for a spontaneous abortion or miscarriage where all the products of conception are not expelled.

Federal funding is available to terminate a pregnancy that was the result of rape or incest. Federal funding is also available if the woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed.



A copy of form 470-0836, *Certification Regarding Abortion*, must be attached to the physician's claim if payment is to be made for an abortion. (See Item H.1.d for more information.) Documentation identifying the reason for the abortion must also be attached to the claim. This includes, but is not limited to:

- ◆ The operative report,
- ◆ Pathology report,
- ◆ Lab reports,
- ◆ Ultrasound report,
- ◆ Physician's progress notes, and
- ◆ Other documents that support the diagnosis identified on the claim.

All abortion claims must be billed with the appropriate ICD-9 abortion diagnosis and CPT abortion procedure code on the HCFA 1500 claim.

**a. Coverage of Mifepristone (Mifeprex or RU-486)**

Mifepristone, when used in combination with Misoprostol, is used to terminate a pregnancy. All of the stated criteria for coverage of abortions apply to the use of Mifepristone (Mifeprex or RU-486). This includes the coverage criteria, form 470-0836, and medical records.

**b. Covered Services Associated With Noncovered 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 patient, 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:

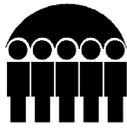
- Services following a septic abortion.
- A hospital stay beyond the normal length of stay for abortions.

**Note:** Family planning or sterilization must not be billed on the same claim with an abortion service. Bill these services separately from the abortion claim.

**c. Noncovered 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, and
  - Charges associated with routine, uncomplicated preoperative and postoperative visits by the patient.
- ◆ Physician and CRNA charges for administering the anesthesia necessary to induce or perform an abortion.
- ◆ Drug charges for medication usually provided to or prescribed for the patient who undergoes an uncomplicated abortion. This includes:
  - Routinely provided oral analgesics, and
  - Antibiotics to prevent septic complication of abortion and Rho-GAM (an immune globulin administered to RH negative women who have an abortion).



- ◆ Charges for other laboratory tests performed before performing the noncovered abortion to determine the anesthetic or surgical risk of the patient (e.g., CBC, electrolytes, blood typing).
- ◆ Charges for histo-pathological tests performed routinely on the extracted fetus or abortion contents.
- ◆ Charges for uterine ultrasounds performed immediately following an abortion.

**d. Certification Regarding Abortion, 470-0836**

Payment cannot be made either to the attending physician, to other physicians assisting in the abortion, to the anesthetist, or to the hospital or ambulatory surgical center if form 470-0836, *Certification Regarding Abortion*, is not submitted with the claim for payment.

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

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 recipient, 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.

See the following pages for a facsimile of form 470-0836.



Iowa Department of Human Services

## Certification Regarding Abortion

### CERTIFY TO ONE OF THE FOLLOWING:

I certify that on the basis of my professional judgment:

**Life of the Mother.**

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

**Fetus Deformed.** The fetus carried by

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

\_\_\_\_\_  
 (Medical indications)

**Rape**

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

**Incest**

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

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

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

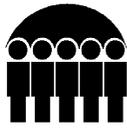
## Conditions for Medicaid Payment for Abortions

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

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

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

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



## 2. Sterilizations

“Sterilization” means any medical procedure, treatment, or operation for the purpose of rendering a person 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 genitourinary tract. For purpose of this definition, mental illness or retardation is not considered an illness or injury.

Payment shall not be made through the Medicaid Program for sterilization of a person who is under 21 at the time of consent or who is legally mentally incompetent or institutionalized.

A “legally mentally incompetent person” is a person 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.

Please note: Reversal of sterilization is not a covered Medicaid service.

### a. Conditions

Medicaid payment may be made for the sterilization of a person when the following conditions are met:

- ◆ The person to be sterilized must voluntarily request the service.
- ◆ A knowledgeable informant must give the person to be sterilized an explanation of the procedures to be performed, upon which the person can base the consent for sterilization.



- ◆ An “informed consent” is required. The person must be age 21 or over when the consent form is signed. The person must be mentally competent and noninstitutionalized in accordance with the above definitions.
- ◆ The person to be sterilized must be advised that the person is free to withhold or withdraw consent to the procedure at any time before the sterilization without prejudicing future care or loss of other program benefits to which the person might otherwise be entitled.

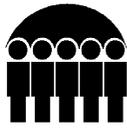
**b. Informed Consent**

“Informed consent” means the voluntary knowing assent from the person to be sterilized; after the person has been given a complete explanation of what is involved and has signed a written document to that effect.

The “informed consent” shall be obtained on form 470-0835 or 470-0835S, *Consent Form*. If the person is blind, deaf, or does not understand the language used to provide the explanation, an interpreter must be provided. The person may be accompanied by a witness of the person’s choice.

The informed consent shall not be obtained while the person is in labor or childbirth, seeking to obtain or obtaining an abortion, or under the influence of alcohol or other substance that affects the person’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 appropriate 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. (Reversal of sterilization is not a covered Medicaid service.)
- ◆ An offer to answer any inquires concerning the proposed procedures.



**c. Time Frame**

The “informed consent” must be obtained at least 30 days but not more than 180 days before the sterilization is performed, except when emergency abdominal surgery or premature delivery occurs. When emergency abdominal surgery occurs, at least 72 hours must have elapsed after the consent form was obtained for the exception to be approved. When a premature delivery occurs, at least 72 hours must have elapsed after the informed consent was obtained, and the documentation must also indicate that the expected delivery date was at least 30 days after the informed consent was signed for the exception to be approved. The patient must be 21 years of age or older at the time of consent.

**d. Consent Form, 470-0835 and 470-0835S**

The physician’s copy of the *Consent Form*, 470-0835 or 470-0835S, must be completely executed in all aspects according to the above directions and attached to the claim in order to receive payment. No substitute form is accepted. A claim for physician’s services for sterilization may be denied, due to either failure to have the consent form signed at least 30 days but not more than 180 days before service is provided or failure to use the official *Consent Form*, 470-0835 or 470-0835S. If so, any claim submitted by the hospital, anesthesiologists, assistant surgeon or associated providers for the same procedure will also be denied. The hospital and other providers associated with the sterilization services must obtain a photocopy of the complete consent form, and attach it to their claim when submitted to the fiscal agent for payment.

All names, signatures and dates on the *Consent Form*, 470-0835 or 470-0835S, 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 patient to be sterilized. Also, the information requested pertaining to race and ethnicity may be supplied voluntarily on the part of the patient, but is not required.



It is the responsibility of the person obtaining the consent form to verify that the patient requesting the sterilization is at least 21 years of age on the date that the patient signs the form. If there is any question pertaining to the true age of the patient, the 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 patient.

The "Physician's Statement" must be completed fully and signed by the PHYSICIAN PERFORMING THE STERILIZATION and dated when signed. One of the paragraphs at the bottom of this statement must be crossed out. Be sure to cross out the paragraph that does not apply to the situation. If paragraph two is appropriate, indicate the expected date of delivery and circumstances involving emergency abdominal surgery.

Since the physician performing the sterilization will be the last person to sign the consent form, the physician should provide a photocopy of the fully completed consent form to every other Medicaid provider involved in the sterilization that will submit a claim, e.g., hospital, anesthetist, assistant surgeon, etc. The only signatures which should be on the completed consent form are those of the patient, the interpreter, if interpretation services were provided, the person obtaining the consent and the physician performing the sterilization.

A supply of the form may be obtained from the fiscal agent on request.

**e. Facsimile of 470-0835 and 470-0835S, Consent Form**

# CONSENT FOR STERILIZATION

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

## CONSENT TO STERILIZATION

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

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

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

I understand that I will be sterilized by an operation known as a \_\_\_\_\_ . The discomforts, risks, and benefits with the operation have been explained to me. All my questions have been answered to my satisfaction.

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

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

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

My consent expires 180 days from the date of my signature below. I also consent to the release of this form and other medical records about the operation to:

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

I have received a copy of this form.

Signature	Month	Day	Year
-----------	-------	-----	------

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

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

## INTERPRETER'S STATEMENT

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

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

Interpreter	Date
-------------	------

## STATEMENT OF PERSON OBTAINING CONSENT

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

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

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

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

Signature of person obtaining consent	Date
Facility	
Address	

## PHYSICIAN'S STATEMENT

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

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

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

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

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

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

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

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

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

- Premature delivery; person's expected date of delivery \_\_\_\_\_
- Emergency abdominal surgery: (describe circumstances): \_\_\_\_\_

Physician	Date
-----------	------

## FORMULARIO DE CONSENTIMIENTO REQUERIDO

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

### CONSENTIMIENTO PARA LA ESTERILIZACIÓN

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

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

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

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

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

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

Tengo por lo menos 21 años de edad y nací el \_\_\_\_\_ día  
\_\_\_\_\_ mes \_\_\_\_\_ año

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

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

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

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

He recibido una copia de este formulario.

firma	mes	día	año
-------	-----	-----	-----

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

#### Raza y Designación Étnica (haga una marca):

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

### DECLARACION DEL INTERPRETE

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

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

Según mi mejor entender esta persona ha comprendido esta explicación.

intérprete	fecha
------------	-------

### DECLARACION DE LA PERSONA QUE OBTIENE ESTE CONSENTIMIENTO

Antes de que \_\_\_\_\_ firmara este  
\_\_\_\_\_ nombre de la persona

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

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

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

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

firma de la persona que obtiene el consentimiento	fecha
establecimiento	
dirección	

### DECLARACION DEL MEDICO

Poco antes de efectuar la operación para la esterilización de \_\_\_\_\_ el \_\_\_\_\_

\_\_\_\_\_ nombre de la persona a ser esterilizada \_\_\_\_\_ fecha de la operación  
le expliqué la naturaleza de la operación llamada \_\_\_\_\_  
\_\_\_\_\_ tipo de operación

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

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

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

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

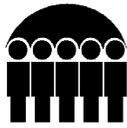
**(Instrucciones para el uso de párrafos finales alternos:** Utilice el primer párrafo que sigue, excepto en casos de parto prematuro o cirugía abdominal de emergencia, en que la esterilización se efectúa menos de 30 días después de la fecha de la firma del formulario de consentimiento. En dichos casos,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

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

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

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

médico	fecha
--------	-------



### 3. Hysterectomies

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

- ◆ The patient or representative has signed an acknowledgment that she has been informed orally and in writing that the hysterectomy will make the patient permanently incapable of reproducing. The vehicle for transmitting the acknowledge that the patient received the explanation before the surgery should not be the *Consent Form*, 470-0835 or 470-0835S.

The statement must be signed by the patient or representative and must be submitted with the claim for Medicaid payment. 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 Patient or Person Acting on Her Behalf)”*

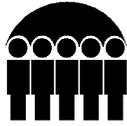
This statement may be added to either the surgery consent form, the claim form, or on a separate sheet of paper, so that the statement can be submitted to the fiscal agent with the related claims.

- ◆ The patient was already sterile before the hysterectomy. The physician must certify in writing that the patient was already sterile at the time of the hysterectomy and has stated 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, the claim form, or on a separate sheet of paper, so that the statement is submitted to the fiscal agent with the related claims.

Any statement or documentation stating the cause of sterility must be signed and dated by a physician. This includes history and physical, operative reports, or claim forms.

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

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

Where the patient is about to undergo abdominal exploratory surgery or a biopsy, and removal of the uterus is a potential consequence of the surgery, the patient should be informed of this possibility and given an opportunity to acknowledge in writing the receipt of this information.

Copies of the statement or documentation required above to determine the medical necessity of the hysterectomy shall be made available for every other Medicaid provider involved that will submit a claim, e.g., hospital, anesthetist, assistant surgeon.



## I. Transportation

To help ensure that recipients have access to medical care within the scope of the program, the Department reimburses recipients under certain conditions for transportation to receive necessary medical care.

Except for “Care for Kids” services, payment is limited to situations when it is necessary for the recipient to travel outside the community to receive needed medical care or, when the recipient lives in a rural area, to travel to the nearest community to receive care.

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

Payment in all situations is limited to the nearest source of adequate and appropriate care. The recipient is reimbursed only for the distance to the nearest doctor, dentist, etc., who can provide the necessary service.

If you refer a Medicaid recipient to a specialist or a hospital in another community, the same policy applies. The recipient will be reimbursed by the Department only for the distance to the nearest available specialist or hospital, unless the attending physician indicates that, in view of the diagnosis and condition of the recipient, a more distant specialist or hospital is the only appropriate source of care.

When there is a nearer specialist of the same type or a nearer hospital, the county office may be contacting you to verify the necessity of referral to the more distant physician or hospital, in order to document the necessity of reimbursing the recipient for the greater distance.

Under the EPSDT “Care for Kids” program, local transportation is available for screening, diagnosis, or treatment. If a recipient is in need of this service, contact the designated DPH agency for assistance. See appendix for list of designated agencies.



CHAPTER SUBJECT:

COVERAGE AND LIMITATIONS

FEDERALLY QUALIFIED  
HEALTH CENTER

CHAPTER PAGE

E - 18

DATE

July 1, 2003

### III. CONTENT OF SCREENING EXAMINATION

A screening examination must include at least the following:

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



## A. History and Guidance

### 1. Comprehensive Health and Developmental History

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

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

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



## 2. Developmental Screening

The primary purpose of screening data is to identify children who need more in-depth evaluation. The developmental component for young children should include the following four areas:

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

In screening children from birth to six years of age, it is recommended that you select recognized instruments, such as the Denver II, that have written standardized procedures for administration, scoring, and interpretation. Criteria for referral vary with the instrument or procedures used.

As the child grows through school age, focus on visual-motor integration, visual-social organization, visual sequential memory, attention skills, auditory processing skills, and auditory sequential memory.

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

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

- ◆ Collect information on the child's or adolescent's usual functioning, as reported by the child, parents, teacher, health professional, or other familiar person.



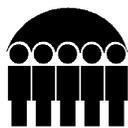
- ◆ In developmental screening, incorporate and review this information in conjunction with other information gathered during the physical exam. Make an objective professional judgment as to whether the child is within the expected ranges. Review the developmental progress of a child not in an isolated context, but 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 ground of 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 is needed. Results of initial screening should not be accepted as conclusions and do not represent diagnosis.

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

### 3. **Mental Health Assessment**

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

- ◆ The patient's life-style, home situation, and "significant others."
- ◆ A typical day--how the patient 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 patient'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 somnambulizing.



Iowa  
Department  
of  
Human  
Services

CHAPTER SUBJECT:

COVERAGE AND LIMITATIONS

FEDERALLY QUALIFIED  
HEALTH CENTER

CHAPTER PAGE

E - 22

DATE

August 1, 1995

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

Source: Boyle Jr., W.E. and Hoekelman, R.A. The Pediatric History, In Hoekelman, R.A. ed. *Primary Pediatric Care*, Second Edition, 1992.

Form 470-3165, *Child Mental Health Screen*, is a tool has been developed for use in the Iowa EPSDT program. A facsimile follows. Use of this form is optional. Create supplies as needed from the sample in the manual.

## Iowa Department of Human Services

**CHILD MENTAL HEALTH SCREEN**

[This form is for screening purposes only. It is not to be used for diagnosis.]

Child's Name	Date	Birth Date	Medicaid No.
Medicaid Provider Agency:			

Source of Information:     Family Interview             Child Interview             Case Review

Begin with the child's current age. Check "YES" or "NO" for each question or if information is not available, leave blank. Continue with the questions in the earlier age groups to determine whether any of the items occurred during that specific age range. For example, if you are screening a 9-year old, begin with Age Group 6-10 and answer all of the questions. If the child has not been sexually abused between the ages of 6 and 10, check "NO." Move to Age Group 0-5. You are told the child was sexually abused at age 4. Mark "YES" for sexual abuse occurring during this age range. There is a section for "OTHER CONCERNS" on page 3.

<i>Age 17 to 21</i>	<i>Yes</i>	<i>No</i>
1. Has had poor performance in school or at work		
2. Has frequent mood swings or confused thoughts		
3. Has attempted to hurt self		
4. Has been assaultive to others		
5. Has had unwed pregnancy		
6. Has been referred to criminal justice system		
7. Has had problems with alcohol and/or other drugs		
8. In danger of placement or already placed out of home		

<i>Age 11 to 16</i>	<i>Yes</i>	<i>No</i>
1. Has difficulties in school (attendance, concentration, or discipline problems)		
2. Has frequent mood swings or confused thoughts		
3. Has attempted to hurt self		
4. Has been assaultive to others		
5. Has had unwed pregnancy		
6. Has been referred to juvenile court		
7. Has had problems with alcohol and/or other drugs		
8. In danger of placement or already placed out of home		

<b><i>Age 6 to 10</i></b>	<b><i>Yes</i></b>	<b><i>No</i></b>
1. Has difficulties in school (attendance, concentration, or discipline problems)		
2. Frequently withdrawn or noncommunicative		
3. Has frequent and uncontrollable temper tantrums		
4. Expresses feelings of sadness and wanting to hurt self		
5. Assaultive to people or deliberately cruel to animals		
6. Has used alcohol and/or other drugs		
7. Has been physically or sexually abused or has abused others		
8. In danger of placement or already placed out of home		

<b><i>Age 0 to 5</i></b>	<b><i>Yes</i></b>	<b><i>No</i></b>
1. Poor appetite or overeating		
2. Restless sleeper (awake all night or having nightmares)		
3. Hyperactive, easily distracted, short attention span		
4. Sets fires		
5. Has major physical or developmental problems		
6. Any aggressive behaviors unusual for his/her age		
7. Has been physically or sexually abused		
8. In danger of placement or already placed out of home		

<b><i>For All Age Groups</i></b>	<b><i>Yes</i></b>	<b><i>No</i></b>
1. Has family or friends available or willing to help in case of emergency		
2. Family has coped well with the child's problems		
3. Child has coped well with major traumas (divorce, death, etc.)		
4. Has sought professional help in the past		

Any other concerns not noted above?

### CONCLUSIONS OF SCREENING

The frequency and severity of the problem and the screener's professional judgment and knowledge of the child and family should be the basis for determining whether the suspected problem requires a referral for assessment.

In your opinion, does the child need a mental health referral?  YES  NO

Is this an emergency referral?  YES  NO

Has the family or child agreed to a mental health referral for assessment?  YES  NO

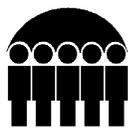
Recommendation for Client:

*Name of Agency*

*Date of Referral*

*Signature and Title of the Person Completing the Form*

[The information on this form cannot be disclosed without the permission of the client.]



#### 4. Health Education/Anticipatory Guidance

Health education which 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, 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 *1994 Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, Arlington, VA. This publication is available from the National Center for Education in Maternal and Child Health (703) 821-8955, ext. 254 or 265.

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



**Suggested Health Education Topics: Birth - 18 Months**

<b><i>Dental Health</i></b>	
Breast or bottle feeding discontinued at 12 months	Teething
Education on fluorides and supplements	Thumb or finger sucking
Infant oral care	Toothbrushing
Nursing bottle mouth	First dental visit
Pacifiers	Use of cup
<b><i>Injury Prevention</i></b>	
Child care options while parents farm	Lock up farm chemicals
Child safety seat restraint	Restricted play areas on the farm
Child safety seats	Smoke detectors
Electric outlets	Stairway gates, walkers, cribs
Farm animals	Syrup of ipecac, poison control
Hot water heater temperature	Telephone numbers
Ingestants, pieces of toys, popcorn, peanuts, hot dogs, powder	
<b><i>Mental Health</i></b>	
Adjustment to new baby	Child care
Balancing home, work, and school	Sibling rivalry
Caretakers expectations of infant development	Support from spouse and friends
<b><i>Nutrition</i></b>	
Bottle propping	Managing meal time behavior
Breast or formula feeding to 1 year	Self feeding
Burping	Snacks
Fluid needs	Weaning
Introduction of solid foods 4-6 months	
<b><i>Other Preventive Measures</i></b>	
Bowel patterns	Fever
Care of respiratory infections	Hiccoughs
Crying or colic	Importance of well-child visits
Effects of passive smoking	Back sleeping



**Suggested Health Education Topics: 2 - 5 Years**

<b><i>Dental Health</i></b>	
Bottle feeding discontinued at 12 months	Importance of dental exam
Dental injuries or emergencies	Sealants on permanent 6 and 12 year molars
Dietary habits and health food	Thumb or finger sucking
Fluoride	
<b><i>Injury Prevention</i></b>	
Booster car seat	Play equipment
Burns and fire	Purchase of bicycles
Cover manure pits	Put up warning signs
Danger of corn cribs and grain bins	Restricted play areas
Dangers of accessible farm chemicals	Street danger
Farm hazards	Teach child how to get help
Grain auger danger	Toys
Importance of protective helmets	Tricycles
Livestock danger	Walking to school
Machinery safety	Water safety
No extra riders on tractor	
<b><i>Mental Health</i></b>	
Adjustment to increasing activity of child	Child care
Balancing home, work, and school	Sibling rivalry
<b><i>Nutrition</i></b>	
Appropriate growth pattern	Managing meal time behavior
Appropriate intake for age	Physical activity
Control issues over food	Snacks
<b><i>Other Preventive Measures</i></b>	
Care of illness	School readiness
Clothing	Sleep
Common habits	Toilet training
Importance of well-child visits	



**Suggested Health Education Topics: 6 - 12 Years**

<b><i>Dental Health</i></b>	
Dental emergency/injury	Mouthguards
Dental referral	Periodontal (gum) disease (at 10 years)
Flossing (at 10 years)	Sealants
Fluoride supplement (discontinue at 13 years)	Thumb/finger sucking
Healthy snacks	Toothbrushing
<b><i>Injury Prevention</i></b>	
Bike (helmet) safety	Livestock danger
Car safety	Machinery safety
CPR training	Mowing safety classes
Dangers of farm ponds and creeks	Refuse rides with strangers
Electric fences	Self-protection tips
Farm safety day camps	Sports safety
Fire safety	Street safety
Gravity flow wagons	Tractor training courses
Gun and hunter safety	Water safety
Importance of knowing emergency numbers and directions to their farm	
<b><i>Mental Health</i></b>	
Discipline	Peer pressure and adjustment
Emotional, physical, and sexual development	School-related concerns
	Sibling rivalry
<b><i>Nutrition</i></b>	
Appropriate intake for age	Managing meal time behavior
Breakfast	Peer influence
Child involvement with food decisions	Physical activity
Food groups	Snacks
Inappropriate dietary behavior	
<b><i>Other Preventive Measures</i></b>	
Adequate sleep	Preparation of girls for menarche
Clothing	Sports
Exercise	Stress
Hygiene	T.V. viewing
Importance of well-child visits	



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

<b><i>Dental Health</i></b>	
Dental emergency and injury prevention	Hygiene regular brushing, flossing, and dental visits
Hazard of smokeless tobacco	
Healthy snacks	Periodontal disease dental carries
<b><i>Development</i></b>	
Normal biopsychosocial changes of adolescence	
<b><i>Gender Specific Health</i></b>	
Abstinence education	Sexual development gender specific
Contraception, condom use	Sexual orientation
HIV counseling or referral	Sexual responsibility, decision making
Self breast exam	Sexually transmitted diseases
Self testicular exam	Unintended pregnancy
Sexual abuse, date rape	
<b><i>Health Consumer Issues</i></b>	
Selection and purchase of health devices or items	Selection and utilization of health services
<b><i>Injury Prevention</i></b>	
ATV safety	Over exposure to sun
CPR and first aid training	ROPS (roll over protective structure)
Dangers of farm ponds and creeks	Seat belt usage
Falls	Smoke detector
Firearm safety, hunting practices	Sports recreation, workshop laboratory, job, or home injury prevention
Gun and hunter safety	Tanning practices
Handling agricultural chemicals	Violent behavior
Hearing conservation	Water safety
Machinery safety	
Motorized vehicle safety (ATV, moped, motorcycle, car, and trucks)	
<b><i>Nutrition</i></b>	
Body image, weight issues	Food fads, snacks, fast foods
Caloric requirements by age and gender	Selection of fitness program by need, age, and gender
Diet to meet needs of growth	
Exercise, sports, and fitness	Special diets



***Relationships and Behavior***

Communication skills	Relationships with adults and peers
Dating relationships	Self esteem building
Decision making	Stress management and reduction

***Substance Use***

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

**B. 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 significant menstrual problems.
- ◆ Testicular examination, include age-appropriate self-examination instructions and health education.



## 1. Growth Measurements

- a. **Recumbent Length:** Measure the length of infants and children up to two years of age on a horizontal length board with a fixed headboard and sliding footboard securely attached at right angles to the measuring surface. Read and record the measurement to the nearest 1/8th inch.
- b. **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 35 1/2 inches tall, the height measurement does not fit on the 2-18 year old chart. Therefore you must 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 1/8th 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.

- c. **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.

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

1. Convert any fractions to decimals.

Examples: 37 pounds 4 ounces = 37.25 pounds

41 1/2 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. This table can be downloaded from the Centers for Disease Control and Prevention website at [www.cdc.gov/growthcharts](http://www.cdc.gov/growthcharts).

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

- e. **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	<del>93</del>	92	7	<del>6</del>	18	<del>45</del>	45 July 15, 1993
Birthdate	-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 birthdate from the clinic visit date. You may 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.



#### **f. Referral and Follow-up of Growth in Infants and Children**

- ◆ Nutrition. See criteria in II.D.2. Nutrition Status.
- ◆ Medical. Most children follow the usual patterns of growth, but a small but significant number of children have growth patterns that cross percentile lines in infancy, familial short stature, constitutional growth delay, and familial tall stature. Some warning signs of growth abnormalities are as follows:
  - Growth of less than 2 inches/year for ages 3 to 10 years.
  - A 25 percentile greater change in weight/height percentile rank.
  - Sudden weight gain or loss.
  - More than 2 SD below or above the mean for height.

### **2. Head Circumference**

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

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

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

### **3. Blood Pressure**

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



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

This is a change from the past when height and weight were both thought to be correlates of blood pressure. Height was determined by the investigators to be a better correlate for children and teenagers because of the prevalence of obesity in young people in this country. The standards appear in Tables 1 and 2.

**a. Use of Blood Pressure Tables in a Clinical Setting**

To use the new tables, you need to measure each child and plot the height on a standard growth chart. Measure the child's systolic and diastolic blood pressure and compare them to the numbers provided in the tables for blood pressure for height, age and sex. The National Heart, Lung and Blood Institute recommends to using the disappearance of Korotkoff's (K5) to determine diastolic blood pressure in children and adolescents.

**b. Interpretation of Blood Pressure Readings**

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.



Iowa  
Department  
of  
Human  
Services

CHAPTER SUBJECT:

COVERAGE AND LIMITATIONS

FEDERALLY QUALIFIED  
HEALTH CENTER

CHAPTER PAGE

E - 36

DATE

July 1, 2003

Reserve pages 36 through 38 for future use.



CHAPTER SUBJECT:  
**COVERAGE AND LIMITATIONS**  
**FEDERALLY QUALIFIED**  
**HEALTH CENTER**

CHAPTER PAGE  
**E - 39**  


---

DATE  
**May 1, 1997**

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

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

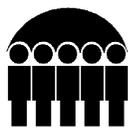
\* Height percentile determined by standard growth curves. Diastolic BP determined by disappearance of Korokoff's sounds (K5), Source: National Heart, Lung and Blood Institute: Update on the 1997 Task Force Report on High Blood Pressure in Children and Adolescents, A Working Group Report from the National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



**Table 2. Blood Pressure Levels for Girls Aged 1 to 17 Years by Percentile of Height**

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

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

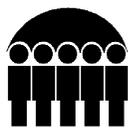


#### 4. Oral Health Screening

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 dental education is provided to the parents or guardians. Unlike other health needs, dental problems are so prevalent that most children over 12 months will need diagnostic evaluation and treatment.

The oral health screening should include all of the following and should be documented in the child's record:

- ◆ Complete or update the dental history:
  - Current or recent dental problems, including pain, or injuries to the mouth;
  - Name of dentist; and
  - Date of child's last dental visit or length of time since last dental visit.
- ◆ Assess risk factors for dental caries:
  - History of previous decay;
  - Stained fissures on primary teeth;
  - White spot lesions; and
  - Visible plaque.
- ◆ Provide visual or tactile inspection of the oral cavity should include:
  - Teeth
    - Number of teeth
    - Tooth eruption pattern
    - Dental caries
    - Missing or broken teeth
    - Malocclusion
    - Oral hygiene status
  - Soft tissue
    - Inflamed or swollen gums
    - Lesions on tongue, cheeks, or gums
- ◆ Provide age-appropriate oral health education to 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 starting at 12 months and semiannually starting at 24 months, unless a dentist recommends more frequent visits;
  - Obvious or suspected dental caries;
  - Pain or injury to the oral tissue; and
  - Difficulty chewing

## C. Laboratory Tests

### 1. Hemoglobin and Hematocrit

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

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

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

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



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

Children under five years of age with incomes under 185% of poverty and hemoglobins 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
<b>Female (nonpregnant)</b>		
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
<b>Male</b>		
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.



## 2. Urinalysis

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

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

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

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

## 3. Metabolic Screening

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

- ◆ Congenital adrenal hyperplasia
- ◆ Galactosemia
- ◆ Hemoglobinopathies
- ◆ Hypothyroidism
- ◆ Phenylketonuria (PKU)
- ◆ Medium chain acyl Co-A dehydrogenase (MCAD) deficiency
- ◆ Biotinidase deficiency

## 4. Hemoglobinopathy Screening

Screen infants not born in Iowa for hemoglobin disorders. Screen children who were born before February 1988, if they are at risk for hemoglobin disorders (those of Caribbean, Latin American, Asian, Mediterranean, and African descent). 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.

### 5. Tuberculin Testing

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

Do the Mantoux skin test on household members of persons for whom tuberculosis is common (e.g., from Asia, Africa, Central America, the Pacific Islands, Caribbean; migrant workers; residents of correctional institutions and homeless shelters; and children in the homes of IV drug users, alcoholics, HIV positives, and prostitutes).

### 6. 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  $\mu\text{g}/\text{dL}$ .

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  $\mu\text{g}/\text{dL}$ .

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.

#### a. Determining Risk Through Asking Questions

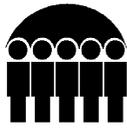
Beginning with the age of 12 months, ask the following questions for all children at each office visit to determine each child's risk for lead poisoning:

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

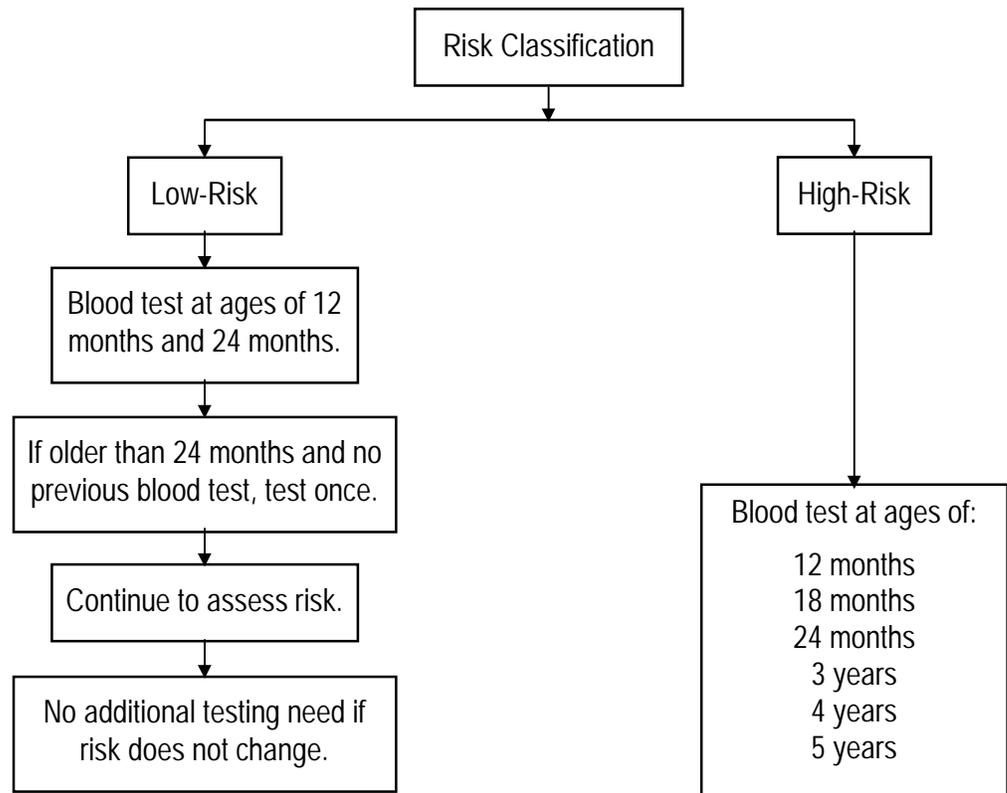


- ◆ Is the pre-1960 home that your child lives in or regularly visits being remodeled or renovated by:
  - Stripping, sanding, or scraping paint on the inside or outside of the house.
  - Removing walls or tearing out lath and plaster.
- ◆ Does your child eat non-food items, such as dirt?
- ◆ Have any of your other children or their playmates had elevated lead levels  $\geq 15 \mu\text{g/dL}$ ?
- ◆ Does your child live with or frequently come in contact with an adult who works with lead on the job or in a hobby? (Examples: painter, welder, foundry worker, old home renovator, shooting range worker, battery plant worker, battery recycling worker, ceramic worker, stained glass worker, sheet metal worker, plumber.)
- ◆ Does your child live near a battery plant, battery recycling plant, or lead smelter?
- ◆ Do you give your child any home or folk remedies? (Examples: Azarcon, Greta, Pay-loo-ah)
- ◆ Does your child eat candy that comes from Mexico or is purchased from a Mexican grocery store?
- ◆ Has your child ever lived in Mexico, Central America, or South America or visited one of these areas for a period longer than two months?

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



**b. Basic Lead Testing Chart (Based on Risk and Age)**

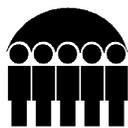


**NOTE:** If you see children at different ages than these, you can change these schedules to correspond with the ages when you do see children.

If capillary samples are used, see next page for follow-up of any level  $\geq 10 \mu\text{g/dL}$ .

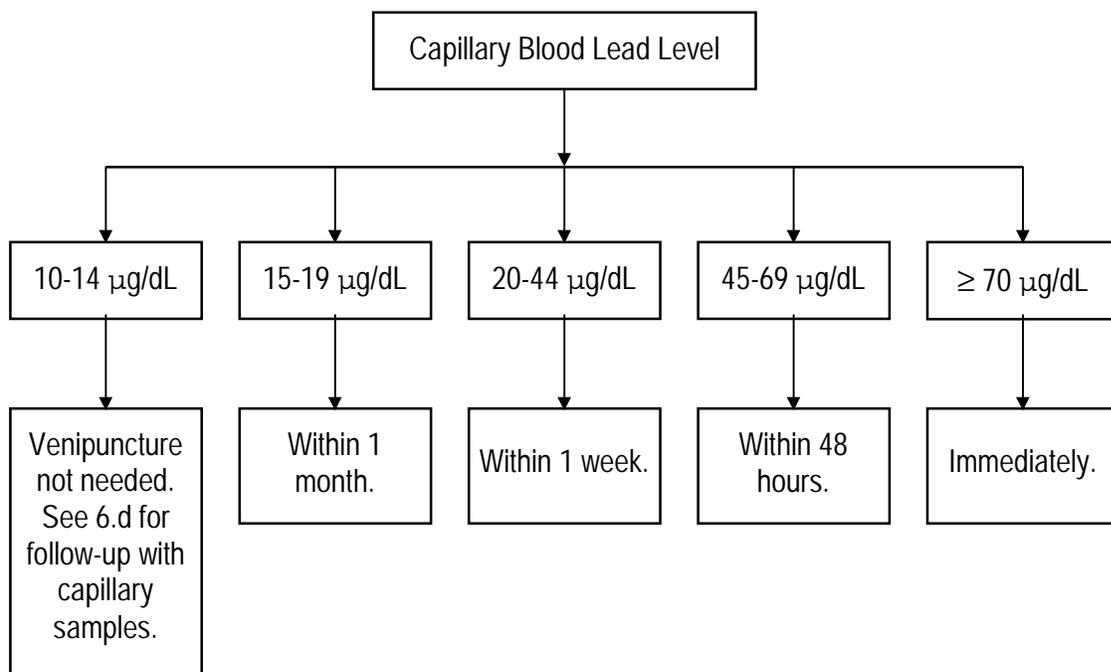
If venous samples are used, see Sections 6.d, 6.e, and 6.f for follow-up of any level  $\geq 10 \mu\text{g/dL}$ .

Source: Center for Disease Control (CDC), *Preventing Lead Poisoning in Young Children* (Revised 12/97).



**c. Schedule for Obtaining Confirmatory Venipunctures**

Children who have blood lead levels  $\geq 15$   $\mu\text{g}/\text{dL}$  on a capillary sample should have these levels confirmed on venous samples according to the timetables below.



If venous level  $< 9$   $\mu\text{g}/\text{dL}$ , return to regular blood lead testing.

If venous level 10-14  $\mu\text{g}/\text{dL}$ , see Section 6.d.

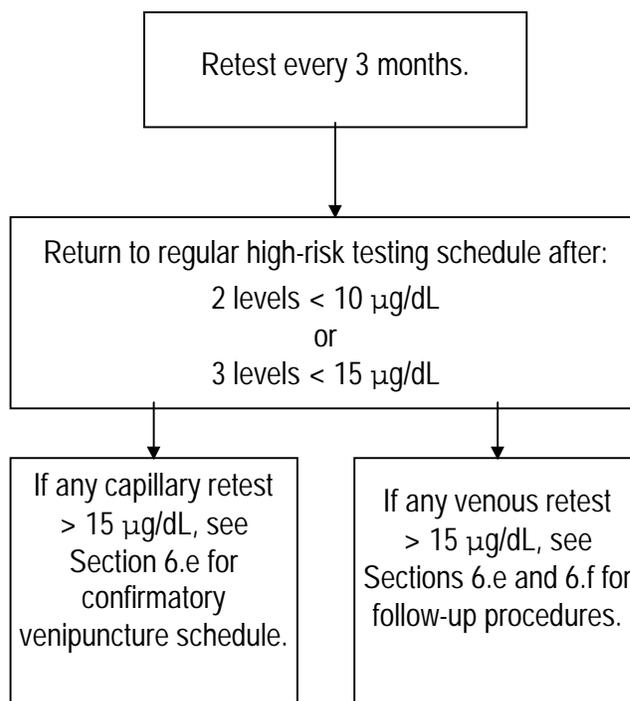
If venous level 15-19  $\mu\text{g}/\text{dL}$ , see Section 6.e.

If venous level  $\geq 20$   $\mu\text{g}/\text{dL}$ , see Section 6.f.

Source: Center for Disease Control (CDC), *Preventing Lead Poisoning in Young Children* (Revised 12/97).



**d. Follow-up of Elevated Blood Lead Levels (10-14  $\mu\text{g}/\text{dL}$ )**

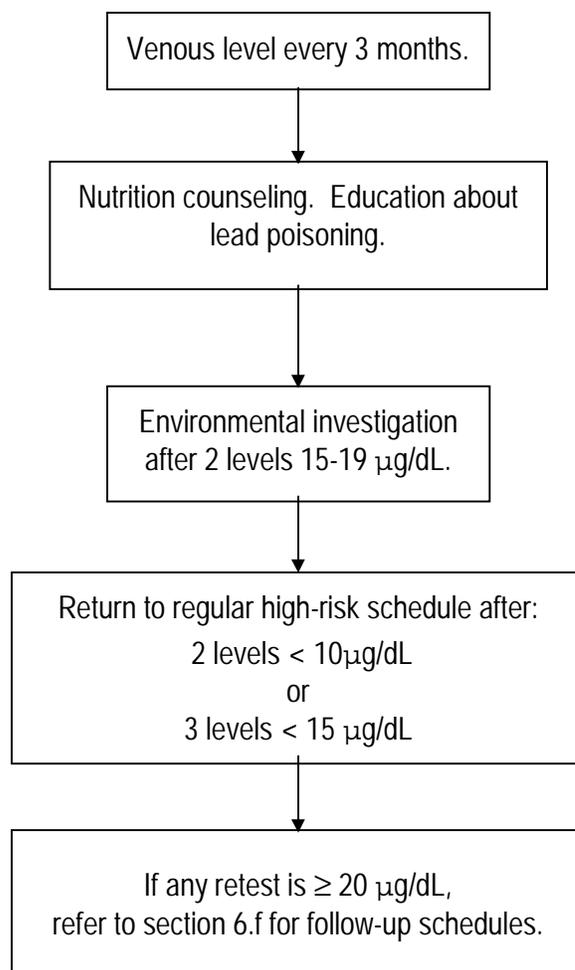


Source: Center for Disease Control (CDC), *Preventing Lead Poisoning in Young Children* (Revised 12/93).



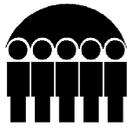
**e. Follow-up of Elevated Venous Blood Leads (15-19  $\mu\text{g}/\text{dL}$ )**

All children who have had venous levels  $\geq 15 \mu\text{g}/\text{dL}$  are considered “high” risk regardless of initial risk assessment.

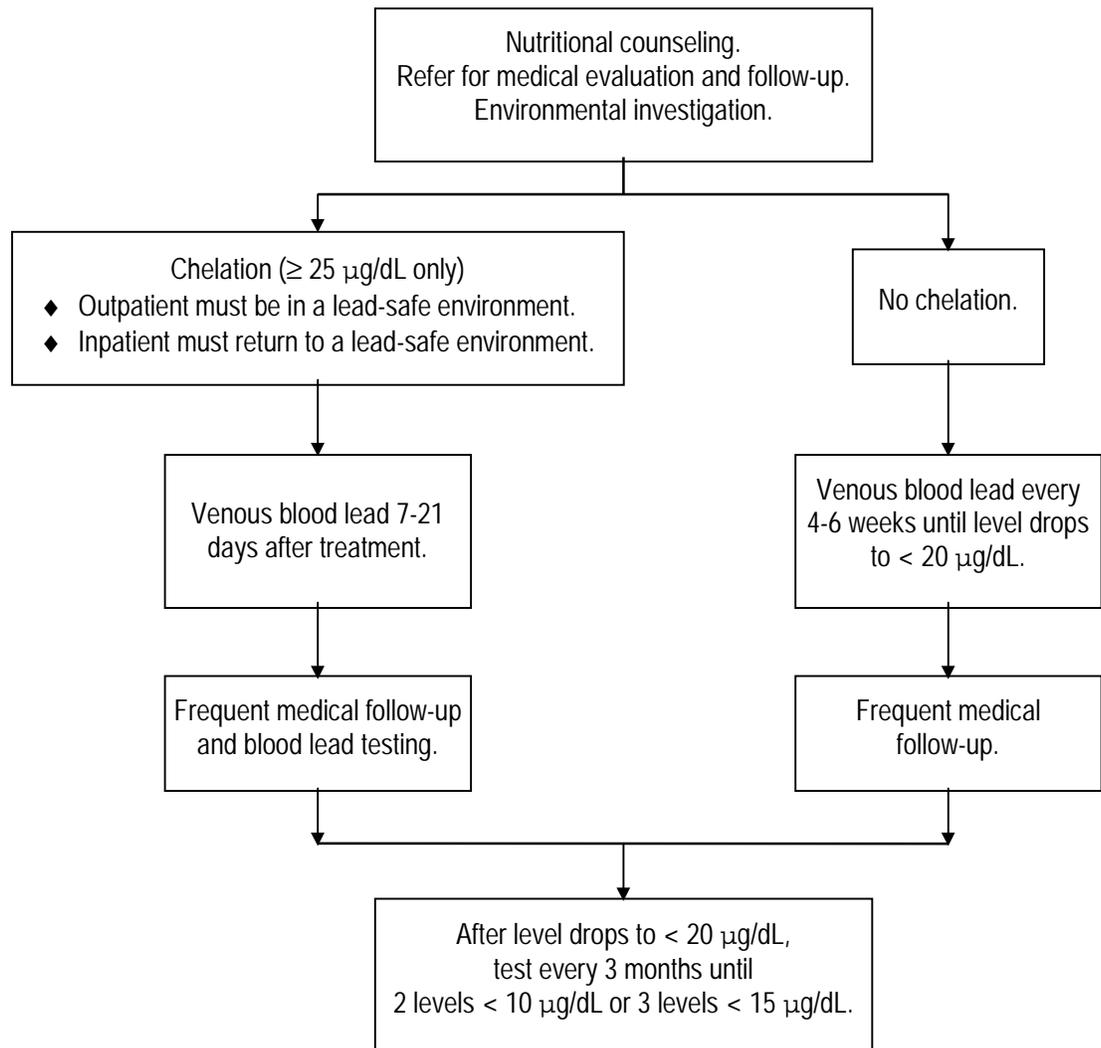


See Sections 6.g and 6.h for time frames for referrals.

Source: Center for Disease Control (CDC), *Preventing Lead Poisoning in Young Children* (Revised 12/93).



**f. Follow-up of Elevated Venous Levels ( $\geq 20 \mu\text{g/dL}$ )**

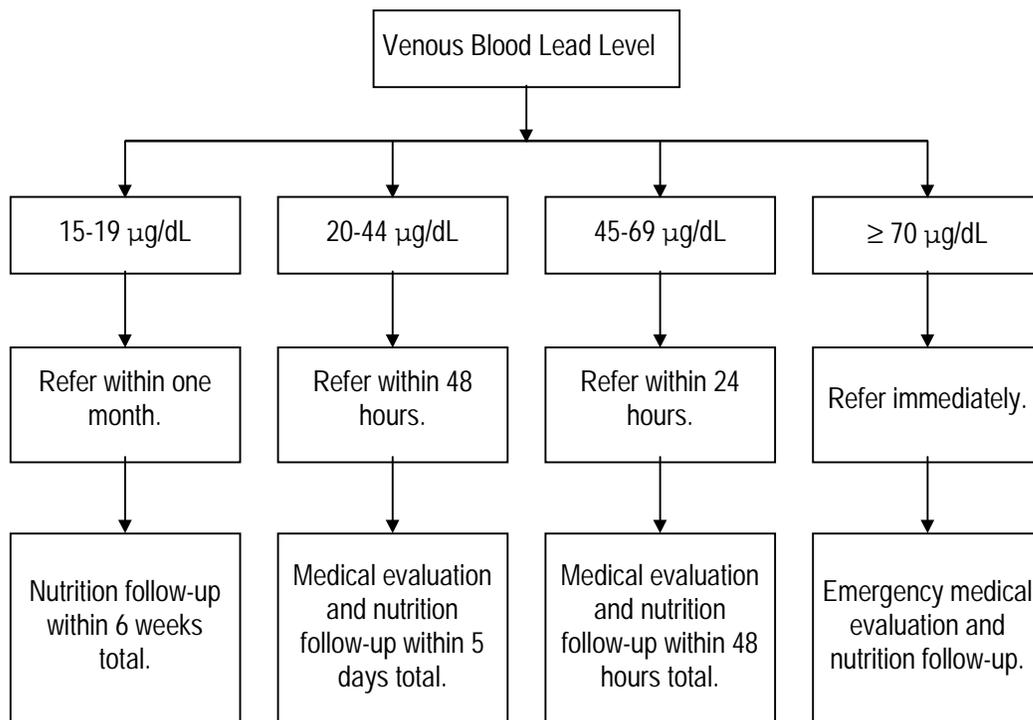


See Sections 6.g and 6.h for time frames for referrals.

Source: Center for Disease Control (CDC), *Preventing Lead Poisoning in Young Children* (Revised 12/93).



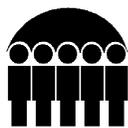
**g. Timelines for Medical and Nutritional Follow-up**



Source: Center for Disease Control (CDC), *Preventing Lead Poisoning in Young Children* (Revised 12/93).

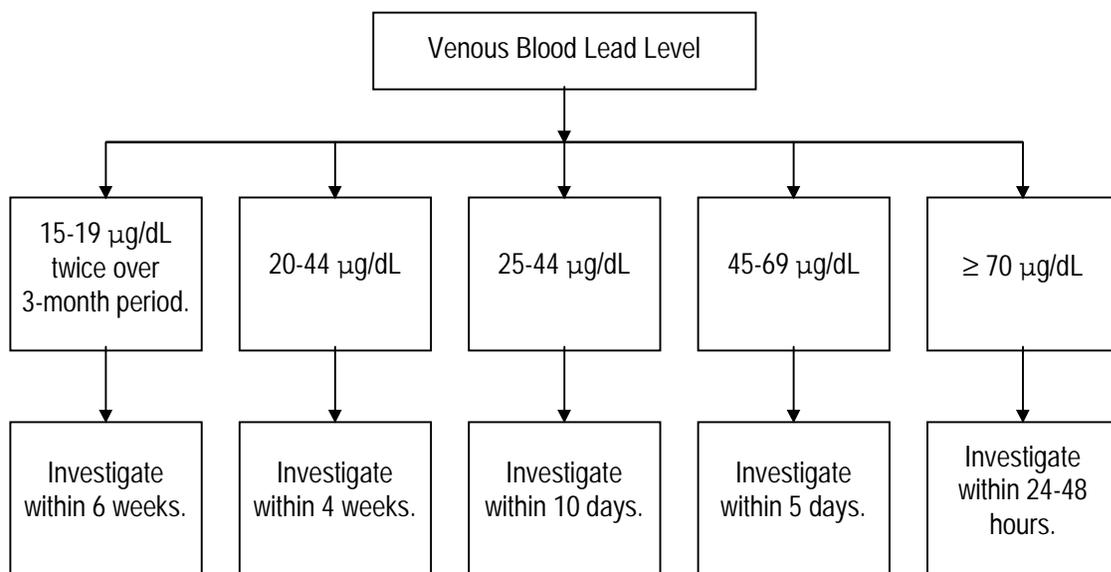
Nutrition information can be obtained by contacting Susan Pohl, Licensed Dietitian, Iowa Department of Public Health at 515/281-4545

Medical management information can be obtained by contacting the Medical Director of Family and Community Health, Iowa Department of Public Health at 515/281-4912.



**h. Timelines for Environmental Follow-up**

**GUIDELINES FOR IDPH FOLLOW-UP**



Source: Center for Disease Control (CDC), *Preventing Lead Poisoning in Young Children* (Revised 12/93).

**i. Resource Persons for Lead Testing, Screening, and Case Management**

Ken Choquette, Coordinator of Lead Prevention Program, Iowa Department of Public Health, 515-281-8220 or 1-800-972-2026.

Rita Gergely, Environmental Specialist, Iowa Department of Public Health, 515-281-6340 or 1-800-972-2026.



## 7. Cervical Papanicolaou (PAP) Smear

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

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

Sexually active females should receive family planning counseling, including pap smears, self breast exams, and educate on prevention of sexually transmitted diseases (STD).

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.

## 8. Gonorrhea Test

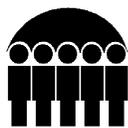
Testing for gonorrhea may be done on persons with:

- ◆ 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.
- ◆ Education on the prevention of STDs.

## 9. 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). Recent sexual partners of persons with positive tests for STD:

- ◆ Educate on the prevention of STD.
- ◆ Educate on the importance of contraception to prevent pregnancy.



## D. Other Services

### 1. Immunization

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

Standards published by the National Vaccine Advisory Committee in May 1992 clarify factors which limit the provision of immunizations. The standards address access to immunizations, education concerning contraindications, practice management activities, and tracking systems.

Every time children are seen, screen their immunization status and administer appropriate vaccines. (See Item b.) You can obtain information about immunizations by contacting 1-800-831-6293.

Many opportunities to immunize children are missed due to lack of knowledge about true contraindications, such as erroneously considering mild illness a contraindication. See Item c 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.

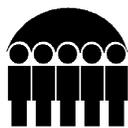
#### a. Standards for Pediatric Immunization Practices

Standard 1. Immunization services are **readily available**.

Standard 2. There are **no barriers** or **unnecessary prerequisites** to the receipt of vaccines.

Standard 3. Immunization services are available free or for a minimal **fee**.

Standard 4. Providers utilize all clinical encounters to **screen** and, when indicated, immunize children.



- Standard 5. Providers **educate** parents and guardians about immunization in general terms.
- Standard 6. Providers **question** parents or guardians about **contraindications** and, before immunizing the child, **inform** them in specific terms about the risks and benefits of immunizations their child is to receive.
- Standard 7. Providers follow only true **contraindications**.
- Standard 8. Providers administer **simultaneously** all vaccine doses for which a child is eligible at the time of each visit.
- Standard 9. Providers use accurate and complete recording procedures.
- Standard 10. Providers **co-schedule** immunization appointments in conjunction with appointments for other child health services.
- Standard 11. Providers **report adverse events** following immunization promptly, accurately, and completely.
- Standard 12. Providers operate a **tracking system**.
- Standard 13. Providers adhere to appropriate procedures for vaccine management.
- Standard 14. Providers conduct semiannual **audits** to assess immunization coverage levels and to review immunization records in the patient populations they serve.
- Standard 15. Providers maintain up-to-date, easily retrievable **medical protocols** at all locations where vaccines are administered.
- Standard 16. Providers operate with **patient-oriented** and community-based approaches.
- Standard 17. Vaccines are administered by **properly trained** individuals.



Iowa  
Department  
of  
Human  
Services

CHAPTER SUBJECT:

COVERAGE AND LIMITATIONS

FEDERALLY QUALIFIED  
HEALTH CENTER

CHAPTER PAGE

E - 57

DATE

July 1, 2003

Standard 18. Providers receive **ongoing education** and **training** on current immunization recommendations.

This information is excerpted from *Standards for Pediatric Immunization Practices*, issued May 11, 1992, by the U.S. Department of Health and Human Services, Public Health Service.

**b. ACIP Recommended Immunization Schedule**

Provide immunization based on the recommended childhood immunization schedule for the United States for January-December of the current year. These recommendations are approved by:

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

The immunization chart can be downloaded from the National Immunization Program website at [www.cdc.gov/nip](http://www.cdc.gov/nip).



**c. Contraindications and Precaution for Immunization**

These conditions apply to DTaP, HBV, Hib, IPV, MMR, pneumococcal conjugate, and varicella as indicated. For more details, see ACIP recommendations (<http://www.cdc.gov/nip/publications/ACIP-list.htm>).

**DtaP:**

Contraindications:

- ◆ Anaphylactic reaction to a prior dose of the vaccine or any of its components
- ◆ Encephalopathy within 7 days of a previous dose of DTP or DtaP

Precautions:

- ◆ Moderate or severe acute illness
- ◆ Underlying unstable, evolving neurologic disorder
- ◆ Any of these conditions within the specified time after a previous dose of DTP or DtaP
  - Fever of  $\geq 40.5^{\circ}\text{C}$  ( $105^{\circ}\text{F}$ ) unexplained by another cause (within 48 hours)
  - Collapse or shock-like state (within 48 hours)
  - Persistent, inconsolable crying lasting  $\geq 3$  hours (within 48 hours)
  - Seizure or convulsion (within 72 hours)
  - Guillian-Barré syndrome (within 6 weeks)

**Hepatitis A:**

Contraindications:

- ◆ Anaphylactic reaction to a prior dose of the vaccine or any of its components (e.g., 2 phenoxyethanol, Alum)

Precautions:

- ◆ Moderate or severe acute illness

**Hepatitis B**

Contraindications:

- ◆ Anaphylactic reaction to a prior dose of the vaccine or any of its components (e.g., baker's yeast)

Precautions:

Moderate or severe acute illness



**HIB:**

Contraindications:

- ◆ Anaphylactic reaction to a prior dose of the vaccine or any of its components

Precautions:

- ◆ Moderate or severe acute illness

**IPV:**

Contraindications:

- ◆ Anaphylactic reaction to a prior dose of the vaccine or any of its components (e.g., neomycin, streptomycin, polymyxin B)

Precautions:

- ◆ Moderate or severe acute illness
- ◆ Pregnancy (If a pregnant woman is at increased risk for infection and requires immediate protection against polio, IPV can be administered in accordance with the recommended schedule for adults.)

**Pneumococcal Conjugate:**

Contraindications:

- ◆ Anaphylactic reaction to a prior dose of the vaccine or any of its components

Precautions:

- ◆ Moderate or severe acute illness

**MMR:**

Contraindications:

- ◆ Anaphylactic reaction to a prior dose of the vaccine or any of its components (e.g., gelatin, neomycin)
- ◆ Immunodeficiency (MMR vaccination is recommended for all asymptomatic HIV-infected persons who do not have evidence of severe immunosuppression for whom measles vaccination would otherwise be indicated. It should be considered for all symptomatic HIV-infected persons who do not have evidence of severe immunosuppression or measles immunity.)
- ◆ Pregnancy
- ◆ TB-untreated, active



Precautions:

- ◆ Moderate or severe acute illness
- ◆ Recent administration of antibody-containing blood products. (See ACIP General Recommendations for correct spacing.)
- ◆ Thrombocytopenia or thrombocytopenic purpura (now or by history)

**Varicella:**

Contraindications:

- ◆ Anaphylactic reaction to a prior dose of the vaccine or any of its components (e.g., gelatin, neomycin)
- ◆ Immunodeficiency (Varicella vaccination should be considered for asymptomatic or mildly symptomatic HIV infected children. Pure humoral immune deficiencies are not a contraindication to varicella.)
- ◆ Pregnancy
- ◆ TB – untreated, active

Precautions:

- ◆ Moderate or severe acute illness
- ◆ Recent administration of antibody-containing blood products (See ACIP General Recommendations for correct spacing.)



## 2. Nutritional Status

To assess nutritional status, include:

- ◆ Accurate measurements of height and weight.
- ◆ A laboratory test to screen for iron deficiency anemia (see Hgb/Hct procedures on III. Item C.1. for suggested screening ages).
- ◆ Questions about dietary practices to identify:
  - Diets which are deficient or excessive in one or more nutrients.
  - Unusual eating habits (such as extended use of bottle feedings, pica, or abnormal behaviors intended to change body weight).
  - Food allergy, intolerance, or aversion.
  - Inappropriate dietary alterations.
- ◆ 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).



**b. Medical Evaluation Indicated (0-12 months)**

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

◆ Measurements

- Wt/Ht < 5th percentile or > 95 percentile (NCHS charts).
- Wt/Age < 5th percentile.
- Major change in wt/ht percentile rank. (A 25 percentile or greater shift in ranking.)
- Flat growth curve. (Two months without an increase in wt/age of an infant below the 90th percentile wt/age.)

◆ Laboratory tests

- < Hct 33%
- < Hgb 11 gm/dL (6-12 months)
- $\geq 15$   $\mu\text{g/dL}$  blood lead level

◆ Health problems

- Metabolic disorder.
- Chronic disease requiring a special diet.
- Physical handicap or developmental delay which 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.



**c. Medical Evaluation Indicated (1-10 years)**

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

◆ Measurements

- Wt/length < 5th percentile or > 95th percentile for 12-23 months.
- BMI for age < 5th percentile or > 95<sup>th</sup> percentile for 24 months and older.
- Wt/Age < 5th percentile.
- Major change in wt/ht 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.
- Physical handicap or developmental delay which may alter nutritional status.
- Metabolic disorder.
- Family history of hyperlipidemias.



- ◆ 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.

**d. 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 which may alter nutritional status.
  - Metabolic disorder.
  - 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.
  - Substance use or abuse.



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

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

### 3. 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 to be carried out 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.

#### a. Birth Through Two Years of Age

Eye evaluations of infants and children birth through two years of age should include:

- ◆ Eyelids and orbits.
- ◆ External examinations.
- ◆ Eye muscle balance.
- ◆ Pupils.
- ◆ Red reflex.
- ◆ Motility.
- ◆ Monocular fixational ability assessment



**b. Two to Four Years of Age**

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

Three-year-old-children who are uncooperative when tested should be retested four to six months later. Make a referral for an eye examination if the child is untestable on the second attempt.

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

**c. At Five Years and Older**

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

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

As the child reaches school age, refractive errors which may require eye glasses for correction become important. The most common refractive error is hyperopia or far-sightedness. Hyperopia, farsightedness, can cause problems in performing close work.

Therefore, referral to an eye care specialist is recommended. Uncorrected hyperopia is very common in learning related vision problems.



VISION SCREENING GUIDELINES		
Function: Recommended Tests	Referral Criteria	Comments
<p><b>Distance visual acuity:</b></p> <ul style="list-style-type: none"> <li>◆ Snellen letters</li> <li>◆ Snellen numbers</li> <li>◆ Tumbling E</li> <li>◆ HOTV</li> <li>◆ Picture tests               <ul style="list-style-type: none"> <li>• Allen figures</li> <li>• LH test</li> </ul> </li> </ul>	<p><b>Ages 3-5 years:</b></p> <ol style="list-style-type: none"> <li>1. &lt;4 of 6 correct on 20 ft line with either eye tested at 10 ft monocularly (i.e., &lt;10/20 or 20/40)</li> <li style="text-align: center;">or</li> <li>2. Two-line difference between eyes, even within the passing range (i.e., 10/12.5 and 10/20 or 20/25 and 20/40)</li> </ol> <p><b>Ages 6 years and older:</b></p> <ol style="list-style-type: none"> <li>1. &lt;4 of 6 correct on 15 ft line with either eye tested at 10 ft monocularly (i.e., &lt;10/15 or 20/30)</li> <li>2. Two-line difference between eyes, even within the passing range (i.e., 10/10 and 10/15 or 20/20 and 20/30)</li> </ol>	<ol style="list-style-type: none"> <li>1. Tests are listed in decreasing order of cognitive difficulty. Use the highest test that the child is capable of performing. In general, the tumbling E or the HOTV test should be used for ages 3-5 years and Snellen letters or numbers for ages 6 years and older.</li> <li>2. Testing distance of 10 ft is recommended for all visual acuity tests.</li> <li>3. A line of figures is preferred over single figures.</li> <li>4. The nontested eye should be covered by an occluder held by the examiner or by an adhesive occluder patch applied to eye. The examiner must ensure that it is not possible to peek with the nontested eye.</li> </ol>
<p><b>Ocular alignment:</b></p> <ul style="list-style-type: none"> <li>◆ Unilateral cover test at 10 ft or 3 m</li> <li style="text-align: center;">or</li> <li>◆ Random-dot-E stereo test at 40 cm (630 s of arc)</li> </ul>	<p>Any eye movement</p> <p>&lt;4 of 6 correct</p>	

Source: Vision screening guidelines developed by the AAP Section on Ophthalmology Executive Committee, 1991-1992. *Pediatrics*, Vol. 98 No. 1, July 1996.



#### 4. Hearing

Objective screening of hearing for all neonates is now recommended by multiple professional medical, audiology, and early childhood education groups. Objective hearing screening performed on newborns and infants will detect congenital hearing loss, but will not identify those children with progressive hearing loss.

Thus, objective hearing screening for all children should be a regular procedure conducted during well-child health screening appointments according to the periodicity schedule. Using high risk factor subjective screening methods is no longer an acceptable alternative to objective hearing screening during early childhood.

Objective hearing screening should be performed on all infants by age three months. 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. There are multiple public and private audiologists serving infants and toddlers.

Other types of objective hearing screening, such as “play audiometry” may begin as soon as a child is developmentally able to understand the procedure and cooperate. Audiometry is typically performed at frequencies of 500, 1000, 2000, 4000, and 6000 Hz at 20 decibels for both ears.

##### a. Subjective Hearing Screening

Subjective screening of hearing may be performed by history and observation during health visits occurring between the appointed times for objective hearing screening according to the periodicity schedule.



**b. Referral Criteria**

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 children should be referred for objective audiology evaluation:

- ◆ A child with congenital anomaly of the ear, nose, throat, or kidney
- ◆ A child with behavior problems
- ◆ A child with developmental delay of onset of speech
- ◆ A child with recurrent upper respiratory infections
- ◆ A child with a family history of hearing loss
- ◆ A child who does not respond to pure tone testing at any of the levels screened

If the parent has any concern about the child's hearing, refer the child for objective audiology evaluation.

Unless a medical problem is apparent, an audiological examination is usually needed before referral or in conjunction with the referral to medical specialist.

**IV. BASIS OF PAYMENT FOR SERVICES**

Federally qualified health centers are reimbursed for services to Medicaid recipients based on 100 percent of the costs which are reasonable and related to the cost of furnishing federally qualified health center services.

Reasonable costs are determined by Iowa Medicaid based on the center's cost report, submitted to the Medicaid fiscal agent on the FQHC Cost Report Form. The costs claimed in the approved cost report cannot exceed the reasonable costs as determined by the applicable Medicare cost reimbursement principles.

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



CHAPTER SUBJECT:

COVERAGE AND LIMITATIONS

FEDERALLY QUALIFIED  
HEALTH CENTER

CHAPTER PAGE

E - 70

DATE

July 1, 2003

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

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

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

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

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

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

Centers must use form 470-3495, *Managed Care Wraparound Payment Request*, to document Medicaid encounters and differences in payments by the managed care organization and the regular Medicaid encounter payment. This form and instructions for its completion are included in Chapter F of this manual.



CHAPTER SUBJECT: <b>COVERAGE AND LIMITATIONS</b>  <b>FEDERALLY QUALIFIED HEALTH CENTER</b>	CHAPTER	PAGE
	E - 71	
	DATE	July 1, 2003

## V. PROCEDURE CODES

Only one face-to-face encounter between a patient and the center health professional can be billed per day, even though the patient may encounter the professional more than once or may encounter more than one professional. An exception to this is when the patient suffers illness or injury requiring additional diagnosis or treatment after the first encounter on a particular day. In that situation, another encounter is reimbursable. Refer those claims to ACS Provider Relations for special handling.

All federally qualified health center services billed on a given date must be submitted as one lump-sum charge under procedure code T1015, federally qualified health center visit except for dental and EPSTD “Care for Kids” screen. In certain instances, two-digit modifiers are applicable. They should be placed after the five-position procedure code. The modifiers applicable are:

<u>Modifier</u>	<u>Description</u>
U1	Care for Kids screen with referral for treatment.
U6	EPSTD “Care for Kids” screen
EP	Services provided as a result of the findings from a Care for Kids (EPSTD) screening examination.
FP	Service related to family planning.
U3	Medical expense services, e.g., those related to mental health diagnoses not covered by the Iowa Plan for Behavioral Health (Iowa Plan).
32	Annual routine physical required for RCF resident
CI	Informing service
U7	Use with D0120 when a dental treatment service is provided.

### A. Dental Services

Dental encounters use D0120. When providing dental treatment service not preventive services use the U7 modifier with the encounter. The diagnosis code for all dental services is 528.9.



Iowa  
Department  
of  
Human  
Services

CHAPTER SUBJECT:

COVERAGE AND LIMITATIONS

FEDERALLY QUALIFIED  
HEALTH CENTER

CHAPTER PAGE

E - 72

DATE

July 1, 2003

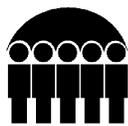
## **B. EPSDT “Care for Kids Services”**

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

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

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

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



## I. REQUEST FOR PRIOR AUTHORIZATION FORM AND INSTRUCTIONS

### A. How to Use

For services requiring prior approval (see Chapter E), form 470-0829, *Request for Prior Authorization*, must be completed and submitted to the fiscal agent. The request will be reviewed by the Medical Unit and a determination of coverage will be made. When a determination has been made, the form will be returned to you. Do not use this form unless prior approval is required by Medicaid for the service being provided.

If the service is approved for coverage, you may then submit your claim for reimbursement. **Important:** Do not return the prior authorization form. You need to place the prior authorization number in the appropriate location on your claim form. (Consult the claim form instructions.) Using this number, the computer will then verify that the service has been approved for payment.

### B. Facsimile of Request for Prior Authorization

(See page 3.)

### C. Instructions for Completing Request for Prior Authorization

1. PATIENT NAME  
Complete the last name, first name and middle initial of the patient. Use the *Medical Assistance Eligibility Card* for verification.
2. PATIENT IDENTIFICATION NUMBER  
Copy this number directly from the *Medical Assistance Eligibility Card*. This number must be eight positions in length (seven numeric digits and one alphabetical character).



3. COUNTY NO.

This is the number of the county where the recipient resides. It may be copied from the *Medical Assistance Eligibility Card*. This is a two-digit code. This area is optional.

4. DATE OF BIRTH

Copy the patient's date of birth directly from the *Medical Assistance Eligibility Card*. Use two digits for each: month, day, year (MM, DD, YY).

5. PROVIDER PHONE NO.

Completing this area may expedite the processing of your *Request for Prior Authorization*. This area is optional.

6. PROVIDER NO.

Leave blank.

7. PAY TO PROVIDER NO.

Enter the seven-digit provider number assigned to you by the Iowa Medicaid Program.

8. DATES COVERED BY THIS REQUEST

Enter the appropriate date span. Be sure to include the date of service. Complete this item using two digits for each: month, day, year (MM, DD, YY). If this request is approved, it will be valid only for this period of time.

9. PROVIDER NAME

Enter the name of the provider requesting prior authorization.

10. STREET ADDRESS

Enter the street address of the provider requesting prior authorization.

11. CITY, STATE, ZIP

Enter the city, state and zip of the provider requesting prior authorization.

12. PRIOR AUTHORIZATION NO.

Leave blank. The fiscal agent will assign a number if the service is approved. You will then place this number in the appropriate area on the claim form.

## Iowa Department of Human Services

**REQUEST FOR PRIOR AUTHORIZATION**

(PLEASE TYPE - ACCURACY IS IMPORTANT)

1. Patient Name (Last) (First) (Initial)			2. Patient Identification No.		3. Co. No.	4. Date of Birth Mo. Day Year	
5. Provider Phone No.	6. Provider No.	7. Pay to Provider No.	8. Dates Covered by Request				
9. Provider Name			From			To	
			Mo.	Day	Year	Mo.	Day
10. Street Address			12. PRIOR AUTHORIZATION NO. (To be assigned by fiscal agent) Enter this number in the appropriate box when submitting the claim form for the services authorized.				
11. City, State, Zip							
13. Reasons For Request (use additional sheet if necessary)							

**SERVICES TO BE AUTHORIZED**

14. Line No.	15. Describe Procedure, Supply, Drug To Be Provided or Diagnosis Description	16. Procedure, Supply, Drug or Diagnosis Code*	17. Units of Service	18. Leave Blank Authorized Units	19. Amount	20. Leave Blank Authorized Amount	21. Leave Blank Status
01							
02							
03							
04							
05							

IF THE PROVIDER OF THESE SERVICES WILL BE OTHER THAN THE PROVIDER NAMED IN BOX 9, PLEASE COMPLETE THIS PORTION.

22. Provider Name		23. Telephone No.	24. Provider No.	25. Pay to Provider No.	
26. Street Address			City	State	Zip
IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the recipient continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the recipient's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the recipient continues to be eligible for Medicaid.			27. Requesting provider  _____ Signature of Authorized Representative      Date		

**FISCAL AGENT USE ONLY**

28. MEDICAID BENEFITS ARE HEREBY <input type="checkbox"/> APPROVED <input type="checkbox"/> DENIED FOR THE RECIPIENT UNDER TITLE XIX, THIS AUTHORIZATION APPLIED ONLY TO THE ELIGIBLE PERSON ABOVE FOR THE SERVICE(S) SPECIFICALLY APPROVED ABOVE.
29. Comments or Reasons for Denial of Benefits

\*PROCEDURE, SUPPLY, DRUG OR DIAGNOSIS CODES AUTHORIZED ON THIS REQUEST MUST BE THE SAME CODES ENTERED ON THE CLAIM FORM

30. Signature	
_____ Fiscal Agent's Authorized Representative	_____ Date

Page 4 was intentionally left blank.



13. REASON FOR REQUEST

Provide the required information in this area for the type of approval being requested. Refer to Chapter E of this manual. (For enteral products, enter the number of cans or packets administered per day.)

SERVICES TO BE AUTHORIZED

14. LINE NO.

No entry is required.

15. DESCRIBE PROCEDURE, SUPPLY, DRUG TO BE PROVIDED OR  
DIAGNOSIS DESCRIPTION

Enter the description of the service or services to be authorized. (For enteral products, enter the product name and NDC number.)

16. PROCEDURE, SUPPLY, DRUG OR DIAGNOSIS CODE

Enter the appropriate code. For prescription drugs, enter the appropriate NDC. For other services or supplies, enter the proper HCPCS code.

17. UNITS OF SERVICE

Complete with the amount or number of times the service is to be performed. (For enteral products, enter the number of cans or packets dispensed for the time span requested.)

18. AUTHORIZED UNITS

Leave blank. The fiscal agent will indicate the number of authorized units.

19. AMOUNT

Enter the amount that will be charged for this line item.

20. AUTHORIZED AMOUNT

Leave blank. The fiscal agent will indicate the authorized amount or indicate that payment will be based on the fee schedule or maximum fee depending on the service provided.

21. STATUS

Leave blank. The fiscal agent will indicate "A" for approved or "D" for denied.



22. PROVIDER NAME  
Complete the name of the provider who will provide services, if other than requestor of prior authorization.
23. TELEPHONE NO.  
Enter the telephone number of the provider who will provide services, if other than requestor of prior authorization. This area is optional.
24. PROVIDER NO.  
Enter the seven-digit Medicaid provider number of the treating provider, if other than requestor of prior authorization.
25. PAY TO PROVIDER NO.  
Enter the seven-digit group provider number for the treating provider, if other than requestor of prior authorization.
26. STREET ADDRESS, CITY, STATE, ZIP  
Complete the street address, city, state and zip of the provider who will provide services, if other than requestor of prior authorization.
27. REQUESTING PROVIDER  
Enter the signature of the provider or authorized representative requesting prior authorization. Also, indicate the date the request was signed.

FISCAL AGENT USE ONLY

28. MEDICAID BENEFITS REQUESTED ARE HEREBY  
Do not complete. The fiscal agent will complete this item after evaluating the request.
29. COMMENTS OR REASON FOR DENIAL OF BENEFITS  
Do not complete. The fiscal agent will complete this section should this request be denied.
30. SIGNATURE  
Do not complete. The person making the final decision on this request will sign and date.





Iowa  
Department  
of  
Human  
Services

CHAPTER SUBJECT:  
BILLING AND PAYMENT  
FEDERALLY QUALIFIED  
HEALTH CENTER

CHAPTER	PAGE
	F - 6b
DATE	
	July 1, 2003

#### **D. Electronic Prior Authorization Requests**

Under the Health Insurance Portability and Accountability Act, there is an electronic transaction for Prior Authorization requests (278 transaction). However, there is no standard to use in submitting additional documentation electronically. Therefore, if you want to submit a prior authorization request electronically, the additional documentation must be submitted on paper using the following procedure:

Staple the additional information to form 470-3970, *Prior Authorization Attachment Control*. (See the previous page for an example of this form.)

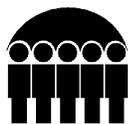
Complete the “attachment control number” with the same number submitted on the electronic prior authorization request. ACS will accept up to 20 characters (letters or digits) in this number. If you do not know the attachment control number for the request, please contact the person in your facility responsible for electronic claims billing.

Mail the Prior Authorization Attachment Control with attachments to:

ACS State Healthcare  
P.O. Box 14422  
Des Moines, IA 50306-3422

Or FAX the information to the Prior Authorization Unit at: 515-327-5127

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



## II. INSTRUCTIONS AND CLAIM FORM

### A. Instructions for Completing the Claim Form

The table below contains information that will aid in the completion of the HCFA-1500 claim form. The table follows the form by field number and name, giving a brief description of the information to be entered, and whether providing information in that field is required, optional or conditional of the individual recipient's situation.

A star (\*) in the instructions area of the table indicates a new item or change in policy for Iowa Medicaid providers.

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

FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
1.	CHECK ONE	<b>OPTIONAL</b> – Check the applicable program block.
1a.	INSURED'S ID NUMBER	<b>REQUIRED</b> – Enter the recipient's Medicaid ID number found on the <i>Medical Assistance Eligibility Card</i> . It should consist of seven digits followed by a letter, i.e., 1234567A.
2.	PATIENT'S NAME	<b>REQUIRED</b> – Enter the last name, first name and middle initial of the recipient. Use the <i>Medical Assistance Eligibility Card</i> for verification.
3.	PATIENT'S BIRTHDATE	<b>OPTIONAL</b> – Enter the patient's birth month, day, year and sex. Completing this field may expedite processing of your claim.



Iowa  
Department  
of  
Human  
Services

CHAPTER SUBJECT:

BILLING AND PAYMENT  
FEDERALLY QUALIFIED  
HEALTH CENTER

CHAPTER PAGE

F - 8

DATE

July 1, 2003

4.	INSURED'S NAME	<b>CONDITIONAL*</b> – If the recipient is covered under someone else's insurance, enter the name of the person under which the insurance exists. This could be insurance covering the recipient as a result of a work or auto related accident.  <b>Note:</b> This section of the form is separated by a border, so that information on this other insurance follows directly below, even though the numbering does not.
5.	PATIENT'S ADDRESS	<b>OPTIONAL</b> – Enter the address and phone number of the patient, if available.
6.	PATIENT RELATIONSHIP TO INSURED	<b>CONDITIONAL*</b> – If the recipient is covered under another person's insurance, mark the appropriate box to indicate relation.
7.	INSURED'S ADDRESS	<b>CONDITIONAL*</b> – Enter the address and phone number of the insured person indicated in field number 4.
8.	PATIENT STATUS	<b>OPTIONAL</b> – Check boxes corresponding to the patient's current marital and occupational status.
9a-d.	OTHER INSURED'S NAME	<b>CONDITIONAL*</b> – If the recipient carries other insurance, enter the name under which that insurance exists, as well as the policy or group number, the employer or school name under which coverage is offered and the name of the plan or program.
10.	IS PATIENT'S CONDITION RELATED TO	<b>CONDITIONAL*</b> – Check the appropriate box to indicate whether or not treatment billed on this claim is for a condition that is somehow work or accident related. If the patient's condition is related to employment or an accident, and other insurance has denied payment, complete 11d, marking the "YES" and "NO" boxes.
10d.	RESERVED FOR LOCAL USE	<b>OPTIONAL</b> – No entry required.



11a-c.	INSURED'S POLICY GROUP OR FECA NUMBER AND OTHER INFORMATION	<b>CONDITIONAL*</b> – This field continues with information related to field 4. If the recipient is covered under someone else's insurance, enter the policy number and other requested information as known.
11d.	IS THERE ANOTHER HEALTH BENEFIT PLAN?	<b>CONDITIONAL</b> – If payment has been received from another insurance, or the medical resource codes on the eligibility card indicate other insurance exists, check "YES" and enter payment amount in field 29.  If you have received a denial of payment from another insurance, check <u>both</u> "YES" and "NO" to indicate that there is other insurance, but that the benefits were denied.  <b>Note:</b> Auditing will be performed on a random basis to ensure correct billing.
12.	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	<b>OPTIONAL</b> – No entry required.
13.	INSURED OR AUTHORIZED PERSON'S SIGNATURE	<b>OPTIONAL</b> – No entry required.
14.	DATE OF CURRENT ILLNESS, INJURY, PREGNANCY	<b>CONDITIONAL*</b> – Chiropractors must enter the date of the onset of treatment as month, day and year. All others – no entry required.
15.	IF THE PATIENT HAS HAD SAME OR SIMILAR ILLNESS...	<b>CONDITIONAL</b> – Chiropractors must enter the current x-ray date as month, day and year. All others – no entry required.
16.	DATES PATIENT UNABLE TO WORK...	<b>OPTIONAL</b> – No entry required.



17.	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	<b>CONDITIONAL</b> – Required if the referring physician does not have a Medicaid number.
17a.	ID NUMBER OF REFERRING PHYSICIAN	<b>CONDITIONAL*</b> –  If the patient is a MediPASS recipient and the MediPASS physician authorized service, enter the seven-digit MediPASS authorization number.  If this claim is for consultation, independent lab or DME, enter the Iowa Medicaid number of the referring or prescribing physician.  If the patient is on lock-in and the lock-in physician authorized service, enter the seven-digit authorization number.
18.	HOSPITALIZATION DATES RELATED TO...	<b>OPTIONAL</b> – No entry required.
19.	RESERVED FOR LOCAL USE	<b>REQUIRED</b> – If the patient is pregnant, write “Y – Pregnant.”
20.	OUTSIDE LAB	<b>OPTIONAL</b> – No entry required.
21.	DIAGNOSIS OR NATURE OF ILLNESS	<b>REQUIRED</b> – Indicate the applicable ICD-9-CM diagnosis codes in order of importance (1-primary; 2-secondary; 3-tertiary; and 4-quaternary) to a maximum of four diagnoses.
22.	MEDICAID RESUBMISSION CODE...	<b>OPTIONAL</b> – No entry required.
23.	PRIOR AUTHORIZATION NUMBER	<b>CONDITIONAL*</b> – Enter the prior authorization number issued by ACS.



Iowa  
Department  
of  
Human  
Services

CHAPTER SUBJECT:

**BILLING AND PAYMENT**  
**FEDERALLY QUALIFIED**  
**HEALTH CENTER**

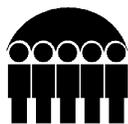
CHAPTER PAGE

F - 11

DATE

November 1, 1998

24. A	DATE(S) OF SERVICE	<p><b>REQUIRED</b> – Enter month, day and year under both the From and To categories for each procedure, service or supply. If the From-To dates span more than one calendar month, represent each month on a separate line. Because eligibility is approved on a month-by-month basis, spanning or overlapping billing months could cause the entire claim to be denied.</p>
24. B	PLACE OF SERVICE	<p><b>REQUIRED</b> – Using the chart below, enter the number corresponding to the place service was provided. Do not use alphabetic characters.</p> <ul style="list-style-type: none"> <li>11 Office</li> <li>12 Home</li> <li>21 Inpatient Hospital</li> <li>22 Outpatient Hospital</li> <li>23 Emergency Room – Hospital</li> <li>24 Ambulatory Surgical Center</li> <li>25 Birthing Center</li> <li>26 Military Treatment Facility</li> <li>31 Skilled Nursing</li> <li>32 Nursing Facility</li> <li>33 Custodial Care Facility</li> <li>34 Hospice</li> <li>41 Ambulance – land</li> <li>42 Ambulance – air or water</li> <li>51 Inpatient Psychiatric Facility</li> <li>52 Psychiatric Facility – partial hospitalization</li> <li>53 Community Mental Health Center</li> <li>54 Intermediate Care Facility/Mentally Retarded</li> <li>55 Residential Substance Abuse Treatment Facility</li> <li>56 Psychiatric Residential Treatment Center</li> <li>61 Comprehensive Inpatient Rehabilitation Facility</li> <li>62 Comprehensive Outpatient Rehabilitation Facility</li> <li>65 End-stage Renal Disease Treatment</li> <li>71 State or Local Public Health Clinic</li> <li>72 Rural Health Clinic</li> <li>81 Independent Laboratory</li> <li>99 Other Unlisted Facility</li> </ul>

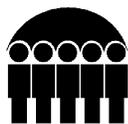


Iowa  
Department  
of  
Human  
Services

CHAPTER SUBJECT:  
**BILLING AND PAYMENT**  
**FEDERALLY QUALIFIED**  
**HEALTH CENTER**

CHAPTER	PAGE
	F - 12
DATE	
November 1, 1998	

24. C	TYPE OF SERVICE	<b>OPTIONAL</b> – No entry required.
24. D	PROCEDURES, SERVICES OR SUPPLIES	<b>REQUIRED</b> – Enter the appropriate five-digit procedure code and any necessary modifier for each of the dates of service. DO NOT list services for which no fees were charged.
24. E	DIAGNOSIS CODE	<b>REQUIRED</b> – Indicate the corresponding diagnosis code from field 21 by entering the number of its position, i.e., 3. DO NOT write the actual diagnosis code in this field. Doing so will cause the claim to deny. There is a maximum of four diagnosis codes per claim.
24. F	\$ CHARGES	<b>REQUIRED</b> – Enter the usual and customary charge for each line item.
24. G	DAYS OR UNITS	<b>REQUIRED</b> – Enter the number of times this procedure was performed or number of supply items dispensed. If the procedure code specifies the number of units, then enter “1.” When billing general anesthesia, the units of service must reflect the <u>total minutes</u> of general anesthesia.
24. H	EPSDT/FAMILY PLANNING	<b>OPTIONAL*</b> – Enter an “F” if the services on this claim line are for family planning. Enter an “E” if the services on this claim line are the result of an EPSDT Care for Kids screening.
24. I	EMG	<b>OPTIONAL</b> – No entry required.
24. J	COB	<b>OPTIONAL</b> – No entry required.
24. K	RESERVED FOR LOCAL USE	<b>CONDITIONAL*</b> – Enter the treating provider’s individual seven-digit Iowa Medicaid provider number when the provider number given in field 33 is that of a group and/or is not that of the treating provider.
25.	FEDERAL TAX ID NUMBER	<b>OPTIONAL</b> – No entry required.
26.	PATIENT’S ACCOUNT NUMBER	<b>OPTIONAL</b> – Enter the account number assigned to the patient by the provider of service. This field is limited to 10 alpha/numeric characters.



Iowa  
Department  
of  
Human  
Services

CHAPTER SUBJECT:  
**BILLING AND PAYMENT**  
**FEDERALLY QUALIFIED**  
**HEALTH CENTER**

CHAPTER PAGE  
F - 13

DATE  
November 1, 1998

27.	ACCEPT ASSIGNMENT?	<b>OPTIONAL</b> – No entry required.
28.	TOTAL CLAIM CHARGE	<b>REQUIRED</b> – Enter the total of the line item charges. If more than one claim form is used to bill services performed, each claim form must be separately totaled. Do not carry over any charges to another claim form.
29.	AMOUNT PAID	<b>CONDITIONAL*</b> – Enter only the amount paid by other insurance. Recipient co-payments, Medicare payments or previous Medicaid payments are not listed on this claim.
30.	BALANCE DUE	<b>REQUIRED*</b> – Enter the amount of total charges less the amount entered in field 29.
31.	SIGNATURE OF PHYSICIAN OR SUPPLIER	<b>REQUIRED</b> – The signature of either the physician or authorized representative and the original filing date must be entered. If the signature is computer-generated block letters, the signature must be initialed. A signature stamp may be used.
32.	NAME AND ADDRESS OF FACILITY...	<b>CONDITIONAL</b> – If other than a home or office, enter the name and address of the facility where the service(s) were rendered.
33.	PHYSICIAN'S, SUPPLIER'S BILLING NAME...	<b>REQUIRED*</b> – Enter the complete name and address of the billing physician or service supplier.
	GRP #	<b>REQUIRED</b> – Enter the seven-digit Iowa Medicaid number of the billing provider.  If this number identifies a group or an individual provider other than the provider of service, the treating provider's Iowa Medicaid number must be entered in field 24K for each line.
<b>BACK OF FORM</b>	NOTE	<b>REQUIRED</b> – The back of the claim form must be intact on every claim form submitted.



Iowa  
Department  
of  
Human  
Services

CHAPTER SUBJECT:  
**BILLING AND PAYMENT**  
**FEDERALLY QUALIFIED**  
**HEALTH CENTER**

CHAPTER PAGE

F - 14

DATE

July 1, 2003

**B. Facsimile of Claim Form, HCFA-1500 (front and back)**

(See the following pages.)

**C. Claim Attachment Control, Form 470-3969**

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

Staple the additional information to form 470-3969, *Claim Attachment Control*. (See the page following the claim form for an example of this form.)

Complete the “attachment control number” with the same number submitted on the electronic claim. ACS will accept up to 20 characters (letters or digits) in this number. If you do not know the attachment control number for the claim, please contact the person in your facility responsible for electronic claims billing.

Do not attach a paper claim.

Mail the *Claim Attachment Control* with attachments to:

ACS State Healthcare  
P.O. Box 14422  
Des Moines, IA 50306-3422

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

HEALTH INSURANCE CLAIM FORM

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
3. PATIENT'S BIRTH DATE MM DD YY SEX M F
4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)
6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other
7. INSURED'S ADDRESS (No., Street)
8. PATIENT STATUS Single Married Other
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
17a. I.D. NUMBER OF REFERRING PHYSICIAN
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? \$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

Table with 7 columns: A (DATE(S) OF SERVICE), B (Place of Service), C (Type of Service), D (PROCEDURES, SERVICES, OR SUPPLIES), E (DIAGNOSIS CODE), F (\$ CHARGES), G (DAYS OR UNITS), H (EPSDT Family Plan), I (EMG), J (COB), K (RESERVED FOR LOCAL USE). Rows 1-6.

25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For govt. claims, see back)
28. TOTAL CHARGE \$
29. AMOUNT PAID \$
30. BALANCE DUE \$
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

**BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.**

**NOTICE:** Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

#### **REFERS TO GOVERNMENT PROGRAMS ONLY**

**MEDICARE AND CHAMPUS PAYMENTS:** A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

#### **BLACK LUNG AND FECA CLAIMS**

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

#### **SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)**

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

**NOTICE:** Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

#### **NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)**

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

**FOR MEDICARE CLAIMS:** See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

**FOR OWCP CLAIMS:** Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990. See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

**FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S):** To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

**ROUTINE USE(S):** Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

**DISCLOSURES:** Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

#### **MEDICAID PAYMENTS (PROVIDER CERTIFICATION)**

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

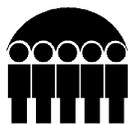
I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

**SIGNATURE OF PHYSICIAN (OR SUPPLIER):** I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

**NOTICE:** This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503.





### III. REMITTANCE ADVICE AND FIELD DESCRIPTIONS

#### A. Remittance Advice Explanation

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

The *Remittance Advice* is separated into categories indicating the status of those claims listed below. Categories of the *Remittance Advice* include paid, denied and suspended claims. PAID indicates all processed claims, credits and adjustments for which there is full or partial reimbursement. DENIED represents all processed claims for which no reimbursement is made. SUSPENDED reflects claims which are currently in process pending resolution of one or more issues (recipient eligibility determination, reduction of charges, third party benefit determination, etc.).

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

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

Note that claim credits or recoupments (reversed) appear as regular claims with the exception that the transaction control number contains a "1" in the twelfth position and reimbursement appears as a negative amount. An adjustment to a previously paid claim produces two transactions on the *Remittance Advice*. The first appears as a credit to negate the claim; the second is the replacement or adjusted claim, containing a "2" in the twelfth position of the transaction control number.



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

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

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

## **B. Facsimile of Remittance Advice and Detailed Field Descriptions**

(See the following page.)

## **C. Remittance Advice Field Descriptions**

1. Billing provider's name as specified on the Medicaid Provider Enrollment Application.
2. *Remittance Advice* number.
3. Date claim paid.
4. Billing provider's Medicaid (Title XIX) number.
5. *Remittance Advice* page number.
6. Type of claim used to bill Medicaid.

MEDICAID MANAGEMENT INFORMATION SYSTEM

RUN DATE 06/12/97

1. TO: [REDACTED] 2. R.A. NO.: 0000006 3. DATE PAID: 05/19/97 4. PROVIDER NUMBER: [REDACTED] 5. PAGE: 1

\*\*\*\* PATIENT NAME \*\*\*\* REGIP ID / TRANS-CONTROL-NUMBER / BILLED OTHER PAID BY COPAY MED RCD NUM /  
 LAST FIRST MI LINE SVC-DATE PROC/MODS UNITS AMT. SOURCES MCAID AMT. PERF. PROV. S EOB EOB

\* 6. CLAIM TYPE: HCFA 1500 \* 7. CLAIM STATUS: PAID

ORIGINAL CLAIMS:

8.	9.	10.	11.	12.	13.	14.	15.	16.		
[REDACTED]	[REDACTED]	4-96331-00-053-0038-00	38.00	0.00	16.06	0.00	860600608B	900 000		
	17. 01	18. 10/3	19. 99212	20. 1	21. 38.00	22. 0.00	23. 16.06	24. 0.00	25. [REDACTED]	000 000
[REDACTED]	[REDACTED]	4-96348-00-018-0060-00	50.00	0.00	35.26	0.00	860600608B	000 000		
	01	11/15/96	J1055	1	41.00	0.00	33.18	0.00	[REDACTED]	F 000 000
	02	11/15/96	9C782	1	9.00	0.00	2.08	0.00	[REDACTED]	F 000 000

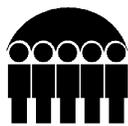
27. REMITTANCE TOTALS

PAID ORIGINAL CLAIMS:	NUMBER OF CLAIMS	2	-----	88.00	51.32
PAID ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0	-----	0.00	0.00
DENIED ORIGINAL CLAIMS:	NUMBER OF CLAIMS	0	-----	0.00	0.00
DENIED ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0	-----	0.00	0.00
PENDED CLAIMS (IN PROCESS):	NUMBER OF CLAIMS	0	-----	0.00	0.00
AMOUNT OF CHECK:			-----		51.32

---- THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION OF BENEFIT (EOB) CODES THAT APPEAR ABOVE:

28. 900 THE CLAIM IS IN SUSPENSE. DO NOT RESUBMIT THE CLAIM.

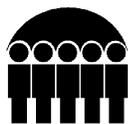
Page 20 was intentionally left blank.



7. Status of following claims:
  - ◆ **Paid** – claims for which reimbursement is being made.
  - ◆ **Denied** – claims for which no reimbursement is being made.
  - ◆ **Suspended** – claims in process. These claims have not yet been paid or denied.
8. Recipient's last and first name.
9. Recipient's Medicaid (Title XIX) number.
10. Transaction control number assigned to each claim by the fiscal agent. Please use this number when making claim inquiries.
11. Total charges submitted by provider.
12. Total amount applied to this claim from other resources, i.e., other insurance or spenddown.
13. Total amount of Medicaid reimbursement as allowed for this claim.
14. Total amount of recipient copayment deducted from this claim.
15. Medical record number as assigned by provider; 10 characters are printable.
16. Explanation of benefits code for informational purposes or to explain why a claim denied. Refer to the end of *Remittance Advice* for explanation of the EOB code.
17. Line item number.
18. The first date of service for the billed procedure.
19. The procedure code for the rendered service.
20. The number of units of rendered service.
21. Charge submitted by provider for line item.



22. Amount applied to this line item from other resources, i.e., other insurance, spenddown.
23. Amount of Medicaid reimbursement as allowed for this line item.
24. Amount of recipient copayment deducted for this line item.
25. Treating provider's Medicaid (Title XIX) number.
26. Allowed charge source code:
  - B** Billed charge
  - F** Fee schedule
  - M** Manually priced
  - N** Provider charge rate
  - P** Group therapy
  - Q** EPSDT total screen over 17 years
  - R** EPSDT total under 18 years
  - S** EPSDT partial over 17 years
  - T** EPSDT partial under 18 years
  - U** Gynecology fee
  - V** Obstetrics fee
  - W** Child fee
27. Remittance totals (found at the end of the *Remittance Advice*):
  - ◆ Number of paid original claims, the amount billed by the provider and the amount allowed and reimbursed by Medicaid.
  - ◆ Number of paid adjusted claims, amount billed by provider and amount allowed and reimbursed by Medicaid.
  - ◆ Number of denied original claims and amount billed by provider.
  - ◆ Number of denied adjusted claims and amount billed by provider.
  - ◆ Number of pended claims (in process) and amount billed by provider.
  - ◆ Amount of check.
28. Description of individual explanation of benefits codes. The EOB code leads, followed by important information and advice.



#### **IV. MANAGED CARE WRAPAROUND PAYMENT REQUEST, EXPLANATION AND INSTRUCTIONS**

##### **A. How to Use**

For services that qualify for managed care wraparound payments (see Chapter E, page 73), form 470-3495, *Managed Care Wraparound Payment Request*, must be completed and submitted to the fiscal agent, Provider Audit Department. This form must be completed on a quarterly basis. It is due thirty (30) days from the end of the prior quarter. The request will be reviewed by the Provider Audit Department and a determination of the proper supplemental (wraparound) payment will be made. Once this determination has been made, payment will be remitted to the FQHC.

##### **B. Instructions for Completing Managed Care Wraparound Payment Request**

1. PROVIDER NAME  
Indicate the name of the FQHC.
2. PROVIDER LOCATION  
Indicate the location of the FQHC (street address, city, state, zip).
3. PROVIDER TYPE  
Indicate FQHC.
4. RECONCILIATION QUARTER ENDING  
Indicate the appropriate reconciliation quarter.
5. PROVIDER MEDICAID I.D. NUMBER  
Indicate the FQHC Iowa Medicaid provider I.D. number.
6. T-XIX MCO ENCOUNTERS (1)  
Indicate the number of Iowa Medicaid managed care organization (MCO) encounters in this space. Enter the number of daily encounters for Iowa Medicaid recipients receiving managed care benefits. These encounters must follow the encounter rules as indicated in the FQHC Provider Manual, Section V. Procedure Codes.



7. EXPECTED MCO PAYMENTS

Indicate the expected payments from managed care organizations (MCO) for the reconciliation quarter. List all dollar amounts normally expected to be received from the managed care organization for the services indicated under Title XIX (Iowa Medicaid) encounters. **Note:** These amounts exclude any sub-capitation arrangements between the FQHC and the managed care organization. If any payments are made over and above the general capitation payments, these must be listed, as well.

8. SUB-CAPITATION PAYMENTS

Indicate sub-capitation payments for the reconciliation quarter. List all dollar amounts of contractual, risk-based capitation payments made on behalf of the managed care organization for Iowa Medicaid recipients, for the provision of care NOT separately reimbursed by encounter.

9. ESTIMATED MCO PAYMENTS TO BE RECEIVED

Indicate the estimated managed care organization (MCO) payments to be received for the reconciliation quarter. Add together the expected MCO payments and the sub-capitation payments.

10. T-XIX REGULAR ENCOUNTER PAYMENTS

Indicate the Title XIX (Iowa Medicaid) regular encounter payments for the reconciliation quarter that would be received if the MCO encounters were regular Medicaid encounters. Multiply the actual FQHC Iowa Medicaid encounter rate times the number of Title XIX MCO encounters.

11. DIFFERENCE REIMBURSABLE TO PROVIDER

Indicate the difference reimbursable to the FQHC. This is the estimated MCO payments to be received by FQHC minus Title XIX (Iowa Medicaid) regular encounter payments.

12. ATTESTATION

At the bottom of the form, indicate the name and title of the person completing the form. The person completing the form also must sign and indicate the date the form is being submitted.



Iowa  
Department  
of  
Human  
Services

CHAPTER SUBJECT:

BILLING AND PAYMENT  
FEDERALLY QUALIFIED  
HEALTH CENTER

CHAPTER PAGE

F - 25

DATE

November 1, 1998

### **C. Facsimile of Managed Care Wraparound Payment Request**

(See the following page.)

Page 26 intentionally left blank.

Iowa Department of Human Services  
**MANAGED CARE WRAPAROUND PAYMENT REQUEST**  
 Rural Health Clinics, Federally Qualified Health Centers  
 Quarterly Managed Care Organization (MCO) Reconciliation Worksheet  
 (Due 30 days from end of prior quarter)

<i>Date Received by ACS</i>	<i>Date Payment Approved</i>	<i>Approved By</i>
<i>Comments:</i>		

<b>Provider Name</b>	<b>Provider Type (RHC-FQHC)</b>
<b>Provider Location</b>	
<b>Reconciliation Quarter Ending</b>	<b>Provider Medicaid ID No.</b>

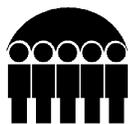
Return To: Provider Audit Dept.  
 ACS  
 P.O. Box 14422  
 Des Moines, IA 50306  
 Fax # 515-327-0945

1	2	3	4	5	6
# Medicaid MCO Encounters	Expected MCO Payments	Subcapitation Payments	Estimated MCO Payments to Be Received	Medicaid Regular Encounter Payments	Difference Reimbursable to Provider

1. Enter the number of daily encounters for Medicaid recipients receiving managed care benefits. These encounters must follow the rules in the RHC and FQHC Provider Manuals, Section V. Procedure Codes (in each).
2. List all dollar amounts normally expected to be received from the managed care organization for the services provided in #1, above. (Note: Exclude any subcapitation arrangements between the FQHC or RHC and the managed care organization.) If any payments are made over and above the general capitation payments, these must be listed here.
3. List all dollar amounts of contractual, risk-based capitation payments made on behalf of the managed care organization (for Iowa Medicaid recipients) for the provision of care NOT separately reimbursed by encounter.
4. Add together the total amounts from Columns 2 and 3.
5. Multiply the actual Medicaid encounter rate times the number of encounters shown in Column 1.
6. Subtract Column 5 from Column 4. This amount represents the wraparound payment that will be reimbursed by the Medicaid Program for the reconciliation quarter indicated.

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

Name	Title of Submitter
Signature	Date Submitted



## V. PROBLEMS WITH SUBMITTED CLAIMS

To inquire as to why a claim was denied or why a claim payment was not what you expected, please complete form 470-3744, *Provider Inquiry*. Attach copies of the claim, the *Remittance Advice*, and any supporting documentation you want to have considered, such as additional medical records. Send these to:

ACS, Attn: Provider Inquiry  
PO Box 14422  
Des Moines, Iowa 50306-3422

To make an adjustment to a claim following receipt of the *Remittance Advice*, use form 470-0040, *Credit/Adjustment Request*. Use the *Credit/Adjustment Request* to notify the fiscal agent to take an action against a paid claim, such as when:

- ◆ A paid claim amount needs to be changed, or
- ◆ Money needs to be credited back, or
- ◆ An entire *remittance advice* should be canceled.

Send this form to:

ACS, Attn: Credits and Adjustments  
PO Box 14422  
Des Moines, Iowa 50306-3422

Do **not** use this form when a claim has been denied. Denied claims must be resubmitted.

### A. Facsimile of Provider Inquiry, 470-3744

You can obtain this form by printing or copying the sample in the manual or contacting the fiscal agent. A facsimile of the form follows.

### B. Facsimile of Credit/Adjustment Request, 470-0040

You can obtain this form by printing or copying the sample in the manual or contacting the fiscal agent. A facsimile of the form follows.

Iowa Medicaid Program  
**PROVIDER INQUIRY**

Attach supporting documentation. Check applicable boxes:  Claim copy  Remittance copy  
 Other pertinent information for possible claim reprocessing.

<b>1. 17-DIGIT TCN</b>	<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 25%;"></td><td style="width: 25%;"></td><td style="width: 25%;"></td><td style="width: 25%;"></td> </tr> </table>				
<b>2. NATURE OF INQUIRY</b>	<div style="display: flex;"> <div style="writing-mode: vertical-rl; transform: rotate(180deg); font-weight: bold; margin-right: 5px;">I N Q U I R Y</div> <div style="border-bottom: 1px solid black; flex-grow: 1;"></div> </div> <div style="display: flex;"> <div style="writing-mode: vertical-rl; transform: rotate(180deg); font-weight: bold; margin-right: 5px;">A</div> <div style="border-bottom: 1px solid black; flex-grow: 1;"></div> </div>				
	<div style="border-bottom: 1px solid black; padding-bottom: 2px;">(Please do not write below this line)</div> <div style="border-bottom: 1px solid black; padding-bottom: 2px;"><b>FISCAL AGENT RESPONSE</b></div>				

<b>1. 17-DIGIT TCN</b>	<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 25%;"></td><td style="width: 25%;"></td><td style="width: 25%;"></td><td style="width: 25%;"></td> </tr> </table>				
<b>2. NATURE OF INQUIRY</b>	<div style="display: flex;"> <div style="writing-mode: vertical-rl; transform: rotate(180deg); font-weight: bold; margin-right: 5px;">I N Q U I R Y</div> <div style="border-bottom: 1px solid black; flex-grow: 1;"></div> </div> <div style="display: flex;"> <div style="writing-mode: vertical-rl; transform: rotate(180deg); font-weight: bold; margin-right: 5px;">B</div> <div style="border-bottom: 1px solid black; flex-grow: 1;"></div> </div>				
	<div style="border-bottom: 1px solid black; padding-bottom: 2px;">(Please do not write below this line)</div> <div style="border-bottom: 1px solid black; padding-bottom: 2px;"><b>FISCAL AGENT RESPONSE</b></div>				

<b>Provider Signature/Date:</b>	<b>MAIL TO: ACS P. O. BOX 14422 DES MOINES IA 50306-3422</b>	<b>ACS Signature/Date:</b>
---------------------------------	--	----------------------------

<b>Provider Please Complete:</b>	7-digit Medicaid Provider ID# _____ Telephone _____	(FOR ACS USE ONLY) PR Inquiry Log # _____ <b>Received Date Stamp:</b>
Name	<div style="border-bottom: 1px solid black; height: 15px;"></div>	
Street		
City, St		
Zip		

Page 30 was intentionally left blank.

Iowa Medicaid Program

CREDIT/ADJUSTMENT REQUEST

Do not use this form if your claim was denied. Resubmit denied claims.

<b>SECTION A: Check the most appropriate action and complete steps for that request.</b>												
<input type="checkbox"/> <b>CLAIM ADJUSTMENT</b> <ul style="list-style-type: none"> <li>◆ Attach a complete copy of claim. (If electronic, use next step.)</li> <li>◆ Attach a copy of the Remittance Advice with corrections in <b>red ink</b>.</li> <li>◆ Complete Sections B and C.</li> </ul>	<input type="checkbox"/> <b>CLAIM CREDIT</b> <ul style="list-style-type: none"> <li>◆ Attach a copy of the Remittance Advice.</li> <li>◆ Complete Sections B and C.</li> </ul>	<input type="checkbox"/> <b>CANCELLATION OF ENTIRE REMITTANCE ADVICE</b> <ul style="list-style-type: none"> <li>◆ Use only if all claims on Remittance Advice are incorrect. This option is rarely used.</li> <li>◆ Attach the check and Remittance Advice.</li> <li>◆ Skip Section B. Complete Section C.</li> </ul>										
<b>SECTION B:</b>												
<b>1. 17-digit TCN</b>												
<b>2. Pay-to Provider #:</b>						<b>4. 8-character Iowa Medicaid Recipient ID: (e.g., 1234567A)</b>						
<b>3. Provider Name and Address:</b>												
<b>5. Reason for Adjustment or Credit Request:</b>												
<b>SECTION C:</b>	<b>Provider/Representative Signature:</b>											
	<b>Date:</b>											
<b>FISCAL AGENT USE ONLY: REMARKS/STATUS</b>												
<b>Return All Requests To:</b>			<b>ACS</b> <b>PO Box 14422</b> <b>Des Moines, IA 50306-3422</b>									