IOWA | Health and Human Services

Number: 101
Title: Purpose and Framework of the Maternal Health Program & Child and Adolescent Health Program Administrative Manual
Effective Date: 10/01/2016
Revision Date: 3/3/2025
Date of Last Review: 3/3/2025
Authority: Iowa Code § 135.11(17), Iowa Administrative Code 641 IAC 76 (135), Social Security Act Title V §§701-710, subchapter V, Chapter 7, Title 42.

Overview

The Maternal Health (MH) Program & Child and Adolescent Health (CAH) Program Administrative Manual is used by the Iowa Department of Health and Human Services (Iowa HHS) staff and contractors. Whenever possible, hyperlinks to primary references have been included in this manual. Please note that website addresses are subject to change without notice.

Policy

The Maternal Health Program & Child and Adolescent Health Program Administrative Manual provides the basis for the development of policies, practices, and programming for MH and CAH services made available through the Department. Policies, procedures, and guidance provided in this manual shall be adhered to by contractors.

Procedure

1. The following terms will be used throughout the manual:
    a. **Contractor** - defined as the local agency contracted for Maternal Health and/or Child & Adolescent Health programs and services.
    b. **Client** - for MH: a pregnant or postpartum individual receiving services from a contractor; for CAH: an infant, child, adolescent, primary caregiver of a client, or other individual receiving services from a contractor.
    c. **Iowa HHS MCAH Data System** – refers to the integrated data system that supports the CAH programs.
2. The MH and CAH Program Administrative Manual delineates the MH/CAH core services and reflects changes in program funding. The manual is a dynamic document that may be continuously edited and updated. Each year, an evaluation to assess whether manual revisions are necessary shall be completed. The annual review and/or revision process does not preclude revisions that might be needed at other times of the year.
3. Each policy shall indicate the date it was updated or revised. Project Directors will be notified by Iowa HHS when a new version of a policy is available. It is the responsibility of the manual user to ensure they are using the most up-to-date policy as posted on the Iowa HHS website.
4. The entire manual with revisions is located on the Iowa HHS website at MCAH Portal Title V Tools.

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Resources

§§701-710, subchapter V, chapter 7, Title 42.
Iowa Administrative Code 641 IAC 76 (135)
Iowa Code § 135.11(17)

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Number: 102
Title: Purpose and Framework of the Maternal Health Program & Child and Adolescent Health Program
Effective Date: 10/01/2016
Revision Date: 03/03/2025
Date of Last Review: 03/03/2025
Authority: Iowa Administrative Code 641 IAC 76 (135), Social Security Act Title V Sec. 501. [42 U.S.C. 701]

Overview

The Child & Adolescent Health (CAH) program promotes the development of systems of care for children and adolescents from birth through age 21 years and their families to provide quality medical and dental homes providing services that are family-centered, community-based, collaborative, comprehensive, coordinated, competent, and developmentally appropriate.

The Maternal Health (MH) program strives to improve the health and well-being of women, pregnant women and their infants. The goals of the MH program are to:

1. Promote the health of women, pregnant women, and their infants by ensuring access to quality preventive health services, especially for populations with less access to health care.
2. Increase health assessments, health screening and follow-up diagnostic and treatment services.
3. Increase the number of women who are provided health education and psychosocial support.
4. Promote the development of community-based systems of medical and oral health care for women, pregnant women and infants.

MH services are designed to be community-based, family-centered, comprehensive, flexible, collaborative, coordinated, and culturally and developmentally appropriate.

The purpose of the federal Maternal and Child Health (MCH) Block Grants to states is to create a federal-state partnership to develop service systems in our nation's communities to meet critical challenges in maternal and child health, including:

1. To provide and assure mothers and children (in particular those with limited availability of health services) access to quality MCH services.
2. To reduce infant mortality and the incidence of preventable diseases and disabling conditions among children.
3. To reduce the need for inpatient and long-term care services.
4. To increase the number of children (especially preschool children) appropriately immunized against disease and the number of children less likely to access healthcare receiving health assessments, follow-up diagnostics, and treatment services.
5. To promote the health of mothers and infants by providing prenatal, delivery, and postpartum care for populations less likely to access healthcare services, and to promote the health of children by providing preventive and primary care services for children with limited access to healthcare.
6. To provide rehabilitation services for blind and disabled individuals under the age of 16 receiving benefits under Title XVI, to the extent medical assistance for such services is not provided under Title XIX.
7. To provide and promote family-centered, community-based, coordinated care for children with special health care needs (CSHCN) and to facilitate the development of community-based systems of services for such children and their families.

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Vision of Title V

Title V envisions a nation where all mothers, infants, children aged 1 through 21 years, including CSHCN, and their families are healthy and thriving.

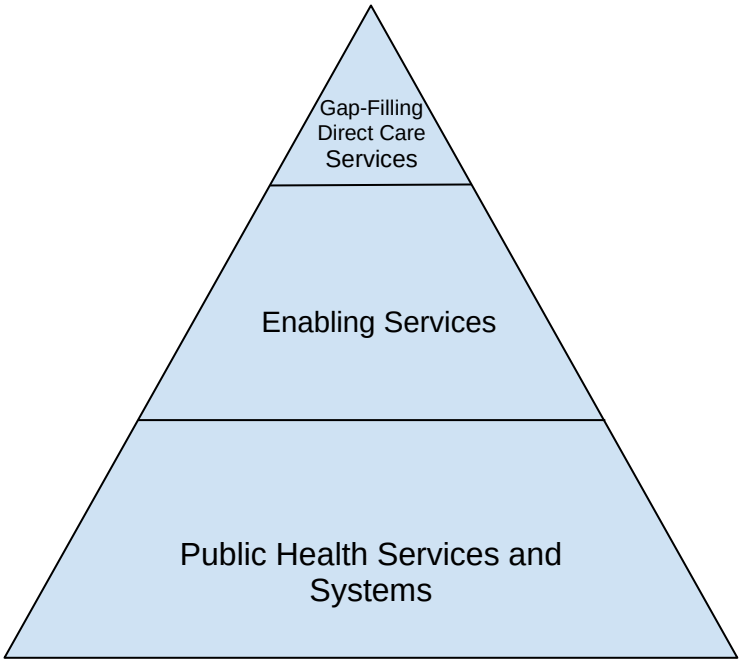
Mission of Title V

The mission of Title V is to improve the health and well-being of the nation's mothers, infants, children and youth, including children and youth with special health care needs, and their families.

Framework

The purpose and goals of the MH program and CAH program are implemented through the framework of the MCH Pyramid, core public health functions, and ten essential services.

MCH Pyramid



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Public Health Services and Systems involve activities that support the development and maintenance of comprehensive health service systems and population-based health services. Examples include:

1. Assessment of community needs and assets (Including the CHNA-HIP)
    a. Organizing open mouth surveys
2. Data collection and analysis
3. Program planning and evaluation
4. Development and monitoring of policies and procedures
5. Establishment of community linkages with primary care providers
    a. Surveying dental offices to identify oral health care accessibility in the service area
    b. Establishing regular, personal contact with dentists to advocate for children, pregnant women, and families
6. Coalition and collaboration building
    a. Conducting strategic planning with local oral health coalitions and other forums to assess community oral health needs
    b. Planning and implementing activities with community partners, such as “Give Kids a Smile Day”
    c. Professional development and training
    d. Educating and training physicians on oral health
    e. Establishing relationships with school health staff to ensure oral health education and prevention services
7. Quality assurance and quality improvement initiatives
    a. Developing referral tracking systems with local medical and dental offices
    b. Conducting in-service staff training to develop oral health education, care coordination, and referral protocols
8. Population-based services that provide preventive personal health services for groups of individuals rather than in one-on-one situations. Examples include:
    a. Oral screenings at a community event (e.g., health fair, open mouth surveys) or for children unable to meet the school dental screening requirement
    b. Breastfeeding promotion and support
    c. Health education for groups
    d. Providing oral health education for Head Start parents or prenatal classes
    e. Sudden Unexpected Infant Death Syndrome (SUIDS) awareness and education
    f. Early care and education (ECE) and school health education
    g. Public health awareness campaigns
    h. Promoting oral health

Enabling services assists families in gaining access to health care services. Examples include:

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1. Medicaid and Hawki Outreach
2. Presumptive Eligibility
3. Care coordination
4. Well visit reminders
5. Assisting with transportation
6. Assisting with interpretation services

Gap-Filling Direct Care Services provided by the MH and CAH programs are available to populations with less access to healthcare services enrolled in the MH/CAH programs based on individual and/or population identified needs**.** See policy 837 Provision of Gap-Filling Direct Care Services.

Core Public Health Services: The core public health functions described in the 1988 Institute of Medicine report, *The Future of Public Health*, provide the framework for the nation's public health system. They include:

1. Assessment
2. Policy Development
3. Assurance

Ten Essential Public Health Services: The 10 Essential Public Health Services (EPHS) describe the public health activities that all communities should undertake. They are:

1. Assess and monitor population health status, factors that influence health, and community needs and assets.
2. Investigate, diagnose, and address health problems and hazards affecting the population.
3. Communicate effectively to inform and educate people about health, factors that influence it, and how to improve it.
4. Strengthen, support, and mobilize communities and partnerships to improve health.
5. Create, champion, and implement policies, plans, and laws that impact health.
6. Utilize legal and regulatory actions designed to improve and protect the public's health.
7. Assure an effective system that enables equitable access to the individual services and care needed to be healthy.
8. Build and support a diverse and skilled public health workforce.
9. Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement.
10. Build and maintain a strong organizational infrastructure for public health.

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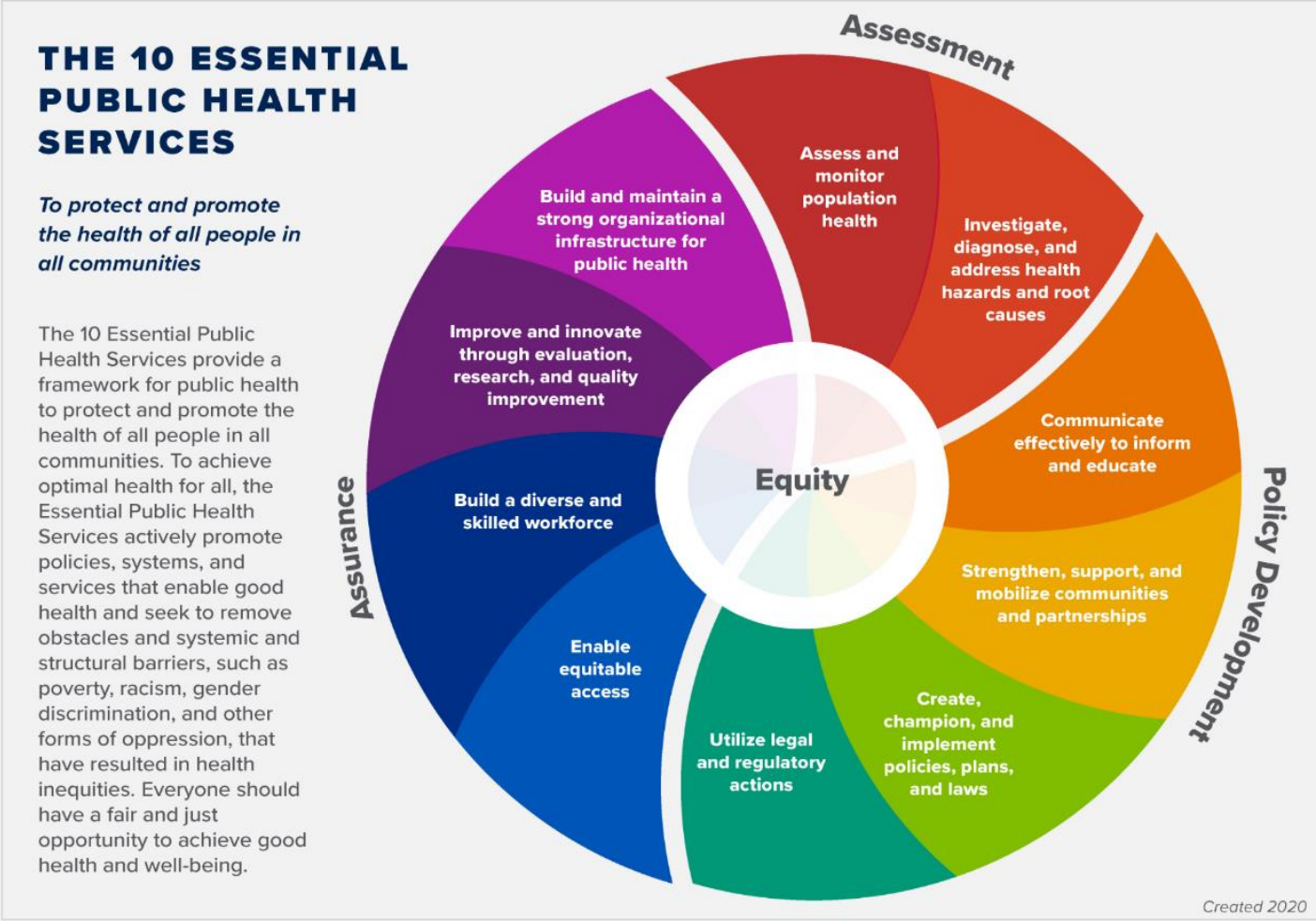

A crosswalk of the 10 Essential Public Health Services with the purpose of the State MCH Block Grants, as defined in Section 501(a)(1) of Title V of the Social Security Act, yielded the following strategies for states to use in their program planning:

1. Conduct ongoing assessment of the changing health needs of the MCH population to drive priorities for achieving equity in access and positive health outcomes.
2. Expand surveillance and other data systems capacity to support rapid investigation of emerging health issues that affect the MCAH population (e.g., Zika and Neonatal Abstinence Syndrome).
3. Inform and educate the public and families about the unique needs of the MCH population.

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4. Mobilize partners, including families and individuals, at the federal, state, and community levels in promoting a shared vision for leveraging resources, integrating and improving MCH systems of care, promoting quality public health services, and developing supportive policies.
5. Provide expertise and support for the formation and implementation of state laws, regulations, and other policies pertaining to the health of the MCH population (e.g., perinatal regionalization/risk-appropriate care and suicide prevention).
6. Integrate systems of public health, health care, and related community services to ensure equitable access and coordination to achieve maximum impact.
7. Promote the effective and efficient organization and utilization of resources to ensure access to necessary comprehensive services for CSHCN and families through public health services, systems, and population health efforts.
8. Educate the MCH workforce to build the capacity to ensure innovative, effective programs and services and the efficient and equitable use of resources.
9. Support or conduct applied research resulting in evidence-based policies and programs.
10. Facilitate rapid innovation and dissemination of effective practices through quality improvement and other emerging methods.
11. Provide services to address unmet needs in health care and public health systems for the MCH population.

Resources
§§701-710, subchapter V, chapter 7, Title 42.
Iowa Administrative Code 641 IAC 76 (135)
Iowa Code § 135.11(17)

Sources
Title V MCH Pyramid
Ten Essential Services
Institute of Medicine. (1988). *The Future of Public Health.* Washington, DC: National Academy Press

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Number: 103
Title: Federal and State Legislative Authority
Effective Date: 10/01/2016
Revision Date: 03/03/2025
Date of Last Review: 03/03/2025
Authority: Iowa Code § 135.11(17); Iowa Administrative Code 641 IAC 76; 641 IAC 50; Public Law 105-17: IDEA '97: PART C; HRSA 42 USC Section 705(A)(5)(F)

Overview

Federal authority for the Maternal Health (MH) & Child and Adolescent Health (CAH) program in Iowa is derived from Title V of the Social Security Act. In 1935, Congress enacted Title V of the Social Security Act, which authorized the Maternal Child Health (MCH) Services Program and provided a foundation and structure for assuring the health of mothers and children. Today, Title V is administered by the Maternal and Child Health Bureau as part of the Health Resources and Services Administration, Public Health Service, U.S. Department of Health and Human Services.

In 1935, Title V created the first federal-state partnerships in MCH services, Crippled Children's Services, and Child Welfare Services. Over the years, the Title V MCH program was amended several times in order to respond to socioeconomic realities and changes in political ideology. A major change to Title V MCH was the creation of the MCH Services Block Grant as part of the Omnibus Budget Reconciliation Act of 1981 (OBRA 81).

The Omnibus Budget Reconciliation Act of 1989 (OBRA 89) significantly changed the MCH Services Block Grant again. Based on these changes, states are now required to focus their efforts on preventive and primary health care for children, pregnant women and infants, and children with special health care needs. OBRA 89 requires states to improve accountability by conducting and submitting a periodic statewide needs assessment and report on the status of women and children served by the block grant. In 2015, an updated performance measure framework was introduced to reflect more clearly the contributions of Title V in improving health outcomes among the MCH population.

Block Grants

The Title V MCH Services Block Grant program currently has three components: formula block grants to 59 states and territories, Special Projects of Regional and National Significance (SPRANS), and Community Integrated Service Systems (CISS) grants.

Each year, Congress sets aside funding for the MCH Block Grant. Individual state allotments are determined by a formula that considers the proportion of low-income children in a particular state compared to the total number of low-income children in the entire U.S. States and jurisdictions must match every $4 of federal Title V money that they receive by at least $3 of state and/or local money (i.e., non-federal dollars). Additional information about the block grant can be found on the HRSA MCHB website.

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Iowa Administrative Code

The Iowa General Assembly has directed Iowa HHS to administer the statewide Maternal and Child Health Program in accordance with the requirements of Title V for the purpose of improving the health of women and children less likely to access healthcare. Iowa Code § 135.11(17). Iowa HHS has adopted administrative rules to implement the program: Iowa Administrative Code 641 IAC 76 provides the authority for Iowa's MCH Program and adopts the Omnibus Reconciliation Act of 1989 (OBRA 89, PL 101-239) requirements. The code gives Iowa HHS responsibility for the operation of the Maternal and Child Health Block Grant (Title V MCH). The Iowa Administrative Code at 641IAC 50 describes the purpose and responsibilities of the state oral health program and dental director.

Grant Application

Iowa HHS periodically solicits proposals to select the most qualified applicants to provide public health services at the community level for the MH and CAH Program. This is accomplished through a competitive Request for Proposal (RFP) for a multi-year project period. A Request for Application (RFA) is developed annually for the contractor's application for continued funding within the project period as defined by the applicable competitive selection document. Contracts are issued for one-year increments based on a review of the RFP and RFAs. Contractors are required to comply with both the general and special conditions of the contract, this Manual, and all relevant laws. This application process complies with Iowa HHS Service Contracting Policy (#FS 07-03-014), as well as 641 Iowa Administrative Code chapters 76 and 176.

Integration of Title V and Medicaid

Between 1967 and 1989, Congress enacted a number of amendments to Title V, adding requirements that MCH programs work closely with Medicaid in a number of activities. The amendments are located in Title V rules at HRSA 42 USC Section 705(a)(5)(F). The amendments require that state Title V MCH programs:

1. Assist with coordination of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program;
2. Establish coordination agreements with their state Medicaid program;
3. Provide a toll-free number for families seeking Title V or Medicaid providers;
4. Provide outreach and facilitate enrollment of Medicaid-eligible children and pregnant women;
5. Share data collection responsibilities, particularly related to infant mortality and Medicaid and
6. Provide services to children with special health care needs and disabilities not covered by Medicaid.

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In Iowa, Medicaid and Iowa HHS Title V enter into a contractual agreement for the purpose of cooperation, developing and sustaining a collaborative relationship to promote the availability of comprehensive, and to promote cost effective and quality health care services.

I-Smile™

The I-Smile™ program is the outcome of Medicaid reform legislation passed in 2005 by the Iowa Legislature. House File 841 included the following language: "…every recipient of medical assistance who is a child twelve years of age or younger shall have a designated dental home and shall be provided with the dental screenings and preventive care identified in the oral health standards under the Early and Periodic Screening, Diagnostic, and Treatment program."
In response, Iowa HHS partnered with the Iowa Dental Association, the Iowa Dental Hygienists' Association, Delta Dental of Iowa, and the University of Iowa College of Dentistry to develop a plan that would fulfill the dental home mandate. The result is called the I-Smile™ Dental Home Program. The Iowa Administrative Code 641, Chapter 50 outlines the administrative details of the dental programs. See Policy 902, The I-Smile Program, for more information.

Integration with Early ACCESS

Congress created the Individuals with Disabilities Education Act, Part C [20 U.S.C. 631] (IDEA), to assist states in designing and implementing systems of early intervention services for infants and toddlers with disabilities and their families. Iowa's Program, called Early ACCESS, is a partnership between families with young children aged birth to three years and providers from the signatory agencies (Iowa Department of Education (DE), Iowa HHS, and Child Health Specialty Clinics (CHSC)). The purpose of this program is for families and staff to work together to identify, coordinate, and provide needed services and resources that will help the family assist their child in growth and development.

Resources

Iowa Code § 135.11(17)
Iowa Administrative Code 641 IAC 76
Public Law 105-17: IDEA '97: PART C
Individuals with Disabilities Education Act, Part C [20 U.S.C. 631] (IDEA)
Iowa Administrative Code 641, Chapter 50
HRSA 42 USC Section 705(a)(5)(F)

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Number: 105-CAH
Title: Admission to Child and Adolescent Health Program
Effective Date: 10/01/2016
Revision Date: 03/05/2025
Date of Last Review: 03/05/2025
Authority: 641 Iowa Administrative Code chapters 76 and 77; Social Security Act Title V Section 506

Overview

The purpose of admission into the Child & Adolescent Health (CAH) program is to assist the client in accessing primary and preventive health care. The CAH program utilizes a medical home model to enable children and adolescents to receive quality care from a primary care provider responsible for both sick and well care. Children and adolescents (birth through age 21) are eligible for the program.

"Medical home" means a team approach to providing health care that originates in a primary care setting; fosters a partnership among the client, the personal provider, and other health care professionals and, where appropriate, the client's family; utilizes the partnership to access all medical and nonmedical health-related services needed by the client and the client's family to achieve maximum health potential; maintains a centralized, comprehensive record of all health-related services to promote continuity of care; and has all of the following characteristics:

1. A personal provider
2. A provider-directed team-based medical practice
3. Whole person orientation
4. Coordination and integration of care
5. Quality and safety
6. Enhanced access to health care
7. A payment system that appropriately recognizes the added value provided to patients who have a patient-centered medical home

Policy

Contractors shall admit children and adolescents to the CAH program to assist them in accessing quality primary and preventive health care primarily through enabling services. Contractors shall provide enabling services to all children and adolescents admitted to the CAH program to access a medical and dental home.

Procedure

A comprehensive assessment of the health status, social determinants of health, and needs of the client and family shall be completed at admission, updated on the date of service or within the 30 days prior, and annually thereafter while the child is enrolled in the program.

The adolescent (18 to 22 years old), or a family member with decision-making responsibility, is asked to sign a consent for services form and a release of information (ROI). A ROI is obtained if any medical record elements or health information will be shared outside the agency (See Policy 302 Client Records). If information will not be shared outside of the agency, a ROI is not required for admission into the CAH program.

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Number: 105-CAH
Title: Admission to Child and Adolescent Health Program
Effective Date: 10/01/2016
Revision Date: 03/03/2025
Date of Last Review: 03/03/2025
Authority: 641 Iowa Administrative Code chapters 76 and 77; Social Security Act Title V Section 506

Enabling services are provided to assist the family in decreasing barriers to accessing preventive services through their medical and dental home.

Direct care services are offered only after enabling services to assist the family in accessing the service from their medical home has failed. Documentation of the enabling services provided must be included in the client's record.

Any client admitted to the CAH program must be entered in the Iowa HHS Maternal Health (MH) & Child and Adolescent (CAH) Health Data System. A ROI is not required for entering data into the MCAH data system.

Resources
Iowa Administrative Code 641 Chapter 76
Iowa Administrative Code 641 Chapter 77
Social Security Act Title V Section 506

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Number: 106-CAH
Title: Child & Adolescent Health Program Eligibility & Voluntary Participation
Effective Date: 10/01/2016
Revision Date: 03/03/2025
Date of Last Review: 03/03/2025
Authority: Iowa Administrative Code 641-76; Social Security Act Title V Section 506

Overview

All clients under 22 years of age who are residents of Iowa are eligible for Child & Adolescent Health (CAH) services. Title V provides financial assistance for clients who qualify based on their insurance status, residence, and family income.

Policy

All children and adolescents under 22 years of age who are residents of Iowa are eligible for (CAH) services. Contractors shall determine eligibility for coverage of services at least annually and bill accordingly.

Procedure

Assist clients who may be eligible for Medicaid or Hawki

1. Clients who are uninsured or underinsured and whose family income falls within income guidelines for Medicaid shall be assisted in applying for Medicaid.
2. Children and adolescents who are uninsured or underinsured and whose family income falls within income guidelines for Hawki shall be assisted in applying for Hawki.

Financial coverage of services for children not eligible for Medicaid or Hawki

1. Clients 22 years of age and younger, living in Iowa, who are uninsured or underinsured and not eligible for Medicaid or Hawki are eligible for services covered by Title V grant funds if their family income falls within the income guidelines for the Hawki program. These clients receive services at no charge. Contractors may use Title V grant funds or program income to cover the cost of services.
2. Clients 22 years of age and younger, living in Iowa, with private insurance:
    a. may have services billed to their insurance,
    b. may be private pay based on a sliding fee scale or
    c. The contractor can use program income to cover the costs of services.
3. Title V grant funds and Medicaid Administrative Funds (MAF) may not be used for children with private insurance or who are underinsured but whose income exceeds Title V/Hawki guidelines.
4. Clients whose family income is at or above 300% of the poverty level qualify for Title V CAH services at full fee.

Assess the income on all children and adolescents

1. Income is assessed on all children and adolescents based on Federal Poverty Guidelines, family income, and household size. Income information is provided by the individual or family (self-declared).

Number: 106-CAH
Title: Child & Adolescent Health Program Eligibility & Voluntary Participation
Effective Date: 10/01/2016
Revision Date: 03/03/2025
Date of Last Review: 03/03/2025
Authority: Iowa Administrative Code 641-76; Social Security Act Title V Section 506

2. Income is calculated as follows:
    a. Annual income is estimated based on the individual and/or family's income for the past three months, unless the individual and/or family's income will be changing or has changed.
    b. In the case of self-employed families, the past year's income tax return (adjusted gross) is used in estimating annual income unless a change has occurred.
    c. Terminated income is not considered.
3. Proof of Medicaid, Hawki, or WIC eligibility serves in lieu of income assessment.
4. Federal Poverty Guidelines are published annually by the U.S. Department of Health and Human Services (DHHS). CAH program eligibility guidelines are adjusted following any change in DHHS guidelines.
5. Family is defined as a group of two or more persons related by birth, marriage, adoption, or residing together and functioning as one socioeconomic unit.
6. Eligibility determination must be done at least once annually. When an individual and/or family's circumstances change in a manner that affects third-party coverage, Medicaid, or Hawki eligibility, an eligibility determination shall be completed.

Residency Requirement
Clients must currently reside in Iowa to receive Title V CAH services.

Voluntary Participation
1. Title V services are provided solely on a voluntary basis. Individuals shall not be subjected to coercion or discrimination in the delivery of services. Acceptance of Title V services is not a prerequisite to eligibility for any other services, assistance, or participation in any other program.
2. Clients are encouraged to ask questions and may refuse service or stop services at any time.

Resources
Iowa Administrative Code 641 Chapter 76

Social Security Act Title V Section 506

Federal Poverty Guidelines

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Number: 201
Title: Required Personnel Policies
Effective Date: 10/01/2022
Revision Date: 03/05/2025
Date of Last Review: 03/05/2025
Authority: Iowa Administrative Code 641-76; Iowa HHS General Conditions for Service Contracts

Policy

The Maternal Health (MH) Program & Child and Adolescent Health (CAH) Program Administrative Manual provides the basis for the development of policies, practices, and programming for MH and CAH services made available through Iowa HHS. Policies, procedures, and guidance provided in this manual shall be adhered to by contractors.

Procedure

1. Contractors and subcontractors must establish and maintain personnel policies that comply with all applicable Federal, State, and local laws and requirements, including but not limited to Title VI of the Civil Rights Act of 1964 (PL 88-352), 45 CFR Part 80, Section 504 of Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990 as amended, the Iowa Civil Rights Act of 1965 as amended, Equal Employment Opportunity Act of 1973, the Age Discrimination Act of 1968 and 1975 and the OWBPA of 1990, 7 CFR Part 15, OSHA, the Drug Free Workplace Act of 1988, the Family and Medical Leave Act (FMLA), Certification of Compliance with Pro-Children Act of 1994, the Patient Protection and Affordable Care Act (ACA) and the Iowa Smokefree Air Act at Iowa Code chapter 142D. Contractors and subcontractors should consult with the agency or organization's legal counsel to ensure compliance with all relevant federal, state, and local laws.
2. Contractors are responsible for ensuring that subcontractors have the required personnel policies and procedures that comply with all applicable Federal, State and local requirements. Contractors shall document the review of subcontractor personnel policies and procedures.
3. Each Contractor and subcontractor providing gap-filling direct health care services shall perform those services under the direction of the Medical Director (See Policy 204 Medical Director).
4. Contractors shall verify licenses of applicants for positions requiring licensure **prior** to employment, and documentation of licenses must be kept current. The Contractor is responsible for assuring all persons, whether employees, contractors, subcontractors, or anyone acting on behalf of the Contractor, are properly licensed, certified, or accredited as required under applicable state law and the requirements of the CAH program.
5. Contractors shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9 .4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by IME and Iowa HHS.

Number: 201
Title: Required Personnel Policies
Effective Date: 10/01/2022
Revision Date: 03/05/2025
Date of Last Review: 03/05/2025
Authority: Iowa Administrative Code 641-76; Iowa HHS General Conditions for Service Contracts

6. Contractors must provide standards of practice for service providers, including staff, contractors, and subcontractors, who are not otherwise licensed, certified, or accredited under state law or administrative code.
7. Contractors shall provide and ensure completion of an orientation to CAH program requirements for all CAH program personnel, including staff, contractors, and subcontractors prior to providing services.
8. Contractors shall ensure all CAH program personnel, including staff, contractors, and subcontractors demonstrate proficiency in providing CAH program services prior to providing services.
9. The Department reserves the right to inquire at any time about the staffing assignments, training, and credentials of any staff member with direct responsibilities in the CAH program.
10. All orientation, training, and continuing education shall be documented in the personnel file.
11. Contractors shall ensure policies and procedures are in place that direct how all programs and services are to be administered.
12. Contractors and subcontract staff should be representative of the population served.
13. Contractors are required to satisfy the minimum staffing and credentialing requirements of the CAH program.
14. Contractors and subcontractors shall maintain documentation of staffing in the form of CAH program continuous time studies, direct hours billed, and/or staff timesheets and supply them upon request.
15. Contractors shall ensure confidential, secure, and appropriate guidelines for teleworking.
16. Contractors shall ensure that if telework is used, health care services are provided from an approved telework site.
17. Contractors shall conduct an evaluation and review of job performance of all CAH program personnel annually.
    a. All CAH program personnel shall have an annual review of competency and performance in the provision of family-centered services.
    b. All CAH personnel providing clinical care shall have an annual review of competency in the skills required for each clinical service offered by the contractor as appropriate for their role.
18. Contractors shall have a written policy on the provision of continuing education, including attendance at professional development activities to promote cultural and linguistic competencies. It is suggested that all personnel have the option to attend continuing education

Number: 201
Title: Required Personnel Policies
Effective Date: 10/01/2022
Revision Date: 03/05/2025
Date of Last Review: 03/05/2025
Authority: Iowa Administrative Code 641-76; Iowa HHS General Conditions for Service Contracts

based on an assessment of training needs, quality assurance indicators, and changing regulations/requirements. Cultural competency training must be documented.

19. Contractors shall have a Child and Dependent Abuse Reporting policy that covers all staff in the CAH program (See Policy 205 Child and Dependent Abuse Reporting).

Resources

Iowa Administrative Code 641-76
Iowa HHS Contract General Conditions for Service Contracts

Number: 202-CAH
Title: Required Personnel
Effective Date: 10/01/2016
Revision Date: 03/05/2025
Date of Last Review: 03/05/2025
Authority: Iowa Administrative Code 641-76, HHS General Conditions for Service Contracts

Overview

A broad range of competencies are required of personnel to carry out Child and Adolescent Health (CAH) public health services and systems, enabling services, and direct health care services. Contractors must secure and retain personnel or subcontractors with expertise in public health, business administration, quality assurance and improvement, policy development, information systems, community systems building, health equity, care coordination, child and adolescent health, and child and adolescent clinical care.

Policy

Contractors are required to satisfy the minimum staffing and credentialing requirements of Iowa HHS and the CAH program.

Procedure

The following positions, credentials, and competencies are required:

Medical Director: See Policy 204 Medical Director

Executive Director: The executive director is responsible for supervisory and contract management tasks related to the CAH program as outlined in the agency application. Communications regarding the CAH contract shall be sent to the executive director. It is the responsibility of the executive director to appropriately disseminate information to the contractor's board of directors, project director, and program coordinators. Information related to the contract may be sent to the board of directors, program director, and program coordinators at the discretion of Iowa HHS. The executive director's responsibilities include, but are not limited to:

1. Serving as contract administrator
2. Supervising the project director and program coordinator(s)
3. Providing overall supervision of CAH programming (planning, development, and evaluation)
4. Overseeing the annual program and budget application
5. Developing and managing subcontracts
6. Assuring that written policies, procedures, and accounting comply with state and federal laws
7. Monitoring budgets and expenditures

Number: 202-CAH
Title: Required Personnel
Effective Date: 10/01/2016
Revision Date: 03/05/2025
Date of Last Review: 03/05/2025
Authority: Iowa Administrative Code 641-76, HHS General Conditions for Service Contracts

8. Coordinating CAH program activities with other agency programs
9. Reporting to the agency board of directors and/or the local Boards of Health

Project Director: The project director is required to have a bachelor's degree in a health or human services field or current license as a registered nurse (RN) with a bachelor's degree in any field; a minimum of six months experience in health or human services; and demonstration of the following skills and experience:

1. Ability to synthesize quantitative and qualitative data to make decisions for program implementation;
2. Strong interpersonal skills and experience building and maintaining relationships with a variety of partners;
3. Strong positive conflict resolution skills;
4. Communication skills, including the ability to communicate with individuals and groups, both small and large, about programs and services;
5. Lived experience as a member of a population with limited access to healthcare or experience working with populations with limited access to healthcare;
6. Experience convening and facilitating groups, such as coalitions or committees, with a focus on a specific topic, health outcome, or population and
7. Understanding of health equity and child and adolescent health needs.

The project director's responsibilities include, but are not limited to:

1. Communicate information to staff, contractors, and subcontractors
2. Manage the CAH contract by:
    a. Ensuring completion of activity work plans and other required forms
    b. Ensuring budgets are in compliance with guidance and state and federal laws
    c. Ensuring completion of contractor reports
    d. Overseeing contractual relationships with subcontractors
    e. Providing written notice of key personnel changes
    f. Ensuring progress on program activities
    g. Monitoring compliance with grant activities and submitting changes to HHS as necessary
    h. Overseeing and coordinating CAH programming
    i. Ensuring provision and coordination of CAH services
    j. Ensuring documentation requirements are met

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Authority: Iowa Administrative Code 641-76, HHS General Conditions for Service Contracts

k. Providing leadership for quality assurance activities including, but not limited to, chart audits and service note reviews.

3. Ensure the provision of high-quality enabling services to clients by:
    a. Ensuring a robust referral network is maintained to meet the needs of all clients by building a referral network throughout the CSA of primary care providers to serve as medical homes; provide comprehensive well child visits to Title V clients, clients during the Presumptive Eligibility period, and clients enrolled in Medicaid Fee-For-Service. These networks shall include:
        i. Providers in all counties of the CSA.
        ii. Providers with lived experience and/or special training in the needs of populations with limited access to healthcare and who provide culturally and linguistically appropriate care for populations with limited access to healthcare.
        iii. Providers outside the contractor's organization/system to ensure client choice.
    b. Ensuring equal opportunity, support, and assistance to clients regardless of the provider chosen.
    c. Collaborating with the I-Smile coordinator to ensure child and adolescent dental services are available.
    d. Ensuring the provision of enabling services to clients.
    e. Ensuring effective, client-centered referrals with follow-up for each client.
4. Planning and oversight of CAH services:
    a. Collect and monitor quantitative and qualitative data to determine program needs for the entire CSA.
    b. Ensure implementation of quality improvement initiatives.
    c. Attend meetings and training relevant to CAH Program operations.
    d. Ensure compliance with state and federal laws and guidelines.
    e. Ensure training for staff and subcontractors.
    f. Ensure participation in the community health needs assessments and health improvement plans (CHNA-HIPs) within the CSA.
    g. Ensure collaboration and community engagement throughout the CSA.
    h. Assist the local boards of health in the performance of the core public health functions of assessment, assurance, and policy development.

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i. Ensure development and implementation of high-quality public health services and systems-level activities.
j. Foster coordination among local programs serving families (Title X, home visiting, WIC, MH, CAH, I-Smile, HCCI, Hawki, etc.) and subcontractors.
k. Provide outreach and education in the community about child and adolescent health.
l. Act as a liaison in the CSA between local public health/boards of health, Iowa HHS, and other agencies and community coalitions.
m. Ensure outreach, engagement, and education with families about CAH programs and services.
n. Engage families to provide direction and feedback for program planning, implementation, and evaluation.
o. Engage the community in communicating and developing solutions to child and adolescent health needs, issues, and concerns.
p. Engage families from populations with limited access to healthcare and community agencies serving populations with limited access to healthcare.

Fiscal Officer: The fiscal officer is responsible for carrying out activities directed by the executive director and project director. The fiscal officer is responsible for the management of accurate accounting for grants and other funds using generally accepted accounting principles and meeting requirements of applicable Federal Office of Management and Budget (OMB) circulars.

Child Care Nurse Consultant: Child Care Nurse Consultants (CCNC) hired or contracted to provide services under the Healthy Child Care Iowa (HCCI) program are required to be a registered nurse with current Iowa licensure in addition to one of the following:

1. Bachelor of Science in Nursing, or
2. Minimum of two years of experience as a registered nurse in community health, public health, pediatric practice, or other pediatric setting.

The CCNC must complete the Iowa Training Project for Child Care Nurse Consultants (ITPCCNC) course supported by Iowa HHS. A minimum of 4-20 hours of work time per unit is expected to complete the 12 units of ITPCCNC training. The training series must

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be completed within three months from the time of enrollment into the course. See the Child Care Nurse Consultant Role Guidance for additional requirements and responsibilities.

Hawki Outreach Coordinator: Contractors are encouraged to hire individuals with recent lived experience. This may include people who:

1. Self-identify as belonging to a population with limited access to healthcare;
2. Have been enrolled in Medicaid or Hawki in the 2 years preceding hire; or
3. Are the parent(s) of a child enrolled in Medicaid or Hawki in the 2 years preceding hire

The responsibilities of the Hawki Outreach coordinator include, but are not limited to:

1. Promoting the implementation of best practice outreach strategies to encourage enrollment in Hawki and Medicaid programs.
2. Ensuring dissemination of approved and up-to-date program information.
3. Completing required reports and attending required meetings.
4. Be a qualified entity to conduct Presumptive Eligibility throughout the CSA.
5. Conducting Hawki and Medicaid Outreach to businesses and organizations in the community, providing onsite Presumptive Eligibility throughout the CSA.
6. Conducting Hawki and Medicaid Outreach outside traditional business hours (8 am to 4:30 pm Monday through Friday) and on weekends to provide education and assistance with Presumptive Eligibility to individuals with a variety of work schedules.

CAH Data Administrator: The responsibilities of the CAH Data Administrator include, but are not limited to:

1. Sharing announcements, updates, and information with all CAH program staff about the HHS Maternal Health (MH)/Child and Adolescent Health (CAH) Data System.
2. Monitoring CAH quality assurance reports and implementing quality improvement plans to improve data entry.
3. Ensuring new CAH staff receive training on the HHS MH/CAH Data System.
4. Assisting CAH program staff in troubleshooting data entry and workflow issues.
5. Attending required training.
6. Monitoring addition and deletion of users.
7. Performing editing functions in the HHS MH/CAH Data System client records.

Number: 202-CAH
Title: Required Personnel
Effective Date: 10/01/2016
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Date of Last Review: 03/05/2025
Authority: Iowa Administrative Code 641-76, HHS General Conditions for Service Contracts

8. Notifying HHS of any security breaches and cooperating with investigations.

I-Smile™ Coordinator: Each CAH Contractor must have an Iowa-licensed dental hygienist serving as the I-Smile™ Coordinator. The I-Smile™ Coordinator must work at least 32 hours a week on activities to build local public health system capacity and to ensure the provision of enabling and population-based oral health services. The I-Smile™ Coordinator is the single point of contact for oral health activities in each CSA and is included on the Key Personnel Form for CAH Contractors. The I-Smile™ Coordinator is also required to collaborate with the MH Contractor for the CSA (See Policy 902 The I-Smile™ Program).

Direct Dental Services Planner (DDSP): Each CAH Contractor must have an Iowa-licensed registered dental hygienist (RDH) or registered dental assistant (RDA) to serve as the Direct Dental Service Planner (DDSP). The DDSP assists the I-Smile™ Coordinator by planning and coordinating direct dental services provided by the Contractor. The DDSP may provide direct dental services (See Policy 902 The I-Smile™ Program and 903 The I-Smile™ @ School Program).

Resources
Iowa Administrative Code 641-76
HHS General Conditions for Service Contracts

IOWA Health and Human Services

Number: 203
Title: Excluded Providers
Effective Date: 10/01/2016
Revision Date: 03/07/2025
Date of Last Review: 03/07/2025
Authority: Section 1903(i)(2) of the Social Security Act (the Act); 42 CFR section 1001.1901(b); section 1128B based on the authority contained in various sections of the Act, including sections 1128, 1128A, and 1156. Iowa Administrative Code 441-79.2.

Overview

The Department supports efforts to prevent Medicaid fraud by requiring Contractors to check the Medicaid exclusion status of individuals and entities prior to entering into employment or contractual relationships. The effect of an exclusion (not being able to participate) is:

1. No payment will be made by any federal health care program for any items or services furnished, ordered, or prescribed by an excluded individual or entity. Federal health care programs include Medicare, Medicaid, and all other plans and programs that provide health benefits funded directly or indirectly by the United States (other than the Federal Employees Health Benefits Plan). For exclusions implemented prior to August 4, 1997, the exclusion covers the following federal health care programs: Medicare (Title XVIII), Medicaid (Title XIX), Maternal and Child Health Services Block Grant (Title V), Block Grants to States for Social Services (Title XX) and State Children's Health Insurance (Title XXI) programs.
2. No program payment will be made for anything that an excluded person furnishes, orders, or prescribes. This payment prohibition applies to the excluded person, anyone who employs or contracts with the excluded person, any hospital or other provider where the excluded person provides services, and anyone else. The exclusion applies regardless of who submits the claims and applies to all administrative and management services furnished by the excluded person.
3. There is a limited exception to exclusions for the provision of certain emergency items or services not provided in a hospital emergency room.

Policy

Contractors shall check the Medicaid exclusion status of individuals/entities prior to entering into employment or contractual relationships and at least annually thereafter. The Contractor will maintain records of these inquiries.

Procedure

The Contractor shall:

1. Check the List of Excluded Individuals and Entities (LEIE) site prior to entering into employment or contractual relationships.
2. Check the site at least annually for current employees and contractors. Contractors should search the HHS-OIG website to capture exclusions and reinstatements that have occurred since the last search.
3. Document that the search was complete for all employees, subcontractors, and contractors.

IOWA | Health and Human Services

Number: 203
Title: Excluded Providers
Effective Date: 10/01/2016
Revision Date: 03/07/2025
Date of Last Review: 03/07/2025
Authority: Section 1903(i)(2) of the Social Security Act (the Act); 42 CFR section 1001.1901(b); section 1128B based on the authority contained in various sections of the Act, including sections 1128, 1128A, and 1156. Iowa Administrative Code 441-79.2.

Resources

DHHS OIG Exclusions Program Background Information
DHHS OIG Exclusions Program
"Special Advisory Bulletin: The Effect of Exclusion From Participation in Federal Health Care Programs"
State Medicaid Director Letter dated January 16, 2009 (SMDL #09-001)
IME Informational Letter #1001 of April 8, 2011
Section 1903(i)(2) of the Social Security Act (the Act);
42 CFR section 1001.1901(b); section 1128B based on the authority contained in various sections of the Act, including sections 1128, 1128A, and 1156.
Iowa Administrative Code 441-79.2.

IOWA | Health and Human Services

Number: 204- MCAH
Title: Medical Director
Effective Date: 10/01/2022
Revision Date: 03/07/2025
Date of Last Review: 03/07/2025
Authority: Iowa Administrative Code 641-76, Iowa HHS General Conditions for Service Contracts

Policy

Contractors must have a formal agreement with a physician (MD or DO) to serve as a medical director. The responsibilities of the medical director include oversight and consultation for Child and Adolescent Health (CAH) or Maternal Health (MH) programs. All clinical policies shall be reviewed and approved annually by the Medical Director. Each contractor and subcontractor providing gap-filling direct health care services must perform those services under the direction of a physician with special training or experience in Child and Adolescent Health for CAH programs or Maternal Health for MH Programs.

Procedure

One physician may serve as the medical director for multiple programs, provided their medical specialty qualifies them to serve in that capacity.

Only licensed or certified professionals operating at a level and within a scope of practice appropriate for their license or certificate may provide gap-filling direct care health services. Physician assistants and registered nurses perform delegated medical functions under protocols and/or standing orders approved by the medical director. Advanced registered nurse practitioners may provide clinical health services based on their licenses and within the contractor's policies and procedures. A medical director may delegate functions to other health care professionals provided such functions are within the professional's scope of practice and consistent with the contractor's policies and procedures (see Policy 201 Required Personnel Policies). Prior to providing gap-filling direct health care services, staff must be oriented to their respective CAH or MH program, trained in the Contractor's policies and procedures, and demonstrate competence in providing the service.

At a minimum, Contractors must meet with their Medical Director once a year to review policies and procedures, obtain standing orders, and conduct general CAH or MH program planning.

Resources

Iowa Administrative Code 641-76
Iowa HHS Contract General Conditions for Service Contracts

IOWA | Health and Human Services

Number: 205
Title: Child Abuse Reporting
Effective Date: 10/01/2016
Revision Date: 03/07/2025
Date of Last Review: 03/07/2025
Authority: Iowa Code § 235B.3(2); Iowa Code § 232.69; 441 Iowa Administrative Code [441] Chapter 175

Overview

The child abuse reporting law is to provide protection to children by encouraging the reporting of suspected abuse. Iowa HHS has the legal authority to conduct an assessment of alleged child and dependent adult abuse.

It's everyone's responsibility to report suspected abuse. Iowa Code section 232.69 defines certain professionals as mandatory reporters of child abuse, and Iowa Code section 235B.3(2) defines certain professionals as mandatory reporters of dependent adult abuse. Professionals in the fields of health, law enforcement, early care and education (ECE), education, mental health, and social work who have contact with children in the course of their work are considered to be mandatory reporters. Although anyone can report child and dependent adult abuse and is encouraged to do so, mandatory reporters are required by law to make a report of suspected abuse within 24 hours of becoming aware of the concern(s).

HF731, signed into law on May 8, 2019, delegates responsibility for mandatory reporter training to the Iowa Department of Health and Human Services. Mandatory reporters are required to complete the training every three years, as appropriate for their role and position. These are the only approved training allowed in Iowa: DS 168 Dependent Adult Abuse Mandatory Reporter Training and DS 169 Child Abuse Mandatory Reporter Training.

Policy

Contractors shall ensure all staff who come in contact with children and dependent adults have completed the Iowa HHS Mandatory Reporter Training on recognizing abuse and training on the contractor's policies and procedures about reporting suspected abuse. Contractors shall have policies and procedures that comply with the Iowa Code and Iowa Administrative Code for mandatory and permissive assessment and reporting of child and dependent adult abuse.

Procedure

Contractors shall have policies in place that specify agency compliance with the Iowa Code that addresses child and dependent adult abuse and reporting of abuse. Contractors shall have written policies outlining the following:

1. Every individual required to report suspected abuse as defined in Iowa Code 232.69(1) and Iowa Code 235B.3(2) must complete 2 hours of mandatory reporter training within their first six months of employment or self-employment and one hour of additional training every three years (unless otherwise specified by federal regulations). If employees or contractors qualify as a mandatory reporter for both child abuse and dependent adult abuse, they are required to take both training and maintain certification for both curricula.

Number: 205
Title: Child Abuse Reporting
Effective Date: 10/01/2016
Revision Date: 03/07/2025
Date of Last Review: 03/07/2025
Authority: Iowa Code § 235B.3(2); Iowa Code § 232.69; 441 Iowa Administrative Code [441] Chapter 175

2. Maintenance of documentation showing completion of training(s) for each employee or contractor.
3. Job classifications that identify staff or contractor positions that are mandatory assessors and reporters of child abuse.
4. The procedure for filing child abuse reports, both verbal and written.
5. Storage and access to written child abuse reports.
6. Process for consulting with a supervisor or medical director when staff is unsure whether to report or not.
7. Provision and procedure for staff who are permissive reporters to report suspected abuse
8. Contractors are responsible for contacting the Department of Human Services for guidance and interpretation of the law.

Resources
Child Abuse: A Guide for Mandatory Reporters, Comm. 164
Dependent Adult Abuse: A Guide for Mandatory Reporters, Comm. 118
Abuse Reporting Hotline: 1-800-362-2178

Sources
Title X Family Planning Manual
Iowa Code § 235B.3(2)
Iowa Code § 232.69
Child Abuse: A Guide for Mandatory Reporters, Comm. 164
Dependent Adult Abuse: A Guide for Mandatory Reporters, Comm. 118
Form 470-0665, Report of Suspected Child Abuse
Chapter 175 Iowa Administrative Code - Child Abuse
Iowa Code:

1. 232.68 – Definition of child and child abuse, including child sex trafficking
2. 232.69 – Mandatory and Permissive reports---Training required
3. 232.70 – Reporting Procedure
4. 232.71B - Duties of Department Upon Receipt of Report
5. 232.73 - Medically relevant tests — immunity from liability
6. 232.77 Photographs, X-rays, and medically relevant tests.
7. 692A - Sex Offender Registry
8. 702.11 Forcible Felony
9. 709.1 – Sexual abuse defined
10. 709.2 – Sexual abuse in the first degree

Number: 205
Title: Child Abuse Reporting
Effective Date: 10/01/2016
Revision Date: 10/10/2024
Date of Last Review: 10/10/2024
Authority: Iowa Code § 235B.3(2); Iowa Code § 232.69; 441 Iowa Administrative Code [441] Chapter 175

11. 709.3 – Sexual abuse in the second degree
12. 709.4 – Sexual abuse in the third degree
13. 710A.1 - Human Trafficking
14. 717C.1- Bestiality
15. 725.1 – Prostitution
16. 726.2 – Incest
17. 728.1- Obscenity
18. 728.12 – Sexual exploitation of a minor

IOWA | Health and Human Services

Number: 300-CAH
Title: Criteria for Becoming an EPSDT Medicaid Screening Center
Effective Date: 10/01/2016
Revision Date: 03/07/2025
Date of Last Review: 03/07/2025
Authority: Medicaid Screening Center Provider Manual, Iowa HHS Omnibus Agreement

Overview

Medicaid Screening Centers (also called Screening Centers) are a type of designated service provider through the Iowa Department of Health and Human Services (HHS) and Iowa Medicaid Enterprise (IME). Screening Centers provide select Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services to Medicaid-eligible clients and can bill for these services in compliance with the Iowa HHS Medicaid Screening Center Provider Manual, Medicaid policies, and the Title V Child and Adolescent Health (CAH) program policies/procedures/guidance.

Policy

Contractors are required to meet and maintain the qualifications necessary for designation as a Medicaid Screening Center. Contractors must comply with quality standards and provide services consistent with guidelines established by Iowa HHS, IME, and the Title V Program. See the Medicaid Screening Center Provider Manual for more information.

Procedure

1. Contractors must maintain Medicaid Screening Center Provider status to bill Medicaid EPSDT Services. The application process and necessary documentation are located on the DHS website: Enrolling as a Medicaid Provider.
2. Only Contractors are eligible to be Screening Centers, subcontractors are not eligible. Services provided by the subcontractor must be processed through the Contractor as the Screening Center.
    a. Contractors (acting as subcontractors) providing services via agreement with another Contractor shall work with the Contractor holding the contract for the service area to determine billing.
    b. This shall be outlined in the written agreement to provide services.
3. A letter authorizing the contractor as a contractor in good standing with the Title V Program will be required by IME to become a Medicaid Screening Center. The Title V Program will provide this letter upon request.

Sources

Medicaid Screening Center Provider Manual

Number: 301
Title: Required Policies and Procedures
Effective Date: 10/01/2022
Revision Date: 03/07/2025
Date of Last Review: 03/07/2025
Authority: Iowa Administrative Code 641-76, Iowa HHS General Conditions for Service Contracts; OCIO Information Technology Standards

Overview

A policy should state the course of action an organization wants to pursue. Procedures describe actions or tasks necessary to meet a specific policy. Policies and procedures must be made available and accessible to all staff and must be maintained with current information.

Policy

Contractors and subcontractors shall have written policies and procedures that guide the administration and operations of the Maternal Health (MH) and Child and Adolescent Health (CAH) programs. These policies and procedures shall comply with federal and state law, Iowa HHS General and Special Contract conditions, Office of Chief Information Officer Standards, the CAH program, and this manual. Additionally, Contractors shall have an individual order or written standing orders for the provision of any gap-filling direct health care service.

Procedure

Policies and procedures should be reviewed and revised annually and no less frequently than every three years.

1. Contractors reviewing policies less than annually shall specify the frequency in a contractor's policy.
2. An effective date, revision effective date, and revision history shall be clearly indicated.
3. The following policies and procedures are required:
    a. Personnel (see Policy 201 Required Personnel Policies)
        i. Staff representation of the client population
        ii. Responsibility and review of subcontractor policies and procedures
        iii. Medical director supervision
        iv. Minimum staffing and credentialing requirements
        v. Excluded providers
    b. Emergency (see Policy 830 Medical and Non-Medical Emergencies)
    c. Fiscal Policies (see Section 400)
        i. Accounting Standards
        ii. Approval authorities
        iii. Bad debt write-off
        iv. Billing procedures
        v. Continuous daily time studies
        vi. Expenditure reports
        vii. Inventory management

Number: 301
Title: Required Policies and Procedures
Effective Date: 10/01/2022
Revision Date: 03/07/2025
Date of Last Review: 03/07/2025
Authority: Iowa Administrative Code 641-76, Iowa HHS General Conditions for Service Contracts; OCIO Information Technology Standards

viii. Lines of responsibility
ix. Method for determining administrative and indirect costs
x. Payment schedule-client fees
xi. Sliding fee scale
xii. Purchasing procedures
xiii. Record-keeping requirements
xiv. Segregation of duties

d. Medical record policies (see Sections 300 and 500)
   i. Limited acceptable abbreviations in client records
   ii. Record security, maintenance, retention, and storage
   iii. Client consent
   iv. Release of information
e. Program policies (see Sections 200, 300, 500, 600, 700, and 900)
   i. Appointment system
   ii. Client eligibility
   iii. Referrals and follow up
   iv. Integration of CAH program and services with other Iowa HHS programs and services
   v. Quality assurance/quality improvement
   vi. Confidentiality
   vii. Review and approval of informational and educational materials
   viii. Client and family input
   ix. Limited English proficiency
   x. Interpretation and use of interpreters
   xi. Confidential, secure, and appropriate guidelines for telework sites
   xii. Certification of Compliance with the Pro-Children Act of 1994. The Contractor must comply with Public Law 103-227, Part C Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act).
f. Gap-Filling Direct Health Care Clinical policies (see Section 800)
g. Contractors must maintain policies and procedures for all direct care clinical services provided. If direct care services are provided at multiple sites, there must be policies specific to the services provided at those locations.
h. Contractors must have individual or written standing orders for all gap-filling direct health care services prior to the provision of a gap-filling direct health care service.
i. Contractors must have individual or written standing orders for all oral health direct care services provided by a nurse prior to the provision of oral health direct care services by a nurse.

Number: 301
Title: Required Policies and Procedures
Effective Date: 10/01/2022
Revision Date: 03/07/2025
Date of Last Review: 03/07/2025
Authority: Iowa Administrative Code 641-76, Iowa HHS General Conditions for Service Contracts; OCIO Information Technology Standards

j. Standing orders must be reviewed and signed off on by the contractor's medical director at least annually and must be accessible to staff providing gap-filling direct health care at all times.

Resources
Iowa HHS General Conditions for Service Contracts
Iowa Administrative Code 641-76
OCIO Information Technology Standards

IOWA | Health and Human Services

Number: 302
Title: Client Records
Effective Date: 10/01/2016
Revision Date: 03/07/2025
Date of Last Review: 03/07/2025
Authority: Iowa HHS General Conditions for Service Contracts; Medicaid Screening Center Manual; 441 Iowa Administrative Code 79.3; 641 IAC 76.11

Overview

Client records support delivery of services, continuity of care, and are important risk management and quality improvement tools.

Policy

Client records shall be specific, factual, relevant, and legible. Client records shall be kept up to date, completed, signed, and dated by the person who provided the service. Contractors must establish a medical record for every client who obtains direct health care services. These records must be maintained and retained in accordance with accepted medical standards, the Maternal Health (MH) and Child and Adolescent Health (CAH) program, Department General and Special Conditions, Iowa HHS Terms for Service Contracts, MED-23-015 IDPH Omnibus Intergovernmental Agreement, and state and federal laws.

Contractors must comply with all state and federal laws, standards, and guidelines regarding documentation in client records, storage, handling, security, retention, access, release, and disclosure of patient health information and client records. All MH and CAH client records (hard copy and/or electronic) are the property of the Department.

Procedure

1. For Healthy Child Care Iowa (HCCI), Early Care and Education (ECE) provider records are required to be kept (electronically or paper) with documentation of the Child Care Nurse Consultant (CCNC) services provided. Refer to the CCNC Role Guidance (on the Iowa HHS CCNC web page) for what shall be contained in the ECE provider record.
2. Contractors shall establish a medical record for every client created for clients obtaining MH services or a CAH gap-filling direct health care service. These records shall be maintained in accordance with accepted medical standards and state and federal laws with regard to record retention. Records must be:
    a. Complete, legible, accurate, and include documentation of all encounters of a clinical nature;
    b. Readily accessible to authorized MH or CAH staff;
    c. Systematically organized to facilitate prompt retrieval and compilation of information;
    d. Secure;

Number: 302
Title: Client Records
Effective Date: 10/01/2016
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e. Confidential; and
f. Available upon request to the client.

3. The client's medical record must contain sufficient information to identify the client, indicate where and how the client can be contacted, justify the clinical impression or diagnosis, and warrant the treatment and end results. The required content of the medical record includes:
   a. Demographic information including sex, race, ethnicity, primary language, and if a translator is needed
   b. First and last name on each page
   c. Date of birth and Medicaid/MH or CAH data system identification number
   d. Pertinent medical history
   e. Problem list with identified problems to facilitate continuing evaluation and follow-up
   f. Entries must be signed by the service provider, including name, credentials, and date
   g. Location where service provided
   h. Necessary follow-up and scheduled revisits
   i. Consent for services – initial and annual updates
   j. Release of information, if applicable
   k. Refusal of services, if applicable
   l. HIPAA Notice of Privacy Policy acknowledgment or declination
   m. List of current medications
   n. Allergies and untoward reactions to drug(s) recorded in a prominent and specific location
   o. Assessment of medical and dental insurance
   p. Name of primary care provider and dentist
   q. If direct health care service, the chart must include or indicate the need for the following:
      i. Physical exam, laboratory test orders, and results, if conducted;
      ii. Reports of clinical findings, diagnostic and therapeutic orders, diagnoses and documentation of continuing care, referral, and follow-up;

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iii. Entries by counseling and social service staff. Contractors must maintain a list of identified problems to facilitate continuing evaluation and follow-up.
iv. Treatment provided, education, and special instructions

4. Client financial information should be kept separate from the client's medical record. If included in the medical record, client financial information should not be a barrier to client services.
5. Documentation of all MH and CAH services must comply with generally accepted principles for maintaining health care records and with Medicaid requirements established in Iowa Administrative Code [441] Chapter 79.3.
6. Contractors are responsible for the accuracy and compliance of their records, including those of all subcontractors.
7. Contractors must comply with Department contract requirements for timely data entry. Documentation of services must be made at the time of service and be available to Iowa HHS by the 15th of the following month. The end of the state or federal fiscal year may shorten the timeframe for documentation to be available for payment.

Electronic Health Records

Contractors transitioning to electronic health records will be held to the requirements of this policy. Every effort must be made to maintain confidentiality in the electronic health record system. Clients should be informed if the agency uses an electronic health record system that can be accessed by other providers and acknowledge that they received that information.

Maintenance, Retention, Security and Property Rights of Client Records

1. See Iowa HHS General Conditions Sections 3, 5, 8, 9, 10, 15, and 28 for additional requirements related to client records. Iowa HHS General Terms for Service Contract requirements are longer for record retention than the Departments. Therefore, contractors are required to follow the HHS record retention requirement for retaining records found in the Iowa HHS General Terms for Service Contracts, Section 2.
2. MH and CAH records will be maintained on the department-approved MH and CAH data system(s).

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3. In the event that a contract is terminated, the Department will provide directions for the transfer of client records. Electronic health records will be transferred in a manner deemed appropriate by the Department.
4. Agencies must have the capability to separate Title V MH and CAH records from other services provided (i.e., WIC, home visiting, and broader medical care) for the purpose of audits and record transfers.
5. Records that are integrated with larger health systems or multiple program data systems (Electronic Health Records, etc.) must be able to be set up and maintained so that Title V services can be extracted from the system without compromising the client's confidentiality related to non-Title V services in the event of an audit or record transfer.
6. Contractors shall provide facilities and equipment that ensure the protection of confidential information at all sites (office, clinics, mobile/satellite, approved telework, etc.) where MH and CAH programs or services are conducted.
7. Contractors and subcontractors are prohibited from using personally owned electronic equipment (cell phones, tablets, computers, etc.), removable media, and other devices to store, view, receive, or send records (medical, accounting, financial, programmatic, statistical, supporting documentation and other MH or CAH program records).
8. Contractors and subcontractors are prohibited from accessing client records in a location that does not protect the confidentiality of the record. Contractors shall not connect to unauthenticated public Wi-Fi networks (free public Wi-Fi typically available in coffee shops, libraries, rest stops, airports, and other public venues) or networks using WEP and WPA to access client records or confidential information. Devices shall not connect to public charging stations\kiosks.
9. Client records shall be physically stored in areas and in such a way as to protect them from moisture and flooding. Contractors are discouraged from storing client records in basements and areas at increased risk for flooding/water damage.
10. Client records must be maintained in a secure manner that prevents unauthorized access.

Release of Records

1. Contractors are required to comply with all applicable regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and subsequent amendments, including Subtitle D of the Health Information Technology for

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Economic and Clinical Health Act, Title XIII of Division A, and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (HITECH) and the federal regulations published at 45 CFR parts 160 and 164.

2. The written consent of the client is required for the release of personally identifiable information, except as may be necessary for treatment services, payment, or health care operation activities or as required or authorized by law, with appropriate safeguards for confidentiality.
3. HIV, substance use, and mental health information shall be handled according to the laws regarding these special classifications of information.
4. A release of information is not required for entering data into the MCAH data system or sharing charts with the Department for audit and quality improvement purposes, or for the performance of other public health activities.
5. When information is requested, agencies should release only the specific information requested. Information collected for reporting purposes may be disclosed only in summary, statistical, or other form, which does not identify particular individuals. Any release of statistical or aggregate data must comply with the Department's Disclosure of Confidential Public Health Information, Records, or Data Policy and all relevant federal and state laws.
6. Upon request, clients transferring to other providers must be given a copy or summary of their record to expedite continuity of care.
7. Contractors shall comply with federal and state laws regarding release for records and charges for release of records. Charges for records released directly to the client must be placed on the appropriate sliding fee scale.
8. Contractors and subcontractors are prohibited from accessing client records, including data entry outside work sites (which includes offices, clinics, and approved telework sites).

Iowa HHS General Conditions, Information Technology Standards and HIPAA

1. Contractors shall follow and comply with all Iowa HHS General Conditions.
2. Contractors shall follow and comply with all State of Iowa Office of the Chief Information Officer Information Technology standards.
3. Contractors are required to comply with all applicable federal and state laws that govern the use, maintenance, privacy, security, and disclosure of client records, including but not limited to HIPAA and subsequent amendments, including Subtitle D of the Health Information Technology for Economic and Clinical Health

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Act, Title XIII of Division A, and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (HITECH) and the federal regulations published at 45 CFR parts 160 and 164.

4. Iowa Code chapter 228
5. 42 CFR Part 2
6. Iowa Code sections 125.37, 125.93
7. Iowa Code sections 141A.6, 141A.9

Resources

Iowa HHS HIPAA Statement
Iowa HHS General Conditions for Service Contracts
OCIO Technology Standards
Medicaid Screening Center Manual
Iowa Administrative Code [441] Chapter 79.3
Iowa Administrative Code [641] Chapter 76.11

Number: 303
Title: Use of Abbreviations in Client Records
Effective Date: 10/01/2022
Revision Date: 03/07/2025
Date of Last Review: 03/07/2025
Authority: Iowa HHS General Conditions for Service Contracts; Medicaid Screening Center Manual; Iowa Administrative Code [441] Chapter 79.3

Overview

Limited use of standardized abbreviations leads to improved communication and understanding between service providers and the delivery of safe and effective care of clients.

Policy

Contractors shall maintain a limited, standardized, and uniform set of codes, symbols, and abbreviations in client records. A written list of approved abbreviations is maintained and accessible to all staff and subcontractors. A written list of do-not-use abbreviations is maintained and accessible to all staff and subcontractors.

Service Provider: Any staff documenting in client record

Procedure

1. Before a new abbreviation is introduced, determine if it is necessary.
2. Do not create an abbreviation that is already in use for some other meaning or has a contradictory or ambiguous meaning. Use comprehensive and up-to-date resources such as the US National Library of Medicine's PubMed, medical abbreviation books, and websites to determine if the abbreviation is in use or if there is already a standardized abbreviation for the word.
3. The contractor shall maintain a written list of approved abbreviations and a written list of do-not-use abbreviations. All approved abbreviations will be cross-checked to ensure they are not included within the Institute for Safe Medication Practices list of error-prone abbreviations.
4. Abbreviations can only have one meaning within the entire organization.
5. Abbreviations are prohibited on patient materials and documents (examples: informed consent forms, client rights documents, client education materials).
6. All staff and subcontractors must have easy access to the written lists and know where to find them.

Resources

2021 Institute for Safe Medication Practices List of Error-Prone Abbreviations
Iowa HHS General Conditions for Service Contracts
Medicaid Screening Center Manual

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Sources

Joint Commission International Standard MOI.4 Use of Codes, Symbols and Abbreviations

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Authority: Iowa HHS General Conditions for Service Contracts; Medicaid Screening Center Manual; Iowa Administrative Code [441] Chapter 79.3; Iowa Administrative Code [641] Chapter 76

Overview

General consent for direct care services must be provided by every client. General consent is required before the patient can be examined or treated or before minor testing (such as lab work or routine imaging studies) can be done.

Policy

All Clients must consent for direct care services. Consent forms must be signed annually or more often if circumstances change who the signatory authority is (i.e., if a parent/guardian provided consent for a minor who has now reached the age of majority, the newly eligible adult must sign their own consent).

Procedure

1. Annually, Contractors must obtain, prior to the provision of any services, written consent for services from the client to indicate voluntary acceptance of MH and CAH direct care services.
2. All consents must be maintained in the client's record.
3. The consent for services must be written in a language understood by the client or translated and witnessed by an interpreter. If a telephone interpreter is used, the company name, name and ID number of the interpreter, and date/time must be documented on the consent.
4. Consent for services must include the date the client was offered or received the organization's Notice of Privacy Practices (NPP).
5. The consent for services must include notification that the MH and CAH client records created and maintained are the property of Iowa HHS and, therefore may be shared with Iowa HHS and its agents, Title V contractors, Iowa Medicaid Enterprise, or designee for audit, preventive health services, quality improvement, and other legally authorized purposes.
6. The consent for services must include authorization from the client (or parent/guardian as applicable) to receive information via text or email.
7. If clients choose to delay or defer a service, counseling must be provided about the risks associated with such a delay and documented in the record.

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Minor Consent

The following is a summary of Iowa laws that govern the ability of a minor to independently consent to medical care, treatment, and services. If MCAH Contractors have questions about the application of the following laws, they should contact their agency's legal counsel to receive guidance.

Definition of Minor: Iowa law generally provides that any person under the age of eighteen is a minor. However, persons who are married prior to the age of eighteen and persons who are incarcerated as adults are deemed to have attained the age of majority and may consent to medical care, services, and treatment.

"*The period of minority extends to the age of eighteen years, but all minors attain their majority by marriage. A person who is less than eighteen years old, but who is tried, convicted, and sentenced as an adult and committed to the custody of the director of the department of corrections shall be deemed to have attained the age of majority for purposes of making decisions and giving consent to medical care, related services, and treatment during the period of the person's incarceration.*" Iowa Code § 599.1. *See also* Iowa Code §§ 135L.1(7), 600A.2(12), 600A.2B(1), 728.1(4).

Emancipated Minors: Iowa Statutory and common law also recognize the majority for 'emancipated' minors, defined as those minors who are absent from the parental home with the consent of the parents, are self-supporting, and have assumed a new relationship inconsistent with being part of the family of the parents. Iowa Code chapter 232C; Vaupel v. Bellach, 154 N.W.2d 149 (Iowa 1967).

1. A minor will not be found to be emancipated solely on the basis of becoming pregnant or giving birth to a child. Bedford v. Bedford, 752 N.W.2d 34, 2008 WL 681138 (Iowa App. 2008).
2. Minors who have been adjudicated as emancipated do not need parental consent to receive medical, dental, or psychiatric care. Iowa Code § 232C.4.

Exemptions to Parent/Guardian Consent for Minors

Under general common law, a health care provider must obtain the consent of a minor's parent or guardian in order to render medical care, treatment, or services to a minor.

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Courts have recognized limited exceptions to the general rule of parental consent. In addition, the Iowa legislature has enacted several statutory provisions that expressly authorize minors to provide independent consent to receive medical care, treatment, and services.
The purpose behind these minor consent statutes is to encourage minors to receive medical care they might not otherwise receive if they had to obtain consent from a parent or guardian.
Every state legislature, including Iowa's, has enacted statutory exceptions to override the common law parental consent rule and give minors the legal authority to consent to some types of medical care for certain diseases, conditions, and situations.

A minor may consent to the following health care services without the permission or consent of their parents or guardians:

1. **Non-medical Services**: Certain public health services provided to minors may not require parental consent if the service does not constitute medical care or treatment. For example, providing educational services to minors under the WIC program does not constitute medical care or treatment and, therefore, does not require consent from a parent or guardian.
2. **Contraceptive Services:** A person may request contraceptive services directly from a licensed physician or a family planning clinic. A minor may give written consent to receive the services, and such consent is not subject to later disaffirmance by reason of minority. Iowa Code § 141A.7(3). Carey v. Population Services, International 431 U.S. 678 (1977)
3. **Emergency Care**: Health care providers (including physicians, physician designees, ARNPs, PAs, RNs, LPNs, and emergency medical care providers) are not required to obtain parental consent prior to rendering "emergency medical, surgical, hospital, or health services" to a minor if the parent or guardian is not "reasonably available." Iowa Code § 147A.10(2).
4. **Sexually Transmitted Diseases:** "A minor shall have the legal capacity to act and give consent to the provision of medical care or services to the minor for the prevention, diagnosis, or treatment of a sexually transmitted disease or infection by a hospital, clinic, or health care provider. Such medical care or services shall be provided by or under the supervision of a physician licensed to practice

medicine and surgery, or osteopathic medicine and surgery, a physician assistant, or an advanced registered nurse practitioner. Consent shall not be subject to later disaffirmance by reason of such minority. The consent of another person, including but not limited to the consent of a spouse, parent, custodian, or guardian, shall not be necessary." Prevention, Diagnosis, and Treatment Iowa Code § 139A.35

5. **Tobacco Cessation Services:** Minors twelve years of age or older may consent to receive tobacco cessation services from IDPH's Quitline provider. The text of the law provides as follows: "A minor who is twelve years of age or older shall have the legal capacity to act and give consent to the provision of tobacco cessation coaching services pursuant to a tobacco cessation telephone and internet-based program approved by the department. Consent shall not be subject to later disaffirmance by reason of such minority. The consent of another person, including but not limited to the consent of a spouse, parent, custodian, or guardian, shall not be necessary." Iowa Code § 142A.11.
6. **Victim Medical and Mental Health Services:** A minor who is the victim of sexual abuse or assault may receive medical and mental health services without the prior consent or knowledge of the minor's parent or guardian under certain circumstances. The text of the law provides as follows: "'Victim' means a child under the age of eighteen who has been sexually abused or subjected to any other unlawful sexual conduct under chapter 709 [sexual abuse statute] or 726 [incest and child endangerment statute] or who has been the subject of a forcible felony. A professional licensed or certified by the state to provide immediate or short-term medical services or mental health services to a victim may provide the services without the prior consent or knowledge of the victim's parents or guardians. Such a professional shall notify the victim if the professional is required to report an incidence of child abuse involving the victim pursuant to section 232.69." Iowa Code § 915.35(1), (2) & (3); HIV/AIDS Care Iowa Code § 141A.7(3).
7. **Substance Abuse Treatment**: Iowa law authorizes a minor to consent to substance abuse treatment. A substance abuse facility or a physician or physician's designee providing substance abuse treatment or rehabilitative services are not required to obtain consent from a parent or guardian prior to providing these services to a minor. Iowa Code § 125.33(1).

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Prenatal Care Services

Iowa law does not expressly address whether minors can receive prenatal care services without consent from a parent or guardian. However, federal and state common law and statutes do likely authorize a minor to consent to these services without parental consent in the majority of health care settings.
Providers with questions about this area of the law are encouraged to contact their own legal counsel for guidance.

Resources

Sample MCAH consent forms are available on the MCAH Project Management Portal.
Iowa HHS General Conditions for Service Contracts
Medicaid Screening Center Manual
Iowa Administrative Code [441] Chapter 79.3
Iowa Administrative Code [641] Chapter 76

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Number: 305
Title: Confidentiality
Effective Date: 10/01/2016
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Authority: Iowa Code Chapters 22, 125, 135, 139A, 141A, 144; Iowa HHS General Conditions for Service Contracts; 45 CFR parts 160 and 164

Overview

Every effort is made to ensure client confidentiality and provide safeguards for individuals against the invasion of their privacy. Information about clients that receive services may not be disclosed without the individual's written consent, except as deemed necessary for treatment services, payment, or health care operation activities or as required or authorized by law, with appropriate safeguards for confidentiality. Concern with respect to the confidentiality of information, however, may not be used as a rationale for noncompliance with laws requiring notification. Information may be disclosed in summary, statistical, or other form that does not identify the individual, with written authorization from Iowa HHS and in conformance with the Department's Disclosure of Confidential Public Health Information, Records, or Data Policy and all relevant federal and state laws.

As a general rule, public health and medical records that contain personally identifiable information of a health-related nature are confidential under Iowa law. Public health records include a record, certificate, report, data, dataset or information which is confidential under federal or state law.

Data that can be used to indirectly establish the identity of a person named in a confidential public health record and medical record by the linking of the released information or data with external information, which allows for the identification of such person, is also confidential.
The authorized sharing of confidential information can benefit the client or program for purposes such as coordination of care, facilitation of referrals, sharing of demographic information, and/or program evaluation.

Policy

1. Contractors are required to comply with all applicable federal and state laws to protect client confidentiality and assure the security of client information, including but not limited to regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and subsequent amendments, including Subtitle D of the Health Information Technology for Economic and Clinical Health Act, Title XIII of Division A, and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (HITECH) and the federal regulations published at 45 CFR parts 160 and 164.

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2. See Sections 8, 9, 10, 15, 22, and 28 of the Department's General Conditions for Service Contracts for additional specific requirements related to confidentiality.
3. All information as to personal facts and circumstances obtained by Contractors and subcontractors about individuals receiving services must be held confidential and must not be disclosed without the individual's documented consent, except as may be necessary to provide services to the patient or as required or authorized by law, with appropriate safeguards for confidentiality
4. Confidential information may not be shared without a signed authorization for release of information unless otherwise required or authorized by law. Such records will be disclosed only under circumstances expressly authorized under state or federal confidentiality laws, rules, or regulations. Contractors may be liable civilly, contractually, and criminally for unauthorized release of such information.
5. The Contractor shall immediately report to the Department any unauthorized disclosure of confidential information.
6. In compliance with the General Terms for Service Contracts within the IDPH/DHS Omnibus Agreement, as amended, between the Department and the Iowa Department of Human Services (DHS), all terms of the IDPH/DHS Omnibus Agreement shall also apply to Contractors. Contractors shall ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of the applicant agree to the same restrictions, conditions, and requirements that apply to the Contractor with respect to such information. These terms include but are not limited to, the following.
    a. Access to Department or DHS Confidential Information: Contractors may have access to confidential information owned by the Department or DHS that is necessary to carry out the responsibilities of the funding opportunity. Access to such confidential information shall comply with the State, the Department and DHS policies and procedures. In all instances, access to the Department and DHS information from outside the United States and its protectorates, either by the Contractor or its affiliates or associates or any subcontractor, is prohibited.
    b. Breach Notification Obligations: The Contractor agrees to comply with all applicable laws that require the notification of individuals in the event of unauthorized use or disclosure of confidential information or other events requiring notification in accordance with applicable law. In the event of a

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breach of the Contractor's security obligations or other event requiring notification under applicable law, the Contractor agrees to follow the Department directives, which may include assuming responsibility for informing all such individuals in accordance with applicable laws and to indemnify, hold harmless, and defend the State of Iowa against any claims, damages, or other harm related to such breach.

c. Business Associate Agreement: When performing certain activities under the Title V, CAH Program, Contractors collect and receive access to certain records and pieces of data that are protected by the Health Insurance Portability and Accountability Act of 1996, as amended, and the federal regulations published at 45 CFR part 160 and 164. When the Contractor performs services on behalf of the Department for which the Department is a business associate of DHS, the Contractor agrees to comply with the business associate agreement addendum (BAA) and any amendments thereof, as posted to the DHS website: https://dhs.iowa.gov/HIPAA/baa. This BAA, and any amendments thereof, is incorporated by reference. The Contractor shall ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of the Contractor agree to the same restrictions, conditions, and requirements that apply to the Contractor with respect to such information.

Resources

Hospital records, medical records, and professional counselor records of the condition, diagnosis, care, or treatment of a patient are confidential. Iowa Code § 22.7(2)
Confidentiality of social security numbers. 42 USC 405(c)(2)(C)(viii)
Personally identifiable information and business identity related to a reportable disease or condition. Iowa Code § 139A.3 and § 139A.30 - 32
Personally identifiable information related to HIV/AIDS. These reports are maintained as "strictly confidential medical information," and specific provisions prevent disclosure of this information except under very limited circumstances. Iowa Code §§ 141A.6, 141A.9
Vital statistics records. Iowa Code § 144.43
Substance abuse program patient information and some licensing information. Iowa Code § 125.37; Iowa Code §§ 22.7(2), 22.7(18); 641 IAC 155.16(5)
Iowa HHS HIPAA Statement
DHHS "*The HIPAA Privacy Rule*"

Number: 306
Title: Client Referral and Follow-Up
Effective Date: 10/01/2016
Revision Date: 03/07/2025
Date of Last Review: 03/07/2025
Authority: Iowa Administrative Code 641-76

Overview

Contractors can support clients' social determinants of health, as well as their mental and physical health, by asking about their social history, referring them to local support services, facilitating access to these services, and acting as a reliable resource person throughout the process. “Individuals consciously act to protect and promote their own health and that of others, albeit within structural constraints largely outside their individual control. The pathways people follow as they seek help and support to deal with social problems can be expected to be complex.” Social determinants of health often create inaccessible, fragmented care, long-lasting, and inadequate resources for families’ needs. Clients are expected to navigate this complex, fragmented system on their own often without knowing how to find what they need or what is available. (Par8o, 2016)

Families eligible for the CAH program often face precarious living situations, low income from paid work, restricted choices in housing and employment, and social environments full of conflict. CAH clients demonstrate great resourcefulness and persistence in the face of exhausting, demoralizing, and formidable challenges (Popay et al, 2007). Contractors can play a significant role in aiding clients in finding solutions and resources in their community by assisting in making appointments, providing complete, up-to-date information about services in the community and eligibility criteria, advocating for the family, and making a well-executed, complete referral with follow up to assure the family received what they needed.

Policy

Referral for services beyond the scope of the agency is expected. Contractors shall have, by prior arrangement, providers or agencies to which clients may be referred for both social determinants of health and medical homes.

Procedure

1. Contractors shall engage in regular communication with providers and resources within the service area to build strong relationships and facilitate effective referral linkages.
2. Contractors shall have a planned mechanism for client follow-up to ensure referral needs are met.
3. Contractors shall have a robust referral linkage with primary care providers in order to promote medical homes.

a. Contractors, particularly those serving as a medical home or are part of a system that serves as a medical home, shall provide equal or more opportunity for clients/families to choose another organization as a medical home, with equal or more support and assistance, in the form of care coordination, provided if a medical home outside the applicant's organization or system is chosen by the client/family, including those that may be a competitor.

4. Contractors shall build referral networks with local primary care providers throughout the CSA to increase access to medical homes for clients by providing comprehensive well visits and screening services for clients enrolled in Title V, clients during the Presumptive Eligibility period, and clients enrolled in Medicaid. Contractors must form referral networks that serve all three client populations (Title V, PE, Medicaid) and must include options for clients enrolled in each Medicaid managed care organization (MCO).
5. Contractors shall have a robust referral linkage with providers of client-centered, culturally and linguistically appropriate services related to the social determinants of health.
6. Contractors shall provide specialized care coordination to populations with limited access to healthcare as they may need additional care coordination to find a provider that meets their needs.
7. Contractors are encouraged to track referrals in the MCAH data system.
8. Contractor referral protocols shall meet the evidence-based practice for referral systems in that they are safe, effective, efficient, patient-centered, and equitable. Contractors shall have a referral protocol that addresses all of the following:
   a. Staff training in making referrals
      i. Contractors shall ensure staff are trained to ask questions about health and social determinants of health in a culturally and linguistically appropriate way and in a manner that encourages trust and relationship building and provides a comfortable environment in which to disclose needs and sensitive information.
      ii. Health equity should be addressed in contractor policies and procedures. Studies have shown that staff screen patients differently, do not screen patients, and offer different services based on the client's appearance, diagnoses (mental health), insurance status, and perceived or documented

income. Emphasis should be placed on universal screening, and the Contractor shall evaluate the process for potential bias.

b. How client needs are determined
   i. Staff shall ask clients if they want a referral/assistance
   ii. Staff shall use motivational interviewing to assess barriers to readiness for assistance
c. How needs are matched with available services
   i. Staff shall ask clients what they are looking for in the referral provider/service - what is important to them (location, race/ethnicity of provider, language spoken).
d. How to identify available community services
   i. Develop a comprehensive list of resources for each referral type in order to provide clients with specific details about the provider
e. How the client is connected to community services
   i. Ask the client how they would like the referral to happen - staff make a connection with the agency on the client's behalf, be introduced to a staff member at the agency, make the appointment for the client, and have the agency contact the client to arrange an appointment.
   ii. Assess barriers to accessing community services.
   iii. Provide specific information to the client about the referral, including what to expect, required documents, eligibility guidelines, and other helpful information about accessing services.
      1. A list of possible services/providers with no additional information on qualifications, if taking new clients, insurance accepted, etc., given to a client is not a referral (Resource directory, food pantry list, clinics/health care provider list, early care and education (ECE) provider list, etc.)
      2. Work with providers/community services to determine what is needed to ensure the referral will be beneficial to the client.
      3. Contractors are encouraged to work closely with their referral network to set roles and responsibilities for each organization, create tools, forms and/or protocols/procedures for evidence-based mutual referrals (listed above safe, timely, etc.) to prevent patients from falling through the cracks, getting referred to services that don’t meet their needs or they are ineligible for (”run around”) and delays in service.

Number: 306
Title: Client Referral and Follow-Up
Effective Date: 10/01/2016
Revision Date: 03/07/2025
Date of Last Review: 03/07/2025
Authority: Iowa Administrative Code 641-76

f. How and when will follow-up after the service be conducted? Contractors are encouraged to close referral loops and request the same from their referral network by communicating the status and result of referrals with appropriate releases of information/client consent.
g. How the referral is documented.

9. See Policy 709 Interpreter Services for ensuring individuals have access to culturally and linguistically appropriate referral services.
10. Contractors shall maintain a system of referral and follow-up
    a. Develop a system to ensure that client follow-up is completed and documented.
    b. Provide follow-up of canceled or missed appointments and reschedule initial and return appointments.
11. Contractors shall provide assistance in rescheduling missed or canceled appointments and working with providers and clients when missed appointments, outstanding balances, and other barriers are preventing access to care.
12. Contractors shall provide assistance in scheduling initial and return appointments for Medicaid-covered services and social determinants of health.
13. Contractors shall periodically assess the effectiveness of their referral process.
14. Contractors shall develop and annually review a county-specific resource directory for clients/families. The development and annual review of the resource directory should include clients/families. The resource directory must meet the following criteria:
    a. Include county-level resources for the county of residence of the client/family. The contractor may opt to include regional, state, and national resources.
    b. Contain medical and dental providers taking Medicaid clients in the client's/family's county of residence.
    c. All resources must be verified by the contractor at the time of review. Resources must include pertinent information such as location, hours of operation, and contact information but should strive to provide more detailed information (e.g., Food Pantry: fresh fruit is available on the first Tuesday of the month, food often runs out by noon; Provider X speaks Spanish, etc.).
    d. Contains information relevant to the health and social determinants of health (SDOH) for clients aged birth to 21 years. Do not include a listing of businesses/organizations in the county that do not offer health/SDOH

services to CAH clients, the listings shall be relevant to the clients/families this program serves.

Resources

https://innovation.cms.gov/files/x/tcpi-changepkgmod-referrals.pdf
https://www.ruralhealthinfo.org/toolkits/care-coordination
Iowa Administrative Code 641-76

Sources

CMS. Managing Referrals – Providing a Patient-Centered Referral Experience
https://innovation.cms.gov/files/x/tcpi-changepkgmod-referrals.pdf

Institute for Healthcare Improvement / National Patient Safety Foundation. Closing the Loop: A Guide to Safer Ambulatory Referrals in the EHR Era. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2017.

Par8o. Making referrals work: the 4 pillars of successful referral management. (2016)

Popay J, Kowarzik U, Mallinson S, et al. Social problems, primary care and pathways to help and support: addressing health inequalities at the individual level. Part II: lay perspectives. J Epidemiol Community Health 2007;61:972–7.

Senitan, M., Alhaiti, A.H. & Lenon, G.B. Factors contributing to effective referral systems for patients with non-communicable disease: evidence-based practice. Int J Diabetes Dev Ctries 38, 115–123 (2018). https://doi.org/10.1007/s13410-017-0554-5

Wallace AS, Luther B, Guo J, Wang C, Sisler S, Wong B. Implementing a Social Determinants Screening and Referral Infrastructure During Routine Emergency Department Visits, Utah, 2017–2018. Prev Chronic Dis 2020;17:190339. DOI: http://dx.doi.org/10.5888/pcd17.190339

IOWA | Health and Human Services

Number: 307
Title: Information Technology Requirements
Effective Date: 10/01/2022
Revision Date: 03/11/2025
Date of Last Review: 03/11/2025
Authority: Iowa HHS General Conditions for Service Contracts, OCIO Information Technology Standards

Overview

The contractor must meet electronic requirements to maintain secured connectivity to support program activities.

Policy

Contractors must comply with and adhere to the Office of the Chief Information Officer (OCIO) State Information Technology Standards, Iowa HHS General Conditions for Service Contracts, and standards related to information technology.

Procedure

1. Contractors shall comply with the State Information Technology Standards.
2. Contractors shall provide work-owned and maintained electronic devices (phones, computers, etc.), removable media, and other devices needed to complete the work of the CAH program. Contractor staff and subcontractors may not use personal devices for **any** CAH program work.
3. Protected Health Information (PHI) shall not be uploaded into the IowaGrants.gov system.
4. Contractors shall have and maintain the technology to securely and efficiently implement the CAH program.
5. Contractors shall have software that is compatible with Iowa HHS programs, the MCAH data system, and communication methods. The minimum required software also includes:
    1. Anti-virus software with current updates
    2. Latest versions of Adobe Reader and internet browser
    3. Adequate bandwidth for reliable operation at all work sites
6. Contractors shall provide local computer support and maintenance of local hardware, operating software, and networking systems. Contractors must have their service agreement on file if contracting for local computer support.
7. Contractors shall notify Iowa HHS prior to upgrading or transferring computers.
8. Contractors shall maintain individual email addresses and the capacity to send and receive electronic communications (email and attachments) for all required positions listed on the Key Personnel Form.

Number: 307
Title: Information Technology Requirements
Effective Date: 10/01/2022
Revision Date: 03/11/2025
Date of Last Review: 03/11/2025
Authority: Iowa HHS General Conditions for Service Contracts, OCIO Information Technology Standards

9. Contractors shall have the ability to generate and receive encrypted emails for sending confidential information and shall encrypt all emails containing confidential information.

Iowa HHS Bureau of Information Management recommends the following minimum Information Technology for both local public health agencies and CAH contractors:

1. Windows 11 Operating System
2. Laptops
    a. Intel Generation 11 (current is 12) or greater CPU. 2.6 or greater clock speed; i5 or i7, quad core CPU. i5
    b. CPUs may provide slightly lower performance to an i7, but adequate while saving money. AMD Ryzen 7 CPU is comparable to an Intel i7 CPU in performance but should save money
    c. 16GB of RAM
    d. 256/512GB SSD hard drive
    e. 802.11ac, 2x2 wireless adapter
    f. 1920 x 1080 (14 or 15”) display
3. Desktops
    a. Intel i7 quad core CPU or comparable AMD Ryzen CPU
    b. 16/32GB RAM
    c. 512GB SSD
    d. Add 1Gb network card (for physical/wired network connectivity); wireless unnecessary
4. Tablets
    a. If tablets are purchased we strongly encourage a Mobile Device Management (MDM) system be implemented to manage these devices. A mobile phone provider may have an MDM system if that is the vendor for your tablets.
5. Physical networking within a building
    a. 1Gb network switches
6. Internet service provider:

Number: 307
Title: Information Technology Requirements
Effective Date: 10/01/2022
Revision Date: 03/11/2025
Date of Last Review: 03/11/2025
Authority: Iowa HHS General Conditions for Service Contracts, OCIO Information Technology Standards

   a. Internet service will depend on the number of staff computers and services in the office, but recommend a minimum of 100Mbps to each computer, meeting hosting device, or internet-connected device
7. Telehealth/Virtual meeting room equipment
   a. We encourage partnering with a local audio/video streaming expert

Resources

Iowa HHS General Conditions for Service Contracts
OCIO Information Technology Standards

IOWA Health and Human Services

Number: 308
Title: Contracts and IowaGrants.gov
Effective Date: 10/01/2016
Revision Date: 03/11/2025
Date of Last Review: 03/11/2025
Authority: Iowa Administrative Code [641] Chapter 76.9 (135)

Policy

Contractors must execute a signed contract issued by the Department in order to provide MH and CAH services. All contract documents and associated documents shall be maintained in IowaGrants.gov per the provisions of the contract.

Procedure

1. When a contract has been executed (signed by both the Contractor and Iowa HHS), the Contractor adopts the provisions and requirements set forth in the Request for Proposal (RFP) for the project period. The Contractor also adopts the provisions and requirements of each subsequent Request for Application (RFA) and the corresponding contract in the project period.
2. The contract includes both general conditions and special conditions.
   a. The HHS General Conditions for Service Contracts apply to all contracts issued by the Department.
   b. The special conditions are specific to the program covered by the contract. All MH and CAH contract agencies and their subcontractors are required to follow both sets of conditions.
3. The IowaGrants.gov website is used for the RFP/RFA process and execution, management, and monitoring of documents for Department service contracts. After an MH and/or CAH contract is awarded, a specific and unique grant site is established for the contractor on the face page of the contract. Documents maintained within the contractor's secure site include but are not limited to, the approved application, service contract, and associated amendments, claims and support documentation, and any additional contractually required reports. The Contractor has the responsibility to ensure appropriate individual(s) have registered within the IowaGrants.gov system.

Resources

Iowa Administrative Code [641] Chapter 76.9 (135)
HHS General Conditions for Service Contracts

Number: 309
Title: Subcontracting
Effective Date: 10/01/2016
Revision Date: 03/11/2025
Date of Last Review: 03/11/2025
Authority: Iowa Administrative Code [641] Chapter 76.9 (135); HHS General Conditions for Service Contracts

Policy

The Contractor is permitted to subcontract for the performance of certain services required under the contract. Subcontracts must adhere to the provisions of Section 5(b) of the HHS General Conditions for Service Contracts.

The Contractor is fully responsible for all work performed by subcontractors. No subcontract into which the Contractor enters with respect to performance under the contract will, in any way, relieve the Contractor of any responsibility for the performance of its duties. The Contractor is responsible for communicating program requirements to the subcontractor and is responsible for ensuring the subcontractor is in compliance with program requirements.

Procedure

1. Subcontractors that enter into an agreement with the Contractor must follow the same state and federal laws, regulations, and policies required of the Contractor.
2. Current individual employees of the State of Iowa may not act as subcontractors under this contract.
3. If the subcontract is over $2,000, it must be approved by the Department in writing and in advance of execution of the subcontract.
4. The Contractor is responsible for ensuring the compliance of the subcontractor. The subcontract must include personnel training, documentation requirements, record retention, payment for services rendered, and ongoing communication of regulations.
5. If a Contractor exchanges personnel services with another entity, a written legal agreement describing the exchange is required. At a minimum, the agreement should address the scope of work to be performed, assurance of qualified personnel, financial exchange, reporting requirements, and time period.
6. The subcontractor must report all program income generated by the subcontract to the Contractor. The Contractor is required to report the program income balance of subcontracts on a monthly basis to the Department.
7. The Contractor and subcontractor must execute a subcontract every year during the project period following review by the Department. The Contractor must

Number: 309
Title: Subcontracting
Effective Date: 10/01/2016
Revision Date: 03/11/2025
Date of Last Review: 03/11/2025
Authority: Iowa Administrative Code [641] Chapter 76.9 (135); HHS General Conditions for Service Contracts

maintain written documentation regarding the annual subcontract and have the documentation available for Department review.

Resources

Iowa Administrative Code [641] Chapter 76.9 (135)
HHS General Conditions for Service Contracts

Number: 310
Title: Contract Revisions and Program Changes
Effective Date: 10/01/2016
Revision Date: 03/11/2025
Date of Last Review: 03/11/2025
Authority: Iowa Administrative Code [641] Chapters 76, 77, and 80

Overview

All parts of a Contractor's final, approved grant application become part of the contract between the Contractor and Iowa HHS. All contract budgets, activity work plans, service delivery forms, and program documents are transferred into the Contractor's grant site as "Components" in IowaGrants.gov. Any program changes require revisions to program components and approval from the Department prior to implementation. Consultants are available to provide technical assistance (TA) and consultation to Contractors. Requests for assistance can be made verbally or in writing. TA can guide contractors in the following areas:

1. Clarifying program requirements and sharing program expertise.
2. Strengthening the ability of Contractors to fulfill the goals of the CAH program by identifying, exploring, or prioritizing issues.
3. Sharing best practices, evidence-based practices, and promising practices
4. Identifying or sharing resources and data
5. Addressing funding or billing issues
6. Addressing quality assurance and/or quality improvement initiatives. Providing advice and independent, objective perspectives to try to resolve problems or facilitate change.

Policy

Contractors shall comply with all requirements and complete all activities outlined in their final, approved grant application. Any necessary changes must be approved by the Department prior to implementation. The last day to submit changes to contract budgets, work plans, and service delivery forms is July 15th.

Procedure

Any program changes require a revision to the corresponding "Component" via the IowaGrants.gov negotiation process. The formal request for approval of program changes must be submitted in writing to IowaGrants.gov, and approval by the Department must be granted prior to changes being implemented. The procedure for requesting a program change is as follows:

1. The Contractor will submit a request through the IowaGrants.gov Correspondence component to the appropriate consultant(s) to negotiate a specific grant component, along with a brief description of the requested program change.

Number: 310
Title: Contract Revisions and Program Changes
Effective Date: 10/01/2016
Revision Date: 03/11/2025
Date of Last Review: 03/11/2025
Authority: Iowa Administrative Code [641] Chapters 76, 77, and 80

2. The consultant or contract manager will negotiate the grant component with the Contractor.
3. The Contractor will make the proposed changes in the grant component and submit them.
4. The consultant or contract manager will review the proposed changes and accept the changes or provide feedback to the Contractor ('renegotiate' the component back, if necessary).
5. A correspondence may be sent to the Contractor from the consultant or other directed staff to notify the Contractor of the request status and/or to initiate the contract amendment process if necessary.

Resources

Iowa Administrative Code [641] Chapters 76
Iowa Administrative Code [641] Chapters 77
Iowa Administrative Code [641] Chapters 80

Number: 311
Title: Equipment and Inventory
Effective Date: 10/01/2016
Revision Date: 03/11/2025
Date of Last Review: 03/11/2025
Authority: Iowa Administrative Code [641] Chapter 76.9 (135); HHS General Conditions for Service Contracts

Overview

The HHS General Conditions for Service Contracts define equipment as any item costing $5,000 or more and having an anticipated life of one year or more.

Policy

If a Contractor desires to purchase equipment that was not approved as part of the current application budget line item, a letter requesting permission for the purchase must be sent prior to purchase to the Department. Grant funds may not be used to purchase motor vehicles.

Procedure

1. The letter requesting permission for the purchase must be sent prior to purchase to the IowaGrants.gov Correspondence component.
2. Upon Department approval of the request to purchase equipment and within one month of purchase, the Contractor must complete and submit an Equipment Acquisition Form through IowaGrants.gov Correspondence.
3. The Equipment Acquisition Form should include the following items:
    a. Description of the equipment to be added
    b. Vendor name
    c. Purchase price
    d. Manufacturer's serial number (if applicable)
    e. State tag number (or contractor inventory number if no state tag has been assigned)
    f. Percentage of the total cost of the item paid for by Department funds and program income
    g. Physical location of item
    h. Date of acquisition
4. The request for reimbursement for the equipment purchased must be included in a monthly claim and supporting documentation in IowaGrants.gov.
5. HHS maintains an inventory of each Contractor's fixed assets (A fixed asset is a long-term tangible asset that a Contractor owns and uses and is not expected to be used or sold within a year).
6. HHS inventory listings are reconciled annually with the Contractor's inventory.

Number: 311
Title: Equipment and Inventory
Effective Date: 10/01/2016
Revision Date: 03/11/2025
Date of Last Review: 03/11/2025
Authority: Iowa Administrative Code [641] Chapter 76.9 (135); HHS General Conditions for Service Contracts

7. The Bureau of Family Health (BFH) will conduct an inventory audit in conjunction with the bi-annual administrative on-site review. All or a sampling of the equipment listed on the HHS electronic inventory will be required to be accounted for upon request.
8. Disposal of property purchased in whole or in part with grant program funds requires prior written authorization of the BFH. Authorization for disposal must be obtained regardless of the method of disposal (i.e., donated, sold, traded in, and discarded). A written request to dispose of property must be sent through the IowaGrants.gov Correspondence.
9. The Contractor may request to delete equipment from their inventories if the equipment has been lost, stolen, broken, is obsolete, or no longer meets the definition of equipment as defined in this policy. The Contractor must send a written request through the IowaGrants.gov Correspondence. The written request must clearly identify the reason for removal.
10. If approved, the Department will send a written approval through the IowaGrants.gov Correspondence component to the Contractor.

Resources

Equipment Acquisition Form
Iowa Administrative Code [641] Chapter 76.9 (135)
HHS General Conditions for Service Contracts

IOWA | Health and Human Services

Number: 312
Title: Request for Exception to Policy
Effective Date: 01/01/2018
Revision Date: 03/11/2025
Date of Last Review: 03/11/2025
Authority: Iowa Administrative Code [641] Chapter 76

Overview

Program requirements and performance standards are in place to maintain the quality of services, protect the public, and assure the proper use of public funds.

Policy

Contractors not in compliance with all MH or CAH program requirements as part of the contract may file a written request for a temporary exception to the policy. An exception to the policy shall not constitute a waiver of any terms and conditions of the contract. It is within the Department's sole discretion whether to grant an exception to the policy. A determination to grant an exception to policy does not affect the rights of the Department to pursue any remedies under the contract or otherwise available under law.

Procedure

1. The request must be sent through the IowaGrants.gov Correspondence component.
2. The Department reserves the right to specify the format for reporting. In the absence of a prescribed format, the Contractor shall include the following components in the request:
    a. The executive director shall submit the request;
    b. Statement of the requirement for which the request for exception is being made;
    c. The rationale for failure to meet the requirement;
    d. The time period for which the exception is requested and
    e. A remediation plan to meet the requirement.
3. The exception to policy may be written for up to one year unless a different time limitation is stated in the requirement and granted by the Department.
4. An extension to an approved exception to policy may be granted only under limited circumstances upon a showing of substantial progress toward compliance. The extension request shall include the rationale for the extension and the progress made to date on the remediation plan.
5. Failure to request an exception to policy to a contract requirement prior to the anticipated noncompliance may result in the reduction or elimination of funding or the enforcement of other remedies authorized by the contract.

Number: 312
Title: Request for Exception to Policy
Effective Date: 01/01/2018
Revision Date: 03/11/2025
Date of Last Review: 03/11/2025
Authority: Iowa Administrative Code [641] Chapter 76

6. Failure to demonstrate satisfactory progress on the remediation plan may result in the reduction or elimination of funding or the enforcement of other remedies authorized by the contract.
7. It will be the decision of the Department whether the exception will be granted. The decision will be entered into IowaGrants.gov within 30 days of the request.
8. To request an exception to policy to reimburse dentists using Title V funds for services not on the preauthorized list of codes, see Policy 919.

Resources

Iowa Administrative Code [641] Chapter 76

IOWA | Health and Human Services

Number: 313
Title: Review and Approval of Informational and Educational Materials
Effective Date: 10/01/2022
Revision Date: 03/11/2025
Date of Last Review: 03/11/2025
Authority: Iowa HHS Contract General Conditions for Service Contracts

Policy

The development and translation of informational and educational materials, marketing materials, advertising, and communications shall be reviewed and approved by Iowa HHS prior to the Contractor's final development or reproduction. This policy applies to the following, including but not limited to presentations, verbal reports (public service announcements), publications (pamphlets, journal articles, reports, books, teaching guides, brochures), press releases, audiovisuals (posters, slides, video clips, film), or other marketing, advertising and informational materials. Any modifications to materials previously approved by Iowa HHS must be re-submitted for approval. Materials developed for the Maternal Health (MH) and Child & Adolescent Health (CAH) program and/or using federal and/or state dollars are generally in the public domain.

Procedure

1. The following are considerations when drafting or reviewing materials:
    a. The educational and cultural backgrounds of the individuals to whom the materials are addressed.
    b. Whether the material is suitable for the population or community to which it is to be made available.
2. All informational and educational materials developed by the program shall cite Title V or Medicaid Administrative Funds (informing, PE, care coordination) as contributing to the development of the materials. Language should include the following: "*This publication was made possible by grant number…*"
3. Contractors must review all print materials distributed and posted to ensure the reflection of a variety of individuals, including different cultures, ethnicities, sex, ages, etc. Contractors must ensure that the printed materials distributed are culturally and linguistically appropriate.
4. Materials may not be copyrighted, patented, or trademarked by the Contractor. All materials developed using state or federal funds as part of the MH and CAH program are generally public domain and shall be shared free of charge or at the cost of printing/sharing with Iowa HHS, other MH and CAH contractors, and other entities requesting to use the materials to promote the health of families.

Resources

HHS Contract General Conditions for Service Contracts

Number: 314
Title: Access, Use, Release and Data Sharing
Effective Date: 10/01/2016
Revision Date: 03/11/2025
Date of Last Review: 03/11/2025
Authority: Iowa HHS General Conditions for Service Contracts, DHS General Terms for Service Contracts

Overview

This policy lays out the expectations of the Contractors for compliance with accessing, using, releasing, and sharing of data.

Policy

1. Contractors shall ensure that client personally identifiable information remains strictly confidential (see Policy 305 Confidentiality and Policy 307 Information Technology Requirements).
2. Contractors shall ensure that when releasing data from the MCAH data system, all contractors and subcontractors comply with the Iowa HHS data sharing agreement Iowa HHS (DSA) Policy #CO 01-16-001, Iowa HHS Research Agreement and Research and Ethics Review Committee Policy # AD 07-12-004, Iowa HHS Disclosure of Confidential Public Health Information Records or Data Policy #CO 01-16-002, the Release of Information and Confidentiality of Records and Data Section within the Iowa HHS General Conditions for Service Contracts, and any future revisions to any of these.
3. Contractors shall assure that all release and sharing of any data originating from DHS complies with the terms and conditions within the Iowa HHS Omnibus Agreement, as amended, including the Iowa HHS Business Associate Agreement.

Procedure

1. Contractors shall use data only for the purposes outlined within the contract and shall ensure that the minimum number of individuals has access to the information, as necessary, to complete program work.
2. All information as to personal facts and circumstances obtained by the project staff about individuals receiving services must be held confidential and not be disclosed without the individual's documented consent, except as may be necessary to provide services to the patient or as required or authorized by law, with appropriate safeguards for confidentiality. Contractors are authorized to disclose identifiable data as necessary to comply with reporting laws, including laws requiring notification or reporting of child abuse, child molestation, sexual abuse, rape, incest, intimate partner violence, human trafficking, or similar reporting laws. Unless authorized or required by law to disclose confidential information, Contractors may disclose information only in summary, statistical or other form which does not identify particular individuals and which complies with all applicable laws and policies. See

Number: 314
Title: Access, Use, Release and Data Sharing
Effective Date: 10/01/2016
Revision Date: 03/11/2025
Date of Last Review: 03/11/2025
Authority: Iowa HHS General Conditions for Service Contracts, DHS General Terms for Service Contracts

Iowa HHS Disclosure of Confidential Public Health Information Records or Data Policy #CO 01-16-002.

3. Contractors may only release their own agency MCAH data in aggregate reports. No identifiable data may be released at any time. Identifiable data includes information that can directly or indirectly be used to establish the identity of a person, such as a name, address or other information that can be linked to external information that allows for identification of the person. Aggregate data should generally not be reported if the count size or numerator is fewer than six or if the denominator is fewer than 100. Any release of MCAH data by Contractors shall comply with all relevant federal and state laws and with Iowa HHS Disclosure of Confidential Public Health Information Records or Data Policy #CO 01-16-002.
4. Any subcontracted entity hosting or maintaining clinical records or identifiable data and all IT staff with access to confidential or protected information must attest to the requirement of these safeguards in the contract, Business Associate Agreement, or an attestation document. Copies of the appropriate documentation will be available for HHS (IDPH) staff to review.
5. All other requests received for the MCAH data system will be referred to the Department.
6. Contractors shall immediately report any suspected unauthorized disclosure of confidential information to the Department.

Documentation:

1. Contractors must submit new user forms to request access for new staff members and must submit a deactivation form when a staff member leaves employment.
2. Each user must electronically sign the confidentiality agreement within the MCAH data system before utilizing the system.
3. If data is downloaded from the system, rerelease must follow the guidelines above, the download must be deleted from the download section of the device used to download the data, and if data is transferred for purposes of providing services, such data shall be sent securely/encrypted.
4. Contractors will ensure that a consent and release form is signed and on file at least once per year for each client served.

IOWA Health and Human Services

Number: 314
Title: Access, Use, Release and Data Sharing
Effective Date: 10/01/2016
Revision Date: 03/11/2025
Date of Last Review: 03/11/2025
Authority: Iowa HHS General Conditions for Service Contracts, DHS General Terms for Service Contracts

Resources

Iowa HHS General Conditions for Service Contracts
Iowa HHS Disclosure of Confidential Public Health Information Records or Data Policy #CO 01-16-002
Iowa HHS Business Associate Agreement
Iowa HHS Data Sharing Agreement (DSA) Policy #CO 01-16-001
Iowa HHS Research Agreement and Research and Ethics Review Committee Policy # AD 07-12-004

Number: 315
Title: Telework
Effective Date: 10/01/2022
Revision Date: 03/11/2025
Date of Last Review: 03/11/2025
Authority: Office of Chief Information Officer (OCIO) information technology standards.

Overview

Telework can be a valuable tool in serving the needs of Maternal Health (MH) and Child and Adolescent Health (CAH) program clients and families. Contractors are to review the appropriateness of telework in their CSA for their employees and clients/families.

Policy

1. The contractor shall have policies and procedures that outline confidential, secure, and appropriate guidelines for telework sites that comply with all state and federal laws, contract special and general conditions, and Office of Chief Information Officer (OCIO) Information Technology Standards.
2. The contractor shall ensure that technology and workspace are confidential, secure, and appropriate for the work being completed at the telework site.
3. The contractor shall have policies and procedures that outline confidential, secure, and appropriate guidelines for teleworking and providing health care services from an approved telework site.

Procedure

Approved Telework Sites

1. Personal electronic equipment, mobile devices, computers, and removable storage devices may not be used. All equipment used to perform MH and CAH program work and services must be work-issued and comply with all OCIO information technology standards, guidelines in this manual, and contract conditions.
2. Contractor staff must use a secure internet connection and/or Virtual Private Network (VPN), hotspot, or other secure internet connection. Staff shall not connect to unauthenticated public Wi-Fi networks or networks using WEP and WPA (e.g., public WI-FI connections at hotels, restaurants, libraries, etc.).

Provision of Work from an Approved Telework Site

1. Contractor staff must have a private space designated for the delivery of services where conversations cannot be overheard or documents/documentation viewed by others not employed by the agency. Common areas of the home or a room shared with someone not employed by the agency would not comply with this policy.
2. Contractor staff cannot provide HIPAA-compliant health care services (including Informing, Care Coordination, Presumptive Eligibility, and gap-filling direct health

Number: 315
Title: Telework
Effective Date: 10/01/2022
Revision Date: 03/11/2025
Date of Last Review: 03/11/2025
Authority: Office of Chief Information Officer (OCIO) information technology standards.

care services) while also actively supervising children or vulnerable adults (e.g., door open to hear/see children play).

3. Contractor policies shall outline any work that may be done while actively supervising children or vulnerable adults.
4. Contractor staff training shall be provided with expectations for providing professional and health care services while teleworking.
5. Contractor policies and procedures for providing services from an approved telework site shall contain information to assure staff have the resources needed to respond to and meet client needs when not present with the client.
6. Contractors shall ensure that all contractor technology meets HIPAA requirements. The Department may request documentation of HIPAA compliance during a site visit, audit, or at any time.

Resources

Office of Chief Information Officer (OCIO) Information Technology Standards.

Number: 316
Title: Child and Adolescent Health Appointments
Effective Date: 10/01/2022
Revision Date: 03/12/2025
Date of Last Review: 03/12/2025
Authority: Iowa HHS Omnibus Agreement

Policy

Maternal Health (MH) and Child and Adolescent Health (CAH) program appointments shall be provided in a manner that meets the needs of all eligible families, including populations with limited access to healthcare services, considers social determinants of health, and promotes health equity.

Procedure

1. Clients or parents/primary caregivers of clients who are MH Program/CAH Program/Medicaid eligible and have used services, and those eligible for MH or CAH Program/Medicaid but have not used services, shall be included in the development of appointment policies and procedures.
2. Clients or parents/primary caregivers of clients with limited access to healthcare services shall be included in the development of appointment policies and procedures.
3. Contractor appointment systems shall be patient-centered.
4. Contractors shall customize appointment systems according to client needs and values. The client should be the source of control, and the client's needs should be anticipated and accommodated.
5. Contractors shall not charge for missed MH and/or CAH services, nor refuse nor restrict MH and/or CAH services to a client due to missed appointments or unpaid bills. Instead, Contractors shall provide enabling and support services to assist clients in accessing MH and CAH services, including but not limited to assistance with accessing health insurance, assistance with transportation, reminder/recalls, and care coordination as part of the MH and/or CAH gap-filling direct health care services.
6. Contractors shall provide MH and/or CAH gap-filling direct health care services outside 8:00-4:30 Monday through Friday.
7. Contractors shall treat clients with compassion, flexibility, and collaboration when a client arrives late or at an incorrect time for an appointment. Every reasonable effort shall be made to provide the service to the client on the day and time they arrive. If the client cannot be accommodated when they arrive, the Contractor shall provide enabling and support services to assist the client in accessing the MH or CAH service at another time convenient to the client.
8. Contractors shall provide a safe, comfortable waiting area for family members, including young children, while waiting for appointments.

Number: 316
Title: Child and Adolescent Health Appointments
Effective Date: 10/01/2022
Revision Date: 03/12/2025
Date of Last Review: 03/12/2025
Authority: Iowa HHS Omnibus Agreement

9. Contractors shall offer adolescents and adults time alone during the appointment with the service provider if accompanied by a parent, guardian, caregiver, spouse, friend or significant other.
10. The presence of individuals accompanying the client in the appointment shall be geared toward the benefit of the client. Contractors should consider the challenges families face in accessing healthcare services and make reasonable accommodations regarding the presence of siblings or other children.
11. Contractors should consider online scheduling, home visits, and other models for scheduling and providing services that meet the needs of clients.

Sources

Committee on the Learning Health Care System in America; Institute of Medicine; Smith M, Saunders R, Stuckhardt L, et al., editors. Best Care at Lower Cost: The Path to Continuously Learning Health Care in America. Washington (DC): National Academies Press (US); 2013 May 10. 7, Engaging Patients, Families, and Communities. Available from: https://www.ncbi.nlm.nih.gov/books/NBK207234/

Using Social Determinants of Health in Patient-Centered Care
https://patientengagementhit.com/news/using-social-determinants-of-health-in-patient-centered-care

Number: 317
Title: Family Engagement
Effective Date: 10/01/2022
Revision Date: 03/12/2025
Date of Last Review: 03/12/2025
Authority:

Overview

Efforts to reduce needs and promote health must be purposefully built into the intent, structure, and function of programs and organizations. This deep-level change includes the engagement of populations with limited access to healthcare services, clients, and families in decision-making. In addition, the proactive engagement of and partnership with communities, clients, and families is central to increasing health literacy, health care access, and health equity.

Policy

Contractors shall partner with clients and their families in programming planning, outreach, implementation, and evaluation.

Procedure

1. Contractors are encouraged to follow the best practice of developing a contract or scope of work outlining duties and compensation for family members, clients and/or youth providing lived experience and their expertise. In obtaining this expertise, Contractors shall ensure compliance with relevant federal and state laws and shall ensure such activity does not create a conflict of interest.
2. Contractors are encouraged to follow the best practice of compensating clients and families for ongoing work and advisory work. CYSHCNet recommends that payments begin at a rate of $25 per hour with a $100 minimum payment. Title V grant funds and Medicaid Administrative Funds (MAF) may be used for this type of compensation.
3. Contractors shall include both individuals/families utilizing MH and/or CAH program services in the past and those who have been eligible in the past but are not receiving services in providing input.
4. Contractors shall partner with and include populations with limited access to healthcare services in family engagement.
5. Contractors shall work toward Engagement and Partnership levels with clients, families, and clients eligible for service but not engaged in service throughout the CSA.

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Authority:

Levels of Engagement		
Category of Engagement	**Expectations**	**Method of Compensation**
Increasing levels of community involvement, impact, trust, and communication		
Participation		
Outreach	• Communication flows from the program to inform community members • Optimally established communication and outreach channels while sharing information with the community	Incentives- a meal, gift cards, contractor provides a service for the community
Speaker	• Clients & families invited to speak at a conference or meeting.	A stipend or honorarium is appropriate
Consultation	• Community members provide one-time or periodic feedback • Develop connections that may be able to grow into deeper levels of participation	A stipend is appropriate
Increasing ownership, empowerment, opportunities, and support for both staff and community		
Engagement		
Involvement	• Clients & families have time-limited contact with the project, for example, reviewing survey questions, reviewing/developing documents, reviewing/developing policies, conducting key information interviews, and participating in one-time or periodic advisory committee meetings. • Clients & families act as facilitators or co-facilitators of a focus group. • Clients & families may be part of a group of individuals serving in similar roles, such as on an advisory committee.	A stipend is appropriate. Compensation should be consistent for all members of the group doing similar work.
Collaborate	• Clients & families have an ongoing relationship with the project but are not employees.	A contract is appropriate,

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	• Having an ongoing relationship means that s/he is participating on a regular basis, which may include attending regular meetings and engaging in scheduled tasks such as survey development, data collection, participant recruitment, etc. • Clients & families may work on an hourly basis or on contract and may require a 1099 form, scope of work, or other documentation for the organization.	based on an hourly rate or on a per-job basis
Partnership		
Shared Leadership	• Decision-making, power, and responsibility are shared. • Development and structure of agenda, programs, and planning depend on client/family involvement. • Clients & families regularly review outcome data to inform decision-making.	A contract is appropriate, based on an hourly rate or on a per-job basis

Resources

Oregon Center for Children and Youth with Special Health Needs. Worksheet: Planning for Meaningful Family Involvement

Issue Brief: A Framework for Assessing Family Engagement in Systems Change

Using Communications to Advance Equity Office of Health Equity, Colorado Department of Public Health & Environment

Honoring All Languages to Advance Equity Family-to-Family Health Information Center (F2F) and the Family Voices Affiliate Organization (FVAO) in Iowa

ASK Resource Center Karen Thompson 5665 Greendale Road, Suite D Johnston, IA 50131

Sources

CYSHCNet. A Standard of Compensation for Youth and Family Partners. 2019.

Colorado's Community Engagement Spectrum, adapted from CDC: McCloskey et al. (2011). Community Engagement: Definitions and Organizing Concepts from the Literature, Principles of Community Engagement: Concepts and Definitions from the Literature (p 8).

Number: 317
Title: Family Engagement
Effective Date: 10/01/2022
Revision Date: 03/12/2025
Date of Last Review: 03/12/2025
Authority:

Simon M, Baur C, Guastello S, Ramiah K, Tufte J, Wisdom K, Johnston-Fleece M, Cupito A, Anise A. Patient and Family Engaged Care: An Essential Element of Health

Equity. NAM Perspect. 2020 Jul 13;2020:10.31478/202007a. doi: 10.31478/202007a. PMID: 35291751; PMCID: PMC8916808.

Number: 318
Title: CAH Child Care Nurse Consultant (CCNC) Services
Effective Date: 10/01/2016
Revision Date: 09/24/2024
Date of Last Review: 09/24/2024
Authority: Child Care Nurse Consultant Role Guidance: To Achieve Performance Measures and Annual Performance Standards, Child Care Health Consultant Competencies

Overview

In May 2019, the National Center on Early Childhood Health and Wellness (NCECHW) released Child Care Health Consultant (CCHC) Competencies. NCECHW is a collaborative effort between the Office of Head Start, the Office of Child Care, and the Maternal and Child Health Bureau. In Iowa, CCHCs are licensed registered nurses with specialized training and are identified as CCNCs. Healthy Child Care Iowa (HCCI) provides structure and fidelity for CCNCs at the local level. CCNCs are part of the CAH team.

Policy

Contractors shall provide CCNC services that adhere to the national Child Care Health Consultant Competencies and CCNC processes for technical assistance, health and safety assessments, training, and care planning for children with special health needs as outlined in the Child Care Nurse Consultant Role Guidance.

Required Resource for Implementation

Child Care Nurse Consultant Role Guidance

Procedure

1. The CCNC collaborates with Early Care and Education (ECE) programs to improve the quality of their health, safety, and wellness practices:
    a. The CCNC reviews the DHS child care database (Kindertrack/NDS 2.0) to identify ECE programs in the service area and offers CCNC services.
    b. The CCNC reviews DHS compliance reports to aid in providing consultation and technical assistance (TA).
    c. The CCNC conducts and documents health and safety assessments using the HCCI program and DHS quality rating system approved tools, forms, and reports.
    d. ECE program requests for Iowa Quality for Kids CCNC assessment tools must be scheduled within 3 weeks of the request.
    e. A Business Partnership Agreement is completed, and a copy is placed in the ECE chart along with documentation of services provided for ECE programs participating with the CCNC.

Number: 318
Title: CAH Child Care Nurse Consultant (CCNC) Services
Effective Date: 10/01/2016
Revision Date: 09/24/2024
Date of Last Review: 09/24/2024
Authority: Child Care Nurse Consultant Role Guidance: To Achieve Performance Measures and Annual Performance Standards, Child Care Health Consultant Competencies

f. Contractors collect CCNC performance measure data and report it annually on IowaGrants.gov.
g. Contractors determine the length of time that records are kept per agency record retention policy and, at minimum, General Conditions Section 9 of the CAH contract.

2. The CCNC collaborates with ECE programs and families to support the care and inclusion of children with special health care needs for equitable access to child care:
    a. When identified or requested by the ECE program, the CCNC assists in the development of care plans/action plans collaborating with the child's health care provider.
    b. When consulting and care planning, a signed consent is required from the child's parent or guardian.
    c. The child's care plan/action plan is signed by the child's health care provider and parent or guardian.
    d. The CCNC may contact the Area Education Agency (AEA) and/or Iowa Child Health Specialty Clinic (CHSC) as appropriate (with consent) to assist with the child's care plan.
    e. The CCNC role in assisting with care planning is to provide collaboration, TA, and training for the ECE provider/staff on the specifics of the plan for full and safe inclusion in the ECE program. The CCNC role is <u>not</u> a delegation of duties.
3. The CCNC identifies and implements health education and helps ECE programs safely manage medication administration:
    a. The CCNC provides HCCI DHS-approved training in the CCNC service area.
    b. All DHS-approved trainings provided by the CCNC are to be posted on I-PoWeR (Iowa's Early Childhood and School Age Professional Workforce Registry) coordinated with an approved training entity (CCR&R, ISU Extension and Outreach, Head Start, Iowa AEYC, etc.)
    c. The CCNC is required to provide a minimum number of *Medication Administration Skills Competency* training and Skills Competency Evaluations (test-out) in the CCNC service area.

Number: 318
Title: CAH Child Care Nurse Consultant (CCNC) Services
Effective Date: 10/01/2016
Revision Date: 09/24/2024
Date of Last Review: 09/24/2024
Authority: Child Care Nurse Consultant Role Guidance: To Achieve Performance Measures and Annual Performance Standards, Child Care Health Consultant Competencies

   d. The CCNC provides ongoing Skills Competency re-assessment every 2 years through the course's 5-year approval period for ECE programs/staff.
   e. The CCNC assists programs with policies regarding safe medication administration and storage.

4. The CCNC helps ECE programs prepare for, respond to, and recover from emergencies/disasters, including communicable disease outbreaks:
   a. Utilize Iowa's specific resources when providing consultation on emergency preparedness planning.
   b. The Iowa Statewide Child Care Emergency Preparedness and Response Plan includes HCCI responsibilities and lists CCNC services as a referral resource.
   c. The CCNC provides consultation and TA to ECE programs on management and response to infectious disease outbreaks.
   d. Contractors shall follow guidance documents and instructions by the Department CADE and/or local public health authority pertaining to communicable diseases.

Resources

Child Care Nurse Consultant Role Guidance: To Achieve Performance Measures and Annual Performance Standards
Child Care Health Consultant Competencies
Iowa Quality Rating System - Iowa Administrative Code 441-118 Iowa Statewide Child Care Emergency Preparedness and Response Plan

IOWA | Health and Human Services

Number: 401
Title: Financial Accountability
Effective Date: 10/01/2016
Revision Date: 03/12/2025
Date of Last Review: 03/12/2025
Authority: 45 CFR 96, 45 CFR 92, 45 CFR 74, HHS Service Contract Terms and Conditions

Policy

The Contractor shall comply with the HHS Service Contract Terms and Conditions, the MCAH financial accountability requirements for contract requirements, and the cost allocation plan.

Procedure

Contract Requirements: The Contractor is expected to comply with the following financial accountability contract requirements:

1. Written financial policies and procedures including, but not limited to:
    a. Supply distribution
    b. Purchasing, bidding, and selection
    c. Check writing and control
    d. Billing
    e. Accounting/bookkeeping
2. Expenditure controls to prevent over-billing of annual budgets.
3. Valid, approved time records for project staff and volunteers that clearly indicate the amount of time the individual spends in each program area. Continuous daily time studies are required. All volunteer time used for a match must be fully documented and approved by the individual whose time is used for the match.
4. Use of generally accepted accounting principles.
5. An independent financial audit is completed annually. This requirement is applicable to subrecipients of federal funds who are required to have an audit made in accordance with the provisions of Office of Management and Budget (OMB) Circular 2 CFR 200: Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards.
6. Required Accounting Records including:
    a. **Cash receipts register:** The cash receipts register lists each receipt of cash or checks with the date received, the payer's name, a brief description, the amount received, and the account credited.
    b. **Cash disbursements register:** The cash disbursements register lists each disbursement in check number order with date paid, payee, check number, amount paid, and account charged.
    c. **General ledger:** The general ledger summarizes the monthly postings from cash receipts and cash disbursements registers by general ledger account, with adequate identification of expenses by each grant or contract.

Number: 401
Title: Financial Accountability
Effective Date: 10/01/2016
Revision Date: 03/12/2025
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Authority: 45 CFR 96, 45 CFR 92, 45 CFR 74, HHS Service Contract Terms and Conditions

   d. **Journal entries:** Journal entries contain explanations and amounts of any adjustments to the general ledger accounts.
   e. **Chart of Accounts**: A listing of the accounts available in the general ledger in which to record entries.
   f. **Payroll time reports**: Time reports show the hours worked on each funded program or grant and the total individual effort. Records must be broken out by funding source on each time report.
   g. **Payroll register**: The payroll register lists each employee's gross pay, federal and state tax withheld, other amounts withheld, net pay, and check number for each paycheck. Note: The payroll register may be included in the cash disbursements register at small agencies.
   h. **Individual earnings records:** Individual earnings records list cumulative remaining during the year for each employee.
7. Expense documentation: The Contractor and subcontractor must keep the following documents on file.
   a. Bank statements and canceled and voided checks
   b. Invoices and bills for purchases of supplies, equipment, telephone utilities, services, etc.
   c. Travel claims with receipts for commercial transportation, meal, and lodging costs reimbursed to employees
   d. Time reports and payroll registers
   e. Copies of leases for office equipment and vehicle rentals
   f. Tax deposit receipts for withholding tax payments
   g. Copies of monthly and final expenditure reports submitted to Iowa HHS
   h. Copies of contracts, budgets, amendments, and all related correspondence from Iowa HHS
   i. Documentation of the methodology used for the allocation of costs
8. Internal control system established by management that is designed to provide reasonable assurance regarding the achievement of objectives in the following categories:
   a. Effectiveness and efficiency of operations
   b. Reliability of financial reporting
   c. Compliance with applicable laws and regulations

IOWA | Health and Human Services

Number: 401
Title: Financial Accountability
Effective Date: 10/01/2016
Revision Date: 03/12/2025
Date of Last Review: 03/12/2025
Authority: 45 CFR 96, 45 CFR 92, 45 CFR 74, HHS Service Contract Terms and Conditions

Accountability Procedures: The following accountability procedures must be followed:

1. Expenditures paid by check should be made using pre-numbered checks.
2. All receipts (cash and checks) are listed individually and deposited in the bank account intact and timely.
3. Bank reconciliations should be prepared monthly and reviewed and approved by a person who is not responsible for receipts or disbursements.
4. If one individual has control over all cash functions (receiving funds, making deposits, reconciling bank statements, making payments, preparing payrolls), the employee must be bonded.
5. If the Contractor has more than one program, a plan for the allocation of costs must be established to indicate how costs are distributed equitably to each program. Formal accounting records that will substantiate the propriety of eventual charges will support all costs included in the plan. The allocation plan should cover all joint costs of the Contractor. This includes costs to all programs of the Contractor, which are to be included in the costs of federally sponsored programs.

Cost Allocation Plan: The Cost Allocation Plan must contain the following:

1. The nature and extent of services provided and their relevance to the program
2. The items of expense to be included
3. The methods to be used in distributing costs
4. An annual review of the plan and necessary revisions

Resources

45 CFR 96
45 CFR 92
45 CFR 74
HHS Service Contract Terms and Conditions
Office of Management and Budget (OMB) Circular 2 CFR 200
Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards

IOWA | Health and Human Services

Number: 402
Title: Budget Revisions
Effective Date: 10/01/2016
Revision Date: 03/12/2025
Date of Last Review: 03/12/2025
Authority: Contract General Conditions

Policy

The MH and CAH Program budget is part of the contract between the Contractor and the Agency. The budget is developed in accordance with the RFP or RFA of the corresponding fiscal year. Contractors must notify the Agency of any contract changes by the due date listed in the contract. If no due date is specified in the contract, the Contractor must obtain approval for budget revisions by the last business day in September.

Procedure

Revisions Requiring Prior Written Approval:

1. Prior written approval is required for a budget revision under the following conditions:
    a. Any change in a line-item cost specifically identified in the Special Conditions of the contract as being restricted.
    b. The opening of any line item not in the approved budget.
    c. The purchase of equipment costing $5,000 or more and possessing a useful life expectancy of greater than one year. Equipment and/or supplies costing less than $5,000 may be purchased without prior approval from Iowa HHS (per General Contract Conditions).
    d. Expenditure variance of more than ten percent (10%) cumulatively of the program budget amount (MH, CAH, HCCI, Hawki, CH-dental, I-Smile™, I-Smile™@School). At no time will a specific program be over-expended. Budget categories are identified in the most current RFP and RFA documents.
2. Requesting a budget revision will be done within IowaGrants. The process is as follows:
    a. The Contractor will submit a request through the IowaGrants Correspondence component to the appropriate consultant(s) and contract specialist to negotiate the budget component, including the program(s) being revised, the dollar amount, and a brief description of the budget change. If the requested revision reduces the amount on the contract face sheet, provide the proposed total. Budget revisions initiated on the part of the Contractor that increase the amount of the total grant funds will not be accepted unless previously approved or requested by the Agency.
    b. The Agency will negotiate the budget component to the Contractor.
    c. The Contractor will make the proposed changes in the budget component and submit.
    d. The Agency will review the proposed changes and accept the changes or provide feedback to the Contractor (“renegotiate” the component).
    e. A correspondence may be sent to notify the Contractor of the request status and/or to initiate the contract amendment process if necessary.

IOWA | Health and Human Services

Number: 402
Title: Budget Revisions
Effective Date: 10/01/2016
Revision Date: 03/12/2025
Date of Last Review: 03/12/2025
Authority: Contract General Conditions

Revisions Not Requiring Prior Written Approval:

1. Routine budget revisions are those that do not substantively change the program plan.
    a. Routine budget revisions include such items as changing cumulative program budget line-item amounts of less than 10% of the total budget amount for a program.
    b. Revising the 'other funds' categories.
    c. Changing a single category of personnel of less than .20 FTE, unless this will take the staff person under a required FTE.
3. Prior approval from the Department is not required for routine budget revisions, however, routine budget revisions must be recorded in the approved budget and in the expenditure workbook.
4. The Contractor must notify the Agency in writing with the explanation of the change and the corresponding revised budget pages.
5. Year-end expenditures will be compared against the revised line-item amount.

Resources

Iowa Grants user guides

IOWA | Health and Human Services

Number: 403
Title: Program Income
Effective Date: 10/01/2016
Revision Date: 03/12/2025
Date of Last Review: 03/12/2025
Authority: Contract General Conditions

Overview

Program income is defined as gross income earned by the Contractor resulting from activities related to fulfilling the terms of the contract. It includes but is not limited to, such income as fees for service, third-party reimbursement, and proceeds from sales of tangible, personal, or real property.

Policy

Program income may be used for allowable costs of the Contractor. A spending plan must be approved by the Agency for use of program income in excess of 5 percent above the amount approved in the program budget. Program income must be used before using the funds received from the Agency. Excess program income may be retained to build a three-month operating capital.

Procedure

The Contractor must develop other sources of financial support for program activities, including the following:

1. Recover all third-party revenues to which the Contractor is entitled as a result of services provided.
2. Garner other available federal, state, local, and private funds.
3. Charge clients according to their ability to pay for services provided, based on a sliding fee schedule. The sliding fee schedule must be based on standardized guidelines provided by the Department. Any changes from these guidelines must have prior written approval by the Department (See Policy 106-CAH Child & Adolescent Health Program Eligibility and Voluntary Participation and 106-MH Maternal Health Program Eligibility and Voluntary Participation).
4. Client billing and collection procedures must be consistent with those established and provided by the Department. Services funded partially or completely by the Agency will not be denied to a person because of inability to pay a fee for the service. Individual and/or immediate family income and family size are used in developing the sliding fee schedule. (See Policy 106-CAH Child & Adolescent Health Program Eligibility and Voluntary Participation and 106-MH Maternal Health Program Eligibility and Voluntary Participation).
5. The Contractor must report to the Agency, within forty-five days, all funding sources using the MH or CAH Expenditure Workbook.

Resources

HHS Service Contract Terms and Conditions

IOWA | Health and Human Services

Number: 404
Title: Documentation of Local Match
Effective Date: 10/01/2016
Revision Date: 03/12/2025
Date of Last Review: 03/12/2025
Authority: 45 CFR, Part 74.23; Iowa Administrative Code 641 IAC 76.13(4)

Overview

The provisions of 45 CFR, Part 74, Subpart C define terms, set standards of allowability and valuation, and establish procedures for the contractor's documentation of local match. Sources that may be used for matching funds are reimbursement for service from third parties such as insurance and Medicaid, client fees, local funds from non-federal sources, or in-kind contributions. In-kind contributions must be documented in accordance with generally accepted accounting principles.

Policy

Contractors shall follow the guidelines outlined in 45 CFR, Part 74, Subpart C for documenting local match.

Procedure

1. In general, local match, whether in cash or in-kind, represents the portion of the contractor costs not borne by the Agency. The basis for determining valuation and charges for all elements of local match, including personal services, materials, equipment, and realty, must be documented in a manner acceptable to the Agency.
2. Charges for property purchased completely with federal funds and any portion of property purchased in part by federal funds are not permissible for inclusion as a local match unless otherwise authorized by federal legislation. However, operating costs (such as housekeeping and maintenance, protection, utilities, etc.) may be included with adequate supporting documentation, even though valuation may be in the form of a square footage rate along with unallowable property charges.
3. The value of volunteer labor and donated services may be included as part of local match and must be documented by the same method that the contractor uses for its paid employees. The valuation used for personal services would ordinarily be the value placed on the task performed and not necessarily the time rate of the individual rendering the service.
4. Fees collected from Medicaid and/or any other private or third-party source must be reported to the state when collected and must be expended on program-related activities. Subcontractors are required to report program income to the contractor. The contractor is required to report program income monthly to the Agency on the supporting documentation workbook that the contractor submits with each claim in IowaGrants.gov.
5. The contractor is certifying that the amount of match reported is available to the Agency to use as federal match. The Agency will consider all the match funds reported by the contractor as available for federal match, although the Agency may elect to use only a portion of the certified match for Title V.

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Authority: 45 CFR, Part 74.23; Iowa Administrative Code 641 IAC 76.13(4)

Resources

45 CFR, Part 74.23
Iowa Administrative Code 641 IAC 76.13(4)
45 CFR, Part 74, Subpart C

IOWA | Health and Human Services

Number: 405
Title: Advances of Contract Funds
Effective Date: 10/01/2016
Revision Date: 02/12/2025
Date of Last Review: 02/12/2025
Authority: Iowa Administrative Code 641 IAC 76.13(3); HHS Service Contract Terms and Conditions

Policy

In the event the Contractor lacks sufficient working capital to provide the services of the contract, an advance not to exceed one month's value of the contractual amount may be provided by the Department. One-third (1/3) of this advance will be deducted from eligible reimbursement of expenses for the 7th, 8th, and 9th months of service.

Procedure

1. Requests for Advance of Contract Funds must be made via IowaGrants.gov Correspondence and must include sufficient justification for the advance.
2. Cash advances, whether permanent or in the form of working capital, must be maintained in interest-bearing accounts.
3. Interest earned by the Contractor on cash advances shall be allocated by the Contractor to the program for which the cash advance was received.
4. All interest earned on cash advances shall be remitted to the Department on a quarterly basis or more frequently if requested by the Department. Interest amounts up to $250 per contract period in the aggregate for all federal funded programs may be retained by the Contractor for administrative expenses only.
5. The quarterly interest earned statement must be attached to a Correspondence in IowaGrants.gov and sent to the Contractor's consultant and contract manager.

Resources

Iowa Administrative Code 641 IAC 76.13(3)
HHS Service Contract Terms and Conditions

IOWA | Health and Human Services

Number: 406
Title: Reimbursement of Expenses
Effective Date: 10/01/2016
Revision Date: 03/12/2025
Date of Last Review: 03/12/2025
Authority: Iowa Code 8A.502

Policy

Contractors are reimbursed for expenses incurred by submitting a monthly claim and supporting documentation workbook located on the IowaGrants.gov grant site.

Procedure

1. The Agency provides the supporting documentation workbook to the Contractor at the start of the contract year. The supporting documentation workbook is an Excel workbook that is used by the Contractor to report the amount of grant funds expended in each line item per program (e.g., MH, CAH, etc.) each month. The supporting documentation workbook is also used by the Contractor to report the amount of funds billed to "other" funding sources (e.g., Title XIX) and received from "other" funding sources each month.
2. A claim, including the supporting documentation workbook, is due 45 days after the month of expenditure.
3. All claims are to be submitted via IowaGrants.gov.
4. The monthly claim must also include the amount of funds billed *to* 'other' funding sources and received *from* 'other' funding sources each month.
5. MH and CAH agencies may choose to bill Medicaid/Medicaid MCOs and not bill private third-party payers for services if using federally approved pediatric preventive ICD-10 codes. Iowa Medicaid and Medicaid MCOs are required to complete the 'pay and chase' for third-party payment for pediatric preventive health services with the designated ICD-10 codes. These ICD-10 codes are listed in State Medicaid Manual Part 3 - Eligibility Transmittal 76 and ensure a claim for pediatric preventive services (including EPSDT services) will not require third-party billing for clients with private insurance. The ICD-10 code must be in the primary diagnosis field on the claim to ensure the claim does not require submission to a third-party payor. Other diagnosis codes may be included in subsequent diagnosis code fields on the claim.

Resources

Iowa Code 8A.502

IOWA Health and Human Services

Number: 407
Title: Fiscal Record Retention
Effective Date: 10/01/2016
Revision Date: 03/12/2025
Date of Last Review: 03/12/2025
Authority: 45 CFR Part 74; HHS Service Contract Terms and Conditions

Policy

Contractors shall retain all fiscal records for a period of seven (7) years from the day the Contractor submits the final expenditure report.

Procedure

1. Contractors shall retain all accounting and financial records, programmatic records, supporting documents, statistical records, and other records reasonably considered pertinent to the MH and/or CAH contract be retained for a period of seven (7) years from the day the Contractor submits its final expenditure report.
2. If any litigation, claim, negotiation, audit or other action involving the records has been started before the expiration of the seven-year period, the records must be retained until completion of the action and resolution of all issues that arise from it, or until the end of the regular seven (7) year period, whichever is later.
3. Client records, which are non-medical, must be retained for a period of seven (7) years after the date of service.
4. Federal regulations and the agreements between the state agency and the Contractor require that all records determined to be pertinent to the contract must be made available to representatives of the state and/or federal government for purposes of an audit, quality improvement, or other legally authorized purposes.

Resources

45 CFR Part 74
HHS Service Contract Terms and Conditions

IOWA | Health and Human Services

Number: 408
Title: Medicaid Administrative Funds Billing
Effective Date: 10/01/2022
Revision Date: 03/12/2025
Date of Last Review: 03/12/2025
Authority: Iowa HHS Omnibus Agreement

Overview

In Iowa, Iowa HHS administers the Iowa Medicaid Program and, therefore, is the administrative agency for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program and the Maternal Health Program. Through a formal written agreement, Iowa HHS provides for Informing (Child and Adolescent Health - CAH only), Care Coordination, Presumptive Eligibility, and related interpretation services for eligible clients. Iowa HHS fulfills this responsibility by contracting with local community-based programs to work with clients in collaborative service areas. This is an arrangement unique to Iowa. These services are paid through Medicaid Administrative Funds (MAF) associated with the written agreement. As a result, these services are frequently referred to as “MAF services”.

Policy

Contractors shall bill expenses related to the quality provision of Informing, Care Coordination, and Presumptive Eligibility services (MAF services) to Iowa HHS in compliance with Iowa HHS Guidelines.

Procedure

1. Include all expenses and staff time spent doing Informing, Presumptive Eligibility, Care Coordination, and related interpretation, not already funded in another way, in a Contractor’s Medicaid Administrative Fund (MAF) billing to Iowa HHS for Medicaid enrolled clients. Examples of activities that may be billed to MAF include the following:
    a. Client Contact - Time spent with the client and locating needed information to contact the client. Telephone, in-person, text, email, videoconference, or home visit with the client for Care Coordination, Informing, and Presumptive Eligibility.
    b. Identification of needed resources and referral - Activities related to identifying appropriate resources and making referrals for the client based upon their needs
    c. Care Coordination - Activities include setting up appointments (outside of the Contractor agency, subcontracts, and parent company), making arrangements for transportation to health services, arranging interpreter services, and linking with other support services.
    d. Documentation - Documentation of services following Iowa HHS guidance.
    e. Maintaining fiscal records - Completing claims forms and preparing submissions to the Medicaid or MCO fiscal agent. Reviewing denials of original billings and resubmitting the corrected claims. Maintaining fiscal records based on generally accepted auditing procedures.

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f. Maintaining supplies - Managing the paper, brochures, postage, printing labels, and other supplies for MAF-funded services.
g. Managing lists and reports - Downloading and analyzing data for quality improvement and reports for staff to do their work related to MAF services.
h. General office work - Answering MAF services phone calls, taking messages, making appointments with the care coordinator, and other work to maintain communication and requirements of the organization such as filling out time studies, travel documents, completing reports, etc. related to MAF-funded services.
i. Staff travel non-client specific - Travel to clinic sites (to provide MAF, not direct care), meetings, and conferences related to MAF-funded services.
j. Developing community linkages - Building and maintaining the referral network for medical home and Care Coordination. Developing and maintaining formal and informal linkages between community agencies, providers, and organizations to build public health services and systems and enabling capacity in the CSA.
k. Meetings - Meetings to plan, communicate, and coordinate the activities of the program, Family Engagement Group meetings, including planning and logistics of coordinating the group, membership recruitment, etc.
l. Continuing education- Staff skill development and education to keep current on policy and best practices related to MAF services.
m. MAF program administration - Management of the program, including supervising the work of MAF-funded staff.
n. Developing educational materials for clients - Creating and maintaining brochures, letters, posters, and other educational materials related to MAF services for clients.
o. Vacation, sick, holiday time - Time allocated for vacation, holiday, and sick days based on the time study allocation of time to MAF and policies of the organization.
p. Time spent coordinating and participating in Maternal Health Coalition meetings that support MAF activities. This could include:
    i. Efforts to recruit coalition members for the purpose of building up referral networks for MAF services.
    ii. Time spent during meetings discussing care coordination and presumptive eligibility for pregnant women for the purpose of increasing referrals to and from the MH program and improving care coordination services.

2. The total cost of providing the service, as billed to MAF, should be included in the time study.
3. Submit all CAH MAF into your line item CAH monthly claims.
4. Complete the MAF section in the MCAH Expenditures and Supporting Documentation workbook.

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5. The MAF section of the workbook will link to the Program Income sections to carry those expenses up appropriately.
6. This is to be entered into IowaGrants.gov within 45 days of the month of expenditures.

Number: 409
Title: Medicaid Managed Care Organization Reimbursement Issue Reporting
Billing Code(s): All
Effective Date: 09/01/2020
Revision Date: 03/12/2025
Date of Last Review: 03/12/2025

Overview

Contractors are required to credential with and bill services to Medicaid Managed Care Organizations (MCO) and Pre-Paid Ambulatory Health Plans (PAHP) for services provided to Child and Adolescent Health (CAH), Oral Health (OH) and Maternal Health (MH) clients enrolled in an MCO or PAHP as part of their CAH Program/Screening Center or MH Program/Maternal Health Center. Understanding that billing/ reimbursement issues may occur, the Iowa Department of Health and Human Services (HHS) has developed processes for Title V Contract Screening Centers and Maternal Health Centers to seek assistance in resolving billing and reimbursement issues.

Policy

Contractors shall follow the procedure set forth in this policy when seeking HHS assistance with MCO or PAHP billing or reimbursement issues.

Procedure

1. Contractors shall work with the relevant MCO or PAHP provider relations on initial concerns. Representatives can be found in MCO or PAHP provider maps or portal (if applicable).
2. If unable to receive a response or resolution in a timely manner, initiate the following procedure:
   a) Email issues to respective MCO or PAHP contact at HHS
      a. For Iowa Total Care, Wellpoint, Molina, and Fee for Service:
         i. Bianca Finley, bianca.finley@hhs.iowa.gov
      b. For Delta Dental, MCNA, and Fee for Service:
         i. Sarah Petersen sarah.petersen@hhs.iowa.gov
         ii. Ashley Miller ashley.miller9@hhs.iowa.gov
      c. Please cc respective program team lead on email:
         i. amy.chebuhar@hhs.iowa.gov for CAH
         ii. Anna.moats-gibson@hhs.iowa.gov for MH
         iii. melissa.woodhouse@hhs.iowa.gov for OH
   b) Include the following information in a secure/confidential email:
      a. Provider Name
      b. NPI
      c. Contact information including phone and email
      d. MCO/PAHP and a summary of the issue
      e. Summary of previous contact communication with the MCO/PAHP
      f. Sampling of claims/Explanation of Benefits/Recoupment letter, or other pertinent documentation

Number: 501-CAH
Title: Service Note Review
Effective Date: 10/01/2022
Revision Date: 03/12/2025
Date of Last Review: 03/12/2025
Authority: Iowa HHS Omnibus Agreement, Iowa Administrative Code [441] Chapter 79.3

Overview

Service Note Review (SNR) applies to Presumptive Eligibility (PE), Informing (INF), and Medical/Dental Care Coordination (CC) services provided as part of the Contractor's CAH program regardless of the payer source. The SNR is conducted per the contract. Reviewers must have knowledge of the program requirements and services and have access to the Maternal Health (MH) and Child and Adolescent Health (CAH) Data System. Project Directors serve as the primary contact for the review.

Policy

Contractors will conduct SNR as specified in the contract to review documentation of Presumptive Eligibility, Informing, Care Coordination, and home visits for Care Coordination to ensure Department compliance.

Required Resources for Implementation

The Department provides a list of Contact IDs and forms to complete the SNR.

Documentation: The following documentation is required for each service:

1. **Presumptive Eligibility:**
    a. Demographics including race, ethnicity, primary language, and interpreter needed
    b. Coverage Explained
    c. Result of Notice of Action (NOA)
    d. NOA number
    e. County of residence
    f. Contacted person
    g. Client/family feedback
    h. Documents kept on file and documents given to family
    i. First and last name of the service provider and their credentials.
    j. Intake assessment addressed with IRIS/IRIS component of the MCAH data system used to assess immunization status

2. **Informing:**
    a. Initial Inform:
        i. First and last name of the service provider and their credentials
        ii. Statement that an informing letter or packet was sent

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iii. County of residence

b. Inform Follow-up
   i. First and last name of the service provider and their credentials
   ii. County of residence
   iii. Description of the attempt to reach the family and the result of the attempt (no answer, phone disconnected, etc.), including any voicemail message left or text message sent and the content of the message
   iv. A follow-up letter is sent (after at least two failed attempts on two different dates)
   v. Follow-ups are required within 30 days of the initial inform
c. Inform Completion
   i. Demographics, including race, ethnicity, interpreter needed, and primary language
   ii. First and last name of the service provider and their credentials
   iii. County of residence
   iv. Contacted person
   v. Explanation of full benefits and services available under the EPSDT Program
   vi. Medical well-visit appointment summary (name of provider; past or upcoming appointments)
   vii. Dental appointment summary (name of provider; past or upcoming appointments)
   viii. IRIS/IRIS component of the MCAH Data System used to assess immunizations
   ix. Client/family feedback provided
   x. Referrals, outcomes, and plan for follow-up
   xi. Intake assessment addressed

3. **Care Coordination**
   a. Demographics including race, ethnicity, primary language, and interpreter needed
   b. County of residence
   c. First and last name of the service provider and their credentials
   d. Concerns and issues
   e. Contacted person
   f. Staff response

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g. If coordinating medical/dental care:
    i. Dental appointment summary (name of provider; past or upcoming appointments)
    ii. Medical appointment summary (name of provider; past or upcoming appointments)
    iii. IRIS/IRIS component of the MCAH Data System used to assess immunizations or caretaker reports if completed by OH staff
    iv. Referrals, outcomes, & plan for follow-up
    v. Client/family feedback provided
    vi. Intake assessment addressed

For **targeted follow-up care coordination** notes that do not involve coordinating medical/dental care, the date of the last wellness exam, name of provider, and assessment of immunization status are not required. Indicate in the note if it is a follow-up care coordination service. Address any additional family needs.

Procedure

1. SNR 1 will occur in the fall/winter of each FFY. SNR 2 will occur in the spring/summer of each FFY. The month selected by the Department for the data pull will be random.
2. For SNR 1, the Department will provide the Agency with a list of Contact IDs and blank Service Note Summations (Child Health: PE, INF, CC. Maternal Health: PE, CC).
    a. The Contractor will review the Contractor documentation using the provided forms as a checklist for included elements. Complete the forms (including contact ID & service date) and by checking the “yes” or “no” boxes to indicate if the required elements of documentation are in the record. If there is more than one box marked “no” the record does not “pass.” An agency review comment field is available for your use for any additional comments (optional).
    b. If the Contractor did not provide a specific type of service to be reviewed, check the ‘No Services This Period’ box on the Service Note Review Summation that verifies this (e.g., if no presumptive eligibility services were provided during the month reviewed).

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   c. Completed review tools are to be sent via confidential email within 30 days from the start of the review process. Do not upload completed summation forms to IowaGrants.gov.
3. For SNR 2, the Department will provide the Contractor with completed Service Note Summations (Child Health: PE, INF, CC. Maternal Health: PE, CC).
   a. The Contractor will use the completed forms and feedback provided by the Department to complete their own quality assurance activity.
4. SNR Quality Improvement Plans are required for Contractors that do not achieve 90% documentation compliance for their review. 90% compliance will be calculated by summing the total service records submitted for review as the denominator, with the number in compliance (marked as pass) as the numerator.
   a. Contractors with continued non-compliance will be required to complete more frequent reviews and may be placed on a Corrective Action Plan, which may result in the reduction or elimination of funding or the enforcement of other remedies authorized by the contract.
   b. Required elements of the Quality Improvement Plan are the actions that will be taken to ensure documentation is in compliance with this policy, the person completing this step and responsible for assuring documentation comes into compliance, and the timeline for when the steps will be taken.
   c. Quality Improvement Plans should be submitted for approval and then uploaded into the Service Note Review - Quality Improvement Plan component. The plan must be uploaded to IowaGrants.gov within 30 days of the receipt of the SNR results from the Department.

Resources
Iowa Administrative Code [441] Chapter 79.3

IOWA | Health and Human Services

Number: 502-CAH
Title: Medical Record Audit
Effective Date: 10/01/2016
Revision Date: 3/18/2025
Date of Last Review: 3/18/2025
Authority: HHS General Conditions for Service Contracts, HHS Omnibus Agreement

Overview

The Iowa Department of Health and Human Services Child and Adolescent Health (CAH) medical record audit is part of the quality improvement program, and the intent is to evaluate the contractor's current practices and identify areas to improve the quality of service delivery and documentation. Presumptive Eligibility, Informing, and Care Coordination are not included in these medical record audit guidelines as they are reviewed during the service note review process (see Policy 501 Service Note Review).

Policy

1. Medical record audits are required of all contractors providing gap-filling direct health care and oral health services. Medical record audits apply to all gap-filling direct care services provided through the CAH program regardless of payer source. CAH gap-filling direct care services include the following services as defined in the Screening Center Provider Manual.
2. Virtual or in-person medical record audits may occur at the discretion of the state Title V program.
3. All gap-filling direct health care services provided for clients under the CAH program must be entered into the Maternal Child and Adolescent Health (MCAH) data system. Documentation of the clinical detail for gap-filling direct health care services must also be maintained in a client's medical record (paper or electronic). Both of these forms of documentation will be reviewed during the audit.
4. Documentation of services must comply with generally accepted principles for maintaining health care records and with Medicaid requirements established by the Iowa Department of Health and Human Services (Iowa HHS) in IAC 441 Chapter 79.3.

Procedure

Internal Medical Record Audit: At least one contractor-conducted (internal) medical record audit must be completed every other year. Following the internal medical record audit, the Contractor is required to submit a MCAH Medical Record Audit Summary form, complete with plans for quality improvement based on the audit findings.
The contractor's internal medical record audit team will be a multidisciplinary team representative of the disciplines providing CAH services (e.g., nurse, social worker, dental hygienist). Contractors shall include subcontractors in the audit process.

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Joint Medical Record Audit: Opposite years from the internal medical record audit, the contractor is required to have an audit conducted by a joint review team composed of contractor and subcontractor staff and staff from the Iowa HHS Division of Public Health/CAH Program. The audit team, including CAH staff, must be large enough so that each team member reviews one to five medical records.

Medical Record Audit Process:

1. A minimum of one week prior to the audit (internal or joint), the Department will provide the contractor with a list of ID numbers randomly selected from the MCAH data system using the selection criteria found in the *Medical Record Selection Requirements* section found below.
2. The contractor shall carefully review the list of ID numbers provided by the MCAH data system to ensure that the selected medical records meet the required selection criteria. Due to the complex nature of selecting IDs that meet all criteria, contractors may not need to review all the medical records included in the list of selected medical records **IF** they have otherwise met the selection criteria outlined below. Some IDs may need to be swapped out for a different ID due to a nuance or error. Contractors wanting to alter the list, review fewer records, or review alternate records shall notify the consultant and get approval.
3. Department and contractor staff shall review the medical records using the most updated medical record audit tools prior to the scheduled virtual audit meeting.
4. For joint audits, the Department will select the ID numbers of the records for CAH staff to review. Most contractors utilize some form of medical record outside of the MCAH data system, whether electronic or paper. In order for the Department staff to properly audit the selected medical records, the contractor shall send the medical records to the Department for each team member to review. The contractor only needs to send non-MCAH data system records to complete the audit for each medical record, as the consultants will have access directly to the MCAH data system for review.
    a. Medical records must be sent to the Department at least five business days in advance of the scheduled audit via secure email. Ensure the medical records include the MCAH data system ID, any paper documentation, and all electronic medical records related to CAH services provided within the past 12 months.

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5. Contractors will ensure that their staff auditing medical records have access to the MCAH data system. If staff do not have access, time should be scheduled for reviewers to work with staff who do have access.
6. The CAH Project Director should set aside time with their staff ahead of time to review the required tools and expectations of medical record audits. CAH Project Directors will assign medical records to reviewers.
7. Contractors and Department staff review assigned medical records independently prior to the scheduled debrief. Contractors may choose to meet prior to the debriefing session to discuss any questions or jointly review medical records.
8. The debriefing session will consist of a round-table style share of medical record audit findings for strengths and areas for improvement and completion of the Medical Record Audit Summary.

Medical Record Audit Summary: One CAH Medical Record Audit Summary will be completed for the entire medical record audit process. Areas to be addressed include:

1. **Strengths**: Summarize strengths identified through the medical record audit process. These may pertain to program implementation and/or documentation.
2. **Telehealth Technology:** In a review of the documentation, is the technology used for telehealth HIPAA compliant? (If more than one platform is in use, are they all HIPAA compliant?)
3. **Recommendations for Improvement:** Identify recommendations for improving program implementation and/or documentation.
4. **Plans for Quality Improvement:** Identify actions to be initiated in response to the findings of this review. Include how results will be shared with staff to improve practice and enhance program development. Specify the person responsible, the projected date of completion for each activity, and how quality improvement will be measured. Provide adequate narrative to fully describe the assessment and plan for quality improvement.

Audit Due Date and Submission: Internal and joint medical record audit results are due to the Department by the date listed in the contract. A copy of the completed Medical Record Audit Summary will be sent via secure mail to the consultant and/or CAH staff completing the audit. When sending records for Department review as part of

the joint audit or with findings in the internal audit, secure methods (encrypted email, etc.) must be used to protect patient confidentiality.

Documentation at Iowa HHS: Once the summary tool is complete for the contractor, CAH staff will upload the summary tool to IowaGrants.gov.

Medical Record Selection Requirements: The following is the required record selection criteria:

1. A minimum of ten CAH medical records for gap-filling direct care services delivered in the 12 months prior to the audit. CAH records may be open or closed at the time of the audit, but the services being reviewed should be complete (e.g., lead tests should have results back and follow-up with the family and primary care provider documented.).
2. Oral health services must be included in the medical record audit.
3. At least one record of each type of gap-filling direct care service provided in the previous 12 months must be reviewed.
4. At least one record from each subcontractor must be reviewed.
5. At least one record from each service site type must be reviewed (e.g., home visits, WIC, school, OB clinic, agency clinic, etc.).
6. If the contractor has 20 or less service providers (in the service area, including subcontractors and other agreements), at least one record from each service provider must be reviewed.
7. If the contractor has more than 20 service providers (in the service area, including subcontractors and other agreements), a minimum of 20 different service providers must be reviewed.

Contractors that subcontract or have another form of agreement with another Title V contractor to provide services in their service area shall work with the subcontract Title V contractor and CAH consultant in advance of the medical record audit to decide if the records will be reviewed as part of the contractor's medical record audit or part of the subcontractor's medical record audit.

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Authority: HHS General Conditions for Service Contracts, HHS Omnibus Agreement

Resources

Screening Center Provider Manual
HHS General Conditions for Service Contracts

Sources

HHS Omnibus Agreement

IOWA | Health and Human Services

Number: 503
Title: Cost Analysis
Effective Date: 10/01/2016
Revision Date: 03/18/2025
Date of Last Review: 03/18/2025
Authority: Office of Management and Budget Circular 2 CFR Part 200; 2 CFR Part 225; 2 CFR Part 230; 2 CFR 215

Overview

The cost analysis establishes the amounts to be billed for each Maternal Health (MH), Child and Adolescent Health (CAH) and/or Oral Health (OH) service provided. Time studies to justify salaries are required by the Office of the Inspector General and the federal Office of Management and Budget (OMB). The Iowa HHS Title V MCAH program establishes approximate costs for all direct services across the state using a Customized Fee Analyzer specific for the state of Iowa.

Policy

All Contractors must adhere to the most recently approved Iowa HHS Costs for Title V MCAH Direct Services.

Procedure

1. Obtain the most recent approved Iowa HHS Costs for Title V MCAH Direct Services at the start of each project period. Contractors shall use the 50th percentile column of the fee as their cost.
2. Ensure the most recent costs are utilized when billing Medicaid MCOs for all MCAH services.
   a. Iowa HHS encourages contractors to determine their individual agency's costs for providing direct services to identify opportunities for improvement in clinic efficiencies and service provision.
3. Maintaining time studies are required for all staff working in the MCAH program. The MCAH Time Study form and instructions have been developed and shall be used for the continuous, daily time studies that must be completed and maintained on file. Contractors may submit an alternate time study form for review for approval and use.

Resources

Office of Management and Budget Circular 2 CFR Part 200; Subpart D - Post Federal Award; Subpart E-Cost Principles; and Subpart F-Audit Requirements
CFR Part 225, Cost Principles for State, Local, and Indian Tribal Governments (OMB Circular A-87);
2 CFR Part 230, Cost Principles for Non-Profit Organizations (OMB Circular A-122) or
2 CFR 215 Uniform Administrative Requirements for Grants and Agreements with Institutions of Higher Education, Hospitals, and Other Non-Profit Organizations (OMB Circular A-110)

IOWA | Health and Human Services

Number: 601
Title: Managed Care Organizations and Prepaid Ambulatory Health Plans
Effective Date: 10/01/2022
Revision Date: 03/18/2025
Date of Last Review: 03/18/2025
Authority: Iowa HHS Omnibus Agreement

Overview

In 2016, Iowa Medicaid went through a modernization process that enrolled the majority of clients enrolled in Medicaid into Medicaid Managed Care Organizations (MCOs). Clients enrolled in MCOs must access medical care from providers enrolled in their chosen or assigned MCO to ensure full coverage of services. The MCO is responsible for providing medical care coordination to their clients.

In 2021, Iowa Medicaid enrolled the majority of clients into Prepaid Ambulatory Health Plans (PAHPs) to pay for clients' dental services. Clients must access dental care from dentists enrolled with their chosen or assigned PAHP to ensure full coverage of dental services. Title V contractors remain responsible for dental care coordination for clients.

Policy

Contractors shall maintain credentialing/provider status with all Medicaid MCOs in Iowa to seek reimbursement for Medicaid EPSDT and Maternal Health (MH) services. Contractors shall maintain credentialing/provider status with all Medicaid PAHPs in Iowa to seek reimbursement for Medicaid EPSDT and MH preventive dental services. Contractors must also attempt to credential with private health insurance companies (third party payers) for MH clients. If unable to credential, the contractor shall request a letter from the insurance company stating they cannot credential Maternal Health Centers.

Procedure

1. Contractors shall:
    a. Follow the enrollment and credentialing process outlined by each MCO.
        i. Wellpoint
        ii. Iowa Total Care
        iii. Molina Healthcare
    b. Follow the enrollment and credentialing process outlined in each PAHP.
        i. Delta Dental of Iowa
        ii. Managed Care of North America (MCNA) Dental
    c. Negotiate a contract for service provision.
    d. Follow the terms of the contract for payment and service provision.
2. Contractors are encouraged to partner with MCOs/PAHPs in serving clients enrolled in managed care.

3. Contractors shall bill third party payers for MH clients or submit a denial or letter stating they cannot be credentialed with claims for clients with third party payers.
    a. Contractors may obtain letters that cover the state from the MCAH Portal.

Resources

Wellpoint
Iowa Total Care
Molina Healthcare
Delta Dental of Iowa
Managed Care of North America (MCNA)
MCAH Project Management Portal – Maternal Health

Number: 602
Title: CAH Immunization Access and Promotion
Effective Date: 10/01/2016
Revision Date: 03/18/2025
Date of Last Review: 03/18/2025
Authority: Iowa Code § 139A.8, Iowa Administrative Code 641-7; Iowa Administrative Code 641-76.11; Social Security Act Section 506

Overview

Increasing the number of children and adolescents appropriately immunized is a core function of the Title V Block Grant legislation. For the policy and procedure on the administration of vaccines, see Immunization & Vaccine Administration

Policy

Contractors shall assist clients in accessing immunization through enabling services and public health services and systems of community and family outreach, education, and immunization promotion.

Procedure

1. Contractors shall:
    a. Advance initiatives to assure clients receive the full schedule of age-appropriate immunizations per the Advisory Committee for Immunization Practices (ACIP).
    b. Coordinate the provision of immunizations in the service area through assessing needs and assuring access through outreach, education, and immunization promotion.
        i. Disseminate public education materials and information that promotes immunizations throughout the service area.
        ii. Engage at the Building Relationships level or higher (see Policy 605 Community Partnerships) with community organizations, groups, and families to promote and provide education about the importance of recommended childhood vaccines.
        iii. Partner at the Common Goal level or higher (See Policy 605 Community Partnerships) with organizations serving populations with limited access to healthcare services, groups, and families to promote and provide education about the importance of recommended childhood vaccines.
    c. At each contact, assess the client's immunization status through one of the following: Iowa Immunization Registry System (IRIS), the IRIS feed of recommended vaccinations in the Maternal Health (MH) and Child Adolescent Health (CAH) data system, or the client’s medical records. Once immunizations are assessed, make appropriate referrals and utilize enabling

Number: 602
Title: CAH Immunization Access and Promotion
Effective Date: 10/01/2016
Revision Date: 03/18/2025
Date of Last Review: 03/18/2025
Authority: Iowa Code § 139A.8, Iowa Administrative Code 641-7; Iowa Administrative Code 641-76.11; Social Security Act Section 506

services to the client's medical home. If immunizations were assessed by a contractor in the past 30 days, immunizations do not have to be re-assessed. Enabling services shall continue to be provided.

i. If the client's immunization history is not in IRIS, and client medical records are not available, parent/caregiver recollection may be used to assist the family in accessing immunizations; however, every effort will be made to obtain immunization records to complete a full assessment. Additionally, contractors shall implement the best practice of updating the client's IRIS record by documenting vaccines in IRIS that were administered at another location in accordance with IRIS requirements. When a parent report is used, document the reason in the MH and CAH data system.

d. Promote initiation and completion of HPV vaccine for age-appropriate clients due to the low completion rate of the HPV vaccine in Iowa. At a minimum, this is accomplished by including information on the importance of the HPV vaccine in the initial Inform packet for clients aged 11 years and older.

2. Contractors receiving funds to provide immunization services, immunization promotion, and outreach or subcontracting with an entity receiving other funds for immunization services, outreach, and promotion such as through the Department's Immunization Bureau, Head Start, Early Childhood Iowa, or other grants/funds shall delineate in writing the services provided as part of those other funding sources and the services that will be provided as part of the CAH program. Resources and staff may be braided to meet the needs of the community provided that duties, funding, and services for each grant are clearly defined, program requirements of each program are met, and expenses are billed appropriately to each funding source. Target populations for each program, program eligibility, and program goals will be outlined. All funding sources and programs shall be disclosed to Title V. Title V funds, and the CAH program and resources shall not supplant other funding sources.

For information on requirements for contractors opting to provide the gap-filling service of immunization administration, including staffing and contingency plans, training, HPV

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Title: CAH Immunization Access and Promotion
Effective Date: 10/01/2016
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promotion and documentation, standing order, and VFC enrollment, see Policy 827 Immunization & Vaccine Administration.

Resources

Iowa HHS Immunization Program
Center for Disease Control and Prevention Immunization Schedules
Immunization Action Coalition
Iowa Code § 139A.8
Iowa Administrative Code 641-7
Iowa Administrative Code 641-76.11
Social Security Act Section 506

Number: 603
Title: CAH Early ACCESS
Effective Date: 10/01/2016
Revision Date: 03/19/2025
Date of Last Review: 03/19/2025
Authority: Individuals with Disabilities in Education Act

Overview

Early ACCESS is Iowa's early intervention system for infants and toddlers under three years old not developing as expected or who have a medical condition that can delay typical development. Early intervention focuses on helping parents and other caregivers so that they can support their child's growth and development during everyday routines and activities.

Congress passed the Individuals with Disabilities Education Act (IDEA) in 1986. The IDEA created the Infants and Toddlers with Disabilities Early Intervention Program (Part C). The goals of IDEA are to improve the development of infants and toddlers with disabilities and improve outcomes for children before entering school. Each state receives federal Part C funds to establish and implement an early intervention system. Early ACCESS is Iowa's early intervention system (IDEA, Part C).

Early ACCESS is not intended to be a stand-alone program. Therefore, families in Early ACCESS may need additional support or services from other providers. Early ACCESS will work with families to identify additional services or resources that may be needed.

Before a family can participate in Early ACCESS, the child must be determined eligible. In Iowa, children with certain diagnosed conditions are automatically eligible for Early ACCESS. For children with no diagnosed condition, an evaluation will be completed by Early ACCESS staff to determine eligibility. A child is eligible if they are found to have at least a 25% delay in one or more areas of development. The evaluation uses information obtained from many sources, including information from parents or caregivers, the referral source (if applicable), through administration of an evaluation tool, direct observations of the child, and/or a review of medical records (if applicable).

If a child is found eligible for Early ACCESS services, child and family assessments are completed. These assessments provide information about the child, such as interests and abilities and what the families would like the child to be able to do. The family assessment is a way for the Early ACCESS team to learn about family routines, what goals they have for their child, and the supports they may be interested in to help the child develop and grow. Once assessments are completed, an Individualized Family Service Plan (IFSP) is developed by the team, which consists of a service coordinator,

Number: 603
Title: CAH Early ACCESS
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service provider(s), and the family. The IFSP contains outcomes, what the family wants the child to be able to do within family routines and activities, and identifies what service(s) will be needed to help the family achieve the outcomes.

To learn more about Early ACCESS, visit the Early ACCESS webpage on the Iowa Family Support Network website. The Early ACCESS website can be used to make a referral for a child, learn what families can expect if they enroll in Early ACCESS, and view videos showing what a home visit is like in Early ACCESS.

Early ACCESS is administered by three state agencies: the Iowa Department of Education (IDOE), the Iowa Department of Health and Human Services (Iowa HHS), and Child Health Specialty Clinics (CHSC). Below are the contributions of each agency to Early ACCESS:

1. IDOE is the lead agency for Early ACCESS. As the lead, they coordinate the fiscal resources available for early intervention and are responsible for the development of policies/procedures to meet federal requirements for the implementation of IDEA Part C. IDOE is responsible for providing education programs and services for preschool and school-age students, including children with disabilities, from birth through 21 years of age. IDOE utilizes the Area Education Agencies (AEAs) to provide early intervention services in Iowa.
2. Iowa HHS, through Title V CAH Contractors, provides developmental and emotional-behavioral screenings (as needed) and screening follow-up to children ages 0-3 years who were referred to Early ACCESS and found not eligible.
3. Iowa HHS assures that children in foster care and children who have a founded or confirmed case of abuse or neglect are provided information about and referred to Early ACCESS.
4. CHSC, through Regional CHSC Centers, provides service coordination for infants and toddlers who are medically complex or were drug-exposed. CHSC also provides nutrition services and medical record reviews/health assessments for children enrolled in Early ACCESS.

Policy
Contractors shall provide developmental screening follow-ups to infants and toddlers ages 0 to 3 years who are not eligible for Early ACCESS services.

Number: 603
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Procedure

1. **AEA Partnership:** In partnership with the Early ACCESS liaison from each AEA serving the CSA, Contractors shall develop a referral process for the AEA to refer infants and toddlers, ages 0-3 years, found not eligible for Early ACCESS to the CAH program for developmental screening follow-up. The referral process shall include:
    a. Name and contact information of Contractor staff whom Early ACCESS will contact to make a referral for developmental screening follow-up;
    b. Child and family information the AEA will share with the Contractor so that Contractor staff can contact families to offer developmental screening follow-up; and
    c. Develop a plan with the Early ACCESS liaison at each AEA serving the CSA to assure Early ACCESS and Contractor staff are informed of the referral process.
2. **Early ACCESS Developmental Screening Follow-up:** Provide support for the developmental needs of children who were found not eligible for Early ACCESS. When the Contractor receives a referral from AEA for developmental screening follow-up, they shall do the following:
    a. Enter referrals received from the AEA for developmental screening follow-up in the Maternal Health (MH) and Child and Adolescent Health (CAH) data system. Document the outcome of the contact in the MH and CAH data system.
    b. Contact families whose child was referred to the CAH program for developmental screening follow-up and request information about developmental and emotional/behavioral screening that has been administered for their child.
    c. Offer to administer gap-filling developmental and emotional/behavioral screening if screenings are not going to be administered by the child's medical home or other provider or if the family doesn't know.
    d. Provide all results of developmental screens and emotional-behavioral screens to the medical home, regardless of the result.
    e. Provide related anticipatory guidance and follow-up services if developmental and/or emotional-behavioral screens are administered and results do not indicate a need for a referral to Early ACCESS. Resources CAH programs can use for education include:

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i. Child development page on the Iowa Family Support Network website
ii. CDC Learn the Signs Act Early website and materials and CDC's free Milestone Tracker app

f. Refer children 0-3 years old to Early ACCESS if developmental and/or emotional-behavioral screens are administered and results indicate a need for a referral to Early ACCESS and provide referral education. Educate families on what they can expect when their child is referred. A resource CAH programs can use is the Early ACCESS referral postcard, which can be ordered at no cost on the Iowa Family Support Network website.
g. Title V refers to the medical home, the AEA, or the Iowa Family Support Network. Title V informs 1st Five regarding patterns in lack of available medical homes or lack of screening in medical homes.
h. Refer to Policy 816 Developmental & Behavioral Health Surveillance & Screenings for documentation and billing of developmental and emotional/behavioral screenings

Resources

Information on Early ACCESS: Iowa Family Support Network
Administrative Rules for Early ACCESS
Memorandum of Agreement for Early ACCESS, Iowa's Part C of IDEA
Learn the Signs Act Early website
CDC Milestone Tracker app

Number: 604
Title: CAH Prevention and Early Intervention for Lead Poisoning
Effective Date: 10/01/2016
Revision Date: 03/19/2025
Date of Last Review: 03/19/2025
Authority: Iowa's EPSDT Periodicity Schedule

Overview

Blood lead testing and follow-up services are part of Iowa's EPSDT Periodicity Schedule. Due primarily to the low testing rates, especially between the ages of 24 through 35 months, the CAH program has chosen the prevention and early intervention of blood lead poisoning through testing of 12 through 35-month-olds as a Title V State Performance Measure.

Policy

Contractors are responsible for assuring access to blood lead testing for children 12 through 35 months in their service area.

Procedure

1. Contractors shall assure every child 12 through 35 months enrolled in the CAH program receives a blood lead test if the child has not been tested in the previous 12 months. Contractors shall utilize enabling services to assist the family in obtaining blood lead testing through their medical home. If enabling services fail, Contractors shall administer blood lead testing (see Policies 805 Blood Draws – Venipuncture and Capillary; 806 Blood Lead Evaluation and Management; 807 Blood Lead Screening, Analysis and Handling/Conveyance Policy).
2. Contractors shall assure blood lead testing is accessible and utilized by building partnerships with community groups and stakeholders to conduct outreach and education with families of young children. Contractors shall:
    a. Engage at the Building Relationships level (see Policy 605 Community Partnerships Policy) or higher with local Childhood Lead Poisoning Prevention Programs (CLPPPs).
    b. Engage at the Building Relationships level or higher with community organizations, groups, and families to provide education about the importance of blood lead testing and blood lead poisoning prevention.
    c. Partner at the Common Goal level or higher with populations with limited access to healthcare services serving organizations, groups, and families.
3. Contractors that are also CLPPP grantees (or subcontracting with CLPPP grantees) or receive other funds (Early Childhood Iowa, Head Start, HUD, etc.) for providing or promoting blood lead poisoning prevention and/or testing shall

Number: 604
Title: CAH Prevention and Early Intervention for Lead Poisoning
Effective Date: 10/01/2016
Revision Date: 03/19/2025
Date of Last Review: 03/19/2025
Authority: Iowa's EPSDT Periodicity Schedule

delineate in writing the services provided as part of those funds and the services that will be provided as part of the CAH program. Resources and staff may be braided to meet the needs of the community provided that duties, funding, and services for each grant are clearly defined, program requirements of each program are met, and expenses are billed appropriately to each funding source. Target populations for each program, program eligibility and program goals shall be outlined. All funding sources and programs shall be disclosed to Title V. Title V funds, and the CAH program and resources shall not supplant other funding sources.

Local Childhood Blood Lead Poisoning Prevention Programs: Iowa HHS contracts with local health departments to serve as local CLPPPs. Contractors with a CLPPP covering a county in their service area shall work collaboratively with the CLPPP in promoting blood lead testing and blood lead poisoning prevention for children.

Responsibilities of a local CLPPP

1. Assuring that primary care providers conduct blood lead testing.
2. Providing medical case management of children with blood lead poisoning, including referring children to CAH program Contractors (nutrition counseling, nursing home visits) or AEA (developmental testing and educational services) for additional services.
3. Providing environmental case management of children with blood lead poisoning.
4. Conducting data management of blood lead test results, case management data and data regarding other housing hazards.
5. Providing education and outreach to the community, including involving the community in solving healthy housing and lead poisoning problems and the establishment of a coalition for the program.

Resources

Childhood Lead Poisoning Prevention Program

Number: 605
Title: Community Partnerships
Effective Date: 10/01/2022
Revision Date: 03/19/2025
Date of Last Review: 03/19/2025
Authority: Contract Special Conditions and Iowa HHS General Conditions for Service Contracts

Overview

Contractors engage in community partnerships, including partnerships with local health care providers, to advance the goals of Title V and engage in the framework of the Maternal Health (MH) and Child Adolescent Health (CAH) Program. Local practitioners and MH/CAH staff need to work cooperatively to best meet the needs of Iowa's pregnant individuals, children, adolescents, and families. The Department and its contractors advocate for a system that minimizes barriers to care, focuses on providing quality, comprehensive care to medical homes, prevents duplication and fragmentation of services, and coordinates resources. The strategies used to achieve this system of care are built on the MH CAH Pyramid and the Ten Essential Services of Public Health, and they utilize culturally appropriate best, promising, and community-generated practices.

Addressing Health Equity Through Partnerships

Contractors shall partner with organizations, individuals, and groups involved with populations with limited access to healthcare services. Authentic community engagement is key to producing change. This often requires doing work differently by continuously centering the community's voice. It is:

1. not a one-and-done approach;
2. building trust and relationships with community members;
3. listening to lived experience and expressed needs;
4. closing the communication and feedback loop with the community to ensure your activities align with what they've expressed;
5. the foundation of the public health services and systems level of the pyramid; and
6. likely the most challenging and engaging work of Title V.

Policy

Contractors shall engage in partnerships and community engagement throughout their collaborative service area (CSA) to ensure programs and services are accessible, meet the needs of the community, and engage the community in providing solutions to needs and concerns.

Procedure

Building community partnerships that lead to policy and practice changes affecting the health of the community typically follows a pattern of deepening engagement, trust, and

Number: 605
Title: Community Partnerships
Effective Date: 10/01/2022
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Authority: Contract Special Conditions and Iowa HHS General Conditions for Service Contracts

shared resources. The table below outlines these levels of engagement and partnership.

Levels of Community Engagement		
Increasing levels of community involvement, impact, trust, and communication		
Category 1: Building Relationships		
Common terms associated with this level		**Typical activities at this level**
Outreach	• Communication flows from the Contractor to inform the community organization or from the community organization to the Contractor. No commitment • Partner has been introduced to the identified health-related topic/issue. Interest level in addressing the health issue may be unknown • Communication initiated	• Meet and greet • Introductions • Dropping off materials (brochures, flyers • Open house
Speaker	• Contractor invites community organizations to speak at a conference or meeting (or vice versa).	• Presentations • One-sided reporting or round-robin sharing of events, services, projects
Referrals	• Contractor provides referrals to the community organization, and/or community organization provides referrals to the Contractor • Referrals are given to the patient without coordination or written agreement between the Contractor and the community organization	Resource Directory • Provider list • Recommended organization or service provider
Category 2: Common Goal		
Feedback Needs Assessment	• Community organization provides one-time or periodic feedback (or vice versa with Contractor providing feedback)	• Surveys, interviews,
Engage Meet Plan	• Community organization reciprocates communication and agrees to discuss partnership development.	• Meetings

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Discuss	• Discussion includes opportunities for activities that can be accomplished together or ways each partner can benefit the other, working toward a similar/same goal • Contractor and community organization partner on short-term or easily implemented activities • Partners build their existing organizational capacity (e.g., staff, service, technological, network, financial) and/or establish new capacities. • Contractors or community organizations are seen as the lead or accountable entities.	• Working on own initiatives that are not coordinated • Getting approvals/buy in • Reporting information, updates with shared interests and shared goals
Increasing ownership, empowerment, opportunities and supports for both staff and community		
Category 3: Supportive Roles		
Shared Space	• Contractor and community organization provide services in the same location or adjacent locations with the intent of supporting each other's programs and clients.	• MCH services provided at WIC sites
Collaboration Collaborative Partnership	• Contractor and community organization have shown ongoing support in addressing the identified issue. A common goal has been defined and both entities provide a supportive role in addressing the issue • Utilize networks, members, staff, volunteers to recruit new members, expand partnerships, serve on coalition	• Coalitions
Service contracts	• Contractor utilizes community partner to provide services	• Provide funding, in-kind
Coordinated Intake and Referrals	• Some data is shared across programs • Written agreements outline each entity's role and responsibility in referrals	• HHLPPSS data input monthly into Iowa Connected • Active referrals with feedback loop
Involve	• Community organization has ongoing or periodic contact with the project,	• Reviewing survey questions,

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	• The partnership develops new ways of working across and within the community, strengthening connections among service providers, with funders, between social service agencies and health systems, with academic research centers, and/or with government agencies.	• Wording of documents, transcribing or translating documents, • Conducting key information interviews, • Participating in periodic advisory committee • Joint enrollment paperwork
Category 4 Strategic Implementation		
Risk-Sharing or Outcomes- Based Resource Sharing	• Contractor and community organization share the risk and responsibilities for outcomes	• ACOs • Dual grantees/Joint applications
	• Coordinated, scheduled communication takes place between partners. Routine communication is reciprocated between partners to accomplish activities or goals that meet/address the issue. • Community organization is a leader in the population or on the issue. Community organization views the partnership as benefiting their organization/population • Clients & families act as facilitators or co-facilitators of a focus group.	• Coalition chair/president • Program consultant • Input on strategic planning • Input on evaluation • Engaging the community
Shared Power/Shared Decision Making	• Funding, decision-making, power, and responsibility are shared equitably. Both are equitably invested in the outcomes, strategies, risk, and benefit • One agency is no longer viewed as the lead	• Joint strategic planning • Joint program implementation • Joint evaluations
Policy and/or Systems-Level Change	• The partnership advances policy changes, influences payment and financing models, and/or contributes to the evidence base of integrated approaches to inform research and practice.	

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Data Integration	• Partners can view and input patient data in real-time through joint/compatible data systems • Partners regularly review program-level and/or outcome data to inform decision-making	Medicaid and MCAH data system

Resources

Iowa HHS General Conditions for Service Contracts

Sources

Iowa HHS 2020 IDPH Partnership Assessment Tool

Nonprofit Finance Fund and Center for Health Care Strategies. (2018) Integrating to Improve Health: Partnership Models between Community-Based and Health Care Organizations.

IOWA Health and Human Services

Number: 606
Title: Public Health Services and Systems Documentation in MCAH Data System
Effective Date: 10/01/2022
Revision Date: 03/19/2025
Date of Last Review: 03/19/2025
Authority: Contract Special Conditions and General Conditions for Service Contracts

Overview

Public Health Services and Systems is the base of the Maternal Health (MH) and Child and Adolescent Health (CAH) Pyramid and, therefore, the majority of the work of CAH Contractors. Documenting this work is critical to measure the progress and outcomes of the CAH program.

Policy

All public health services and systems activities outlined in the RFP, RFA, contract, and the Contractor's approved work plans shall be documented in Community Events in the MH and CAH data system. In addition, Contractors shall document other public health services and systems pyramid-level activities conducted on behalf of the CAH program, including outreach activities, group education, and community partnership activities in the MH and CAH data system following Department guidelines.

Procedure

1. Document public health services and systems activities required by the RFP, RFA, and agency contract, including the Contractor's approved work plans.
2. Document public health services and systems activities conducted on behalf of the CAH program.
3. Activities to be documented in 'Community Events' in the MH and CAH data system go beyond activities typically associated with the term "community events" and include meetings, presentations, collaborations, Family Engagement group related activities, outreach, partnerships, and other meaningful interactions with community partners to advance and build community infrastructure and capacity. Follow each program's guidance for how to use 'Community Events.'
4. Contractors may document brief outreach covering multiple topics (meeting round robin sharing, social media posts, media, email listservs, etc.) not required in the RFP, RFA, contract, or Contractor's activity plan, in the 'Client Overview Episode' in the MH and CAH data system.
5. Complete documentation for the month within 15 days of the end of the month within the MH and CAH data system.
6. Guidance on documenting 'Community Events' in the MH and CAH data system:

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Child and Adolescent Health Quick Guide for Completing Community Events

<table>
<tr><th colspan="2">CAH Community Event</th></tr>
<tr><td colspan="2">Owner: Update with who the MCAH data system owner will be - this does not need to be the specific individual conducting the event.</td></tr>
<tr><td>Date
Update to reflect the actual date of the Event. Option to date the Event in the future and leave as unsuccessful for a reminder to enter data.</td><td>Time/Duration
Enter the duration of the event in minutes, Time is optional

Description
Optional</td></tr>
<tr><td>Outcome
Successful</td><td>Reschedule Reason
Optional</td></tr>
<tr><td>County of Service
Select the County of Service/Event (if virtual, select the county where the provider/program/organization is located)</td><td rowspan="2">Interaction Type
Select the method of communication used for the activity:
□ Email
□ Face to Face
□ Media
□ Phone
□ Virtual</td></tr>
<tr><td rowspan="2">Result
Select the performance measure/topic associated with the activity.
□ Hawki
□ Immunizations
□ Infant/Child Well Visit
□ MAF-Informing, Care Coordination, PE/Insurance
□ Medical/Dental Home
□ NPM10 Adolescent Well Visit
□ NPM6 Developmental Screening
□ NPM13 Oral Health
□ SPM2 Blood Lead Testing
□ SPM3 Child Care Nurse Consultation
□ SPM4 Adolescent Mental Health
□ SPM 6 Health Equity
□ Title V Role & Services
□ Other</td></tr>
<tr><td>Location
Document:
□ Business
□ Children’s Board (Mental Health)
□ Community Organization
□ Dentist/Orthodontist
□ Department of Human Services
□ Early Childhood Education Program
□ Family Planning
□ Hospital/Urgent Care
□ Local Board of Health/Local Public Health Agency</td></tr>
<tr><td>Type of Event</td><td></td></tr>
</table>

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Select from the dropdown: □ *Adolescent Partner Promotion* □ *Collaboration/Partnership Meeting* □ *Community Outreach Activity* □ *Drop off/Send promotional items, brochures, outreach items (includes brief education/discussion)* □ *Educational Presentation* □ *Employers/Employees* □ *Group Family Education* □ *Health Fair* □ *Immunization Clinics (no client billing)* □ *Introduction to staff and/or services* □ *Media/social media* □ *Lead Testing Clinics (no client billing)* □ *Other Event* □ *Priority Population Participation/Recruitment* □ *Provider/Clinic Education* □ *Requesting Input/Feedback*	□ *Mental Health Care Provider* □ *Parents/Caregivers* □ *Parent/Family Organization* □ *Primary Care Clinic/Provider* □ *School* □ *School Nurse* □ *Substance Abuse Program* □ *University/ Community College* □ *Youth* □ *Youth Serving Organization* □ *Other*
	Quantity *Enter the number of people served or reached through the activity.*
Comment	

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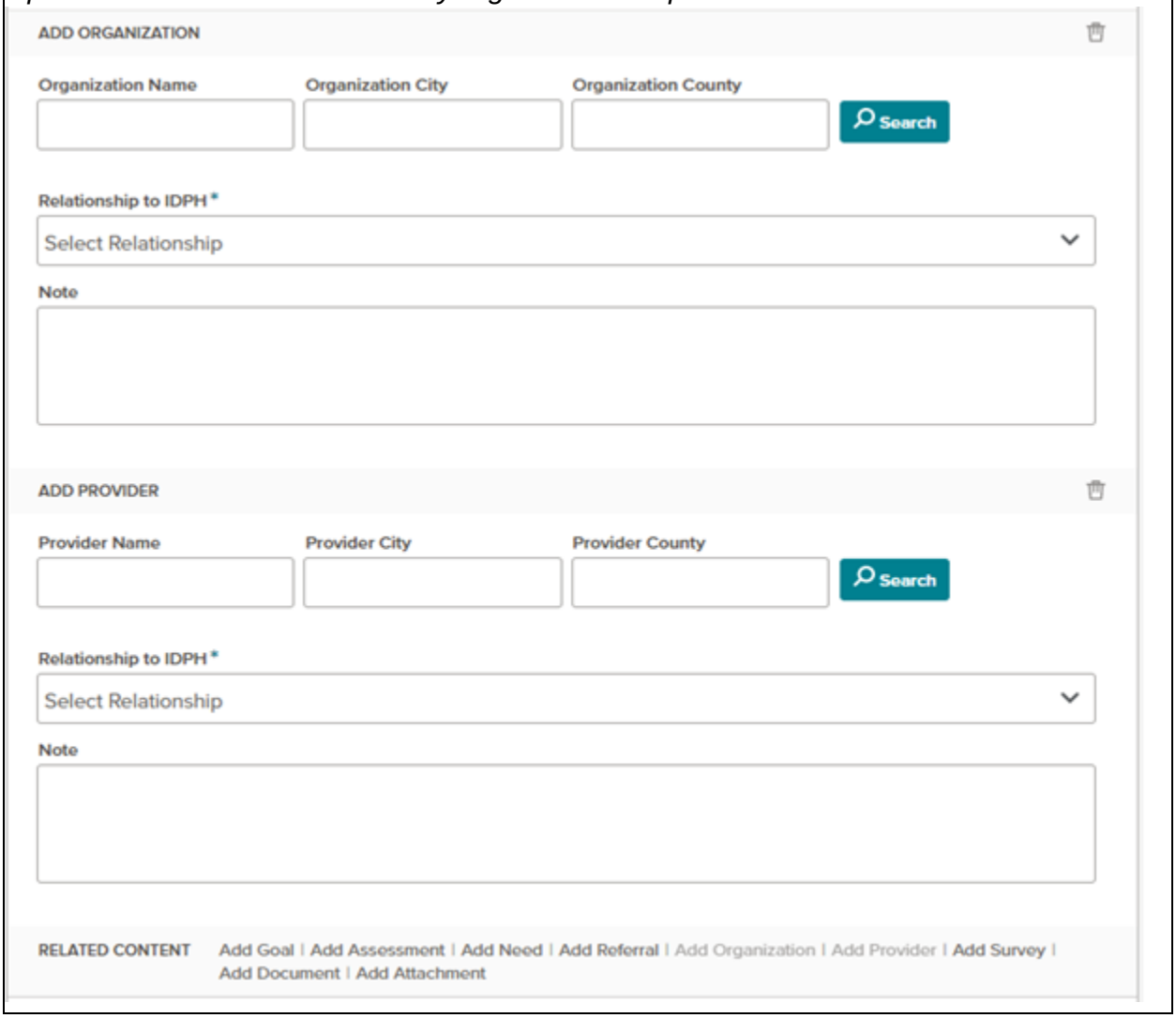
Optional: Use this field to add any organization or provider or additional notes



Episode - Child and Adolescent Health
Type - Community Event
Date/Time/Duration - Enter the date of the meeting, communication, or event, and duration. Duration should be entered in minutes. Time is optional. For phone calls and email correspondence, include the entire amount of time spent on all communication.

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Example: 1 minute for initial call with voicemail. A 10-minute return phone call later that day or the next day = 11 min. 10 minutes for several days of back-and-forth emails related to logistics for an event plus 90 minutes for the event = 100 minutes.

Description - Optional, not visible in reports.

Outcome - Mark “successful’. Can mark as “unsuccessful” if you would like to add events in advance and go back in and update details.

Reschedule Reason - Optional

Result - Select the performance measure or topic associated with the activity.

1. For general outreach related to your CAH program and not specific to an NPM or SPM, select “Title V Role and Services”.
2. If several result areas discussed (NPMs, SPMs) and spent less than ~15 minutes on each topic, select “Title V Roles and Services”.
3. MAF- Contractor is engaging with a community partner related to informing, care coordination, presumptive eligibility and/or expanding access to EPSDT services. Examples: Working with population or group of clients on making MAF services culturally appropriate and family centered. Working with a health care provider on developing a bi-directional referral system. Working with adolescents enrolled in Medicaid on health literacy including how to use insurance, scheduling appointments, etc.

County of Service - County event took place in.

Type of Event - Select the type of event that describes the activity

1. Adolescent Partner Promotion - Contractor is partnering with other organizations or agencies to promote the adolescent well visit to parents/caregivers.
2. Collaboration/Partnership Meeting - Meetings in which the purpose is collaboration or partnership on the selected NPM or SPM
3. Community Outreach Activity - Contractor participating/hosting an event in the community, typically a large outreach event - examples: community baby shower; participation in homecoming events (float, participating in an after party, tailgate,

etc.), hosting a family event in a park; a float, booth or event at a festival, farmer's market, city days, county fair, etc.

4. Educational Presentation - Contractor provided an educational presentation to a partner organization or the community
5. Drop off/Send promotional items (includes brief education/discussion) - Contractor drops off or sends brochures, promotional items, posters, etc. Includes brief education/discussion of the result area(s) related to the items.
6. Group Family Education - Contractor provided education to families in a group setting, such as a health literacy class, typical child development, Mental Health 1st Aid, etc.
7. Health Fair - Contractor participated in a health fair.
8. Immunization Clinic (no client billing) - Contractor provided a mass vaccination clinic with no client billing.
9. Introduction to Staff and/or Services - Contractor set up a meeting, dropped by or sent written information to a community partner or provider to introduce staff and/or services. Also include networking, open houses or meet and greet events.
10. Media/Social Media - Contractor social media posts, newspaper and radio ads, editorials, interviews, etc.
11. Lead Testing Clinics (no client billing) - Contractor provided a mass lead testing clinic with no client billing
12. Other Event - Event not otherwise represented by a category. If the event can be captured as another category, do so. This category will be difficult to track by report.
13. Priority Population Participation/Recruitment - Contractor events or meetings specifically targeting/designed to include participation from populations with limited access to healthcare services and/or recruit populations to sit on agency boards and coalitions. If not specifically designed for a population with limited access to healthcare services, do not include in this category.
14. Provider/Clinic Education - Face to face or virtual education to providers, nurses, and/or clinic administration on the selected NPM or SPM.
15. Requesting input/feedback - Meetings, communication, or events specifically for soliciting input or feedback; for example, getting input and feedback on grant activities from the local board(s) of health.

Number: 606
Title: Public Health Services and Systems Documentation in MCAH Data System
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Authority: Contract Special Conditions and General Conditions for Service Contracts

Result - Select the appropriate NPM, SPM or Foundational activity. For any of the above events in which the agency briefly discusses multiple result areas or the overall CAH program, select Title V Role & Services

Location - Select the location or the main partner of the event or meeting.

Quantity - Enter the number of people served or reached through the activity. At a provider office did you speak to 1 person or 5? At a health fair, how many people did you talk to at the event? Not how many people overall attended the event, or how many people picked up a pen. Social Media, how many people reposted or commented on your post. Total readership of community newsletter or newspaper not needed. Can leave blank for events where a count is not known.

Comment - Optional and can be used for additional details if needed by the agency. Note that comments will not show up in any reports.

Related Content (Optional) -

1. Add Organization - Select Organization from the drop-down menu. Multiple Organizations can be added to an activity. If the Organization is not available in the drop-down and will be a frequent partner, request it to be added to the drop-down.
2. Add Provider - Select Provider from the dropdown. Multiple Providers can be added to an activity. If the Provider is not available in the dropdown, request that the MCAH data system add providers that are not in the system.
3. Add Goal/Assessment/Need/Referral/Survey/Document/Attachment - Optional, not included in reports.

Resources
General Conditions for Service Contracts

IOWA | Health and Human Services

Number: 607
Title: Child Health Specialty Clinics
Effective Date: 10/01/2022
Revision Date: 03/19/2025
Date of Last Review: 03/19/2025

Overview

Child Health Specialty Clinics (CHSC) administers Iowa's Maternal and Child Health Title V Program for children and youth with special health care needs in partnership with the Iowa Department of Public Health and serves children and adolescents (birth through age 21 years) with or at risk of chronic health conditions or disabilities including psychosocial, physical, and health-related educational or behavioral needs. CHSC is overseen by the University of Iowa Division of Child and Community Health and is part of the Carver College of Medicine and the Stead Family Department of Pediatrics.

CHSC operates under a System of Care approach to provide services for children and youth with special healthcare needs that recognizes the importance of family, school, and community and seeks to promote the full potential of all children and youth. CHSC partners with families, service providers, communities, policymakers, and state departments. CHSC has a network of regional centers and satellite locations across Iowa.

Policy

Contractors shall work collaboratively with CHSC to serve children and adolescents with special health care needs who may reside in their collaborative service area (CSA).

Procedure

Refer clients to CHSC.

Documentation:

1. Document public health services and systems-level work with CHSC in ‘Community Events’ in the MCAH data system.
2. Document client-specific enabling services related to CHSC in the client record in the MCAH data system and the client's medical record.

Resources

https://chsciowa.org/about-chsc

IOWA | Health and Human Services

Number: 608
Title: Appropriate Use of Gap-Filling Direct Care in Community Partnerships
Effective Date: 10/01/2022
Revision Date: 02/12/2025
Date of Last Review: 03/31/2025

Overview

As CAH Contractors engage in collaboration and partnerships within the community, a tangible good that's easy for partners to understand and value is the provision of direct care services. It can be both easier to explain and sometimes to provide direct care services for a potential or existing partner than explaining the concept of enabling services and assisting in establishing a medical home or partnering to build capacity among primary care providers to provide the services. However, building high-quality systems of care, local community capacity, and strengthening enabling services to assist clients in accessing a medical home is the priority of the Title V program.

Direct care services are to be gap-filling only services, not ways to build relationships with other organizations. Often non-CAH programs within the Contractor's agency or outside community organizations will seek to meet their program or other requirements by requesting the CAH Contractor partner to provide direct services. CAH Contractors also often think of other programs within their agency or community that they know have program requirements similar to CAH requirements as a useful way to address program requirements. Examples of programs/organizations where this has occurred include Head Start/Early Head Start, home visiting programs (HOPES, MIECHV, etc.), and schools. The layering of funds and services on the same sets of families that are already in the system of care leaves fewer resources available for harder-to-reach families and those not already receiving assistance in accessing these services.

When CAH program resources are used to meet existing program requirements or eligibility criteria, this can also lead to the supplanting of funds, which is not allowed. For example, using CAH program resources to meet the Head Start Program Performance Standards 1302.42 Child Health Status and Care. This Head Start standard includes the provision of and payment for enabling services (health care coverage, a medical home, care coordination, etc.) and direct care services (vision and hearing screens, well-child visits, nutrition assessment, blood lead testing, etc.). Another example is using CAH program resources to meet home visiting program, school, AEA, or IQ4K requirements for developmental screening.

Policy

Contractors shall not utilize their CAH program or screening center status to provide direct care services to meet other programs' requirements, eligibility, or enrollment criteria or as an incentive for partnership or program participation. Contractors shall work with the State Title V CAH program for approval of all direct care services in compliance with Policy 800 Provision of Gap-Filling Direct Care Services.

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Procedure

Contractors may engage in partnerships and collaborations to provide enabling services to assist families in establishing and accessing a medical home unless those services are already a requirement of the partnering program or organization.

Contractors shall engage with other organizations, programs, families, and groups to promote high-quality systems of care, local community capacity, medical homes, and enabling services throughout their CSA. Examples include gathering input and disseminating to stakeholders, coordinating coalitions and groups to assess needs and barriers, centering clients/families at the center of creating solutions, being involved in the programs and solutions of other community organizations and other Public Health Services and Systems, and Enabling Level services.

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Number: 701-CAH
Title: EPSDT Program and Medicaid Administrative Fund Services
Effective Date: 10/01/2022
Revision Date: 03/31/2025
Date of Last Review: 03/31/2025
Authority: Iowa HHS Omnibus Agreement, Contract Special Conditions, Iowa HHS General Conditions for Service Contracts

Overview

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program provides comprehensive health care for Medicaid-enrolled clients under the age of 21. The EPSDT program was implemented in 1967 by the United States Congress. Every state's Medicaid program has an EPSDT Program; in Iowa, the program is also known as the EPSDT Care for Kids Program.

Contractors focus on activities of the EPSDT program, including informing, care coordination, Presumptive Eligibility (PE), and gap-filling screening, in order to assist clients in getting to their medical homes early and within the recommended time frames. Medical homes and specialists are primarily responsible for screening, diagnosis, and treatment. The acronym EPSDT stands for:

1. **Early**: Children should receive quality health care beginning at birth and continuing throughout childhood and adolescence, including the identification, diagnosis, and treatment of medical conditions as early as possible.
2. **Periodic**: Children should receive well-child visits at regular intervals throughout childhood and adolescence, according to the Iowa EPSDT Periodicity Schedule. Health care may be provided between regularly scheduled visits.
3. **Screening**: Children should be screened for health, developmental, and social-emotional concerns. Services should include health history, developmental and behavioral assessment, physical exam, immunizations, lab tests, nutrition/obesity prevention, OH exam, health education (anticipatory guidance), and vision and hearing screenings.
4. **Diagnosis**: Children should receive further evaluation of health, developmental, or social-emotional problems identified during well-child visits that may require treatment.
5. **Treatment**: Children should receive treatment for health, developmental, or social-emotional problems identified during well-child visits.

In Iowa, Iowa HHS administers the Iowa Medicaid Program and, therefore, is the administrative agency for the EPSDT program. Iowa HHS engages Title V contractors to provide EPSDT Informing, care coordination, Presumptive Eligibility, and related interpretation services for eligible clients. This is an arrangement unique to Iowa. The services of Informing, care coordination, and presumed eligibility, as well as the interpretation and transportation services, are paid through Medicaid Administrative Funds (MAF). As a result, these services are frequently referred to as "MAF services" in the CAH program and as they form the bulk of the Enabling level of the MCH Pyramid and may also be referred to as enabling services.

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Authority: Iowa HHS Omnibus Agreement, Contract Special Conditions, Iowa HHS General Conditions for Service Contracts

Policy

Contractors are responsible for providing the following services to clients 0 to 21 years of age enrolled in Medicaid:

1. Informing for all newly Medicaid-enrolled clients
2. Dental care coordination
3. Medical care coordination for clients not enrolled in Medicaid-managed care (Fee-For-Service or FFS)
4. Well-visit reminders for clients served in the past two years who are in the Maternal Health (MH) and Child and Adolescent Health (CAH) data system "Agency Home."
5. Presumptive eligibility
6. Interpretation services pertaining to these listed services

Contractors are also responsible for providing these services for clients 0 to 22 years of age eligible for Title V (see Policy 106 Child & Adolescent Health Program Eligibility & Voluntary Participation):

1. Medical care coordination
2. Dental care coordination
3. Well-visit reminders for clients served in the past two years who are in the MCAH data system "Agency Home."
4. Interpretation services pertaining to these listed services
5. Transportation services pertaining to these listed services

Contractors are required to have policies and procedures outlining how staff are to provide these services.

Procedure

Staff skills and competencies needed to conduct the required EPSDT/Medicaid Administrative Funds (MAF) Services include:

1. Cultural and linguistic competence to communicate the information in a meaningful way to all clients
2. Relate to clients to encourage involvement in EPSDT services
3. Assess client needs and refer to appropriate providers
4. Understand the impact of the client's culturally-related health beliefs
5. Engage in a client/family-centered, strength-based approach
6. Tailor informing services to address client choices, preferences, and special needs such as language barriers, low literacy levels, etc.

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7. Understand Medicaid and EPSDT programs, including the Iowa EPSDT Periodicity Schedule and dental periodicity schedule
8. Understand immunization schedules for birth to 21 years old from the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP)
9. Ability to promote preventive care, including immunizations
10. Ability to promote medical and dental homes
11. Knowledge of and ability to explain child and adolescent growth and development
12. Establish and maintain linkages with local primary care providers and community resources
13. Motivational interviewer training is encouraged for all staff involved in providing EPSDT services.

Medicaid Administrative Fund Billing

The activities required for effective Informing, care coordination, Presumptive Eligibility, and interpretation and transportation of those services may be included in a Contractor's MAF billing to Iowa HHS. MAF funds include all expenses and staff time spent doing Informing, Presumptive Eligibility, care coordination (including dental), and related Interpretation and transportation. For example, care coordination is not just the time spent talking, emailing, or texting with the client; Contractors can bill for the time spent looking up numbers, searching through resources, and making calls that do not get answered, etc. Expenses for printing, paper, phone service, etc., should also be included in the MAF monthly billing. In addition, these activities should be included in the time study – so the contractor may determine the full cost of services. Please be aware of the following exceptions to MAF billing:

1. If the purpose of a home visit is to provide direct care services, a home visit for care coordination cannot be billed.
2. The entirety of the maternal health postpartum home visit is part of the maternal health services. Any care coordination on behalf of the baby is considered part of this postpartum visit. Do not bill the CAH program for care coordination for any part of this maternal health visit.

Required Resources for Implementation

1. Contractor-specific training on each service, policy, and procedures
2. Orientation and training on the statewide expectations, policies, and procedures for MAF services

Resources

Iowa HHS General Conditions for Service Contracts

Number: 702
Title: CAH Informing Services
Effective Date: 10/01/2022
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Authority: HHS Omnibus Agreement; CMS Medicaid Manual

Overview

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program provides comprehensive health care for Medicaid-enrolled clients under the age of 21. According to the federal Centers for Medicare and Medicaid Services (CMS), there are two important features of the EPSDT program: assuring the availability and accessibility of required healthcare resources and helping Medicaid clients use these resources.

Through the process of "informing", the family is provided information about the services they are eligible for that are covered under Medicaid (i.e., the variety of medical, dental, and support services). The purpose of informing is to educate and assist the client in understanding their Medicaid benefits and the importance of preventive medical and oral health care to improve client health outcomes throughout their life.

Policy

Contractors shall use clear and nontechnical language to provide a combination of written and oral methods to inform all eligible clients effectively describing what services are available under the EPSDT program, the benefits of preventive health care, where the services are available, that they are available at no cost to the family, how to obtain them; and that necessary transportation and scheduling assistance is available.

Contractors shall provide quality Informing services for each newly enrolled Medicaid client from birth to 21 years of age in each county of the collaborative service area (CSA). Informing services shall be completed within 30 days of receiving the client informing list and completed each month of the year. Contractors shall notify the Department in writing within ten (10) calendar days of any circumstances that impact the Contractor's ability to provide the required Informing services.

Required Resources for Implementation

EPSDT Informing training

Procedure

Contractors shall:

1. Provide all three steps of the Informing service, including Initial Inform, Inform Follow-ups (if necessary), and Inform Completion.

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2. Develop and annually review Contractor policies and procedures to ensure the Informing services are meeting the needs of clients/families. Policies and procedures shall include detailed information on all three required steps of the Informing process and be consistent with Department guidelines.
    a. Clients and family members of the CSA, clients/family members eligible for Informing, and clients/family members from populations with less access to healthcare services shall be included in the development and review of the policies and procedures regarding Informing, call/text scripts, and the contents of the Informing packet. Clients/families will be engaged to make recommendations for policy/procedures related to connecting with families, providing input on how families are communicated with, how to communicate information, and ensuring processes and information are family-centered.
    b. Develop and annually review age-specific Informing scripts that comply with Department guidelines to be used when contacting clients. Ensure call and text scripts are vetted for relevance and understanding by clients/families.
    c. Develop and annually review a county-specific resource directory for clients/families. The development and annual review of the resource directory should include clients and family members of the CSA, clients/family members eligible for Informing or other CAH program services, and clients/family members from populations with less access to healthcare services. The resource directory must meet the following criteria:
        i. Include county-level resources for the county of residence of the client/family. The Contractor may opt to include regional, state, and national resources.
        ii. Contain medical and dental providers taking Medicaid clients in the client's/family's county of residence.
        iii. All resources must be verified by the contractor at the time of review. Resources must include pertinent information such as location, hours of operation, and contact information, but should strive to provide more detailed information (e.g., Food Pantry: fresh fruit is available on the first Tuesday of the month, food often runs out by noon; Provider X speaks Spanish, etc.).

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iv. Contain information relevant to the health and social determinants of health (SDOH) for clients age birth to 21 years. Do not include a listing of businesses/organizations in the county that do not offer Health/DOH services to CAH clients; the listings should be relevant to the clients/families this program serves.

3. Provide informed services in the primary language of the client. Provide interpretation services to inform when needed (see Policy 708 Interpretation Services).
4. Coordinate care and facilitate access to community resources for clients/families based upon needs identified by them during the Informing process.
5. Engage in ongoing quality assurance and quality improvement activities related to Informing.
6. Document all Informing services provided by the Contractor or through subcontractors at the time of service and be made available to Iowa HHS by the 15th of the month following the month of service.
7. Check the Medicaid eligibility status of clients using the Iowa Medicaid Enterprise (IME) Eligibility Verification System (ELVS) at 800-338-7752 or 515-323-9639 or online through the IME ELVS Web Portal.

Initial Inform:

1. In the first week of every month, Contractors shall utilize a monthly Informing list filtered from the MCAH data system to identify all children/families eligible for the Informing service in their CSA. The report will give the child's name and contact information so the informing process can begin.
    a. Informing services are provided for the family unit rather than an individual client. Some clients have never before received Medicaid benefits, while others may have received them in the past. Any client who becomes eligible again after being off Medicaid for the previous 90 days or more is considered to be newly eligible and shall receive Informing services.
    b. Clients must be informed within 30 days of receiving the monthly Informing list. The month of June must be completed by the 30*th* of the month due to the end of the State Fiscal Year.
2. Contractors shall complete Initial Informing by mailing an introductory packet to the families of all newly enrolled Medicaid clients from birth to 21 years. This

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mailing shall include an initial welcome letter, Medicaid EPSDT brochure, I-Smile™ information, age-appropriate preventive health care education, and community resources that address social determinants of health (e.g., health care providers and dentists accepting Medicaid, food pantries, Child Care Resource and Referral, mental health resources, etc.). The packet shall include contact information for the Contractor, and let the client know that the Contractor will be attempting to reach the family.

3. Contractors shall include the days and hours families can expect contacts to be made and when the Contractor has staff available to answer contacts from the family, including those outside normal business hours (8:00 a.m. - 4:30 p.m. M-F). Families have expressed that specificity about how and when to expect contacts will ensure better outcomes.

Inform Follow-Up:

1. Inform Follow-ups are attempts to conduct an Inform Completion.
2. Contractors shall complete informal follow-ups by making phone, text, and/or face-to-face attempts to reach the client/families with the goal of having a dialogue about the benefits available to them through Medicaid. Inform Follow-ups are required to use the following methods:
    a. A minimum of two attempts to contact the client/family must be made on different dates/times during the 30 days. These hours must:
        i. It consists of staff actively making contact attempts and being available live to answer calls/texts and/or in-person visits.
        ii. Be communicated in the Initial Inform packet as times the client/family can expect calls, texts, or visits and that staff will be available to return calls and texts. Therefore, the hours must be scheduled in advance.
3. Contractors must make at least one attempt by live phone call or an in-person visit. Additional phone calls may be made, including the use of technology-assisted calling. However, the option to be easily routed to a live person for Inform Completion must be available when the technology-assisted calls are made.
4. Contractors may utilize text messaging provided that such messaging is HIPAA compliant and follows HHS guidance. Texting may be used to encourage the family to contact the Contractor (as an informed follow-up attempt) or accept the Contractor's call (pre-text). No protected health information (PHI) shall be

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included in texts. Appropriate use of texting for Inform Follow-ups would be similar to: “This is Mandy with (Name of Contractor); I am trying to reach you to discuss important information about your child’s Medicaid coverage (or health insurance). Please call me at (phone number)” or “I will be attempting to call you from this number.” Texts must be sent from a Contractor-owned device. No personal devices may be used.

5. If a phone number in the MCAH data system does not work, the Contractor shall attempt to locate a phone number through other resources, including collaboration with other entities (such as WIC).
6. If the client cannot be reached by the above requirements, a follow-up written communication must be sent reinforcing components of the EPSDT program, encouraging the use of preventive health care, and containing Contractor contact information. A follow-up postcard may be mailed; however, postcards may not contain PHI, and postcards must comply with state and federal laws, HIPAA, and Department guidelines.
7. If repeated attempts to reach the client are unsuccessful, the Contractor may elect to release ownership of the client per Department and Contractor guidelines. Do not mark it as ‘unsuccessful’; instead, leave the client open in case of future contact. The client will automatically be closed by the MCAH data system after 12 months.

Inform Completion:

1. Contractors shall conduct Inform Completion by having a conversation that includes the benefits of establishing a medical and dental home, the comprehensive array of services available through Medicaid, including interpretation and transportation resources, the benefits and importance of preventive care, how and where Medicaid benefits can be used, and resources available in the community to address the social determinants of health. The following topics are to be discussed:
    a. How managed care and managed care assignments work, and the right to switch managed care companies.
    b. How to select a primary care provider with MCO coverage and the right to switch assigned primary care providers.
    c. Federal rules mandate that clients have the freedom to choose their health care/dental providers. To comply with these rules, Contractors must be

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prepared to discuss provider options with each client. Clients enrolled in Medicaid have the ability to choose a provider under their Medicaid status (Fee-for-Service or managed care). Clients must be informed of the financial consequences of choosing a non-Medicaid provider since Medicaid will not pay for services given by a non-Medicaid provider. A client's choice of a non-Medicaid provider should not be considered a refusal of services.

d. Where screening services are available and how to obtain them.
e. Encouraging and assisting the family to establish medical and dental homes for their children.
f. Support services available through the EPSDT program (such as transportation, translation, interpretation, and early care and education (ECE)).
g. Community resources needed to meet social determinants of health needs of the client/family.
h. All Medicaid-eligible clients have the right to appeal Medicaid decisions. Information on filing an appeal can be found on the HHS Appeal webpage. Clients who have questions specific to the appeal process may contact their HHS worker or the HHS Appeals Section at 515-281-3094. Clients wishing to appeal may also wish to contact an attorney or Iowa Legal Aid at 1-800-532-1275. In Polk County, clients may call 515-243-1193.

2. Contractors shall use clear and nontechnical language and provide a combination of written and oral methods to inform all eligible clients effectively describing what services are available under the EPSDT program, the benefits of preventive health care, where the services are available, how to obtain them; and that necessary transportation and scheduling assistance is available.
3. The goal for Inform Completions in each CSA is 70%.
4. Contractors may determine additional ways to successfully reach clients/families. Contractors are encouraged to work with clients/families and populations with less access to healthcare services to determine additional or new ways to reach families, including partnerships with community organizations that are trusted and utilized by families.

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Personnel:

1. Contractors are required to designate employees to carry out informing services. Staffing is dependent upon the number and needs of clients in the CSA. Staff need the following competencies to provide the Informing service:
    a. Communicate complex information in an understandable way using plain, non-technical language with clients. Utilize the client's primary language. Engage a qualified interpreter when needed (see Policy 708 Interpretation Services).
    b. Relate to clients to encourage involvement in preventive health care and to assess client needs and barriers.
    c. Be knowledgeable of community resources and refer to appropriate providers to meet client needs.
    d. Tailor Informing services to address client choices, preferences, and special needs such as language barriers, low literacy levels, and hearing or sight impairment.
    e. Understand the Medicaid program, including components of Iowa's Periodicity schedule.
    f. Understand the CDC and ACIP Childhood Immunization Schedules and be able to communicate the schedule to clients.
    g. Understand and explain child and adolescent growth and development.
    h. Establish and maintain linkages with local providers and community resources.
2. Develop and maintain a comprehensive contingency plan to provide informing services in the event of staff vacancies and emergency situations. The contingency plans must be fully operational and implemented within ten business days of a vacancy or emergency event. The plan shall include provisions for technology failure and inaccessibility (e.g., building flood/fire/unsafe structure, facility relocation, system hacking, etc.) and assures adequate staffing to provide the Informing service to all eligible clients every month of the year.
3. All staff, including subcontractors, performing the Informing process shall be trained on and have access to the Informing scripts, policies, and procedures, which shall include guidance on documentation of the Informing process in the MCAH data system.
4. See Policy 201 Required Personnel for additional requirements related to personnel.

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Documentation
Contractors must document each step of the Informing process in the MCAH data system for each newly eligible client in the family. The MCAH data system User Manual in the Document Library of the MCAH data system provides specific guidelines for documenting services.

Resources
CMS Medicaid Manual
IME ELVS Web Portal
CDC and ACIP Childhood Immunization Schedules
Iowa's Periodicity schedule
HHS Appeal website

Number: 703-CAH
Title: Care Coordination (Medical, Dental, Home Visit, Transportation, Interpretation)
Effective Date: 10/01/2016
Revision Date: 04/01/2025
Date of Last Review: 04/01/2025
Authority: Iowa HHS Omnibus Agreement, Iowa HHS Childhood Lead Poisoning Prevention Program

Overview

The Title V program is a medical home model and seeks to assure that the client's overall health is improved through care coordination to a medical home and to meet the social determinants of health (see Policy 105 Admission to CAH Services). Care coordination enables clients to:

1. Overcome barriers to access health care
2. Become independent health consumers
3. Develop healthy beliefs, attitudes, and behaviors
4. Make informed healthcare choices
5. Establish and maintain medical and dental homes
6. Improve their health and mental and physical well-being
7. Address social determinants of health

Specific care coordination activities will depend on the needs and preferences of the client. The following list contains possible care coordination activities:

1. Assisting clients in accessing periodic well-child screenings and dental screenings
2. Assisting in establishing medical and dental homes
3. Assisting with scheduling appointments (outside of the Contractor's organization)
4. Assisting the client to prepare a list of questions or concerns prior to the medical or dental visit
5. Following up to make sure the client received the care intended at the appointment
6. Following up to reschedule missed appointments
7. Assisting clients when referral for further care is needed
8. Arranging support services such as transportation to Medicaid providers or interpreter services
9. Establishing and implementing a plan(s) of care
10. Linking clients to other community organizations to address social determinants of health

Policy

Contractors shall actively locate and provide care coordination to clients enrolled in Title V**,** clients during the Presumptive Eligibility (PE) period, and clients enrolled in Medicaid Fee-For-Service (FFS) (clients not enrolled in a Managed Care Organization (MCO)).

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Authority: Iowa HHS Omnibus Agreement, Iowa HHS Childhood Lead Poisoning Prevention Program

The contractor will provide care coordination to all clients when providing a gap-filling direct health care service.

Procedure

1. Contractors shall develop and annually review policies/procedures and ensure they are consistent with Department guidelines for care coordination; contractors shall ensure policies/procedures regarding documentation of care coordination in the Maternal Health (MH) and Child Adolescent Health (CAH) data system follow required Department guidelines.
2. Contractors shall develop a plan for actively locating eligible clients who would benefit from care coordination. Contractors shall include ways to identify eligible clients for care coordination that are in addition to clients self-identifying as needing care coordination, care coordination associated with the provision of gap-filling direct health care services, and clients during the PE period.
3. Contractors shall include the following core elements related to Title V in care coordination:
    a. Assistance in establishing a medical or dental home if the client does not have one.
    b. Assessment of immunization status (see Policy 602 Immunization Access and Promotion).
    c. Assistance in accessing any missing ACIP recommended vaccines.
    d. Assessment of whether the child is current on well visits and dental screenings.
    e. Assistance accessing a well visit and/or dental screening if due/overdue.

Follow-up medical and dental care coordination to previous care coordination within 30 days does not require the re-assessment of each of these elements. Professional judgment and circumstances guide reassessment during follow-up care coordination. If it has been more than 30 days since the last contact or assessment of these core elements, reassess for additional care coordination needs related to these core elements. Note in the documentation that the service is a follow-up care coordination.

If conducting targeted care coordination of an immediate need, assist the family as needed to meet their need. Pursue full medical and dental care coordination to assess core care coordination and assist with those needs once the family's immediate need is met.

4. Contractors shall assist clients/families with health literacy by assessing their needs and then structuring education based on those needs to help them

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understand how insurance works, how to make appointments, how to obtain referrals or specialty care, the importance of preparing questions for the primary care provider, etc. In addition, it helps clients understand changes in coverage and processes involved in transitioning from one type of coverage to another. Provide additional education or assistance in understanding health literacy for populations with less access to healthcare services, as needed.

5. Contractors shall build a referral network throughout the CSA of primary care providers to serve as medical homes, provide screening services and comprehensive well-child visits to Title V clients, clients during the Presumptive Eligibility period, and clients enrolled in Medicaid Fee-For-Service. If the Contractor is a medical home or part of a health system that serves as a medical home, the referral network must include providers outside their organization to provide choice to clients. Contractors shall provide equal opportunity to choose another organization for services, with equal support and assistance, regardless of which provider is chosen.
6. Contractors shall build a referral network of community resources to meet clients' social determinant health needs throughout the CSA.
7. Contractors shall provide care coordination in the client's primary language. Provide interpretation services for care coordination when needed (see Policy 709 Interpretation Services).
8. Contractors shall engage in ongoing quality assurance and quality improvement activities related to the care coordination process and documentation of care coordination entered into the MH and CAH data system.
9. Care coordination services are conducted via phone, back and-forth text or email, or face-to-face (in person or via technology) dialogue with Medicaid clients to assist them with Medicaid-related services such as medical, dental, mental health, transportation, Child Health Specialty Clinics (CHSC), AEA, etc.
10. Leaving a message, sending a text without a response from the client, or mailing information is not care coordination.
11. As long as Medicaid-related services/programs are addressed, linkage to non-Medicaid resources (such as early care and education (ECE), WIC, parenting programs, social services, legal services, food, clothing, housing, and shelter services) may also be included in the time spent with the client.
12. Contractors must have agency-specific protocols that are consistent with Department guidelines for providing care coordination. Care coordination staff, clients, family members, and populations with less access to healthcare services insights are important to guide the Contractor in making appropriate changes to services, protocols, and educational materials.

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13. Contractors shall ensure materials are at an appropriate reading level and culturally appropriate for the client.
14. Contractors shall assist with arranging local transportation to Medicaid-covered services for Medicaid Fee-For-Service clients, including clients during the Presumptive Eligibility period. Contractors can bill Medicaid for transportation costs and utilize Medicaid Administrative Funds to cover care coordination.
15. Contractors shall arrange local transportation for Title V clients. Title V grant funds cover care coordination and transportation expenses.
16. Clients enrolled in a Medicaid MCO may be referred to their MCO for care coordination services (see Policy 601 Managed Care Organizations).
17. Children with special health care needs may be referred to CHSC for specialized care coordination. CHSC staff are skilled in coordinating client-centered care that is effective, convenient, and offers informed options to families.
18. See Policy 906 Dental Care Coordination for additional information on dental care coordination.

Care Coordination Home Visit for a High Blood Lead or Medically Necessary Condition

1. Most care coordination activities will involve talking to clients on the telephone or at the Contractor's office, clinic setting, or approved telework site. However, a Contractor must be prepared to provide home visits to clients when needed.
    a. A home visit may be needed/indicated for a client who requires medically necessary care coordination for a health-related condition. Such necessity may include clients that lack phone service or are otherwise hard to reach.
    b. Provide information about available medical services.
    c. Assist the client in making and coordinating appointments, removing barriers, and accessing care.
    d. Utilize referral network to assist clients in accessing services and social determinants of health.
2. Each client with a blood lead level equal to or above 15 micrograms per deciliter (mcg/dL) must receive a skilled nursing visit. An RN may follow up on this high blood lead level by making a care coordination home visit to:
    a. Assess the client's knowledge of lead poisoning and instruct the client regarding nutrition, cleaning, and other relevant issues.
    b. Evaluate the home for other children living or visiting routinely and, if appropriate, make arrangements for testing of those children.
    c. Assist the client in making and keeping follow-up appointments.

Number: 703-CAH
Title: Care Coordination (Medical, Dental, Home Visit, Transportation, Interpretation)
Effective Date: 10/01/2016
Revision Date: 04/01/2025
Date of Last Review: 04/01/2025
Authority: Iowa HHS Omnibus Agreement, Iowa HHS Childhood Lead Poisoning Prevention Program

d. Remind the family to notify the client's lead program case manager if the family moves.
e. Remind the family to inform the client's current and future healthcare providers of the elevated lead level and any subsequent tests that may demonstrate a lower blood lead level.
f. See Policy 604 Prevention and Early Intervention for Lead Poisoning and Iowa HHS Childhood Lead Poisoning Prevention Program for more information on blood lead poisoning in children.

Personnel

1. Contractors are required to designate employees to carry out care coordination services. Staffing is dependent upon the number and needs of clients in the CSA. Staff need the following competencies to provide the Care Coordination service:
    a. Communicate complex information in an understandable way using plain, non-technical language with clients. Utilize the client's primary language. Engage a qualified interpreter when needed.
    b. Relate to clients to encourage involvement in preventive health care and to assess client needs and barriers.
    c. Be knowledgeable of community resources and refer to appropriate providers to meet client needs.
    d. Tailor care coordination to address client choices, preferences, and special needs such as language barriers, low literacy levels, culture, and hearing or sight impairment.
    e. Understand the Medicaid program, including components of Iowa's Periodicity schedule.
    f. Understand the CDC and ACIP Childhood Immunization Schedules for birth through 18 year olds and be able to communicate the schedule to clients.
    g. Understand and explain child and adolescent growth and development.
    h. Establish and maintain linkages with local providers and community resources.
2. Contractors shall train all staff and subcontractor staff who provide services to CAH clients in care coordination and in utilizing the MH and CAH data system to document care coordination in compliance with Department guidelines.
3. All staff, including subcontractors, performing care coordination shall be trained on and have access to the resource directory, referral network, policies, and

Number: 703-CAH
Title: Care Coordination (Medical, Dental, Home Visit, Transportation, Interpretation)
Effective Date: 10/01/2016
Revision Date: 04/01/2025
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Authority: Iowa HHS Omnibus Agreement, Iowa HHS Childhood Lead Poisoning Prevention Program

procedures, including guidance on documenting care coordination in the MH and CAH data system.
4. All staff, including subcontractors performing care coordination, shall be trained in motivational interviewing techniques.
5. See Policy 201 Required Personnel for additional requirements related to personnel.

Documentation

1. Contractors must document care coordination in the MH and CAH data systems.
2. For targeted follow-up care coordination notes that do not involve coordinating medical/dental care, the date of the last well visit, provider name, and immunization status assessment are not required. Indicate in the note if it is a follow-up care coordination service. Address any additional family needs.
3. If care coordination is provided for multiple clients in the family, document the care coordination in each client's record in the MH and CAH data system.

Resources

Iowa HHS Childhood Lead Poisoning Prevention Program
CDC and ACIP Childhood Immunization Schedules for birth through 18 year olds
Iowa's Periodicity schedule.

Number: 704-CAH
Title: Presumptive Eligibility for Medicaid and Hawki (Healthy and Well Kids in Iowa)
Effective Date: 10/01/2016
Revision Date: 04/07/2025
Date of Last Review: 04/07/2025
Authority: Social Security Act Section 1902 [42 U.S. C. 1396a]

Overview

Presumptive Eligibility (PE) provides full Medicaid coverage for a limited time, while the Iowa Department of Health and Human Services makes a formal Medicaid eligibility determination. The goal of the PE process is to offer immediate health care coverage to individuals "presumed" to be eligible for Medicaid or Hawki before there has been a full Medicaid determination. The presumptive period lasts until a formal determination is made (enrollment or denial), the application is withdrawn, or until the last of the month following the date of application.

Policy

Contractors shall assist clients in accessing Presumptive Eligibility (PE) through enabling services and public health services and systems. To be eligible for PE, the child and adolescent must be between the ages of 0 and 19, be an Iowa resident, be a U.S. citizen or lawful permanent alien, and meet income requirements. Contractors are required to have a Qualified Entity (QE) within their agency to process applications, and only one PE application can be completed in any 12-month period.

Policy for Medicaid and Hawki Eligibility for Children:

The Medicaid presumptive eligibility process ensures children and adolescents can get immediate healthcare coverage of either Medicaid or Hawki once a final determination is made. Contractors receiving Medicaid Administrative Funds (MAF) to provide PE services can bill CAH MAF for staff time spent doing the PE for clients.

Procedure

The following procedure will be used for conducting a PE:

1. The Hawki Outreach Coordinator will complete the Qualified Entity (QE) Medicaid Presumptive Eligibility Portal (MPEP) Access Request Form and participate in web-based training through the Iowa Department of Health and Human Services. Only a trained QE is allowed to do PE determinations for CAH clients.
2. The QE will use the Medicaid Presumptive Eligibility Portal (MPEP) (self-service portal) for presumptive Medicaid or Hawki eligibility determinations. See Policy 706 in Hawki Outreach Coordinator.
3. The QE will ask the families for the required information from the Medicaid Presumptive Eligibility Portal Application. Paper applications may be completed. The paper application is the "Application for Health Coverage and Help Paying

Number: 704-CAH
Title: Presumptive Eligibility for Medicaid and Hawki (Healthy and Well Kids in Iowa)
Effective Date: 10/01/2016
Revision Date: 04/07/2025
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Authority: Social Security Act Section 1902 [42 U.S. C. 1396a]

Costs" Application for Health Coverage and Help Paying Costs (form 470-5170) and the Addendum to Application for Presumptive Eligibility (form 47-5192) Addendum to Application for Presumptive Eligibility.

4. The QE will submit all information to MPEP. It is important to obtain all necessary information through MPEP and try not to leave any blanks if possible. A social security number is required for the child but not the parent. If a parent is undocumented or does not have a SSN, the application will not be affected or denied.
5. Once a Contractor has all the information entered into MPEP, eligibility will be determined. If the eligibility is not what was expected, it is important to go back through the application to ensure all information was entered correctly prior to accepting the PE results.
6. To fully submit the application, the Contractor must accept the PE results.
7. After accepting the results, the option to print the Notice of Action (NOA) and application summary are available. Print both, provide a copy to the family, and place a copy in the family's file. This is the only opportunity the QE will have to print the NOA and summary. The family uses the printed NOA as proof of coverage and can be shown to a medical provider in place of a Medicaid card. PE records must be kept for seven years for audit purposes.
8. If the application was entered directly into MPEP, the applicant must sign the printed signature page that goes into their file.
9. Document PE, care coordination, and enabling services provided to the client as part of the PE application process into the MCAH Data System. Care coordination shall take place with all PEs to provide families with information on the support services available through EPSDT, resources in their community, and available health care services.
10. If there are problems or questions about PE, please contact the IME MPEP Support desk imempepsupport@hhs.iowa.gov or call the Iowa HHS help desk at 1-855-889-7985. Please note that the phone number for the Iowa HHS help desk is the same number used for all programs, so there may be a delay when using this line.

Number: 704-CAH
Title: Presumptive Eligibility for Medicaid and Hawki (Healthy and Well Kids in Iowa)
Effective Date: 10/01/2016
Revision Date: 04/07/2025
Date of Last Review: 04/07/2025
Authority: Social Security Act Section 1902 [42 U.S. C. 1396a]

Resources

HHS Presumptive Eligibility
General Information – Presumptive Eligibility Frequently Asked Questions
Application for Health Coverage and Help Paying Costs
Addendum to Application for Presumptive Eligibility
Social Security Act Section 1902 [42 U.S. C. 1396a]

Number: 704-MCAH
Title: Presumptive Eligibility for Medicaid for Pregnant Women and Children
Effective Date: 01/01/2024
Revision Date: 05/02/2025
Date of Last Review: 05/02/2025
Authority: Social Security Act Section 1902 [42 U.S. C. 1396a]

Overview

Presumptive Eligibility (PE) provides full Medicaid coverage for a limited time while the Iowa Department of Health and Human Services (HHS) makes a formal Medicaid eligibility determination. The goal of the PE process is to offer immediate health care coverage to individuals "presumed" to be eligible for Medicaid before there has been a full Medicaid determination. The presumptive period lasts until a formal determination is made (enrollment or denial), the application is withdrawn, or until the last of the month following the date of application.

Policy

Contractors shall assist clients in accessing Presumptive Eligibility (PE) through enabling services and the public health services and systems. The Department understands that on occasion Maternal Health (MH) agencies or Child Adolescent Health (CAH) agencies may be assisting with PE applications during work with a specific client in their population who has a family member identified to be in need of PE assistance as well. It is the goal of Iowa HHS to decrease barriers to accessing care and streamline services for individuals seeking services. Therefore, the following policy procedure guidance is available to support MH and CAH agencies who may be working in some capacity with overlapping families, in order to decrease duplication of service provision and support the 'no wrong door approach' for those seeking assistance. It is not intended to encourage agencies to routinely advertise, promote, or target PE services to the population not typically served by their respective agency. To be eligible for PE, the child, adolescent, caregiver, and/or parent must be an Iowa resident and a U.S. citizen or lawful permanent alien and meet income requirements. Only one PE application may be completed in any 12-month period. To be eligible for PE, the pregnant woman must be an Iowa resident and meet income requirements. A PE application may be done for each pregnancy and is not limited to the 12-month period.

Procedure

1. Staff at the contracted agency will complete the Qualified Entity (QE) Medicaid Presumptive Eligibility Portal (MPEP) Access Request (Form 470-5201) and participate in web-based training through the Iowa Department of Health and Human Services. Only a trained QE is allowed to do PE determinations for Maternal Health and Child Adolescent Health clients.

Number: 704-MCAH
Title: Presumptive Eligibility for Medicaid for Pregnant Women and Children
Effective Date: 01/01/2024
Revision Date: 05/02/2025
Date of Last Review: 05/02/2025
Authority: Social Security Act Section 1902 [42 U.S. C. 1396a]

2. All agencies employing QE staff must be annually approved by the Iowa Department of Health and Human Services as a Presumptive Provider (PP).
3. MH and CAH agencies can choose for the agency to be approved as the PP to provide PE for any of the following categories: Pregnant women, Children, and Hospitals (includes: former foster care children, individuals 19-64 years old, parents and caretakers, children, pregnant women). If the agency is approved as a PP in the hospital category, only clients who meet the definitions of the MH or CAH populations may be billed to MAF for reimbursement.
4. The QE will use the Medicaid Presumptive Eligibility Portal (MPEP) for presumptive Medicaid eligibility determinations. The QE will ask the families the required information from the Medicaid Presumptive Eligibility Portal (MPEP) or paper applications may be completed. The paper application is the Application for Health Coverage and Help Paying Costs (form 470-5170) and the Addendum to Application for Presumptive Eligibility (form 470-5192).
5. The QE will submit all information into MPEP. It is important to obtain all necessary information required through MPEP and try not to leave any blanks if possible.
    a. A social security number is not required for pregnant clients. For MH clients who do not meet citizenship requirements for full Medicaid coverage, the PE application should **not** be submitted for ongoing Medicaid coverage.
    b. To be eligible for PE, the client's family income must be below 375% of the Federal Poverty Level (FPL). Household size includes the unborn child.
    c. The number of babies expected by a pregnant person is not marked as required, however the application will be denied if this is not entered correctly (needs to be at least 1).
    d. A social security number is required for the child, but not the parent. If a parent is undocumented or does not have a SSN, the application will not be affected or denied.
6. Once the QE has all the information entered into MPEP, eligibility will be determined by Iowa HHS. If the eligibility is not what was expected, it is important to go back through the application to ensure all information was entered correctly.
7. To fully submit the application, the QE must accept the PE results.

Number: 704-MCAH
Title: Presumptive Eligibility for Medicaid for Pregnant Women and Children
Effective Date: 01/01/2024
Revision Date: 05/02/2025
Date of Last Review: 05/02/2025
Authority: Social Security Act Section 1902 [42 U.S. C. 1396a]

8. After accepting the results, the option to print the Notice of Action (NOA) and application summary are available. Print both, provide a copy to the family including the rights and responsibilities and place a copy in the family's file. This is the only opportunity the QE will have to print the NOA and summary. The family uses the printed NOA as proof of coverage, and can be shown as proof of medical, dental, and pharmacy insurance coverage. PE records must be kept for 7 years for audit purposes.
9. If the application was entered directly into MPEP, the applicant must sign the printed signature page that goes into their file.
10. Document PE, care coordination, and enabling services provided to the client as part of the PE application process, into the Maternal and Child Adolescent Health (MCAH) Data System. Care coordination shall take place with all PEs to provide families with information on the support services available through EPSDT, resources in their community, and available health care services.
11. If there are problems or questions about PE, contact IME Provider Enrollment at imeproviderenrollment@hhs.iowa.gov or call the HHS help desk at 1-855-889-7985. Note that the phone number for the help desk is the same number used for all programs, so there may be a delay when using this line.

Billing
Contractors receiving Medicaid Administrative Funds (MAF) to provide PE services can bill MH CAH MAF for staff time spent doing the PE for clients.

Resources
Presumptive Eligibility Iowa HHS
General Information – Presumptive Eligibility Frequently Asked Questions
Application for Health Coverage and Help Paying Costs
Addendum to Application for Presumptive Eligibility
Social Security Act Section 1902 [42 U.S. C. 1396a]

Number: 705
Title: CAH Hawki Outreach
Effective Date: 10/01/2016
Revision Date: 04/07/2025
Date of Last Review: 04/07/2025
Authority: Title XXI of the Social Security Act 1902 [42 U.S. C. 1396a]

Overview

The Healthy and Well Kids in Iowa (Hawki) is Iowa's part of the federal Children's Health Insurance Program (CHIP). This federal/state partnership provides critical medical and dental health care coverage to clients/families who do not qualify for traditional Medicaid but cannot afford private coverage. Hawki outreach builds and strengthens local infrastructure through local partnership development, engagement, and promotion/distribution of Hawki materials particularly focused in serving the highest need areas. Outreach is focused on locating working families without health insurance for their children. The Iowa Department of Health and Human Services provides funds to contractors to provide oversight for statewide Hawki community-based outreach and the employment of a Hawki Outreach Coordinator in each CSA. See policy 706 Hawki Outreach Coordinator.

Policy

Contractors shall provide community-based outreach throughout their entire CSA as outlined in the current RFP, RFA, CAH contract, and approved work plan on file with the Department. Contractors shall maintain at least one staff person who is a Qualified Entity to provide PE throughout the CSA (See Policy 706 Hawki Outreach Coordinator).

Procedure

1. The Hawki Outreach Coordinator will review the client/family needs of all clients indicating they do not have insurance or adequate insurance coverage, assess eligibility for Medicaid/Hawki, and provide PE and care coordination.
2. Contractors shall promote and distribute Hawki brochures (English and Spanish) and eligibility requirements for Hawki (including income guidelines) in the community, on their websites, and on social media platforms.
3. Contractors shall include the following entities in their community-based outreach:
    A. **Schools** - outreach may include visits with school staff but shall focus on times/events when potentially eligible families are present in school settings (i.e., parent-teacher conferences, back-to-school events, community and adult education, summer lunch distribution, etc.).

Number: 705
Title: CAH Hawki Outreach
Effective Date: 10/01/2016
Revision Date: 04/07/2025
Date of Last Review: 04/07/2025
Authority: Title XXI of the Social Security Act 1902 [42 U.S. C. 1396a]

B. **Other** - outreach with CSA-specific community sectors/groups and entities such as, but not limited to: faith-based organizations, social service groups/programs, and other programs engaging with the child/adolescent population and families.

C. **Priority populations** - outreach may include working with non-profit organizations, employers, and community leaders whose work focuses on populations with less access to healthcare resources (i.e., EMBARC, Iowa International Center, etc.).

D. **Employees without access to employer-sponsored health insurance** - outreach may include visits with independent contractors (gig workers), self-employed persons, and employees that are part-time or lack access to employer-sponsored health insurance (e.g., restaurant/grocery stores/food service industry, retail, early care and education (ECE) providers, entrepreneur incubators, artist cooperatives, farm cooperatives, etc.).

Resources

Healthy and Well Kids in Iowa (Hawki)
InsureKidsNow.gov
Social Security Act Section 1902 [42 U.S. C. 1396a]

Number: 706
Title: CAH Hawki Outreach Coordinator
Effective Date: 10/01/2016
Revision Date: 04/07/2025
Date of Last Review: 04/07/2025
Authority: Title XXI of the Social Security Act 1902 [42 U.S. C. 1396a]

Overview

The Healthy and Well Kids in Iowa (Hawki) program is Iowa's part of the federal Children's Health Insurance Program (CHIP). This federal/state partnership provides critical medical and dental health care coverage to clients/families who don't qualify for traditional Medicaid but can't afford private coverage. The Iowa Department of Health and Human Services provides funds to MCAH Contractors to provide oversight for statewide Hawki community-based grassroots outreach and employment of a Hawki Outreach Coordinator (HOC) in each CSA (see Policy 705 Hawki Outreach). The HOC builds and strengthens local infrastructure through local partnership development, engagement, and promotion/distribution of Hawki materials to serve populations who are underserved and uninsured, increases local public health system capacity, and ensures critical enabling and population services are performed in the CSA.

Policy

CAH Contractors will employ or contract a Hawki Outreach Coordinator (HOC) to serve their CSA. The HOC will provide community-based grassroots outreach to each of the required populations (see Policy 705 Hawki Outreach) and be a certified Qualified Entity (QE) through Iowa HHS.

Procedure

Becoming a Qualified Entity: The Hawki Outreach Coordinator (HOC) and contingency HOC are required to be a certified Qualified Entity (QE). They will complete the Qualified Entity (QE) Medicaid Presumptive Eligibility Portal (MPEP) Access Request and participate in web-based training through the Iowa Department of Health and Human Services. Only a trained QE is allowed to do PE determinations for CAH clients.

1. In the application to become a QE, Contractors are required to check the box to receive future emails from IME. IME will send out newsletters and up-to-date information. The contractor can choose the "children" or "hospitals" box and then select your *provider type* (Screening Center for CAH).
2. To be certified as a QE, Contractor staff or subcontractors will:
    a. Review the Provider Education PE and MPEP Training
    b. Review the Memorandum of Understanding with a Provider for PE Determinations.

Number: 706
Title: CAH Hawki Outreach Coordinator
Effective Date: 10/01/2016
Revision Date: 04/07/2025
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Authority: Title XXI of the Social Security Act 1902 [42 U.S. C. 1396a]

c. Request access to MPEP by completing the Qualified Entity (QE) Medicaid Presumptive Eligibility Portal (MPEP) Access Request Form. The Access Request Form will set the certified QE up to obtain usernames and passwords for MPEP.

PE for Clients: A certified QE shall assist clients who may meet eligibility requirements for either for Hawki or Medicaid in applying for PE through the Medicaid Presumptive Eligibility Portal (MPEP) portal that is used by an approved qualified entity (QE) for presumptive eligibility (see Policy 704 Presumptive Eligibility for Medicaid and Hawki). Only one PE may be completed in any 12-month period. Contractors are highly encouraged to ask about “all” and other family members who may need assistance with health care coverage. Assuring health care coverage for all the family is the ultimate goal.

Procedure for Outreach:

1. The HOC will focus outreach and PE to specific required populations, which include schools, populations with less access to healthcare services, employees without access to employer-sponsored health insurance, and other populations (see Policy 705 Hawki Outreach).
2. The HOC will:
   a. Use best practice outreach strategies to encourage enrollment in Hawki and Medicaid programs. This could include meeting parents of young children where they congregate (i.e., school, church, library, YMCA, etc.), connecting with adults of the populations through work, social events, church, community-sponsored events, etc., and connection with other community organizations serving these populations.
   b. Ensure dissemination of approved and up-to-date program information. This could include through the Contractor's website and social media accounts, visiting small employers, schools, grocery stores, etc.
   c. Complete required reports and attend required Hawki meetings.
   d. Conduct Hawki Outreach to businesses and organizations in the community providing onsite PE throughout the CSA.

Number: 706
Title: CAH Hawki Outreach Coordinator
Effective Date: 10/01/2016
Revision Date: 04/07/2025
Date of Last Review: 04/07/2025
Authority: Title XXI of the Social Security Act 1902 [42 U.S. C. 1396a]

e. Conduct Hawki Outreach outside traditional business hours (8 am to 4:30 pm Monday through Friday) and on weekends to provide education and assistance with PE to individuals with a variety of work schedules.
f. Build partnerships within HHS programs including; WIC, 1st Five, I-Smile™ and CCNC.

Resources

Qualified Entity (QE) Medicaid Presumptive Eligibility Portal (MPEP) Access Request
Provider Education PE and MPEP Training
Social Security Act Section 1902 [42 U.S. C. 1396a]

Number: 707-CAH
Title: Applying for Health Coverage—Hawki and Medicaid
Effective Date: 10/01/2016
Revision Date: 04/18/2025
Date of Last Review: 04/18/2025
Authority: Iowa Administrative Code 641 IAC 76.7 (135)

Overview

The purpose of applying for Medicaid and Hawki health care coverage is to get access for uninsured children and adolescents in Iowa to receive quality, affordable health care coverage either through Medicaid (eligible birth to 21) or Hawki (eligible birth up to age 19). When applying for either Hawki or Medicaid health care coverage, Contractors are assisting clients in obtaining health care coverage through managed care organizations (MCOs) who are contracted with the Iowa Department of Health and Human Services to provide benefits to clients. Free or low-cost oral health coverage is available through Medicaid, and Hawki or clients can apply for Hawki Dental Only if they have existing medical insurance and meet income requirements.

Policy

The Hawki Outreach Coordinator (HOC) or trained agency staff (that have completed a web-based training module and are certified by Iowa HSS) can assist families in applying for Medicaid or Hawki by gathering the necessary information for the application in the MPEP (Medicaid Presumptive Eligibility Portal). Once a presumptive eligibility determination is completed in the IME MPEP system, the client will be provided a Notice of Action (NOA) declaring approval or denial for presumptive eligibility benefits. The client can choose for the presumptive eligibility application to be sent to IME for continuing eligibility determination of ongoing Medicaid or Hawki benefits. Medicaid or Hawki eligibility determination must be completed at least once annually. If the individual and/or family's circumstances change in a manner that affects third-party coverage or Title XIX or Title XXI eligibility, eligibility determination shall be completed at that time.

Procedure

Applying directly for Medicaid or Hawki: There are two ways Contractors can assist clients in applying for Medicaid or Hawki. Contractors should discuss with the family and select the application process that best fits the needs of the family. The options include:

1. Self-Service Portal (online): Contractors use the Self Service Portal Home Page to directly input client data to see if clients are eligible for health care coverage.

Paper Application: The Contractor can also download the paper Application for Health Coverage and Help Paying Costs and Addendum to Application for Presumptive Eligibility for the client to complete. Once completed, the client can mail it directly to

Number: 707-CAH
Title: Applying for Health Coverage—Hawki and Medicaid
Effective Date: 10/01/2016
Revision Date: 04/18/2025
Date of Last Review: 04/18/2025
Authority: Iowa Administrative Code 641 IAC 76.7 (135)

HHS or bring it back to the Contractor to be mailed to Iowa HHS. It is recommended that Contractors use the Self-Service Portal vs paper application for efficiency and to expedite HHS response to the application.

Assessing Income: Income is assessed on all children and adolescents based on Federal Poverty Guidelines (published annually by the U.S. Department of Health and Human Services (DHHS)), family income, and household size. It is *not* the role of the Hawki Outreach Coordinator or other staff to verify income for a household; the individual or family self-declares income information.

Eligibility Criteria for Medicaid:

1. Children and adolescents ages birth to 21 years; adults 19-64 of age
2. Resident of Iowa and a citizen of the U.S or qualified alien; and
3. Household gross income up to 167% of the Federal Poverty Level.

Eligibility Criteria for Hawki: Some households may be required to pay a monthly premium based on family income. No family pays more than $40 a month, and some pay nothing.

1. Children and adolescents aged birth to 19 years;
2. Resident of Iowa and a citizen of the U.S or qualified alien;
3. Not a dependent of a State of Iowa employee;
4. Have no other health insurance (including Medicaid); and
5. Household gross income up to 302% of the Federal Poverty Level.

Resources

Application for Health Coverage and Help Paying Costs
Addendum to Application for Presumptive Eligibility
Healthy and Well Kids in Iowa (Hawki)
Medicaid Programs
Iowa HHS Self Service Portal
Iowa Administrative Code 641 IAC 76.7 (135)

IOWA Health and Human Services

Number: 708
Title: Medical and Dental Transportation
Billing Codes: Non-emergency bus A0110; Non-emergency taxi A0100; Non-emergency wheelchair van A0130; Non-emergency by volunteer A0090; Non-emergency mini-bus/transportation system A0120; Parking fees, tolls A0170
Effective Date: 10/01/2022
Revision Date: 04/21/2025
Date of Last Review: 04/21/2025
Authority: Screening Centers Provider Manual

Overview

Medicaid non-emergency medical transportation (NEMT) is an important benefit for clients who need to get to and from medical/dental services but have no means of transportation, this can include:

1. Not having a valid driver's license;
2. Not having a working vehicle available in the household;
3. Being unable to travel or wait for services alone or
4. Having a physical, cognitive, mental, or developmental limitation.

Policy

To help ensure that Medicaid members have access to medical and dental care within the scope of the program, Contractors will arrange NEMT for Medicaid-eligible non-MCO enrolled clients and Title V eligible clients.

Procedure

NEMT for Medicaid-eligible non-MCO enrolled clients and Title V eligible Clients

1. Contractors are eligible for reimbursement of non-emergency medical and dental local transportation when they arrange or provide transportation using the service codes listed for eligible clients.
2. The transportation must be to a Medicaid-enrolled provider for a Medicaid-covered service on the day of the Medicaid-covered service to be eligible for reimbursement.
3. Transportation must be in compliance with state laws (i.e., using child car seats) and must be the most appropriate for the circumstances of the family.
4. Contractors must maintain documentation of transportation service.

Documentation

Complete in the MCAH data system:

1. First and last name of service provider & credentials.
2. The invoice for the cost of the transportation service must be accessible. This may be reported in the 'Comments' field or maintained on a transportation log.
3. If the Title V agency keeps a service log containing key information, the 'Comments' in the MCAH data system must include a reference to this record.

IOWA | Health and Human Services

Number: 708
Title: Medical and Dental Transportation
Billing Codes: Non-emergency bus A0110; Non-emergency taxi A0100; Non-emergency wheelchair van A0130; Non-emergency by volunteer A0090; Non-emergency mini-bus/transportation system A0120; Parking fees, tolls A0170
Effective Date: 10/01/2022
Revision Date: 04/21/2025
Date of Last Review: 04/21/2025
Authority: Screening Centers Provider Manual

Billing:

1. The following are billable codes for billing IME for Medicaid fee-for-service (non-MCO) clients. This includes clients on presumptive eligibility:
    a. Code A0110: Non-emergency bus (per round trip)
    b. Code A0100: Non-emergency taxi (per round trip)
    c. Code A0130: Non-emergency wheelchair van (per round trip)
    d. Code A0090: Non-emergency by volunteer (per mile)
    e. Code A0120: Non-emergency mini-bus or non-profit transportation system (per round trip)
    f. Code A0170: Parking fees, tolls
2. Local transportation billed should align with the agency's transportation plan.
3. Bill actual cost of transportation for the date the transportation was provided to the health-related appointment.
4. There is no payment for the transportation service if the client does not show up for the ride.

NEMT for Medicaid eligible MCO enrolled clients

NEMT for Medicaid-eligible MCO-enrolled clients is facilitated through a transportation broker contracted by Iowa HHS or the MCO for transportation services for clients.

1. MTM is the transportation broker for Medicaid fee-for-service (non-MCO) clients. They arrange and pay for transportation (both in-town and out-of-town) to Medicaid-covered services. For information about their policies and processes, visit their website or call them at 866-572-7662.
2. Each Medicaid MCO has their own transportation broker for serving MCO-enrolled clients:
    a. Wellpoint: Access2Care at 844-544-1389
    b. Iowa Total Care: Access2Care at 877-271-4819
    c. Molina: Access2Care at 866-849-2062
3. When a member needs transportation or reimbursement for transportation, the member must contact the broker 72 business hours in advance for approval and scheduling.

Resources

Iowa DHS Medicaid Screening Center Provider Manual
Iowa EPSDT Periodicity Schedule

Sources

CMS: Non-Emergency Medical Transportation (NEMT)

IOWA Health and Human Services

Number: 709
Title: Interpretation Services
Billing Codes: Sign language or oral interpretive services - T1013 or D9990; Telephonic oral interpretative services - T1013UC
Effective Date: 10/01/2016
Revision Date: 04/21/2025
Date of Last Review: 04/21/2025
Authority: Section 1557 of the Patient Protection and Affordable Care Act; 45 CFR § 92.101

Overview

More than 25 million Americans speak English “less than very well,” according to the U.S. Census Bureau (2014). This population is less able to access health care and is at higher risk of adverse outcomes such as drug complications and decreased patient satisfaction. Title VI of the Civil Rights Act mandates that interpreter services be provided for patients with Limited English Proficiency (LEP) who need this service despite the lack of reimbursement. Changes in 2016 to Section 1557 of the Affordable Care Act (ACA) significantly changed the requirements for medical interpretation. Contractors must assure they are in compliance with Section 1557 and the most current version of the regulations implementing this Act.

Policy

Contractors will ensure that persons with LEP have meaningful access and an equal opportunity to participate in services, activities, programs, and other benefits. Contractors shall also provide for communication of information contained in vital documents, including but not limited to waivers of rights, consent to treatment forms, financial and insurance benefit forms, etc.
All interpreters, translators, and other aids required by federal law shall be provided without cost to the person being served, and clients and their families will be informed of the availability of such assistance free of charge. Qualified interpreters (see below for definition) must be used for medical interpretation and may include staff interpreters, contracted interpreters, formal arrangements with local organizations providing interpretation or translation services, or video/telephone interpretation services. Minor children and adult family members are prohibited from serving as medical interpreters. The two exceptions to this rule allow (1) for minor children to interpret or facilitate conversation only in an emergency involving an imminent threat to safety or welfare and if a qualified interpreter is not available or (2) for an adult accompanying an individual with LEP to interpret or facilitate conversation only in an emergency involving an imminent threat to safety or welfare and if a qualified interpreter is not available; or if the individual with LEP specifically requests that the adult interpret or facilitate conversation, the adult agrees, and reliance on the adult is appropriate under the circumstances. (Source: Section 1557 of ACA).

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Procedure

Identifying persons with LEP and their language: Contractors will promptly identify the language and communication needs of all clients. If necessary, staff will use a language identification card (or "I speak cards," available on the Department of Justice Limited English Proficiency website) or posters to determine the language. In addition, when records of past interactions with clients or family members are kept, the language used to communicate with the client will be included as part of the record.

Obtaining a qualified interpreter: Contractors are responsible for maintaining an accurate and current list showing the name, language, phone number, and hours of availability of contracted interpreters or qualified staff interpreters (not just bilingual staff who have other duties). A "qualified interpreter" is defined as an interpreter who "via a remote interpreting service or an on-site appearance":

1. adheres to generally accepted interpreter ethics principles, including client confidentiality;
2. has demonstrated proficiency in speaking and understanding both spoken English and at least one other spoken language; and
3. is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary and phraseology.

Qualified bilingual/multilingual staff: Qualified bilingual/multilingual staff is defined as "a member of a provider's workforce who is designated to provide oral language assistance as part of the individual's current, assigned job responsibilities and who has **demonstrated**" [emphasis supplied] that he or she is proficient in speaking and understanding both spoken English and at least one other spoken language, including any necessary specialized vocabulary, terminology, and phraseology, and is able to effectively, accurately, and impartially communicate directly with individuals with limited English proficiency in their primary languages.

Sign language interpreters should be licensed pursuant to Iowa Administrative Code Chapter 154E.

Minors as interpreters: Minor children are banned from serving as medical interpreters. The only exception to this rule is "an emergency involving an imminent threat to the safety or welfare of an individual or the public where no qualified interpreter is immediately available." However, since most leading national telephone and video remote interpreting companies can make qualified interpreters available in hundreds of languages within seconds, this exception should be regarded as limited.

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Family/Friends as interpreters: Adult family members and friends are prohibited from acting as medical interpreters. However, there are two allowable exceptions to this general rule. First, adult family members and friends may be used as medical interpreters in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter is immediately available. Second, adult family members and friends may be used as medical interpreters where the LEP person "specifically requests that the accompanying adult interpret or facilitate communication and the accompanying adult agrees to provide such assistance." However, the rule makes plain that providers are not relieved of their legal duty to provide a qualified medical interpreter where an LEP patient elects to use an adult family member or friend since even then, "reliance on that adult [family member or friend must be] appropriate under the circumstances."

Providing written translations: Contractors will provide translation of written materials, if needed, as well as written notice of the availability of translation, free of charge, for clients. Written translators must:

1. Adhere to generally accepted translator ethics principles, including client confidentiality;
2. Have demonstrated proficiency in writing and understanding both written English and at least one other written non-English language; and
3. Be able to translate effectively, accurately, and impartially to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology.

Public/patient notice requirement: Contractors will inform clients of the availability of language assistance, free of charge, by providing written notice in language clients will understand. Contractors must provide a notice encompassing seven factors, including that the entity does not discriminate (on the basis of national origin, immigration, language and disability and other factors) and that it provides appropriate interpreters and auxiliary aids and services, free of charge, to ensure effective communication for individuals who are LEP or have a disability. These notices must include taglines in the top 15 languages spoken nationally. These notices must be included in "significant publications" and posted in "conspicuous physical locations where the entity interacts with the public." In particular, such notices must be accessible from the organization's website.

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

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

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

Documentation of the service: The billing provider must document in the client's record the:

1. Interpreter's name or company,
2. Date and time of the interpretation,
3. Service duration (time in and time out), and
4. Cost of providing the service.

Billing interpreter services: Follow these guidelines for billing interpreter services:

1. For medical services bill code T1013 – documenting verbal or sign language interpretation.
    a. For telephonic interpretive services use modifier "UC" to indicate that the payment should be made at a per-minute unit.
    b. The lack of the UC modifier will indicate that the charge is being made for the 15-minute face-to-face unit.
    c. Enter the number of minutes actually used for the provision of the service. The 15-minute unit should be rounded up if the service is provided for 8 minutes or more. Because the same code is being used but a conditional modifier may be necessary, any claim where the UC modifier is **not** used, and the units exceed 24 will be paid at 24 units.
2. For dental services bill code D9990 - documenting verbal or sign language interpretation services.
    a. Interpretation is only billable when provided in conjunction with a direct dental service. In addition, the service must be face-to-face (not telephonic) and is billable one time per day per member (no longer billed in 15-minute increments).
    b. For information on access to telephonic translation services, please refer to the contact information for each dental plan administrator:
        i. IME Provider Services Unit: 1-800-338-7909
        ii. Delta Dental of Iowa (DDIA) Provider Services: 1-800-472-1205

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iii. Managed Care of North America (MCNA) Provider Services 1-855-856-6262.

3. Billable interpretation services are provided by interpreters who provide **only** interpretation services. Agency staff with other roles cannot have split FTEs that include billable interpretation.
4. Interpreters are either employed or contracted by the Contractor billing the services.
5. Service providers who are also bilingual are not reimbursed for interpretation, only for their medical/dental services.
6. Interpretation services must facilitate access to Medicaid covered services. Providers may bill Medicaid only if the services are offered in conjunction with another Medicaid covered service.
7. Contractors may bill Iowa HHS for interpretation services during care coordination, Informing, and Presumptive Eligibility using MH and CAH MAF funds.
8. Medicaid does not reimburse for written translation of printed documents. Written translation of printed documents used during care coordination, informing, and presumptive eligibility may be billed to Iowa HHS using MAF funds.

Documentation

1. Document in the MCAH data system
2. Document in medical record. Include the service for which the interpretation was provided, the name of the interpreter or company, the duration of service, and the cost of service.
3. If the Title V agency keeps a service log containing the above information, the 'Comments' in MCAH data system and medical record must include a reference to this record.

Resources

Section 1557 of the Affordable Care Act (ACA)
45 CFR § 92.101
Title VI of the Civil Rights Act
Iowa Administrative Code Chapter 154E
Iowa HHS Medicaid Screening Center Provider Manual
Iowa EPSDT Periodicity Schedule
Limited English Proficiency (LEP) Resources for Effective Communication
Nondiscrimination and the ACA, Health Advocate, a publication of the National Health Law Program, September 2015 by Mara Youdelman, J.D.
DHHS press release announcing the release of the final ACA section 1557 rules.

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Sources

National Council on Interpreting in Health Care
American Family Physicians Journal: Appropriate Use of Medical Interpreters
Section 1557 of the Affordable Care Act (ACA)
45 CFR § 92.101
New 2016 ACA Rules Significantly Affect the Law of Language Access, CME Learning, D. Hunt, J.D., May 14, 2016.

IOWA | Health and Human Services

Number: 710
Title: CAH Well Child Exam Reminders
Effective Date: 10/01/2022
Revision Date: 04/21/2025
Date of Last Review: 04/21/2025
Authority: Iowa HHS Omnibus Agreement

Overview

Providing well-child exam reminders based on the EPSDT Care for Kids Periodicity Schedule is the responsibility of CAH program Contractors. A report that includes these populations comes from the MCAH data system at the first of the month. This identifies clients to be reminded of upcoming well-child exams.

Policy

Contractors shall remind eligible clients about upcoming or overdue well-child exams.

Procedure

1. Clients eligible for well-child exam reminders live in your CSA and are enrolled in Fee-For-Service Medicaid or live in your CSA and were enrolled in the CAH program in the last two (2) years per the MCAH data system.
2. A report that includes these populations comes from the MCAH data system and is available to the Contractor around the first of the month. This identifies clients to be reminded of upcoming well-child exams.
3. If the well child exam reminder is conducted by phone conversation with the client, texting to and from the client, or face-to-face, this may be categorized as care coordination if care coordination is provided (see Policy 703 Care Coordination).
4. If the well-child exam reminder is conducted by mailing a letter or postcard, sending a text message that is not responded to by the client, leaving a voicemail message, or by phone, text, or in person, but care coordination is not provided. This is entered into the MCAH data system as a ‘Task’ – ‘Send/Give Educational Materials’.

Documentation: See the MCAH data system User Manual for guidance on documenting this service

Billing

1. Contractors may use Medicaid Administrative Funds (MAF) to cover expenses related to the well-visit exam reminder for clients enrolled in Medicaid.
2. Contractors may use Title V funds to cover expenses related to the well-visit reminder for clients enrolled in Title V (see Policy 106 Child & Adolescent Health Program Eligibility & Voluntary Participation for Title V eligibility).

Resources

Iowa HHS Omnibus Agreement

Number: 800
Title: Provision of Gap-Filling Direct Care Services
Effective Date: 10/01/2022
Revision Date: 04/21/2025
Date of Last Review: 04/21/2025
Authority: RFP 58823005; Contract Special Conditions

Overview

Title V resources are intended to be utilized following the Title V Maternal Child Health pyramid, with the majority of resources allocated to public health services and systems, followed by enabling services to assist a child in establishing and accessing a medical home for well and sick care. See Policy 105 Admission to Child and Adolescent Health (CAH) Services. When these levels of the pyramid fail to assure needed preventive health care, Title V contractors may provide gap-filling direct health care services while continuing to invest primarily in lower pyramid levels to increase community capacity.

Policy

1. Contractors provide gap-filling direct health care services based on need and in compliance with the Title V pyramid and medical home model.
2. Parents are present for gap-filling direct care services except for services covered under statutory provisions, which expressly authorize minors to provide independent consent to receive medical care, treatment, and services.
3. All CAH program gap-filling direct care health services must be approved by the State Title V program prior to provision, regardless of funding source.
4. For services provided as part of the CAH program, Contractors may not claim exemption to direct care service provision requirements of the CAH program based on funding source or not billing the services. Direct services to children birth through 21 must be clearly funded and managed by a separate program with appropriate authority to administer the program and medical supervision to claim exemption to the CAH program requirements.

Procedure

Contractors shall:

1. Develop policies and procedures for the provision of each direct care service.
2. Obtain individual or standing orders for direct care clinical services.
3. Assure staff are appropriately trained and competent to provide the service.
4. Assure staff are appropriately credentialed and working within their scope of practice.
5. Follow all guidelines, policies, and procedures outlined in the Administrative Manual.
6. See Policy 304 Client Consent for Services for a listing of services minors may access independently.

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7. Ensure enabling services to establish and access a medical home are fully utilized prior to providing direct care services.
8. Gap-filling direct health care services are approved through the State Title V program through an approved work plan or direct care application on file with Iowa HHS.
   The following categories of need will be considered in the application process:

Statewide Need-Based Gap-Filling Services:

1. Contractors are authorized to provide the following services to any child by having an approved work plan on file with Iowa HHS and shall continue to provide the services as described in their work plan, following Iowa HHS guidelines, Medicaid guidelines, and state and federal laws.
   a. Blood lead testing of 12-47 month olds
      i. Evaluation and management with lead testing
   b. Immunizations
      i. Human Papillomavirus vaccine
   c. Oral health services
   d. Interpretation services
   e. Non-emergency medical transportation
2. Contractors may apply to provide the following services that have been identified as needs statewide when minimal enabling services have failed.
   a. Caregiver and client depression screening
      i. Behavioral counseling for alcohol misuse
      ii. Annual alcohol and/or substance abuse screening
   b. Caregiver and client intimate partner violence screening
   c. Caregiver and client SBIRT
   d. Emotional/behavioral assessment
   e. Mental health assessment and services
   f. Psychosocial counseling
   g. Health education and anticipatory guidance
   h. Nursing or social work home visit for provision of a statewide need-based gap-filling service

Health Equity Need-Based Gap-Filling Services:

1. Contractors may apply to provide the following services to populations with less access to healthcare services when minimal enabling services have failed:

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a. Developmental screen
b. Nursing or social work home visit for provision of a statewide or health equity need-based gap-filling service with populations with less access to healthcare services

Individual Need-Based Gap-Filling Services:

1. Contractors may apply to provide the following services to clients based on the client, parent, caregiver, or community provider expressing a specific concern or need for the client. E.g., During a psychosocial counseling session, the adolescent client states, “I have a few partners, but I’m on the pill, so I don’t worry about condoms.”; WIC refers an infant with PKU for intensive nutrition counseling.
    a. Preventive medicine counseling
    b. Nutrition counseling, nutrition status evaluation
    c. Nursing or social work home visit for provision of a need-based gap-filling service

Contractors Serving as a Medical Home:

Contractors serving as medical homes may provide the full array of screening center/EPSDT screening services. Contractors desiring to serve as a medical home under the CAH program must request permission from the State Title V program. See Policy 105 Admission to Child & Adolescent Health Services for the definition of a medical home. The contractor must provide justification to provide direct services and evidence of their capacity to serve as a comprehensive medical home. Adequate justification includes a lack of primary care providers to provide the service or barriers to accessing these services through primary care providers. This could include documentation of Medically Underserved Area (MUA), Medically Underserved Population (MUP), or Health Professional Shortage Area (HPSA) for the county; data that support the identification of medically underserved populations; and/or data that support a lack of medical practitioners willing to provide well-child exams for Medicaid or uninsured/underinsured children. Outreach and service provision in new ways to respond to the needs of populations with less access to healthcare resources may be considered by Iowa HHS as justification.

Contractors serving as a medical home as part of their CAH program shall provide comprehensive, well-child exams for all children enrolled in their program, including all the elements outlined in the EPSDT Periodicity Schedule. In addition, they must have

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the capacity to provide acute care and ongoing health and disease management. It is anticipated that very few contractors will meet this category of need for CAH services.

Provision of Direct Care Services Not Otherwise Outlined
Contractors noting a gap in direct care services in their community shall collaborate with community partners to increase capacity and infrastructure through the utilization of public health services and systems and enabling services to meet that need in the community.
Contractors unable to solve the community need through public health services and systems and enabling services may propose providing a direct care service to the State Title V program through an exception to the policy. This type of exception to policy shall include a detailed documentation of the scope of the problem, efforts to ameliorate the problem, target population, plan for service provision, and continued public health services and system and enabling service work that will be maintained to grow community capacity.

Contractors with multiple programs providing direct care
Contractors (and/or their subcontractors) that also provide direct care as part of another provider status, contract, or funding source, including but not limited to home health, LPHA/LPHS, MIECHV, ECI, MHDS, Head Start/Early Head Start, school/school-based health clinic, CLPPP, mental health/behavioral health or substance abuse grantee, etc. shall delineate in writing the activities and services provided as part of the CAH program and those provided as part of another program/contract/provider status/funding source. Resources and staff may be braided to meet the needs of the community provided that duties, funding, and services for each grant are clearly defined, program requirements of each program are met, and expenses are billed appropriately to each funding source. Target populations for each program, program eligibility, and program goals shall be outlined. All funding sources and programs shall be disclosed to Title V. Title V funds, and the CAH program and resources shall not supplant other funding sources.

Direct care services provided as part of the CAH program must comply with the policies, procedures, rules, and regulations found within this manual, regardless of the funding source. Contractors and their subcontractors may not claim exemption to CAH program requirements based upon the payment source for the services provided or exclude services as not being provided by their CAH program simply due to the funding source. Only when there is proper medical oversight, functional authority, policies, and

procedures, etc., that indicate the service falls under a separate program may the services be excluded from the CAH program and guidelines.

IOWA | Health and Human Services

Number: 801
Title: Adolescent and Caregiver Tobacco, Alcohol & Drug Use Assessment
Billing Code(s): Annual Alcohol Screening – H0049; Initial Alcohol Misuse Annual Screening – G0442; Caregiver Risk Assessment - 96161
Effective Date: 10/01/2022
Revision Date: 04/21/2025
Date of Last Review: 04/21/2025
Authority: Iowa HHS Medicaid Screening Center Provider Manual

Overview

The CRAFFT is the most well-studied adolescent substance use screening tool and has been shown to be valid for adolescents from diverse socioeconomic and racial/ethnic backgrounds. It is recommended by the American Academy of Pediatrics Bright Futures Guidelines for preventative care screenings and well-visits, the Center for Medicaid and Children's Health Insurance Plans (CHIP) Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program and the National Institute of Alcohol Abuse and Alcoholism (NIAAA) Youth Screening Guide.

Early age of first use of alcohol and drugs can increase the risk of developing a substance use disorder during later life, making prevention and early intervention a promising strategy for identifying substance misuse before more serious problems develop. Effective screening is meant to assess whether a longer conversation to assess the context of use, frequency, and other risks and consequences of alcohol and other drug use is warranted.

Screening, Brief Intervention and Referral to Treatment (SBIRT) is a comprehensive, integrated, public health approach for early identification and intervention with clients whose patterns of alcohol and/or drug use put their health at risk. This is for unhealthy alcohol and other substance use, which includes the full spectrum of unhealthy use from risky use and/or substance use disorder (abuse and dependence). SBIRT screening may include a brief intervention for those who screen positive, which includes the administration of the following:

1. Annual Alcohol Screen - Code H0049
    a. CRAFFT for adolescents under age 18 years
        i. Administration of the tool
        ii. Brief intervention
2. SBIRT for clients aged 18 to 21 years - Code G0442
    a. Two questions prescreen
    b. AUDIT – Alcohol Use Disorders Identification Test AND/OR DAST – Drug Abuse Screening Test
    c. Brief Intervention
3. Brief intervention must be provided by an RN or social worker (BSW or licensed).
4. Brief intervention is a required component of the service. It incorporates principles of motivational interviewing.

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5. For Code G0442, time in and time out are required for a minimum of 15 minutes of service.
6. For Codes H0049 or 96161, report the total time of the service (duration).
7. Codes G0442 and H0049 cannot both be billed for the same day for the same client.
8. Codes G0442 and H0049 cannot be billed in conjunction with Code 99408.

Policy

Risk assessment for tobacco use, including vaping (e-cigarettes), alcohol, and drug use, is required for all visits for youth 11 through 20 years of age. Contractors shall have an individual order from a primary care provider, or the client shall meet the criteria of the standing order signed by the medical director for the screening.

Required Credentials

RN or social worker (BSW or licensed).

Screening Tools

Use a structured interview designed to detect serious substance use in adolescents, such as the CRAFFT screener or SBIRT.

1. SBIRT = Screening, Brief Intervention, and Referral to Treatment. SBIRT includes:
    a. 2-question pre-screen
2. The CRAFFT includes:
    a. Administration of the tool
    b. Brief intervention
3. AUDIT - Alcohol Use Disorders Identification Test
    a. Administration of the test
    b. Brief intervention

Caution: Although the SBIRT tool indicates that less than three drinks a day for women is low risk, encourage women who think they might be pregnant or are pregnant not to drink any alcohol. There is no known safe amount of alcohol consumption for pregnant women.

Procedure

Recognize the importance and complexity of confidentiality issues. Providing a place where the adolescent can speak confidentially is associated with greater disclosure of risk behavior involvement. Consider using a paper survey or computerized version before the adolescent meets with the provider.

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Time alone with the provider during the visit is associated with greater disclosure of sensitive information.

1. During the intake process, assess alcohol and drug use.
2. If there is a positive response to either the alcohol or drug use question, proceed to having client complete full screenings as indicated below:
    a. AUDIT - screening for alcohol use for clients 18 years and older
    b. DAST - screening for illicit drug use for adult clients
    c. CRAFFT - screening for illicit drug use, alcohol use and if using CRAFFT+N, nicotine use.
3. After the client has completed the appropriate screening, score the tool.
4. Utilize motivational interviewing techniques obtained through the SBIRT training to talk with clients about the results of the screening.
5. If a client scores in any zone beyond low/no risk, or if any drug or alcohol use is detected during pregnancy, utilize motivational interviewing techniques to complete the brief intervention and referral to treatment if needed.
6. Throughout the process, provide patient education on the dangers of alcohol and drug use.
7. Prior to releasing any substance abuse, HIV, or mental health information for referrals, ensure the client has signed the appropriate Release of Information.
8. Provide a referral to alcohol or substance use treatment if needed. This is best completed through a warm handoff to support the client through the process.
9. Follow your agency's policy for Mandatory reporting in situations that require this per Iowa's mandatory reporting law.

Documentation

Complete in MCAH data system:

1. First and last name of service provider & credentials.
2. Add the appropriate survey to the service and complete the fields.
3. In the 'Comments' field, reference the client's chart for full detail/ description/ clinical record of the service provided as needed to complete the documentation. Capture:
    a. Name of the tool, including date/ version of tool
    b. Results/scoring
    c. Interpretation of results
    d. The nature and outcome of the brief intervention
    e. Client questions/ concerns
    f. Referral/follow-up

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4. In the client's record: Documentation must adhere to requirements in IAC 441-79.3(2).

Billing

Use Code 99408 for the child (15-30 minutes)
Use Code 99409 for the child (over 30 minutes)
For a billable service, the following must be provided and documented:

The CRAFFT with brief intervention OR
The AUDIT and/or DAST with brief intervention

If providing this service for a child's caregiver (over age 21), bill the service as a caregiver risk assessment – Code 96161 - under the child's Medicaid number.

Resources

Iowa HHS Medicaid Screening Center Provider Manual
Iowa EPSDT Periodicity Schedule

Sources

Bright Futures: Performing Preventive Services - Tobacco, Alcohol & Drug Use Assessment
Minnesota Teen and Child Check-up: Tobacco, Alcohol, and Drug Use Risk Assessment

IOWA | Health and Human Services

Number: 804
Title: Behavior Counseling for Alcohol Misuse
Effective Date: 10/01/2022
Revision Date: 04/22/2025
Date of Last Review: 04/22/2025
Authority: Iowa HHS Medicaid Screening Center Provider Manual

Description in Brief
This is face-to-face behavioral counseling for alcohol misuse.

Overview
Counseling interventions in the primary care setting can improve unhealthy alcohol consumption behaviors in clients engaging in risky or hazardous drinking. Behavioral counseling interventions for alcohol misuse vary in their specific components, administration, length, and number of interactions.

Policy
If indicated by the alcohol screening tool, provide a brief face-to-face behavioral counseling session for alcohol misuse. Contractors shall have an individual order by a primary care provider, or the client shall meet the criteria of the standing order signed by the medical director for the screening.

Required Credentials
RN or social worker (BSW or licensed).

Procedure
Accompanying the 'Screen and Intervene' approach is a framework used to promote reducing or quitting addictive behaviors. The five A's framework (ask, advise, assess, assist, and arrange) is adapted for alcohol use below.

Along with 'Screen and Intervene,' health care providers can use these steps to help promote the reduction of alcohol use or quitting for clients.

1. **Ask:** identify and document the risky alcohol use status of every client beginning at age 11 at least yearly. See the Adolescent Tobacco, Alcohol & Drug Use Assessment policy/procedure for more information on screening.
2. **Advise:** In a clear, strong, and personalized manner, advise every risky drinker to reduce alcohol use or quit.
3. **Assess:** For the current risky drinker, assess whether the client is willing to reduce alcohol use or quit at this time.
4. **Assist:** For the client willing to reduce alcohol use or quit, assist them in developing a personalized plan for how and when to do so, and provide or refer them for counseling or additional behavioral treatment. For clients unwilling to change their drinking at this time, provide interventions designed to increase readiness to change. For the client who recently reduced alcohol use or quit and for the client facing challenges to remaining alcohol-free, provide relapse prevention.

Number: 804
Title: Behavior Counseling for Alcohol Misuse
Effective Date: 10/01/2022
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5. **Arrange**: For the client willing to reduce alcohol use or quit, arrange for follow-up contacts beginning within the first week after the change date. For the client unwilling to reduce alcohol use or quit at this time, address risky drinking and willingness to reduce alcohol use or quit at their next clinic visit.

Some adolescents, such as those with alcohol/drug dependence and co-occurring mental disorders, will require more directive intervention, parental involvement, and referral to intensive treatment.

Become familiar with treatment resources in your community. Adolescent-specific treatment is uncommon in many communities but, if possible, refer adolescents to programs that are limited to adolescents or have staff specifically trained in counseling adolescents.

Documentation

1. Time in and time out are required.
2. Complete in MCAH data system:
    1. Service fields.
    2. First and last name of service provider & credentials.
    3. In the ‘Comments’ field, reference the client's chart for full detail/ description/ clinical record of the service provided.

Billing (IME/Medicaid MCO)
Use Code G0443 (15 minutes)

Resources
§§701-710, subchapter V, chapter 7, Title 42.
Iowa Administrative Code 641 IAC 76 (135)
Iowa Code § 135.11(17)

Sources
American Academy of Family Physicians: Addressing Alcohol Use Practice Manual
Bright Futures: Performing Preventive Services - Adolescent Alcohol and Substance Use and Abuse

IOWA Health and Human Services

Number: 805
Title: Blood Draws – Venipuncture and Capillary
Billing Codes: Collection of venous blood by venipuncture - 36415; Collection of capillary blood specimen - 36416
Effective Date: 10/01/2022
Revision Date: 04/22/2025
Date of Last Review: 04/22/2025
Authority: Iowa HHS Medicaid Screening Center Provider Manual

Description in Brief

Code 36415 Collection of venous blood by venipuncture;
Code 36416 Collection of capillary blood specimen

Overview

The choice of site and procedure (venous site, finger-prick – also referred to as "capillary sampling") will depend on the volume of blood needed for the procedure and the type of laboratory test to be done. The blood from a capillary specimen is similar to an arterial specimen in oxygen content and is suitable for only a limited number of tests because of its higher likelihood of contamination with skin flora and smaller total volume.

Policy

Appropriate blood draw type (i.e. venipuncture and finger-prick) will be utilized to obtain necessary samples. Contractors shall have an individual order from a primary care provider, or the client shall meet the criteria of the standing order signed by the medical director for the screening.

Required Credentials

Service is provided by a licensed healthcare provider (MD, DO, ARNP, PA, or RN), a CMA, or a phlebotomist. This is not a comprehensive list of providers; others may be trained in and have blood draws in their scope of practice or be delegated the task by a licensed health care provider.

Procedure

Capillary Draws: Children over 6 months of age and who weigh more than 22 lbs. should have a finger-prick versus a heel stick. Follow the procedure below to obtain a capillary blood sample:

1. **Selection of site and lancet:** In a finger-prick, the blade depth should not go beyond 2.4 mm, so a 2.2 mm lancet is the longest length typically used. The recommended depth for a finger-prick is:
    a. for a child over 6 months and below 8 years – 1.5 mm
    b. for a child over 8 years – 2.4 mm.
2. **Patient immobilization** is crucial to the safety of the pediatric undergoing phlebotomy and to the success of the procedure. A helper is essential for properly immobilizing the patient for venipuncture or finger-prick. First, immobilize the child by asking the helper to:
    a. sit with the child on the helper's lap;
    b. immobilize the child's lower extremities by positioning their legs around the child's in a cross-leg pattern;

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   c. extend an arm across the child's chest and secure the child's free arm by firmly tucking it under their own;
   d. grasp the child's elbow (i.e., the skin puncture arm) and hold it securely;
   e. use his or her other arm to firmly grasp the child's wrist, holding it palm down.
3. Warm the heel or finger with a warm compress for several minutes before sampling to help dilate the blood vessels.
4. Clean the area with alcohol.
5. Using a sterile lancet, puncture the finger on the ventral lateral surface near the tip (or the heel on the lateral aspect, avoiding the posterior area).
   a. Too much compression should be avoided because this may cause a deeper puncture than is needed to get good flow.
   b. DO NOT use a surgical blade to perform a skin puncture.
   c. DO NOT puncture the skin more than once with the same lancet or use a single puncture site more than once because this can lead to bacterial contamination and infection.
6. Wipe away the first drop of blood with a dry gauze, then collect blood with a capillary tube/container. Avoid “milking” the capillary stick site, as this increases tissue fluid in the sample and may falsely lower the result.
7. A graphic depiction of the procedure is on the next page:

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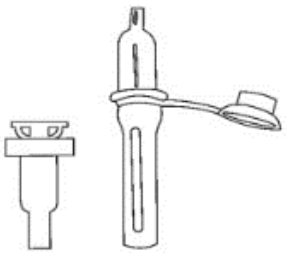
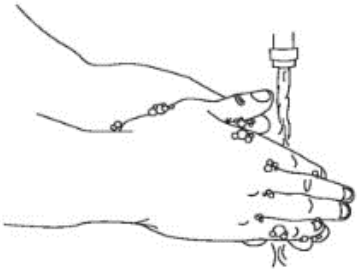
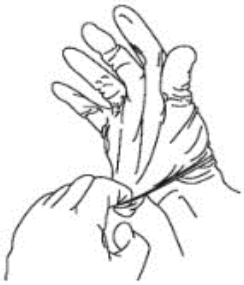


1. Lancet and collection tube.

2. Assemble equipment and supplies.

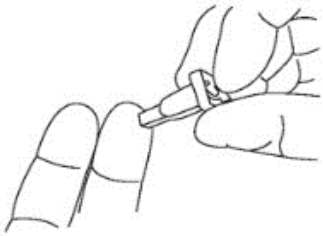


3. Perform hand hygiene (if using soap and water, dry hands with single-use towels).

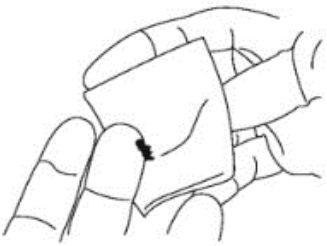


4. Put on well-fitting, non-sterile gloves.

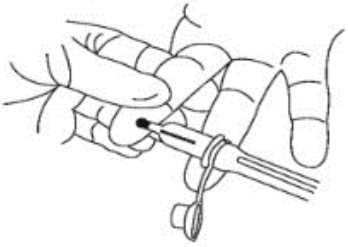
5. Select the site. Apply 70% isopropyl alcohol and allow to air dry.



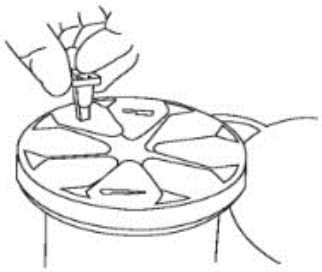
6. Puncture the skin.



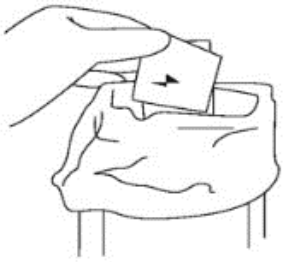
7. Wipe away the first drop of blood.



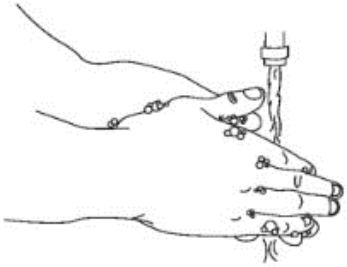
8. Avoid squeezing the finger too tightly.



9. Dispose of all sharps appropriately.



10. Dispose of waste materials appropriately.



11. Remove gloves and place in general waste. Perform hand hygiene (if using soap and water, dry hands with single-use towels).

IOWA | Health and Human Services

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Venipuncture

There are times when venous blood draws are appropriate, such as when obtaining a blood sample for a Tuberculosis IGRA test or confirming a blood lead level. The following is a procedure for pediatric venipuncture.

1. **Selection of needle gauge:**
    a. Use a winged steel needle, preferably 23 or 23 gauge, with an extension tube (a butterfly):
        i. Avoid gauges of 25 or more because these may be associated with an increased risk of hemolysis
        ii. use a butterfly with either a syringe or an evacuated tube with an adaptor; a butterfly can provide easier access and movement, but the movement of the attached syringe may make it difficult to draw blood.
    b. Use a syringe with a barrel volume of 1–5 ml, depending on collection needs; the vacuum produced by drawing using a larger syringe will often collapse the vein.
    c. When using an evacuated tube, choose one that collects a small volume (1 ml or 5 ml) and has a low vacuum; this helps to avoid collapse of the vein and may decrease hemolysis.
    d. Where possible, use safety equipment with needle covers or features that minimize blood exposure. Auto-disable (AD) syringes are designed for injection and are not appropriate for phlebotomy.
2. **Patient immobilization** is crucial to the safety of the pediatric undergoing phlebotomy and to the success of the procedure. A helper is essential for properly immobilizing the patient for venipuncture. Immobilize the child as described below.
    a. Designate one staff as the technician and another staff member or a helper to immobilize the child.
    b. Ask the two adults to stand on opposite sides of an examination table.
    c. Ask the immobilizer to:
        i. stretch an arm across the table and place the child on its back, with its head on top of the outstretched arm;
        ii. pull the child close, as if the person were cradling the child;
        iii. grasp the child's elbow in the outstretched hand;
        iv. use their other arm to reach across the child and grasp its wrist in a palm-up position (reaching across the child anchors the child's shoulder and thus prevents twisting or rocking movements; also, a firm grasp on the wrist effectively provides the phlebotomist with a “tourniquet”).

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3. Warm the arm with a warm compress for several minutes before sampling to help dilate the blood vessels.
4. Apply a tourniquet.
5. Clean the area with alcohol.
6. Puncture the skin 3–5 mm distal to (i.e., away from) the vein; this allows good access without pushing the vein away.
7. If the needle enters alongside the vein rather than into it, withdraw the needle slightly without removing it completely and angle it into the vessel.
8. Draw blood slowly and steadily.
9. Remove the tourniquet once the necessary volume of blood is withdrawn.
10. Place dry gauze over the venipuncture site, slowly withdraw the needle, and apply mild pressure to the wound.
11. Ask the helper to continue applying mild pressure.
12. A graphic depiction of the procedure is on the next page:

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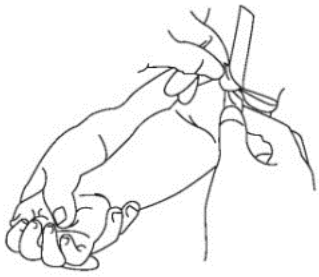
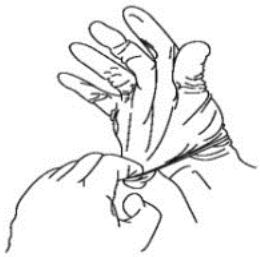
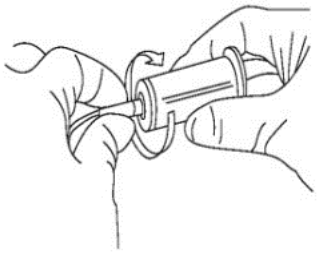
4. Immobilize the baby or child.

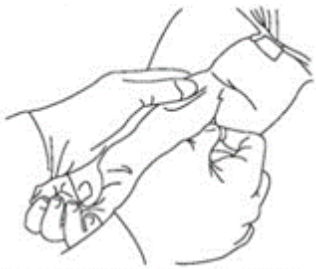


5. Put the tourniquet on the patient about two finger widths above the venepuncture site.





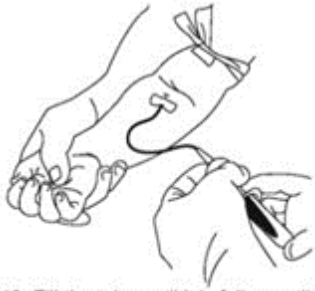
9. Disinfect the collection site and allow to dry.



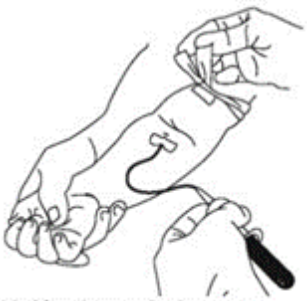
10. Use a thumb to draw the skin tight, about two finger widths below the venepuncture site.

11. Push the vacuum tube completely onto the needle.

12. Blood should begin to flow into the tube.



13. Fill the tube until it is full or until the vacuum is exhausted; if filling multiple tubes, carefully remove the full tube and replace with another tube, taking care not to move the needle in the vein.



14. After the required amount of blood has been collected, release the tourniquet.

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Documentation: Documentation must adhere to requirements in IAC 441-79.3(2).

1. Report the total time of the service (duration).
2. Complete in MCAH data system: first and last name of service provider & credentials

Billing

1. Use only one of the following:
   Code 36415 for venous draw.
   Code 36416 for capillary draw.
2. Note that these codes may deny as 'incidental services' if billed in conjunction with other direct care services
3. A blood lead draw and 99000 handling/conveyance cannot both be billed. Only one of the three codes can be billed.

Resources

§§701-710, subchapter V, chapter 7, Title 42.
Iowa Administrative Code 641 IAC 76 (135)
Iowa Code § 135.11(17)

Sources

WHO Guidelines on Drawing Blood: Best Practices in Phlebotomy
WHO Guidelines on Drawing Blood: Capillary Sampling

Number: 806
Title: Blood Lead Evaluation and Management
Effective Date: 10/01/2022
Revision Date: 04/22/2025
Date of Last Review: 04/22/2025
Authority: Iowa HHS Medicaid Screening Center Provider Manual

Description in Brief

Code 99211- Office visit for the evaluation and management of an established patient. According to CPT, an established patient is one who has received professional services from the health care provider or another health care provider of the same specialty in the same practice within the past three years. Code 99211 cannot be reported for services provided to patients who are new to the provider. E&M is a clinical encounter direct care service. 99211 is a face-to-face encounter, and telephone calls do not meet the requirements for 99211.

Overview

In the Child Health Screening Center, Evaluation and Management (E & M) is for a face-to-face encounter with a client to conduct all of the following:

1. Health history related to blood lead testing, such as via the Blood Lead Screening Tool,
2. Clinical decision-making based on the results of the blood lead screening tool, such as type of test (capillary or venous), or if the blood lead test is warranted based on the blood lead screening tool or if the client should be assisted in accessing blood lead testing through their medical home, or another physical assessment or clinical decision making related to the blood lead test.
3. Education and/or anticipatory guidance specific to the child about lead poisoning based on their risks and/or blood test results and follow-up instructions when doing a blood lead draw.

For E&M, if a clinical need cannot be substantiated, 99211 should not be used. For example, 99211 would not be appropriate for mass blood lead testing or situations where the client's health history is not assessed via the Blood Lead Screening Tool.

Policy

Contractors will provide assessment, clinical decision-making, education, and anticipatory guidance to clients and families regarding blood lead testing and results.

Required Credentials

Service is provided by one of the following licensed health care providers: MD, DO, ARNP, PA, or RN.

Number: 806
Title: Blood Lead Evaluation and Management
Effective Date: 10/01/2022
Revision Date: 04/22/2025
Date of Last Review: 04/22/2025
Authority: Iowa HHS Medicaid Screening Center Provider Manual

Procedure

Code 99211 describes a face-to-face encounter with a patient consisting of elements of both evaluations (requiring documentation of a clinically relevant and necessary exchange of information) and management (providing patient care that influences, for example, medical decision-making or patient education).

1. The evaluation shall include an assessment of the client's blood lead testing history using medical records, a search of the Maternal Health (MH) and Child and Adolescent Health (CAH) data system, or, as a last resort, parent recall.
2. Contractors shall use the Blood Lead Screening Tool to determine the child's risk factors to guide clinical decisions about testing.
3. Education shall include nutritional ways to mitigate lead exposure (i.e., foods with calcium, iron, and vitamin C) and environmental ways to mitigate exposure (i.e., using wet paper towels to clean up lead dust, clean windows, floors, play areas; wash hands often and before eating/sleeping; and place contact paper or duct tape over peeling paint). CDC Brochure: 5 things you can do to help lower your child's lead level.
4. Anticipatory guidance shall include the next testing date, how results will be provided, developmental milestones and tasks that could increase lead poisoning, etc.

Documentation: Documentation must adhere to requirements in Iowa Administrative Code [441] Chapter 79.3(2).

In the MH and CAH data system, complete the following:

1. First and last name of service provider & credentials
2. In the 'Narrative' field, reference the client's chart for full detail/ description/ clinical record of the service provided. Specify what the E & M is related to (e.g., lead test)
3. Report the total time of the service (duration)

Billing:

1. Use Code 99211
2. This encounter code can only be used once per day per client.
3. E & M is a clinical encounter direct care service. This code **cannot** be used for:
    a. Providing care coordination services
    b. E & M on the same day as a full well-child screen

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   c. Explaining the purpose of a developmental test, interpretation of the test, anticipatory guidance, and needed referral for evaluation when conducting a developmental or social/emotional screening. (These activities are already included in the G0451 and 96127 codes.)
4. Do not bill E & M related to immunization administration. Instead use 'immunization administration with counseling' (Code 9046/90461).
5. Service delivered other than face-to-face, such as via telephone, text or letter

Resources

Iowa Administrative Code [441] Chapter 79.3(2)
CDC Brochure: 5 things you can do to help lower your child's lead level
Iowa HHS Medicaid Screening Center Provider Manual

Number: 807
Title: Blood Lead Screening, Analysis, and Handling/Conveyance
Billing Codes: Blood Lead Analysis, CLIA Waived Blood Lead Analysis - 83655, 83655QW; Handling or conveyance of specimen for transfer to a laboratory - 99000
Effective Date: 10/01/2022
Revision Date: 04/23/2025
Date of Last Review: 04/23/2025
Authority: Screening Centers Provider Manual

Description in Brief

Collection of blood sample ***and*** lab analysis of blood lead level using the Lead Care II.

1. Code 83655, 83655QW Blood Lead Analysis, CLIA Waived Blood Lead Analysis
2. Code 99000 Handling or conveyance of specimen for transfer to a laboratory

Overview

Protecting children from exposure to lead is important to lifelong good health. No safe blood lead level in children has been identified. Even low levels of lead in blood have been shown to affect IQ, ability to pay attention and academic achievement.

Lead exposure occurs when a child comes in contact with lead by touching, swallowing, or breathing in lead or lead dust. Lead quickly enters the blood and can harm a child's health. Even after removing lead hazards from a child's environment, blood levels do not drop right away, so prevention is key.

The health effects of exposure are more harmful to children less than six years of age because their bodies are still developing and growing rapidly. Young children also tend to put their hands or other objects, which may be contaminated with lead dust, into their mouths, so they are more likely to be exposed to lead than older children. Lead is quickly absorbed into the bloodstream.

Once a child ingests lead, their blood lead level rises. Once a child's exposure to lead stops, the amount of lead in the blood decreases gradually. The child's body releases some of the lead through urine, sweat, and feces. Lead is also stored in bones. It can take decades for the amount of lead stored in the bones to decrease. Many things affect how a child's body handles exposure to lead, including:

1. Child's age
2. Nutritional status
3. Source of lead exposure
4. Length of time the child was exposed
5. Presence of other underlying health conditions

Although lead in blood represents only a portion of the total amount of lead present in the body, a blood lead test is the best available way to assess a person's exposure to lead.

Number: 807
Title: Blood Lead Screening, Analysis, and Handling/Conveyance
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Mandatory Blood Lead Testing in Iowa

In Iowa, legislation requires all children entering kindergarten to have at least one blood lead level test, and the results are required to be reported to the Iowa HHS Bureau of Environmental Health Services.

Iowa House File 158 was passed in 2007, amended in 2008, and became effective July 1, 2008. This is known as “mandatory blood lead testing.” The goal of this legislation is to protect Iowa children under the age of 6 years from lead damage in their developing brains and nervous systems and to reduce the number of children with developmental and learning problems related to lead exposure.
Information regarding mandatory reporting of lab tests can be found on the Iowa HHS Childhood Lead Poisoning Prevention Program webpage.

Policy

1. Every child 12 through 35 months enrolled in the CAH program shall be tested for blood lead poisoning if the child has not been tested in the previous 12 months.
2. Contractors shall utilize enabling services to assist the family in obtaining blood lead testing through their medical home. If enabling services fail, Contractors shall administer blood lead level testing. Appropriate follow-up based on the result, including confirmation, if needed, shall be completed.
3. The contractor must report lead test results to the Agency in accordance with Agency requirements.
4. Contractors shall have an individual order by a primary care provider, or the client shall meet the criteria of the standing order signed by the medical director for the screening.

Required Credentials

Blood lead screening and testing is provided by a licensed health care provider, MD, DO, ARNP, PA, RN, LPN, and CMA. This is not a comprehensive list of providers, others may be trained in and have blood draws in their scope of practice or be delegated the task by a licensed health care provider.

Number: 807
Title: Blood Lead Screening, Analysis, and Handling/Conveyance
Billing Codes: Blood Lead Analysis, CLIA Waived Blood Lead Analysis - 83655, 83655QW; Handling or conveyance of specimen for transfer to a laboratory - 99000
Effective Date: 10/01/2022
Revision Date: 04/23/2025
Date of Last Review: 04/23/2025
Authority: Screening Centers Provider Manual

Procedure

1. Assess if a child ages 12-35 months has had a blood lead test in the past year. If not, utilize enabling services to assist the family in accessing blood lead testing through their medical home. If enabling services fail, administer blood lead level testing.
2. Do not assume that all children are at low risk, administer the Iowa Lead Poisoning Risk Questionnaire and Blood Lead Testing Gudelines to all children to determine next steps.
3. Once the Iowa HHS Screening tool has been administered, provide blood lead level testing as indicated.
4. During a blood lead test, a small amount of blood is taken from the finger or arm and tested for lead. Two types of blood tests may be used. Do not use erythrocyte protoporphyrin (EP) as a screening tool for lead poisoning because it is not sensitive enough to identify children with blood lead levels below 25 µg/dL.
    a. **A finger-prick or capillary test** is usually the first step to determine if a child has elevated blood lead levels. While finger-prick tests can provide fast results, they also can produce higher results if lead on the skin is captured in the sample. For this reason, if a blood lead test result equal to or greater than 10 ug/dl is obtained by capillary specimen (finger prick), it must be confirmed using a venous blood sample.
    b. **A venous blood draw** takes blood from the child's vein. This type of test can take a few days to receive results and is often used to confirm elevated blood lead levels seen in the first capillary test.

Action Levels:

1. For instructions on what to do at each blood level, see the Childhood Lead Poisoning Prevention Program webpage.
2. Venous blood lead levels of 20 µg/dL or higher result in automatic eligibility for Early ACCESS services for children ages 0-3.
3. The Lead Care II is the only CLIA-waived testing device approved by Iowa HHS. **Child Health agencies using the Lead Care II must report the results of all blood lead testing electronically to the Bureau of Lead Poisoning Prevention.**
4. If a blood lead test result of 15 µg/dL or higher is obtained from a Lead Care II, a venous sample must be drawn and sent to a reference lab for a confirmatory test.

Number: 807
Title: Blood Lead Screening, Analysis, and Handling/Conveyance
Billing Codes: Blood Lead Analysis, CLIA Waived Blood Lead Analysis - 83655, 83655QW; Handling or conveyance of specimen for transfer to a laboratory - 99000
Effective Date: 10/01/2022
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Authority: Screening Centers Provider Manual

Documentation: Documentation must adhere to requirements in Iowa Administrative Code [441] Chapter 79.3(2).
Report the total time of the service (duration).

1. Complete in the MCAH data system:
   a. Service fields
   b. First and last name of service provider & credentials
   c. If completing a Childhood Lead Poisoning Questionnaire, add this 'Survey' and complete fields

Billing

1. A blood lead draw and handling/conveyance cannot both be billed. Only one of the three codes can be billed.
2. When using Code 83655, include the QW modifier to indicate a CLIA waived test.
3. Do not bill codes 36415, 36416, or 99000 when using 'blood lead analysis' (Code 83655). The scope of Code 83655 includes the lead draw.

Resources

Iowa Lead Poisoning Risk Questionnaire and Blood Lead Testing Gudelines
Iowa HHS Childhood Lead Poisoning Prevention Program
Iowa Administrative Code [441] Chapter 79.3(2).
What to do at Each Level - Childhood Lead Poisoning Prevention Program webpage.

Sources

Bureau of Environmental Health Services
Screening Center Provider Manual
Iowa EPSDT Periodicity Schedule

IOWA Health and Human Services

Number: 808
Title: Blood Pressure
Effective Date: 10/01/2022
Revision Date: 04/23/2025
Date of Last Review: 04/23/2025
Authority: Screening Center Provider Manual

Overview

Non-invasive blood pressure (BP) measurement is an essential component of pediatric physical assessment. Correct technique for measuring BP is necessary to ensure accuracy of readings, while ensuring minimal discomfort to the client.

Policy

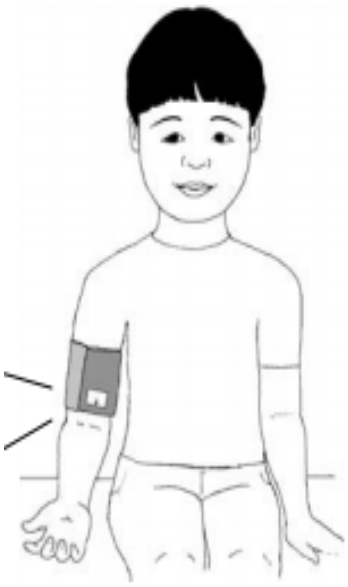
The blood pressure of children should be assessed as part of the well visit starting at 3 years of age. Children less than 3 years of age should have their BP checked under special conditions, including a history of prematurity, congenital heart disease malignancy, and other systemic illnesses. Contractors shall have an individual order from a primary care provider, or the client shall meet the criteria of the standing order signed by the medical director for the screening.

Required Credentials

CMA, LPN, RN, PA, ARNP, DO, or MD

Procedure

1. Gather supplies
2. Squeeze all the air out of the cuff.
3. A screening blood pressure is ideally obtained on the right arm.
4. Cuff size is important. A proper-sized cuff covers at least two-thirds of the upper arm.
5. Line up the artery marking (arrow) on the cuff with the front of the elbow. Wrap the cuff around the upper arm, directly on the skin (not over the sleeve). The bottom edge should be about one inch above the elbow crease, and allow enough room under the cuff so that two of your fingers can fit.
6. If using a manual blood pressure cuff, place the flat part of the stethoscope over the elbow crease below the artery markings on the cuff. Hold gently in place.
7. If using a digital or automatic blood pressure cuff, turn on the machine according to directions. The cuff will automatically inflate and then deflate as it reads the blood pressure. Skip to #13.



8. With your other hand, tighten the screw on the bulb to close the valve. Squeeze the bulb quickly until the needle on the gauge is 20 to 30 points above where you expect the higher blood pressure number to be.
9. Loosen the screw to release the pressure in the cuff at a slow, even rate (about 2 to 3 mm per second).

Number: 808
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10. Watch the gauge as you release the air. As the needle falls, listen and note:
    - **Systolic pressure** (top number) - the point on the gauge where the first clear tapping sounds are heard.
    - **Diastolic pressure** (bottom number) - the point at which the sounds stop.
11. When all sounds stop, deflate the cuff rapidly and completely.
12. Chart the blood pressure reading.
13. If the reading is outside of the normal ranges in the vital signs summary table below, contact the healthcare provider and report the findings. Click here for a full table of Blood Pressure Levels for Boys and Girls by Age and Height Percentage. Note that the client's normal range and clinical condition should always be considered.

IOWA | Health and Human Services

Number: 808
Title: Blood Pressure
Effective Date: 10/01/2022
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Group (weight in kg)	Age (years)	Height (cm)	Blood pressure (mmHg) (50th-90th percentile)			
			Boys		Girls	
			Systolic	Diastolic	Systolic	Diastolic
Infant	1-12 months		72 -104	37-56	72-104	37-56
Toddler	1	**77-87**	86-101	41-54	85-102	42-58
(10-14 Kg)	2	**86-98**	89-104	44-58	89-106	48-62
Preschooler	3	**92-105**	90-105	47-61	90-107	50-65
	4	**98-113**	92-107	50-64	92-108	53-67
(14-18Kg)	5	**104-120**	94-110	53-67	93-110	55-70
School-age	6	**111-127**	90-109	59-73	91-108	59-73
	7	**116-134**	91-111	60-74	92-110	60-74
(20-42 Kg)	8	**120-140**	93-113	60-75	94-112	60-75
	9	**125-145**	94-115	61-75	95-114	61-76
	10	**130-151**	96-117	62-76	97-116	62-77
	11	**135-157**	98-119	62-77	99-118	63-78
	12	**141-164**	100-121	63-78	100-120	64-78
Adolescent	>13	**147-172**	102-124	64-80	102-121	64-79
(50 Kg)						

* For Newborn infants, BP values vary considerably during the first few weeks of life and the definition of HTN in preterm and term neonates also varies.

Sources
https://medicine.uiowa.edu/iowaprotocols/pediatric-vital-signs-normal-ranges
Screening Center Provider Manual
Iowa EPSDT Periodicity Schedule

IOWA Health and Human Services

Number: 809
Title: Caregiver Depression Screening
Billing Code: Depression Screening - 96161
Effective Date: 10/01/2022
Revision Date: 04/23/2025
Date of Last Review: 04/23/2025
Authority: Screening Center Provider Manual

Description in Brief

Depression screening using the Patient Health Questionnaire-9 (PHQ-9) or The Edinburgh Postnatal Depression Scale (EPDS).

Overview

Due to the long-term consequences of perinatal depression on children, screening for depression is an important part of preventive pediatric care (Berkule et al., 2014). Children of depressed parents are more likely to perform lower on cognitive, emotional, and behavioral assessments (Berkule et al., 2014). They more commonly have difficulties in social and educational situations and have an increased risk of mental health issues later in life (Ferro & Boyle, 2015). An estimated 10-35 percent of mothers experience depression during the postpartum period (Berkule, et al., 2014).

Policy

Universal caregiver depression screening will be provided at the following infant well-child visits: 0-1 month, 2-month, 4-month, and 6-month visits. Screening may be offered more frequently or at other infant visits as needed up through 12 months of age and annually thereafter.

Procedure

1. Record the name of the completed screening instrument and that you performed the screening as a “risk assessment” in the child’s medical record.
2. Use one of two approved screening tools:
    a. https://med.stanford.edu/content/dam/sm/neonatology/documents/edinburghscale.pdf Edinburgh Postnatal Depression Scale (EPDS) (www.priority.ucsf.edu) The Edinburgh Postnatal Depression Scale (EPDS) may be used as the tool for caregiver depression screening for up to one year following the birth of the child.
    b. https://med.stanford.edu/fastlab/research/imapp/msrs/_jcr_content/main/accordion/accordion_content3/download_256324296/file.res/PHQ9%20id%20date%2008.03.pdf (PHQ-9) (www.phqscreeners.com)

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3. The PHQ-2 does not have adequate validity studies to show that it is accurate or reliable for screening postpartum depression, particularly for caregivers who have lower income levels.
4. Medicaid will reimburse for using the Edinburgh Postnatal Depression Scale or the Patient Health Questionnaire 9 (PHQ-9). The PHQ-2 is not a separately reimbursable service.
5. Assure that referral resources are available as needed.
6. Assure that staff providing the service have been appropriately trained.

Documentation

1. For code 96161, report the total time of the service (duration).
2. Complete in MCAH data system
    a. Service fields
    b. First and last name of service provider & credentials
    c. Add a “Survey” with scores when providing a PHQ-9 or EPDS
    d. In the ‘Comments’ field, reference the client's chart for full detail/ description/ clinical record of the service provided as needed to complete the documentation. Capture:
        i. Who the depression screening is for – caregiver
        ii. Name of the screening tool, including date/version of the tool
        iii. Results/scoring
        iv. Interpretation of results
        v. Client questions/concerns
        vi. Referral/follow-up

Billing (IME/Medicaid MCO)

1. Use Code 96161 for the caregiver of a child health client. Bill under the child’s Medicaid number. Code 96161 is an encounter code and is not billed based on time.

Resources

Iowa HHS Medicaid Screening Center Provider Manual
Iowa EPSDT Periodicity Schedule

IOWA | Health and Human Services

Number: 809
Title: Caregiver Depression Screening
Billing Code: Depression Screening - 96161
Effective Date: 10/01/2022
Revision Date: 04/23/2025
Date of Last Review: 04/23/2025
Authority: Screening Center Provider Manual

Sources

Minnesota Child and Teen Checkups: Maternal Depression Screening.

Berkule, S., Brockmeyer Cates, C., Dreyer, B., Huberman, H., Arevalo, J., Burtchen, N., & Mendelsohn, A. (2014). Reducing maternal depressive symptoms through promotion of parenting in pediatric primary care. Clinical Pediatrics, 460-469.

Ferro, M., & Boyle, M. (2015). The impact of chronic physical illness, maternal depressive symptoms, family function, and self-esteem on symptoms of anxiety and depression of children. Journal of Abnormal Child Psychology, 177-197.

Hodgkinson, S., Beers, L., Southammakosane, C., & Lewin, A. (2014). Addressing the mental health needs of pregnant and parenting adolescents. Pediatrics, 133(1).

Olson, A. L., Dietrich, A. J., Prazar, G., & Hurley, J. (2006). Brief maternal depression screening at well-child visits. Pediatrics, 207-216.

Siu, A. a. (2016). Screening for Depression in Adults: US Preventive Services Task Force Recommendation Statement. JAMA, 381-387.

IOWA Health and Human Services

Number: 810
Title: Preventative Medicine Counseling for Chlamydia or Gonorrhea
Billing Codes: 99401 (15-minute unit) and 99402 (30-minute unit)
Effective Date: 10/01/2022
Revision Date: 04/25/2025
Date of Last Review: 04/25/2025
Authority: Screening Center Provider Manual

Description in Brief

Preventive medicine counseling: Counseling, risk factor reduction, and behavioral change intervention services related to testing for chlamydia and/or gonorrhea.

Overview

All sexually active adolescents are at risk for STIs and should receive behavioral counseling interventions. Other types of CAH visits that may warrant preventive medicine counseling include a client presenting for pregnancy testing or is currently pregnant, discloses they are in an unsafe relationship or have a coercive partner, discloses drug or alcohol use, or discloses depression or other mental health concerns.

Policy

At the initial visit and annually thereafter, adolescents should be asked about sexual activity (either current sexual activity or intention to become sexually active) and provided counseling based on risk. Contractors shall have an individual order by a primary care provider, or the client shall meet the criteria of the standing order signed by the medical director for the counseling.

Procedure

1. If sexually active or considering becoming sexually active, the client must be counseled about STIs and be given the information needed to reduce their risk of acquiring or transmitting STIs and HIV.
2. Clients should be made aware that whenever they have unprotected sexual intercourse (no barrier method is used), they are exposed to any STIs their partner has and also to any diseases that the partner's former or current partners have.
3. Clients need to be made aware of common STIs, their symptoms and complications, and the importance of diagnosis and treatment.
4. Clients will be informed about where to go for testing, treatment, and follow-up if services are not provided on-site.
5. Counseling and Education should address the following areas:
    a. Individual dialogue about personal risks and risk reduction
    b. At-risk behavior, risk reduction and further evaluation
    c. Abstinence is the most effective method to avoid STIs and HIV
    d. Barrier methods can significantly reduce, but not eliminate, STIs
    e. Oral sex can also result in STIs
    f. HIV education, risks, and referral

IOWA | Health and Human Services

Number: 810
Title: Preventative Medicine Counseling for Chlamydia or Gonorrhea
Billing Codes: 99401 (15-minute unit) and 99402 (30-minute unit)
Effective Date: 10/01/2022
Revision Date: 04/25/2025
Date of Last Review: 04/25/2025
Authority: Screening Center Provider Manual

Required Credentials

Must be provided by an RN

Documentation

In the MCAH data system: Documentation must adhere to requirements in Iowa Administrative Code [441] Chapter 79.3(2)

1. Document under 'Type – Service – Health Services'.
2. Under 'Type of Service', select the correct service code and description.
3. Time in and time out are required for this service.
4. Complete in the MCAH data system:
    a. Service fields.
    b. First and last name of service provider & credentials.
    c. In the 'Comments' field, reference the client's chart for full detail/ description/ clinical record of the service provided. Specify what the preventive medicine counseling is related to (i.e. chlamydia and/or gonorrhea screening).

Resources

Screening Center Provider Manual
Iowa Administrative Code [441] Chapter 79.3(2)

IOWA | Health and Human Services

Number: 811
Title: CLIA Compliance
Effective Date: 10/01/2022
Revision Date: 04/25/2025
Date of Last Review: 04/25/2025
Authority: 42 CFR 493.3

Overview

The Clinical Laboratory Improvement Amendments of 1988 (CLIA) regulations include federal standards applicable to all U.S. facilities or sites that test human specimens for health assessment or to diagnose, prevent, or treat disease. Exceptions to the CLIA regulations exist for certain testing. For more information, please refer to 42 CFR 493.3**.**

Policy

Any contracting agency conducting laboratory testing in the provision of services through a contract with Iowa HHS must be certified and in compliance with Clinical Laboratory Improvement Amendments (CLIA) as required by the Centers for Medicare and Medicaid Services (CMS).

Procedure

Contractors must assure that any laboratory they submit samples to be CLIA accredited. However, there are CLIA waivers available for a variety of tests frequently provided in the clinic setting. Visit the CMS CLIA website for a full list of eligible tests.

For additional information and application for CLIA certification or waiver, see the CLIA website at the State Hygienic Laboratory website or call 319-335-4500.

Resources

Iowa HHS Medicaid Screening Center Provider Manual

Sources

CMS: Tests granted waived status under CLIA
CMS.Gov: Clinical Laboratory Improvement Amendments (CLIA)
State Hygienic Laboratory CLIA Website

IOWA | Health and Human Services

Number: 812
Title: Clinical Supervision Requirements
Effective Date: 10/01/2022
Revision Date: 04/25/2025
Date of Last Review: 04/25/2025
Authority: Iowa Code Chapter 152; Iowa Administrative Code [645] 327; Iowa Code Chapter 148

Overview

Health care workers (i.e., PA, RN, LPN, and CMA) who provide direct patient care are required to do so under the direction of a physician (MD or DO) or ARNP in accordance with Iowa law. Additionally, physicians and ARNPs supervising Maternal Health (MH) and Child Adolescent Health (CAH) health care workers must have maternal health and/or pediatric training or experience in the applicable MCAH program.

Policy

Contractors and subcontractors providing direct care services must do so under the direction of a physician (MD or DO) or Advanced Registered Nurse Practitioner (ARNP) in compliance with Iowa scope of practice laws. Additionally, physicians or ARNPs providing clinical supervision must have maternal health and/or pediatric training or experience in the applicable Maternal and/or Child & Adolescent Health (MCAH) program.

Required Credentials

MD, DO, ARNP, PA, RN, LPN, or CMA

Procedure

Physicians or ARNPs providing clinical supervision must do so in compliance with the Iowa scope of practice requirements, or in the case of CMAs, the American Association of Medical Assistants (AAMA) for the health care workers they are supervising in accordance with the most current requirements found below:

1. Physician Assistant (PA)
2. Registered Nurse (RN)
3. Licensed Practical Nurse (LPN)
4. Certified Medical Assistant (CMA)

Documentation

Iowa HHS requires documentation of the full name, credentials, and state licensing information for each clinical supervisor as described in the policy above.

Resources

Physician Assistant scope of practice information
Registered Nurse scope of practice information
Licensed Practical Nurse scope of practice information
Certified Medical Assistant scope of practice information
Iowa Code Chapter 148

IOWA | Health and Human Services

Number: 813
Title: Comprehensive Health Screening (Well-child Exam)
Billing Codes: Initial screen – Code 99381: 0-12 month; Code 99382: 1-4 year; Code 99383: 5-11 year; Code 99384: 12-17 year; Code 99385: 18-21 year; Periodic screen – Code 99391: 0-12 month; Code 99392: 1-4 year; Code 99393: 5-11 year; Code 99394: 12-17 year; Code 99395: 18-21 year
Effective Date: 10/01/2022
Revision Date: 04/25/2025
Date of Last Review: 04/25/2025
Authority: Medicaid Screening Center Manual

Description in Brief

The initial or periodic well-child exam per Iowa's EPSDT Care for Kids Periodicity Schedule and as described in the Medicaid Screening Center Manual.

Required Resources for Implementation

Appropriate equipment and tools to complete a comprehensive exam. The contractor must meet the definition of a medical home to conduct comprehensive health screenings.

Overview

A comprehensive health screening, also called a well-child exam, is an age-based point-in-time screening for children enrolled in the Title V CAH program. A well-child exam includes a comprehensive medical history, physical exam, health screening, developmental screening/history, and an assessment of both physical and mental health development.

Iowa's EPSDT Care for Kids Periodicity Schedule provides a minimum basis for follow-up examinations at critical points in a child's life. Periodic screening, diagnosis, and treatment allow the flexibility necessary to strengthen the preventative nature of the program. Periodic screens may be obtained as required by foster care, educational standards, or when requested for a child.

These recommendations for preventive health care of children and youth represent a guide for the care of well children who receive competent parenting, who have not manifested any important health problems, and who are growing and developing satisfactorily. Other circumstances may indicate the need for additional visits or procedures. If children or youth come under care for the first time at any point on the schedule, or if any of the items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest time.

Policy

Contractors serving as the client's medical home complete or update a comprehensive health screening in accordance with Iowa's EPSDT Care for Kids Periodicity Schedule.

Required Credentials

The exam is provided by an ARNP, PA, MD, or DO; portions of the exam may be delegated to trained staff.

IOWA Health and Human Services

Number: 813
Title: Comprehensive Health Screening (Well-child Exam)
Billing Codes: Initial screen – Code 99381: 0-12 month; Code 99382: 1-4 year; Code 99383: 5-11 year; Code 99384: 12-17 year; Code 99385: 18-21 year; Periodic screen – Code 99391: 0-12 month; Code 99392: 1-4 year; Code 99393: 5-11 year; Code 99394: 12-17 year; Code 99395: 18-21 year
Effective Date: 10/01/2022
Revision Date: 04/25/2025
Date of Last Review: 04/25/2025
Authority: Medicaid Screening Center Manual

Procedure

1. **History:** The medical history can be taken from the child, if age-appropriate, or from a parent, guardian, or responsible adult. The history shall Include the following:
    a. Identification of specific concerns
    b. Family history of illnesses
    c. The child's history of illnesses, diseases, allergies, and accidents
    d. Information about the child's social or physical environment that may affect the child's overall health
    e. Information on current medications or adverse reactions or responses due to medications
    f. Immunization history
    g. Developmental history to determine whether development falls within a normal range of achievement according to age group and cultural background
    h. Identification of health resources currently used
2. **Mental Health Assessment:** A mental health assessment using an approved, standardized instrument is recommended for all visits aged 6 through 11 years and is required for ages 12 through 20 years. This includes obtaining the child and family's mental health history and the child's history of exposure to trauma.
3. **Developmental Surveillance**: Developmental surveillance is required for every health maintenance visit and is not separately reimbursable. Developmental surveillance consists of reviewing family and child strengths and risk factors, eliciting caregiver concerns, reviewing developmental milestones, observation of the child, monitoring, and anticipatory guidance. Any child who is identified as having a developmental concern should undergo developmental screening using a standardized screening tool. If potential developmental concern is noted, the child should be referred immediately for more in-depth diagnostic evaluation (see Policy 816 Developmental and Behavioral Health Surveillance and Screening).
4. **Psychosocial/Behavioral Assessment:** See Policy 816 Developmental & Behavioral Health Surveillance & Screenings.
5. **Exam**: Comprehensive histories should be taken at initial and interval well visits. An unclothed/undressed and draped physical exam is required at each well-visit, and should include an assessment of:
    a. Growth:
        1. Use the WHO growth charts to monitor growth for infants and children ages 0 to 2 years of age in the U.S.

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2. For infants birth to 24 months, assess:
    i. Length-for-age and weight-for-age
    ii. Head circumference-for-age and weight-for-length
3. For children 2 to 5 years of age, assess:
    i. Weight-for-stature
4. Use the CDC growth charts to monitor growth for children aged 2 years and older in the U.S.
5. For children and adolescents 2 to 20 years, assess:
    i. Stature-for-age and weight-for-age
    ii. BMI-for-age

b. All organ systems (i.e., hearing, vision, etc.)
c. Blood pressure should be checked annually beginning at 3 years of age. Infants and children with risk factors should have blood pressure checked before 3 years (see Policy 808 Blood Pressure)

6. **Health Education & Anticipatory Guidance:** See policies 860 Anticipatory Guidance, 861 Anticipatory Guidance: Birth - 10 years or 862 Anticipatory Guidance 11-20 years)
7. **Assessment of Immunization status:** Evaluate the child's vaccination history and provide recommended vaccinations based on the child's age and vaccination status following the CDC and ACIP recommended vaccines.
8. **Oral Health Screening & Risk Assessment**
9. **Nutrition/Obesity Prevention**

Documentation

1. Document the total time of the service (duration).
2. Document any care coordination activity in conjunction with direct care as part of the documentation for the direct care service.
3. Complete in MCAH data system.
    a. First and last name of service provider & credentials
    b. In the 'Comments' field, reference the client's chart for full details, a description, and a clinical record of the service provided.

IOWA | Health and Human Services

Number: 813
Title: Comprehensive Health Screening (Well-child Exam)
Billing Codes: Initial screen – Code 99381: 0-12 month; Code 99382: 1-4 year; Code 99383: 5-11 year; Code 99384: 12-17 year; Code 99385: 18-21 year; Periodic screen – Code 99391: 0-12 month; Code 99392: 1-4 year; Code 99393: 5-11 year; Code 99394: 12-17 year; Code 99395: 18-21 year
Effective Date: 10/01/2022
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Date of Last Review: 04/25/2025
Authority: Medicaid Screening Center Manual

Billing

Use the following well-child exam codes:

1. **Initial screen:**
   Code 99381: 0-12 mo.
   Code 99382: 1-4 yr.
   Code 99383: 5-11 yr.
   Code 99384: 12-17 yr.
   Code 99385: 18-21 yr.

2. **Periodic screen:**
   Code 99391: 0-12 mo.
   Code 99392: 1-4 yr.
   Code 99393: 5-11 yr.
   Code 99394: 12-17 yr.
   Code 99395: 18-21 yr.

Objective visual screens (99173/99174) and objective hearing screens (92551/92555) may be billed separately from the well-child exam code if provided on the same day. (See Hearing and Vision policies). Use modifier U1 for a screen that results in a referral for treatment.

Resources

WHO growth charts
CDC growth charts
Iowa's EPSDT Care for Kids Periodicity Schedule.

Sources

EPSDT Care for Kids Webpage
Iowa DHS Medicaid Screening Centers Provider Manual

IOWA Health and Human Services

Number: 815
Title: Depression Screening
Billing Code: Annual depression screening for children/adolescents – G0444
Effective Date: 10/01/2022
Revision Date: 04/25/2025
Date of Last Review: 04/25/2025
Authority: Screening Center Provider Manual

Description in Brief

This is an annual depression screening using the Patient Health Questionnaire-9: Modified for Teens (PHQ-9)*, or Pediatric Symptom Checklist (PSC). Code G0444.
*The Edinburgh Postnatal Depression Scale (EPDS) may be used for an adolescent for up to one year following pregnancy or giving birth.

Overview

Major depression in children and adolescents is a relatively common disorder. Depression in prepubescent children occurs equally in males and females. Adolescents are different, with depressive disorders after puberty occurring in twice as many females as males.
Depression is related to serious morbidity and mortality. Depressed children and adolescents frequently have comorbid mental disorders, such as:

1. Anxiety disorders
2. Attention-deficit/hyperactivity disorder
3. Disruptive disorders, including conduct disorder and oppositional defiant disorder
4. Eating disorders

Depressed adolescents are at higher risk of alcohol and substance abuse. Generally, depression precedes the onset of alcohol and substance abuse by 4 to 5 years, so identification of depression may provide an opportunity for prevention. Depressed adolescents also experience significant impairment in school functioning and in interpersonal relationships.
Adolescents who are depressed also are at increased risk of suicide ideation, suicide attempts, and completed suicides. Suicide is the third leading cause of death in youth aged 15 to 19. Suicide is the fourth leading cause of death in youth aged 10 to 14. In this age group, 5 times as many males as females completed a suicide attempt.

Policy

Screening of children and adolescents for depression beginning at 12 years of age using a standardized assessment tool. Clinicians shall assess the risk for anxiety disorders and screen as indicated, beginning at 8 years of age.

Required Credentials

RN or a person with at least a bachelor's degree in social work, counseling, sociology, psychology, family and community service, health or human development, health education, or individual and family studies.

IOWA Health and Human Services

Number: 815
Title: Depression Screening
Billing Code: Annual depression screening for children/adolescents – G0444
Effective Date: 10/01/2022
Revision Date: 04/25/2025
Date of Last Review: 04/25/2025
Authority: Screening Center Provider Manual

Assure that staff providing the service have been appropriately trained in the tool, counseling/anticipatory guidance, referral network, community resources, and agency policy.

Procedure

1. Screen for depression using the Patient Health Questionnaire-2 (PHQ-2). If screening is positive on the PHQ-2, the PHQ-9 should be administered. Medicaid will reimburse for the PHQ-9 or other standardized tools. The PHQ-2 is not a separately reimbursable service.
2. Interview all adolescents who have a positive PHQ-9 screen for depression. Assess them for depressive symptoms and functional impairment based on the Diagnostic and Statistical Manual of Mental Disorders (DSM-V-TR) criteria for major depressive disorder, dysthymia, and depression not otherwise specified. Assess for comorbid conditions, both medical and psychiatric.
    a. Perform a safety assessment for suicide risk.
    b. Does the adolescent now have suicidal thoughts or plans?
    c. Have prior attempts occurred?
    d. Does the plan or previous attempt have significant lethality or efforts to avoid detection?
    e. Has the adolescent been exposed to suicide attempt/ completion by peers or family members?
    f. Does the adolescent have alcohol or substance abuse problems?
    g. Does the adolescent have a conduct disorder or patterns of aggressive/impulsive behavior?
    h. Does the family show significant family psychopathology, violence, substance abuse, or disruption?
    i. Does the adolescent have the means available (especially firearms and toxic medications)?
3. If PHQ-9 is positive, discuss referral to a mental health resource. Make an immediate referral to a mental health provider or emergency services if severe depression, psychotic, or suicidal ideation/risk is evident.
4. Document HEADSS/HE2 ADS3 assessment, scores of depression screening tools, referrals discussed or made, and follow-up plans.
5. Assure that referral resources are available as needed.
6. Assure that staff providing the service have been appropriately trained.

Documentation

1. Time in and time out are required for Code G0444.
2. For code 96161, report the total time of the service (duration).

IOWA | Health and Human Services

Number: 815
Title: Depression Screening
Billing Code: Annual depression screening for children/adolescents – G0444
Effective Date: 10/01/2022
Revision Date: 04/25/2025
Date of Last Review: 04/25/2025
Authority: Screening Center Provider Manual

Complete in the MCAH data system:

1. First and last name of service provider & credentials.
2. Add a “survey” with scores when providing a PHQ-9, PSC, or EPDS.
3. In the ‘Comments’ field, reference the client's chart for full detail/ description/ clinical record of the service provided as needed to complete the documentation. Capture:
    a. Who the depression screening is for – caregiver or adolescent
    b. Name of the screening tool, including date/version of tool
    c. Results/scoring
    d. Interpretation of results
    e. Client questions/concerns
    f. Referral/follow-up

Billing

Use Code G0444 for annual depression screening for children/adolescents (15-minute unit)

Resources

Screening Center Provider Manual
Iowa EPSDT Periodicity Schedule

Sources

Bright Futures: Performing Preventive Services - Child and Adolescent Depression
Minnesota Child and Teen Checkups: Mental Health Screening

IOWA | Health and Human Services

Number: 816
Title: Developmental & Behavioral Health Surveillance & Screenings
Billing Codes: Developmental Test - G0451; Emotional/Behavioral Assessment - 96127
Effective Date: 10/01/2022
Revision Date: 04/25/2025
Date of Last Review: 04/25/2025
Authority: Screening Center Provider Manual

Overview

Based on Iowa EPSDT's Three Levels of Developmental Care, Contractors will engage in multiple types of Developmental & Behavioral Health Surveillance and Screening, depending on whether they serve as a Medical Home or as a Child Health Screening Center, or both.

1. **Developmental Surveillance** is completed by Contractors serving as a Medical Home. Surveillance is different from developmental screening. Developmental surveillance is a flexible, continuous process in which knowledgeable professionals perform skilled observations of children during the provision of health care. Developmental surveillance is required for every well-child visit and consists of reviewing family and child strengths and risk factors, eliciting caregiver concerns, reviewing developmental milestones, observation of the child, monitoring, and anticipatory guidance.
2. **Developmental Screening** (G0451): is completed by Contractors serving as a Child Health Screening Center. It is a "brief assessment procedure designed to identify children who should receive more intensive diagnosis or assessment." The primary purpose of developmental screening is to identify children who may need more comprehensive evaluation. Developmental screening is a regular part of the well-child visits for all children. It assesses whether a child is developing in appropriate areas: speech/language, fine/gross motor skills, and cognitive skills. (Screening Center Provider Manual). It is most commonly done in the primary care physician's office or another provider who might be caring for the child (e.g., early childhood settings or ECS). The tools used for screening in most Iowa health systems offering primary care well-child visits are ASQ-3 and the Survey of Well-being of Young Children (SWYC). This could also include the Modified Checklist for Autism in Toddlers-Revised/Follow-Up (MCHAT-R/F).
3. **Emotional/behavioral Assessment** (96127): is completed by Contractors serving as a Child Health Screening Center. It includes scoring and documentation using a standardized instrument (e.g., attention-deficit /hyperactivity disorder (ADHD)) scale. The assessment serves as a mechanism to identify social, emotional, or behavioral concerns. The tool used for screening most commonly is the ASQ-SE-2.

Developmental screens may be completed in compliance with the Iowa EPSDT Periodicity Schedule when the child has not received a developmental screening at the

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medical home, early care and education (ECE), home visiting program, etc. The results are then reported to the medical home and documented appropriately in the child's medical record and in the MCAH data system.

Policy
Contractors will address EPSDT Periodicity Schedule recommendations for Developmental & Behavioral Health Surveillance and Screening as a gap-filling service when a child is not receiving these services within the medical home. EPSDT Periodicity recommendations call for developmental surveillance to be conducted at every well-child visit within their primary care provider's office. The recommendations state that any child who is identified as having a developmental concern should undergo developmental screening using a standardized screening tool. If potential developmental concern is noted, the child is referred immediately for more in-depth diagnostic evaluation.

Providers
Review the tool-specific requirements as they may differ. Only Medical Homes will complete surveillance. Child Health Screening Centers may complete standardized developmental screening or social/emotional screening.

Required Resources for Implementation
Standardized screening tool and tool-specific training requirements.

Documentation
Capture in documentation: Name/copy of tool used (fully completed) with service provider signature, credentials, and date. Narrative report on the results and interpretation of results, referrals/action taken/next steps, and family feedback/questions/concerns/history.

Procedure
1. Establish a policy on when client/family needs will be assessed to determine whether the child is encountering a gap in service. Common opportunities for needs/gaps assessment include informing during a clinical or direct service, during care coordination, etc.

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2. Assess Need for Gap-Filling Service**:** If the Contractor is not serving as the Medical Home, discuss the child's medical home status, early childhood education and care enrollment, home visiting program enrollment, etc., with the parent or legally authorized representative to determine whether the child is receiving surveillance and screening within the medical home or has received a recent standardized developmental screen in a different setting.
3. Utilize enabling services to assist the family in establishing a medical home, making an appointment for a well visit, etc. to remove barriers to accessing a developmental screen.

Developmental Surveillance (Medical Homes only):

1. Review family and child strengths and risk factors, ask about caregiver concerns, review developmental milestones, observe the child, and provide monitoring and anticipatory guidance using age-appropriate developmental checklists to record milestones during preventative care visits as part of developmental surveillance.
    a. The Bright Futures Pediatric Intake Form assesses for family risk factors as does the social history component of the Iowa Child Health and Development Record (CHDR). CHDR includes developmental surveillance questions on age-specific forms for children from birth through age 21.
2. The adolescent population presents a different developmental challenge. Many of the more readily apparent developmental concerns should already have been identified and be under treatment. Focus developmental screening on such areas of special concern such as learning disabilities, peer relations, psychological or psychiatric problems, and vocational skills. For further information on developmental screening, see:
    a. Care for Kids Provider Website
    b. Medicaid Screening Center Manual
    c. Developmental Behavioral Online website of the American Academy of Pediatrics
    d. Assuring Better Child Health and Development (ABCD) Electronic Resource Center of the National Academy for State Health Policy
3. Any child presenting at an appropriate recommended screening time per the EPSDT periodicity schedule and does not have a diagnosis should undergo developmental screening using a standardized screening tool. If potential

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developmental concern is noted, the child should be referred to the appropriate medical specialty immediately for more in-depth diagnostic evaluation.

Family Risk Factor Surveillance:

1. Assess family risk factors using the Bright Futures Pediatric Intake Form or the social history component of the Iowa Child Health and Development Record (CHDR).
2. CHDR includes developmental surveillance questions on age-specific forms for children from birth through age 21.

Developmental Screening (HCPCS code name: Developmental Testing G0451)

Description in Brief: Developmental screen with interpretation and report. This serves to identify children who may need more comprehensive evaluation. Use recognized instruments such as Ages and Stages Questionnaire-3 (ASQ-3), Parent's Evaluation of Developmental Status (PEDS), or The Modified Checklist for Autism in Toddlers-Revised/Follow-Up (M-CHAT-R/F).

1. If the Contractor is a medical home, conduct developmental screening as part of a well-child exam at 9, 18 months and 24-30 months. ASQ-3 is the suggested tool. If not a medical home, this may be provided as a gap-filling service if the child does not have a medical home, developmental screening has not already been conducted, and enabling services are unsuccessful.
2. Developmental screening personnel qualifications are instrument-specific; refer to each instrument's instruction manual for more information. For the ASQ-3, staff must be trained by a trained trainer. Brookes Publishing offers train-the trainer sessions approximately four times per year.
3. Medicaid will reimburse for a standardized screening tool (billing code 96110).
4. Developmental screening documentation must include the name of the screening instrument(s) used, the score(s), and the anticipatory guidance provided to the parent or caregiver related to the screening results.
5. If the screening results are atypical, documentation must include the plan of care and, when appropriate, a referral to the medical home or a medical specialist, local community service agency, and/or other resources as appropriate.

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Social-emotional:

1. If the contractor is a medical home, conduct a social/emotional screening as part of each well child exam. The ASQ:SE-2 is the suggested tool. If not a medical home, this may be provided as a gap-filling service if enabling services are unsuccessful.
2. The emotional/behavioral assessment includes the scoring and documentation (narrative description) of the service.
3. In MCAH data system:
    a. Document under 'Type – Service – Health Services'.
    b. Under 'Type of Service', select the correct service code and description.
    c. Report the total time of the service (duration).
    d. Complete the following:
        i. Service fields.
        ii. First and last name of service provider & credentials.
        iii. Add (ASQ:SE-2) appropriate for the child's age and complete the score.
        iv. In the 'Comments' field, reference the client's chart for full detail/description/clinical record of the service provided as needed to complete the documentation.
    e. Capture in documentation:
        i. Name/copy of tool used (fully completed) w/service provider signature, credentials, and date
        ii. Narrative report on the results and interpretation of results
        iii. Referrals /action taken/next steps
        iv. Family feedback /questions/ concerns
        v. Documentation must adhere to requirements in IAC 441-79.3(2).

Autism Screening:

1. If the Contractor is a medical home, conduct autism screening as part of the well visit at 18 and 24 months. M-CHAT R/F is the suggested screening tool. If not a medical home, this may be provided as a gap-filling service if enabling services are unsuccessful.
2. Medicaid will reimburse for a standardized screening tool (billing code 96110).
3. Any child suspected of autism spectrum disorder should be referred immediately for services, diagnostic evaluation, and receive an audiological evaluation.

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Title: Developmental & Behavioral Health Surveillance & Screenings
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Referral and Management:
Refer the child for evaluation *as soon as concerns are identified.* Review the screening results with the child's parent or caregiver and discuss the types of services available from the local Area Education Agency (AEA) (educational) and the medical home (medical). Explain the referral process and ensure prompt referral, with follow up to ensure evaluation and treatment are in-process.

1. **Medical Evaluation** – A comprehensive medical evaluation determines whether a medical diagnosis is appropriate, the cause and extent of any delay, and treatment options. A medical diagnosis is required for some supportive services and insurance coverage.
2. **Developmental Evaluation** (birth to age three)- A comprehensive developmental evaluation by a qualified early childhood professional for children birth to 3 years old can identify the extent of delay and determine if a child is eligible for early intervention. If eligible, early intervention services are provided to the child and family. Refer the child to the Iowa Family Support Network or their local AEA to get them connected to early intervention.
3. **Educational Evaluation** (ages three to five) - A comprehensive educational evaluation by a qualified early childhood education professional for children 3 to 5 years old can identify the extent of delay and determine learning supports available to the family. Refer the child for early childhood education either directly to the Iowa Family Support Network or AEA.
4. **Mental Health Evaluation** - A qualified early childhood mental health professional can support families and young children with social-emotional concerns, and provide comprehensive evaluation for ASD, trauma, and more.

Results:
Provide the results of all screens to the child's medical home and encourage the family to share the results with other care providers (family members, early care and education providers, etc.).

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Follow Up:
Establish a process for follow up with the family after referral to ensure access to appropriate and effective services. Communicate and coordinate with educational and other professionals, with the parent's permission.

Documentation:
Documentation must adhere to requirements in Iowa Administrative Code [441] Chapter 79.3(2).
In MCAH data system:

1. Document under 'Type – Service – Health Services'.
2. Under 'Type of Service', select the correct service code and description.
3. Report the total time of the service (duration).
4. Complete in MCAH data system:
    a. Service fields.
    b. First and last name of service provider & credentials.
    c. Add (ASQ-3 or M-CHAT) appropriate for the child's age, and complete the scores.
    d. In the 'Comments' field, reference the client's chart for full detail/description/ clinical record of the service provided as needed to complete the documentation.
    e. Capture in documentation:
        i. Name/copy of tool used (fully completed) w/service provider signature, credentials, and date
        ii. Narrative report on the results and interpretation of results
        iii. Referrals/action taken/next steps
        iv. Family feedback/questions/concerns/history

Adjusting age for prematurity is necessary if a child was born more than 3 weeks before his or her due date and is chronologically under 2 years of age (ASQ Calculator).

Billing (IME/Medicaid MCO):
Bill IME for Medicaid fee-for-service (non-MCO) clients. This includes clients on Presumptive Eligibility. Bill the MCO for MCO enrolled Medicaid clients. Use Code G0451. Do not use E&M for the following activities, as these are included in the scope of the developmental screen service:

Number: 816
Title: Developmental & Behavioral Health Surveillance & Screenings
Billing Codes: Developmental Test - G0451; Emotional/Behavioral Assessment - 96127
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1. Explaining the purpose of a developmental test
2. Scoring and interpretation of results of the test
3. Anticipatory guidance and
4. If indicated, referral for evaluation.

Service: Emotional/behavioral assessment (96127)

Description in Brief: This is an emotional/behavioral assessment that includes the scoring and documentation (narrative description) of the service. The Ages & Stages Questionnaire: Social-Emotional (ASQ:SE2) is approved for use.

Documentation: Documentation must adhere to requirements in Iowa Administrative Code [441] Chapter 79.3(2).
In MCAH data system:

1. Document under 'Type – Service – Health Services'.
2. Under 'Type of Service', select the correct service code and description.
3. Report the total time of the service (duration).
4. Complete in MCAH data system:
    a. Service fields.
    b. First and last name of service provider & credentials.
    c. Add (ASQ:SE-2) appropriate for the child's age and complete the score.
    d. In the 'Comments' field, reference the client's chart for full detail/description/ clinical record of the service provided as needed to complete the documentation.
5. Capture in documentation:
    a. Name/copy of tool used (fully completed) w/service provider signature, credentials, and date
    b. Narrative report on the results and interpretation of results
    c. Referrals/action taken/next steps
    d. Family feedback/questions/concerns/history

Billing (IME/Medicaid MCO):
Bill the IME for Medicaid fee-for-service (non-MCO) clients. This includes clients on presumptive eligibility. Bill the MCO for MCO enrolled Medicaid clients. Use Code

Number: 816
Title: Developmental & Behavioral Health Surveillance & Screenings
Billing Codes: Developmental Test - G0451; Emotional/Behavioral Assessment - 96127
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96127. Do not use E&M for the following activities, as these are included in the scope of the emotional/behavioral assessment:

1. Explaining the purpose of an emotional/behavioral assessment
2. Scoring and reporting of results
3. Anticipatory guidance and
4. If indicated, referral for further evaluation.

Resources

Care for Kids Provider website
Developmental Behavioral Online website of the American Academy of Pediatrics
Assuring Better Child Health and Development (ABCD) Electronic Resource Center of the National Academy for State Health Policy
National Center of Home Initiatives for Children with Special Needs website of the American Academy of Pediatrics
Iowa Administrative Code [441] Chapter 79.3(2).

Sources

EPSDT Care for Kids Periodicity Schedule
Iowa Department of Health and Human Services Screening Center Provider Manual

IOWA | Health and Human Services

Number: 817
Title: Documentation of Services in MCAH Data System
Effective Date: 10/01/2022
Revision Date: 04/28/2025
Date of Last Review: 04/28/2025
Authority: IAC 441 Chapter 79.3

Policy

All services provided under the CAH program must be documented. All services provided under the CAH program must be documented in the Iowa HHS MCAH data system in compliance with Iowa HHS requirements.

Procedure

All services provided under the CAH program must be entered into the Iowa HHS MCAH data system. This web-based record system allows for collection of the child's demographic information, identification of needs, and documentation services. The MH Data System User Manual can be found on the MCAH Portal.

Documentation must comply with generally accepted principles for maintaining health records and with requirements established by Iowa HHS in Iowa Administrative Code [441] Chapter 79.3.

Contractors are responsible for the accuracy and compliance of their records, including those of all subcontractors and must document Informing, Care Coordination & Presumptive Eligibility entirely in the MCAH data system.

Contractors must comply with Iowa HHS contract requirements for timely data entry. Documentation of services must be made at the time of service and be available to Iowa HHS by the 15th of the following month. End of state or federal fiscal year may shorten the timeframe for documentation to be available for payment.

Resources

Iowa HHS Medicaid Screening Center Provider Manual
Iowa Administrative Code [441] Chapter 79.3

IOWA | Health and Human Services

Number: 818
Title: Evaluation and Management
Billing Code: Evaluation and Management - 99211
Effective Date: 10/01/2020
Revision Date: 04/28/2025
Date of Last Review: 04/28/2025
Authority: Screening Centers Provider Manual

Procedure

E&M can be billed by a PCP serving as a medical home for services other than blood lead testing. Medical home PCPs shall follow agency policies for expectations and guidance in using this code. Screening Centers not designated as medical homes provide this code with blood lead testing.

Documentation

1. Report the total time of the service (duration).
2. Complete in the MCAH data system:
   - First and last name of service provider & credentials.
   - In the 'Comments' field, reference the client's chart for full detail/description/ clinical record of the service provided. Specify what the E&M is related to (e.g., lead test).
3. Do not bill E & M related to immunization administration. Instead use 'immunization administration with counseling' (Code 90460/90461).

Billing

1. Use Code 99211
2. This encounter code can only be used once per day per client.

This code **cannot** be used for:

1. Providing care coordination services
2. E&M on the same day as a full well-child screen
3. Explaining the purpose of a developmental test, interpretation of the test, anticipatory guidance, and needed referral for evaluation when conducting a developmental or social/emotional screening (These activities are already included in the G0451 and 96127 codes).
4. Service delivered other than face-to-face, such as via telephone, text, or letter

Resources

Iowa's EPSDT Care for Kids Periodicity Schedule
Iowa Department of Public Health Childhood Lead Poisoning Risk Questionnaire

Sources

EPSDT Care for Kids Webpage
Screening Centers Provider Manual

Number: 819
Title: Facilities & Accessibility of Services
Effective Date: 10/01/2016
Revision Date: 04/28/2025
Date of Last Review: 04/28/2025
Authority: 45 CFR part 84; Public Law 101-336; Public Law 103-227; Iowa Smokefree Air Act - Iowa Code 142D

Overview

This policy/procedure focuses on the requirements of the Contractor and subcontractors for location selection, available times of services, and state and federal law surrounding accessibility and environment.

Policy

Title V Contractors and subcontractors must comply with 45 CFR part 84, any applicable provisions of the Americans with Disabilities Act (Public Law 101-336) and the requirements of Public Law 103-227, also known as the Pro-Children Act of 2001, and the Iowa Smokefree Air Act - Iowa Code 142D.

Procedure

1. Facilities in which Title V project services are provided should be geographically accessible to the population served and should be available at times convenient to those seeking services (i.e., they should have evening and/or weekend hours) in addition to daytime hours. Iowa HHS defines usual business hours as between 8:00 AM and 4:30 PM. Services are encouraged to be available outside of usual business hours. The facilities should be adequate to provide the necessary services and should be designed to ensure comfort and privacy for clients and to expedite the work of the staff.
2. Contractors shall work with clients and potential clients in site selection. Contractors shall take into consideration other programs and services available at or near the site for families.
3. Facilities under consideration must meet applicable standards established by the federal, state, and local governments (e.g., local fire, building, and licensing codes). In general, clinic locations should provide a comfortable waiting area, an adequate reception area, offer private areas for client interviews, include a sufficient number of enclosed single exam rooms to accommodate service needs and allow for private conversations, provide office space separate from client service areas for staff to make follow-up phone calls and complete documentation; and include a secure storage room area for files and supplies.
4. Contractors and subcontractors must comply with 45 CFR part 84, which prohibits “discrimination on the basis of handicap in federally assisted programs

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and activities", and which requires among other things, that recipients of federal funds operate their federally assisted program so that when, viewed in their entirety, they are readily accessible to people with disabilities.

5. Contractors and subcontractors must also comply with any applicable provisions of the Americans with Disabilities Act (Public Law 101-336). The agency's compliance with the ADA and 504 requirements are evaluated during the Administrative On-Site Review. Contractors must comply with ACA Section 1557 which prohibits discrimination based on race, color, national origin, sex, age or disability in health programs and activities that receive federal funds. Section 1557 assists populations that have been most vulnerable to discrimination in health care and health coverage.
6. Contractors and all subcontractors must comply with the requirements of Public Law 103-227, also known as the Pro-Children Act of 2001, and the Iowa Smokefree Air Act - Iowa Code 142D, which prohibits tobacco products, including vaping, in any portion of any indoor facility owned, leased, or contracted by an organization and used routinely for the provision of health, early care and education (ECE), or early childhood development services, education or library services to children under age 18, if the services are funded by federal programs either directly or through state or local governments, by a federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are contracted, operated, or maintained with such federal funds.
7. Contractors shall display safety information signage, such as weapons, smoking, and animal restrictions (except service animals), prominently at the entrance to the facility.

Resources

Iowa HHS Medicaid Screening Center Provider Manual
Public Law 103-227
Iowa Smokefree Air Act - Iowa Code 142D
ACA Section 1557
45 CFR part 84
Public Law 101-336

Sources

Pro Child Act of 2001

IOWA Health and Human Services

Number: 820
Title: Growth Measurements – Child & Adolescent
Effective Date: 10/01/2022
Revision Date: 04/28/2025
Date of Last Review: 04/28/2025
Authority: Iowa HHS Medicaid Screening Center Provider Manual

Overview

Measuring height and weight accurately is important when monitoring a child's health. Height and weight measurements are used to calculate body mass index, or BMI, a measure of healthy versus unhealthy weight. They are also important when tracking a child's growth.

Policy

Comprehensive histories are taken at initial and interval well visits and will include an assessment of growth. Contractors shall have an individual order by a primary care provider, or the client shall meet the criteria of the standing order signed by the medical director for the growth measurement.

Required Credentials

MD, DO, ARNP, PA, RN, or CMA

Procedure

Taking Standing Height: *Standing height is used to measure children who are more than two years old and can stand without assistance. Children should be measured without shoes and heavy outer clothing such as sweaters and coats.*

1. Remove socks and shoes on the child and remove or push aside any barrettes, braids, or hairstyles that might interfere with the measurement. High hairstyles will need to be flattened as much as possible.
2. Place the child's feet flat and either the knees or feet together in the center of the measuring board with their back to the board.
3. Place the right hand on the shins or knees and push against the board. Make sure that the child's legs are straight. The position of the legs is important. The line that bisects the body from the side is called the "mid-axillary line." Make sure the mid-axillary line is perpendicular to the base of the board. This may mean that the child's feet may not touch the back of the measuring board, particularly in overweight or obese children.
4. Ask the child to look straight ahead. Make sure the child's line of sight (Frankfort Plane) is level with the floor. The line from the hole in the ear to the bottom of the eye socket (Frankfort Plane) should be perpendicular to the board or table. In overweight, obese, and older children, when the head is placed in the proper position, according to the Frankfort Plane, there will be a space between the back of the child's head and the back of the measuring board. Do not judge the position of the child's head by looking at the top of the head. Use the Frankfort Plane.
5. Make sure that the shoulders are level, the hands are at the child's side, and the head, shoulder blades, and buttocks are against the board, if appropriate.

Number: 820
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Authority: Iowa HHS Medicaid Screening Center Provider Manual

6. Lower the headpiece on top of the child's head. Make sure that you push through the child's hair.
7. When the child's position is correct, read the measurement to 1/8 inch.

Common Measurement Errors:

1. Improper equipment used
2. Equipment is not properly installed.
3. Footwear, heavy outer clothing, hats or hair barrettes are not removed.
4. Feet are not flat on the floor.
5. Knees are bent.
6. Head is not in the proper position.
7. Measurement is not read at eye level.

Weighing Children and Adolescents: Children and Adolescents should be measured using a beam balance scale or a digital standing scale.

Beam Balance Scale:

1. Ask the child to remove shoes and any heavy clothing such as jackets, sweatshirts, sweaters, etc.
2. Ask the child to step onto the scale. Make sure the child is centered on the platform and the arms are at their side.
3. Move the large 50-pound weight until you find the first notch where the beam falls, then move the weight back one notch.
4. Slowly push the small pound weight across the beam until it is balanced. You may need to move it back and forth in small increments several times to reach balance.
5. Read the measurement to the nearest 1/4 pound.
6. Record the weight on the data collection sheet. Make sure it is accurate and legible.
7. Have the child step off of the scale and return the weights on the beam to zero in preparation for the next measurement. *Note: It is acceptable to take two measurements that agree within ¼ lb and use either one of those measurements.*

Digital Scale:

1. Activate the scale by turning it on. Zeroes will appear on the display panel. Make sure the scale is on "lb" rather than "kg".
2. Ask the child to remove shoes and any heavy clothing such as jackets, sweatshirts, sweaters, etc.

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3. Ask the child to step onto the scale. Make sure the child is centered on the platform and the arms are at their side.
4. The weight will appear on the display panel. If the weight changes (e.g., from 22.1 lb to 22.2 lb), record either number. Record the weight to the nearest ¼ lb.
5. Record the weight on the data collection sheet. Make sure it is accurate and legible.

Common Weighing Errors:

1. Improper equipment is used.
2. Scale is not properly zeroed or balanced.
3. Footwear and heavy outer clothing are not removed.
4. Individuals are not properly centered on scale platform.
5. Child is holding onto Assistant or scale.
6. Child is not remaining still on the scale.

Body Mass Index: Body Mass Index (BMI) is a person's weight in kilograms divided by the square of height in meters. BMI screens for weight categories that may lead to health problems, but it does not diagnose the body fat level or health of an individual. BMI is the recommended parameter for monitoring the growth of children 24 months and older. BMI can be determined using a handheld calculator. The steps for calculating BMI using pounds and inches are listed below.

1. Convert any fractions to decimals. Examples: 37 pounds 4 ounces = 37.25 pounds 41½ inches = 41.5 inches
2. Insert the values into the formula: [weight (lb.) / height (in.) / height (in.)] X 703 = BMI Example: (37.25 lb. / 41.5 in. / 41.5 in.) X 703 = 15.2

A reference table can also be used to calculate BMI. Click the link for the CDC 2-20 years Boys and the 2-20 years Girls tables.

The CDC BMI Percentile Calculator for Child and Teen can also be used to calculate BMI. If the BMI-for-age is less than or equal to the 5th percentile, the child is considered underweight. If the BMI-for-age is between the 85th and 94th percentiles, the child is considered to be at risk for being overweight. Children with a BMI equal to or greater than the 95th percentile are considered overweight.

Documentation

Record measurements as soon as they are taken to reduce errors. Plot weight and height against age and weight against height on the CDC growth chart for children under 2 years of age (see

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Policy 921 Growth Measurement - Infant). For children 2-20 years, plot weight and height against age and BMI against age on the appropriate growth chart.

Resources
CDC BMI charts for boys and girls
Clinical Growth Charts (CDC and WHO)
Iowa HHS Medicaid Screening Center Provider Manual

Sources
Height and Weight Measurements
Iowa HHS Medicaid Screening Center Provider Manual
Iowa EPSDT Periodicity Schedule

IOWA Health and Human Services

Number: 821
Title: Growth Measurements - Infant
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Authority: Iowa HHS Medicaid Screening Center Provider Manual

Overview

Measuring height and weight accurately is important when monitoring an infant's health. Height and weight measurements are used to calculate your body mass index, or BMI, a measure of healthy versus unhealthy weight. They are also important when tracking a child's growth.

Policy

Comprehensive histories are taken at initial and interval well visits, including an assessment of growth. Contractors shall have an individual order by a primary care provider, or the client shall meet the criteria of the standing order signed by the medical director for growth measurement.

Required Credentials

MD, DO, ARNP, PA, RN, or CMA

Procedure for Taking the Recumbent Length

Recumbent length refers to stature taken while lying down. Recumbent length is used to measure infants and children less than two years of age. Recumbent length can also be used for children two to three years of age who have great difficulty standing on their own; these children must be measured lying down, and the measurement should be recorded as recumbent length.

1. Infants should be wearing only a clean disposable diaper and undershirt.
2. A child over the age of one should be wearing only light clothing. Shoes, sweaters, coats, etc. should be removed.
3. If hair or barrettes interfere with placing the child's head directly against the measuring board.
4. Place the sliding footpiece at the end of the measuring board and check to see that it is sliding freely.
5. Lay the child down on their back on the measuring board. *Note: While the infant is on the measuring board, you must hold and control the child so that he/she will not roll off or hit his/her head on the board.*
6. Place the child's head against the headpiece. If the head is not against the headpiece, hold the child at the waist and lift or slide the child towards the headpiece.
7. Check to be sure that the child's head is in the correct position. The line from the hole in the ear to the bottom of the eye socket (Frankfort Plane) should be perpendicular to the board or table, making certain that the child's chin is not tucked in against their chest or stretched too far back.

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8. Position the child's body so that the shoulders, back, and buttocks are flat along the center of the board.
9. Place your left hand on the child's knees. Hold the movable footpiece with your right hand and firmly place it against the child's heels. A child's legs and feet can be very strong. You may have to straighten them with your hands.
10. Check the child's position: head against the headpiece with eyes looking straight up, body and legs straight and flat in the center of the measuring board, heels and feet firmly against the footpiece.
11. When the child's position is correct, read and record the length measurement to the nearest 1/8".

Common Errors in Measuring Recumbent Length:

1. Improper equipment used.
2. Shoes, sandals, socks are not removed.
3. Child's head is not in the correct position.
4. Child's head is not against the headpiece.
5. Legs are not straightened or properly positioned.
6. Heels are not flat against the footboard.
7. Heels or legs are not flat against the recumbent board.
8. Only one leg is extended rather than both legs.

Weighing Infants

Procedure for Weighing Infants/Children using the Beam Balance Scale:

1. Cover the scale with paper.
2. Remove the infant's clothing to a dry diaper.
3. Place the child on his/her back or sit on the tray of the scale. Make sure the child is centered in the tray and is not touching anything off of the scale tray including other parts of the scale.
4. Move the pound weight until you find the first notch where the beam falls, then move the weight back one notch.
5. Slowly push the ounce weight across the beam until it is balanced. You may need to move it back and forth several times in small increments to reach balance.
6. If the beam continues to move (e.g. when the child moves), steady the beam with your hand. It may be difficult to get the beam as steady as you would like; be patient and as careful as possible.
7. Read and record the measurement to the nearest 1 ounce or 1/16 pound.
8. Remove the child from the tray of the scale and return the weights on the beam to zero in preparation for the next measurement.

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Procedure for Weighing Infants/Children using a Digital Infant Scale:

1. Cover the scale with paper.
2. Activate the scale by turning it on. Zeroes will appear on the display panel. Make sure the scale is on "lb" rather than "kg".
3. Remove the infant's clothing to a dry diaper.
4. Place the child on their back or sit on the tray of the scale.
5. Make sure that the infant or child is not touching anything off of the scale.
6. The weight will appear on the display panel. If the weight changes (e.g., from 15lb 4oz to 15lb 5oz), record either number. Read and record the weight to the nearest 1 ounce.

Common Errors in Measuring Weight of Infants/Children:

1. Improper equipment is being used.
2. The scale is not properly zeroed or balanced.
3. Necessary clothing is not removed.
4. The child is not placed in the center of the scale tray.
5. The parent is touching the infant/child.
6. The infant/child is touching something off the scale or the scale itself.

Documenting Growth: Record measurements as soon as they are taken to reduce errors. Plot weight and height against age and weight against height on the CDC growth chart for children under 2 years of age. See the CDC Clinical Growth Charts to download paper copies.

Resources

Clinical Growth Charts (CDC and WHO)
Iowa HHS_ Medicaid Screening Center Provider Manual
Iowa Code § 135.11(17)

Sources

Height and Weight Measurements
Iowa HHS_ Medicaid Screening Center Provider Manual
Iowa EPSDT Periodicity Schedule

IOWA Health and Human Services

Number: 822
Title: Head Circumference
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Authority: Iowa HHS Medicaid Screening Center Provider Manual

Overview

Head circumference is a measurement of a child's head around its largest area. It measures the distance from above the eyebrows and ears and around the back of the head. During routine checkups, the distance is measured in centimeters or inches and compared with:

1. Past measurements of a child's head circumference.
2. Normal ranges for a child's sex and age (weeks, months), based on values that experts have obtained for normal growth rates of infants and children's heads.

Measurement of the head circumference is an important part of routine well-baby care. During the well-baby exam, a change from the expected normal head growth may alert the health care provider of a possible problem. For example, a head that is larger than normal or that is increasing in size faster than normal may be a sign of several problems, including water on the brain (hydrocephalus). A very small head size (called microcephaly) or very slow growth rate may be a sign that the brain is not developing properly.

Policy

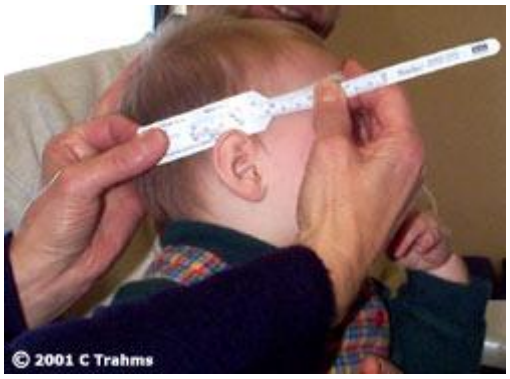
Head circumference measure is an important part of growth measurement for infants and young children and is conducted at child well-visits until the child is two years old. Contractors shall have an individual order by a primary care provider, or the client shall meet the criteria of the standing order signed by the medical director for growth measurement.

Required Credentials:

MD, DO, ARNP, PA, RN, or CMA

Procedure

1. An accurate head circumference measure is obtained with a flexible non-stretchable measuring tape. A plastic tape such that one end inserts into the other is recommended.
2. Head circumference is generally measured on infants and children until age two years.
3. The tape is positioned just above the eyebrows, above the ears, and around the biggest part of the back of the head. The goal is to locate the maximum circumference of the head.



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4. Any braids, barrettes, or other hair decorations that will interfere with the measurement should be removed.
5. The infant or child may be more comfortable in the arms or on the lap of a parent.
6. The tape is pulled snugly to compress the hair and underlying soft tissues.
7. The measurement is read to the nearest 0.1 cm or 1/8 inch and recorded on the chart.
8. The tape should be repositioned and the head circumference remeasured.
9. The measures should agree within 0.2 cm or 1/4 inch.
10. If the difference between the measures exceeds the tolerance limit, the infant should be repositioned and remeasured a third time. The average of the two measures in closest agreement is recorded.
11. Further evaluation is needed if the CDC Infant Head Circumference Growth Chart (girls and boys) reveals a measurement:
    a. Above the 95th percentile.
    b. Below the 5th percentile.
    c. Reflecting a major change in percentile levels from one measurement to the next or over time.

Documentation
Record measurements as soon as they are taken to reduce errors. Plot head circumference against the child's age on the CDC Head circumference-for-age chart for children birth to 36 months of age (boys and girls).

Resources
CDC Head Circumference chart for boys and girls
Clinical Growth Charts (CDC and WHO)
Iowa HHS Medicaid Screening Center Provider Manual

Sources
HRSA: Accurately Weighing & Measuring Technique
Head Circumference - Medline Plus
Height and Weight Measurements
Iowa HHS Medicaid Screening Center Provider Manual
Iowa EPSDT Periodicity Schedule

IOWA | Health and Human Services

Number: 824
Title: Hearing Testing
Billing Codes: Pure tone air only – 92551; Speech audiometry threshold only - 92555
Effective Date: 10/01/2022
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Description in Brief

1. 92551 Pure tone - air only is a hearing screening for both ears that involves the use of a device that produces a series of tones.
2. 92555 Speech Audiometry (threshold only) is a hearing screening.
3. OAE hearing screening is not included in Medicaid's Screening Center package and is, therefore, not a billable service. A child in need of OAE should be referred for further evaluation (e.g., an audiologist).

Overview

Iowa law requires universal hearing screening of all newborns and infants. The primary purpose of newborn hearing screening is to identify newborns who are likely to have hearing loss and who require further evaluation. A secondary objective is to identify newborns with medical conditions that can cause late-onset hearing loss and to establish a plan for continued monitoring of their hearing status.

Passing a screening does not mean that a child has normal hearing across the frequency range. Because minimal and frequency-specific hearing losses are not targeted by newborn hearing screening programs, newborns with these losses may pass a hearing screening. Because these losses have the potential to interfere with the speech, language, and psychoeducational development of children, monitoring of hearing, speech, and language milestones throughout childhood is essential.

Policy

Hearing screening shall be performed as part of the 4-year-old well visit, and again once between the ages of 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. Any child not passing a hearing screening, regardless of age, must be referred for evaluation and follow-up. Contractors shall have an individual order from a primary care provider, or the client shall meet the criteria of the standing order signed by the medical director for the screening.

Providers

A licensed healthcare provider (MD, DO, ARNP, PA, RN).

Procedure

Confirm the initial screen was completed, verify results, and follow up as appropriate. Follow guidelines for best practices from Iowa's Early Hearing Detection and Intervention Program (EHDI).

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Newborns and Children Under 6 Months of Age: Newborn infants who have not had an objective hearing test should be referred to a diagnostic audiology center that specializes in infant screening using one of the latest audiology screening technologies. Infants who do not pass the initial hearing screen and the subsequent rescreening should have appropriate audiology and medical evaluations to confirm the presence of hearing loss before three months. All infants with confirmed hearing loss should be referred for early intervention services before six months of age.

The following risk indicators are associated with either congenital or delayed-onset hearing loss. Heightened surveillance of all children with risk indicators is recommended by the Joint Committee on Infant Hearing Screening. Regardless of whether the infant passed their newborn hearing screen if they have the following risk indicator, they should be seen by an audiologist at a diagnostic audiology center for a hearing evaluation no later than three months after the occurrence:

1. Bacterial and viral meningitis (especially herpes viruses and varicella) or encephalitis
2. Congenital Cytomegalovirus (CMV) confirmed in infant
3. Extracorporeal membrane oxygenation (ECMO)
4. Head injury (especially basal skull/temporal bone fracture)
5. Chemotherapy

A child should see an audiologist at a diagnostic audiology center for a hearing evaluation by nine months of age if one or more of the following risk factors are present in the period immediately before or right after birth.

1. Family history of hearing loss (permanent, sensorineural hearing loss since childhood)
2. Cranio-facial anomalies (includes cleft lip or palate, microtia (abnormally small ear), atresia (blocked or abnormally small ear canal), ear dysplasia, microphthalmia, white forelock, congenital microcephaly, congenital or acquired hydrocephalus, or temporal bone abnormalities
3. Exchange transfusion for elevated bilirubin regardless of length of stay, NICU stay longer than five days
4. Aminoglycoside (includes Gentamycin, Vancomycin, Kanamycin, Streptomycin, and Tobramycin) administered for more than five days
5. In utero infections such as herpes, rubella, syphilis, and toxoplasmosis
6. Asphyxia or Hypoxic Ischemic Encephalopathy
7. Syndromes (includes: Trisomy 21-Down syndrome, Goldenhar, Pierre Robin, CHARGE association, Rubinstein-Taybi, Stickler, Usher, osteopetrosis, Neurofibromatosis type II, Treacher Collins, Hunter syndrome, Friedreich's ataxia, Charcot-Marie-Tooth syndrome or visit the Hereditary Hearing Loss website)

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Children Over 6 Months of Age and Adolescents: An objective hearing screening should be performed on all children who do not have a documented objective hearing screening or documented parental refusal. This screening should be conducted by a qualified screener or audiologist during the well visit according to the periodicity schedule. Any child who does not pass the screening should be immediately referred to an audiologist for diagnostic evaluation.

Iowa EPSDT recommends in-office screening using audiometry as part of the well visit, beginning at 4 years. Screen at least once between the ages of 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years, using audiometry to include frequencies between 6000-8000 HZ.

Documentation
Complete in MCAH data system documentation must include the following:

1. First and last name of service provider & credentials.
2. Reference the client's chart for full detail/description/clinical record of the service provided. Include the type of screening performed, tool used, results, referral/follow-up needed, and family questions/concerns.
3. The correct service code and description.
4. Report the total time of the service (duration).

In the client's record: Documentation must adhere to requirements in Iowa Administrative Code [441] Chapter 79.3(2).

Resources
Iowa EPSDT Periodicity Schedule
Iowa Early Hearing Detection and Intervention Program Best Practices
Iowa Early Hearing Detection and Intervention Program

Sources
Bright Futures, Guidelines for Health Supervision of Infants, Children and Adolescents
Iowa HHS Medicaid Screening Center Provider Manual
Iowa EPSDT Periodicity Schedule

IOWA Health and Human Services

Number: 825
Title: Hemoglobin/Hematocrit
Effective Date: 10/01/2022
Revision Date: 04/28/2025
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Authority: Screening Center Provider Manual

Description in Brief

1. Code 85014: Hematocrit level (Hct)
2. Code 85018: Hemoglobin level (Hgb)

Overview

Iron deficiency (ID) is the most common nutritional deficiency in the world. Iron Deficiency Anemia (IDA) is a common cause of anemia in young children. IDA is associated with psychomotor and cognitive abnormalities in children. Infants and toddlers in the following groups are at highest risk for ID and IDA:

1. History of prematurity or low birth weight
2. Inadequate nutrition
3. Lead exposure
4. Weaning to cow's milk and/or formulas with low-iron or no iron before 12 months
5. Exclusive breastfeeding beyond 4 months of age without supplemental iron
6. Children of low socioeconomic status or with special health needs, feeding problems, or poor growth and development

Policy

Children will have hemoglobin drawn at 12 months, and the risk of anemia assessed at 4 months, 15 months, and at every visit afterward. Menstruating females should be evaluated for risk of iron deficiency anemia at every visit. Contractors shall have an individual order from a primary care provider, or the client shall meet the criteria of the standing order signed by the medical director for the screening.

Providers

MD, DO, ARNP, PA, RN, LPN, or CMA

Procedure

Anemia Risk Assessment:

Assess the child for any of the following risk factors for anemia. If risk factors are present, plan to draw hemoglobin. Risk factors include:

1. Infancy
    a. Prematurity
    b. Low birth weight
    c. Use of low-iron formula or infants not receiving iron-fortified formula

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    d. Early introduction of cow's milk as a major source of nutrition. If infants are not yet consuming a sufficient alternate source of iron-rich foods, the replacement of breast milk or formula may lead to insufficient iron intake.
2. Early and Middle Childhood (ages 18 months–5 years)
    a. At risk of iron deficiency because of special health needs
    b. Low-iron diet (e.g., non-meat diet)
    c. Environmental factors (e.g., poverty, limited access to food)
3. Middle Childhood (6–10 years)
    a. Strict vegetarian diet and not receiving an iron supplement.
4. Adolescence (11–21 years)
    a. Extensive menstrual or other blood loss
    b. Low iron intake
    c. Previously diagnosed with iron-deficiency anemia

Blood Draw: Three basic methods are used to determine Hgb concentration and Hct level:
1. Venipuncture with analysis by an automated cell counter,
2. Capillary sampling with analysis by a hemoglobin meter or
3. Capillary sampling with a microhematocrit analysis by centrifuge.

Follow the policy/procedure on blood draws for the procedure on how to properly implement one of the methods above.

Follow-up
Abnormal lead results will need further workup and treatment, such as lead avoidance, possibly abatement, and potentially chelation.

For abnormal anemia results, see Table 1 below; iron replenishment and supplementation may be the first and only step. However, it is important to determine whether abnormalities continue or whether other etiologies exist that warrant further investigation and treatment.

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Table 1. Fifth Percentile Cutoffs for Various Measures of Iron Deficiency in Childhood

Age, y	Hgb, g/dL	Hct, %	MCV, fL	ZnPP µg/dL	RDW, %	%TIBC saturation	Ferritin, µg/L
Newborn	<14.0	<42	NA	NA	NA	NA	<40
0.5–2.0	<11.0	<32.9	<77	>80	>14	<16	<15
2.0–4.9	<11.1	<33.0	<79	>70	>14	<16	<15
5.0–7.9	<11.5	<34.5	<80	>70	>14	<16	<15
8.0–11.9	<11.9	<35.4	<80	>70	>14	<16	<15
12.0–15.0 (male)	<12.5	<37.3	<82	>70	>14	<16	<15
12.0–15.0 (female)	<11.8	<35.7	<82	>70	>14	<16	<15
>15.0 (male)	<13.3	<39.7	<85	>70	>14	<16	<15
>15.0 (female)	<12.0	<35.7	<85	>70	>14	<16	<15

Abbreviations: Hct, hematocrit concentration; Hgb; hemoglobin concentration; MCV, mean corpuscular volume; NA, not applicable (no standards available); RDW, red blood cell distribution width; %TIBC, percent total iron-binding capacity; ZnPP, zinc protoporphyrin concentration.
Source: Reproduced from Kleinman, RE (2009) Pediatric Nutrition Handbook, 6th Edition, Elk Grove Village, IL

For more information, refer to the recommendations in the Clinic Report - Diagnosis and Prevention of Iron Deficiency and Iron-Deficiency Anemia in Infants and Young Children

Documentation

1. Complete in MCAH data system:
    a. Service fields
    b. First and last name of service provider & credentials.
    c. In the ‘Comments’ field, reference the client's chart for full detail/description/clinical record of the service provided.
2. In the client’s record: Documentation must adhere to requirements in IAC 441-79.3(2).
3. If hemoglobin testing is covered by the WIC program, it cannot be billed to Medicaid.

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Resources

Iowa EPSDT Periodicity Schedule
Minnesota Child and Teen Checkup: Hemoglobin or Hematocrit

Sources

Bright Futures, Guidelines for Health Supervision of Infants, Children and Adolescents
Bright Futures: Performing Preventive Services: Screening
Iowa HHS Medicaid Screening Center Provider Manual
Iowa EPSDT Periodicity Schedule

IOWA Health and Human Services

Number: 826
Title: Home Visits/Nursing Home Visits
Effective Date: 10/01/2022
Revision Date: 04/29/2025
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Authority: Screening Centers Provider Manual

Description in Brief

Home visit for nursing services (per hour) for the purpose of providing assessment and evaluation of a known medical condition such as failure to thrive, asthma, and diabetes.

Overview

A home visit allows the health worker to assess the home and family situation in order to provide care and health related activities. In performing home visits, it is essential to prepare a plan of visit to meet the needs of the client and achieve the best results of desired outcomes.

Purpose of a nursing home visit include:

1. To assess the living condition of the patient, family and their health practices in order to provide the appropriate services.
2. To give health education regarding the prevention and control of diseases.
3. To establish a close relationship between the care provider and client for the promotion of health.
4. To assess needs and promote the utilization of community services.

Principles of a nursing home visit include:

1. A home visit must have a purpose or objective.
2. Planning for a home visit should make use of available information about the client and family and give priority to the essential needs of the individual/family.
3. Planning and delivery of care should involve the client and family.
4. The plan should be flexible.

Guidelines regarding the frequency of home visits:

1. The physical, psychological, and educational needs of the client and family.
2. The acceptance of the family for the services to be rendered, and their interest in additional services.
3. The policy of the agency.
4. Take into account other health agencies and the number of health and human services personnel already involved in the care of a specific family.

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Policy

Home visits shall be provided to children and families for the purpose of nursing services and social work services as appropriate based on the needs of the clients. Contractors shall have an individual order by a primary care provider, or the client shall meet the criteria of the standing order signed by the medical director for a nursing home visit.

Required Credentials

Nursing assessment/evaluation must be provided by a RN and the social work home visit must be provided by a BSW or licensed social worker.

Procedure

1. Schedule in advance and at a time that is convenient for the client
2. Review and make changes as needed to an intake assessment completed in the past 30 days. If an intake assessment has not been completed in the past 30 days, complete an intake assessment with the client.

Home Visit for Nursing Services: a home visit made for the purpose of providing nursing services include taking a medical history, nursing assessment, evaluation of patient, and plan of care. This service must be provided by a registered nurse. A home visit for nursing services shall include:

1. Focused health history: This collects specific information about a clear health-related issue or need with which a patient presents. The information gathered is used to inform the immediate care of the patient.
2. Nursing assessment
3. Nursing evaluation
4. Nursing services
5. Plan of care

Social Work Home Visit: a home visit made for the purpose of providing social work services including taking a social history, psychosocial assessment, counseling services, and plan of care. This service must be provided by a BSW or licensed social worker.

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Documentation

1. Time in and time out are required for this service. Report the total time of the service (duration).
2. Complete in MH and CAH data system:
   a. Service fields.
   b. First and last name of service provider & credentials.
   c. In the 'Comments' field, reference the client's chart for full detail/description/ clinical record of the service provided.
3. In the client's record: Documentation must adhere to requirements in Iowa Administrative Code [441] Chapter 79.3(2).

Billing

1. For a nursing assessment/evaluation home visit use code S9123 (per hour)
   a. For time spent, include only face-to-face time. Do not include travel time or time documenting the service.
   b. A limit of ten units (hours) per client over a period of 200 days is placed on this code. Payment for services beyond this limit will require documentation to support the medical need for more visits.
   c. Must be provided by a registered nurse.
   d. Must include:
      i. Medical history including chief complaint
      ii. Nursing assessment
      iii. Nursing evaluation
      iv. Plan of care
   e. Use code T1001: Nursing assessment/evaluation for nursing assessment/evaluation outside of the home setting (i.e., WIC clinic or school setting).
   f. This is an encounter code and is not based upon a timed unit.
   g. Bill the IME for Medicaid fee-for-service.
2. In the client's record: Documentation must adhere to requirements in Iowa Administrative Code [441] Chapter 79.3(2).
3. For a social work home visit use code S9127 (encounter code)
   a. Must be provided by a BSW or licensed social worker.
   b. Report the total time of the service (duration). This is an encounter code and is not based upon a timed unit.

Number: 826
Title: Home Visits/Nursing Home Visits
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c. A home visit for care coordination service cannot also be billed for any portion of the home visit for social work services.
d. The entirety of the maternal health postpartum home visit is part of the maternal health services. Any care coordination on behalf of the baby is considered part of this postpartum visit. Do not bill the home visit for social work services in addition.

Resources

Screening Center Provider Manual
Iowa EPSDT Periodicity Schedule
Iowa Administrative Code [441] Chapter 79.3(2)

IOWA | Health and Human Services

Number: 827
Title: Immunizations and Vaccine Administration
Billing codes: Immunizations Administration with Counseling – 90460/90461; Initial/subsequent administration of vaccine (single or combination), subcutaneous or intramuscular – 90471/90472; Initial/subsequent administration of vaccine (single or combination) by intranasal or oral means – 90473/90474
Effective Date: 10/01/2022
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Description in Brief

1. Administration of immunizations and counseling for children through age 18 includes:
    a. Immunization administration through any route.
    b. Counseling by a qualified health professional.
2. Counseling for each component of the vaccine is required. It shall include reviewing immunization records, explaining the need for the immunizations, and providing anticipatory guidance (education) & follow-up instructions when administering vaccine. It includes provision of the most current VIS.

Overview

Childhood vaccines protect children from a variety of serious or potentially fatal diseases, including diphtheria, measles, mumps, rubella, human papillomavirus, polio, tetanus, whooping cough (pertussis) and others.

Policy

1. Contractors serving as a medical home shall evaluate immunization status at every visit. If vaccinations are due they should be given at that visit as long as there are no contraindications.
2. Non-medical home Contractors shall assess immunization status at each contact and utilize enabling services and referral networks to assure access to immunizations in the client's medical home.
3. Contractors shall have an individual order by a primary care provider, or the client shall meet the criteria of the standing order signed by the medical director for vaccine administration.

Required Credentials

Must be provided by a licensed healthcare provider (MD, DO, ARNP, PA, RN or LPN).

Procedure

1. **Immunization Administration:** If a gap in immunization access was identified at the time of the service application (i.e., Request for Proposal (RFP) or Request for Application (RFA)), a Contractor may have been granted permission to provide vaccine administration as a direct care, gap-filling service. The service of vaccine administration also includes related

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assessment, education, anticipatory guidance, and follow-up. The following are required only for Contractors providing direct care immunization services:

a. **Staffing and Contingency Plans:** Provide adequate staffing levels of immunization providers (i.e., RN, LPN, CMA) and maintain contingency plans for those staff so that immunizations are available at all times direct care services are provided.
b. **Training:** Ensure staff and subcontractors administering any vaccines and/or providing well or acute care visits to children receive comprehensive, competency-based training on vaccine administration policies and procedures before administering vaccines and annually thereafter. Training that may be used includes CDC's You Call The Shots "Understanding the Basics: General Best Practice Guidelines on Immunizations", and "Vaccine Administration" modules.
c. **HPV Promotion and Documentation:** Recommend all adolescent vaccines, including HPV vaccine, at each visit to children age 11 years and older. If the HPV vaccine is declined, the Contractor shall document the reason for the declination by client/parent/guardian or the medical contraindication in the MCAH data system.
d. **Standing Orders:** Maintain standing orders for immunization services giving all qualified and trained personnel the ability to administer all age-appropriate vaccines in accordance with the ACIP Immunization Schedules.
e. **VFC Enrollment:** Participate in the Vaccines for Children (VFC) program. This program supplies federally purchased vaccines at no cost to public and private health care providers throughout the state. Clients eligible to receive VFC provided vaccines include children enrolled in Medicaid, children who do not have health insurance, and children who are American Indian or Alaska Native. In addition, children who have health insurance that does not cover the cost of vaccines are considered to be 'underinsured', and are eligible to receive VFC vaccines at FQHCs, RHCs, and public health facilities. VFC participation requires enrolled providers to maintain and administer all ACIP recommended vaccines. For more information, see Iowa HHS Immunization Program's VFC website.

2. **Assess the need for vaccines:**
   a. The client's immunization status should be reviewed at each contact. Using the client's immunization history, Contractors should assess for all routinely recommended vaccines as well as any vaccines that are indicated based on existing medical condition(s), occupation, or other risk factors.

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   b. To obtain a client's immunization history, utilize Iowa's Immunization Registry Information System (IRIS) or recommended vaccinations in the Maternal Health (MH) and Child and Adolescent Health (CAH) data system or the client's medical records. In most cases, health care providers should only accept written, dated records as evidence of vaccination. If a client has an out-of-state/country immunization record, the health care provider should take time to create an IRIS record for the client and add the historical immunizations.
   c. Missed opportunities to vaccinate should be avoided. If a documented immunization history is not available, administer the vaccines that are indicated based on the client's age, medical condition(s), and other risk factors, such as planned travel.
3. **Screen for contraindications and precautions:**
   a. Before administering any vaccine, clients should be screened for contraindications and precautions, even if the client has previously received that vaccine. The client's health condition or recommendations regarding contraindications and precautions for vaccination may change from one visit to the next.
   b. To assess clients correctly and consistently, use a standardized, comprehensive screening tool such as those available through the Immunization Action Coalition.
4. **Educate clients/parents about needed vaccines**: Vaccine Information Statements (VISs) are a resource for education of vaccinations. VISs are documents that inform vaccine recipients or their parents about the benefits and risks of a vaccine. Federal law requires VISs be provided to the client when routinely recommended childhood vaccines are administered. The VIS must be given:
   a. Before the vaccine is administered
   b. Regardless of the age of the person being vaccinated
   c. Every time a dose of vaccine is administered, even if the client has received the same vaccine and VIS in the past

   CDC encourages the use of all VISs, whether the vaccine is covered by the law requiring VIS or not. VISs can be provided at the same time as a screening questionnaire, while the client is waiting to be seen. They include information that may help the client or parent respond to the screening questions and can be used by providers during conversations with clients.
5. Contractors and subcontractors shall have standing orders on file giving all qualified and trained personnel the ability to provide immunization counseling and immunization administration.

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6. Contractors and subcontractors serving as medical homes shall train all qualified personnel in immunization counseling and administration within 3 months of the beginning of the project period or hire.
7. **After-care instructions:** Client and parent education should also include a discussion of comfort and care strategies after vaccination. After-care instructions should include information for dealing with common side effects such as injection site pain, fever, and fussiness (especially in infants). Instructions should also provide information about when to seek medical attention and when to notify the health care provider about concerns that arise following vaccination. After-care information can be given to clients or parents before vaccines are administered, leaving the parent free to comfort the child immediately after the injection. Pain relievers can be used to treat fever and injection-site pain that might occur after vaccination. In children and adolescents, a non-aspirin-containing pain reliever should be used. Aspirin is not recommended for children and adolescents.
8. **Vaccine Administration:**
    a. **Infection Control**: follow routine infection control procedures when administering vaccines.
    b. **Hand Hygiene:** Hand hygiene is critical to prevent the spread of illness and disease. Hand hygiene should be performed before vaccine preparation, between clients, and any time hands become soiled. Hands should be cleansed with a waterless, alcohol-based hand rub or soap and water. When hands are visibly dirty or contaminated with blood or other body fluids, they should be washed thoroughly with soap and water.
    c. **Gloves:** Gloves should be worn when administering vaccines, including intranasal or oral vaccines, to children and adolescents. Gloves will be changed, and hand hygiene performed between clients. Gloves will not prevent needle stick injuries. Any needle stick injury should be reported immediately to the site supervisor, with appropriate care and follow-up per the organization policies.
    d. **Vaccine Preparation:** Preparing vaccine properly is critical to maintaining the integrity of the vaccine during transfer from the manufacturer's vial to the syringe and, ultimately, to the client. CDC recommends preparing and drawing up vaccines just before administration. During preparation:
        i. Follow strict aseptic medication preparation practices.
        ii. Perform hand hygiene *before* preparing vaccines.

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iii. Use a designated, clean medication area that is not adjacent to areas where potentially contaminated items are placed.
iv. Avoid distractions. Some facilities have a no-interruption zone, where health care professionals can prepare medications without interruptions.
v. Prepare vaccinations for *one* client at a time.
vi. Always follow the vaccine manufacturer's directions, located in the package inserts.

e. **Choosing the Correct Vaccine**: Vaccines are available in different presentations, including single-dose vials (SDV), manufacturer-filled syringes (MFS), multidose vials (MDV), oral applicators, and a nasal sprayer. Always check the label on the vial or box to determine:
   1. It is the correct vaccine and diluent (if needed).
   2. The expiration date has not passed. Expired vaccine or diluent should never be used.
      i. **Single-Dose Vials (SDV)**: Most vaccines are available in SDVs. SDVs do not contain preservatives to help prevent microorganism growth. Therefore, vaccines packaged as SDVs are intended to be punctured once for use in *one* client and for *one* injection. Even if the SDV appears to contain more vaccine than is needed for one client, it should not be used for more than one client. Once the appropriate dosage has been withdrawn, the vial and any leftover contents should be discarded appropriately. SDVs with any leftover vaccine should never be saved to combine leftover contents for later use.
      ii. **Manufacturer-Filled Syringes (MFS)**: MFSs are prepared with a single dose of vaccine and sealed under sterile conditions by the manufacturer. Like SDVs, MFSs do not contain a preservative to help prevent the growth of microorganisms. MFSs are intended for *one* client for *one* injection. Once the sterile seal has been broken, the vaccine should be used or discarded by the end of the workday.
      iii. **Multidose Vials (MDV)**: A MDV contains more than one dose of vaccine. MDVs are labeled by the manufacturer and typically contain an antimicrobial preservative to help prevent the growth of microorganisms.

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Because MDVs contain a preservative, they can be punctured more than once. MDVs used for more than one client should only be kept and accessed in a dedicated, clean medication preparation area, away from any nearby client treatment areas. This is to prevent inadvertent contamination of the vial through direct or indirect contact with potentially contaminated surfaces or equipment. Only the number of doses indicated in the manufacturer's package insert should be withdrawn from the vial. Partial doses from two or more vials should never be combined to obtain a dose of vaccine.

iv. **Oral Applicators and Nasal Spray**: An oral applicator is for use with oral vaccines and contains only one dose of medication. Oral vaccines do not contain a preservative. Rotavirus vaccine is administered using an oral applicator. An intranasal sprayer is used for the live, attenuated influenza vaccine.

f. **Inspect the Vaccine:** Each vaccine and diluent (if needed) should be carefully inspected for damage, particulate matter, or contamination before using. Verify the vaccine has been stored at proper temperatures

g. **Check the Expiration Date of the Vaccine or Diluent:** Determining when a vaccine or diluent expires is an essential step in the vaccine preparation process. The expiration date printed on the vial or box should be checked before preparing the vaccine. When the expiration date has only a month and year, the product may be used up to and including the last day of that month unless the vaccine was contaminated or compromised in some way. If a day is included with the month and year, the product may only be used through the end of that day unless the vaccine was contaminated or compromised in some way**.**

1. **Beyond-Use Date (BUD):** In some instances, vaccine must be used by a date earlier than the expiration date on the label. This time frame is referred to as the "beyond-use date" (BUD). The BUD supersedes but should never exceed the manufacturer's expiration date. Vaccines should not be used after the BUD. The BUD should be noted on the label, along with the initials of the person making the calculation. Examples of vaccines with BUDs include:

i. Reconstituted vaccines have a limited period for use once the vaccine is mixed with a diluent. This time period is discussed in the package insert.

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ii. Some MDVs vials have a specified period for use once they have been punctured with a needle. For example, the package insert may state the vaccine must be discarded 28 days after it is first punctured.
iii. Some MDVs have a specific number of doses that can be withdrawn. Once the maximum number of doses has been removed, the vial should be discarded, even if residual vaccine remains in the vial.
iv. Manufacturer-shortened expiration dates may apply when vaccine is exposed to inappropriate storage conditions. The manufacturer might determine the vaccine can still be used but will expire on an earlier date than the date on the label.

2. **Reconstitute Lyophilized Vaccine:** Reconstitution is the process of adding a diluent to a dry ingredient to make it a liquid. The lyophilized vaccine (powder or pellet form) and its diluent come together from the manufacturer. Vaccines should be reconstituted according to manufacturer guidelines using only the diluent supplied for a specific vaccine. Diluents vary in volume and composition, and are specifically designed to meet volume, pH balance, and the chemical requirements of their corresponding vaccines. A different diluent, a stock vial of sterile water, or normal saline should never be used to reconstitute vaccines. If the wrong diluent is used, the vaccine dose is not valid and must be repeated using the correct diluent. Vaccine should be reconstituted just before administering by following the instructions in the vaccine package insert. Once reconstituted, the vaccine should be administered within the time frame specified for use in the manufacturer's package insert; otherwise, the vaccine should be discarded. Changing the needle between preparing and administering the vaccine is not necessary unless the needle is contaminated or damaged.

h. **Supplies:** OSHA requires that safety-engineered injection devices (e.g., needle-shielding syringes or needle-free injectors) be used for injectable vaccines in all clinical settings to reduce the risk of needle stick injury and disease transmission. For specific guidance on selecting needles and syringes vaccine type and age and size of the client, see the CDC Pink Book, Vaccine Administration chapter. General guidance when selecting supplies to administer a vaccine by injection includes:
   1. Inspect the packaging; never use supplies with torn or compromised packaging.

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2. Some syringes and needles are packaged with an expiration date. If present, check the expiration date. Never use expired supplies.
3. Use a separate syringe and needle for each injection. Never administer a vaccine from the same syringe to more than one client, even if the needle is changed.

9. **Procedural Pain Management:** Vaccinations are the most common source of procedural pain for healthy children and can be a stressful experience for persons of any age. Fear of injections and needle stick pain are often cited as reasons why children and adults refuse vaccines. Evidence-based pharmacologic, physical, and psychological interventions exist to ease the pain associated with injections. Combining the interventions described below has been shown to improve pain relief.
    a. **Inject vaccines rapidly without aspiration**: Aspiration is not recommended before administering a vaccine. Aspiration prior to injection and injecting medication slowly are practices that have not been evaluated scientifically. Aspiration was originally recommended for theoretical safety reasons and injecting medication slowly was thought to decrease pain from sudden distention of muscle tissue. Aspiration can increase pain because of the combined effects of a longer needle-dwelling time in the tissues and shearing action (wiggling) of the needle. There are no reports of any person being injured because of failure to aspirate.
    b. **Inject vaccines that cause the most pain last:** Many persons receive two or more injections at the same clinical visit. Some vaccines cause more pain than others during the injection. Because pain can increase with each injection, the order in which vaccines are injected matters. Some vaccines cause a painful or stinging sensation when injected; examples include measles, mumps, and rubella; pneumococcal conjugate; and human papillomavirus vaccines. Injecting the most painful vaccine last when multiple injections are being administered can decrease the pain associated with the injections.
    c. **Breastfeeding children during vaccine injection**: Mothers who are breastfeeding should be encouraged to breastfeed children age 2 years or younger before, during, and after vaccination. Several aspects of breastfeeding are thought to decrease pain by multiple mechanisms: being held by the parent, feeling skin-to-skin contact, suckling, being distracted, and ingesting breast milk. Potential adverse events such as gagging or spitting up have not been reported. Alternatives to breastfeeding include bottle-feeding

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with expressed breast milk or formula throughout the procedure, which simulates aspects of breastfeeding.

d. **Sucrose/glucose**: Children (age 2 years or younger) who are not breastfed during vaccination may be given a sweet-tasting solution such as sucrose or glucose one to two minutes before the injection. The analgesic effect can last for up to 10 minutes following administration and can mitigate vaccine injection pain. Parents should be counseled that sweet-tasting liquids should only be used for the management of pain associated with a procedure such as an injection and not as a comfort measure at home.
e. **Topical pain relievers**: Topical anesthetics block transmission of pain signals from the skin. They decrease the pain as the needle penetrates the skin and reduce the underlying muscle spasm, particularly when more than one injection is administered. These products should be used only for the ages recommended and as directed by the manufacturer. Because using topical anesthetics may require additional time, some planning by the health care provider and parent may be needed. Topical anesthetics can be applied during the usual clinic waiting times, or before the client arrives at the clinic provided parents and clients have been shown how to use them appropriately. There is no evidence that topical anesthetics have an adverse effect on the vaccine immune response.
f. **Oral pain relievers:** The prophylactic use of antipyretics (e.g., acetaminophen and ibuprofen) before or at the time of vaccination is not recommended. There is no evidence these will decrease the pain associated with an injection. In addition, some studies have suggested these medications might suppress the immune response to some vaccine antigens.
g. **Route and Site for Vaccination:** The recommended route and site for each vaccine are based on clinical trials, practical experience, and theoretical considerations. There are five routes used to administer vaccines. Deviation from the recommended route may reduce vaccine efficacy or increase local adverse reactions. Some vaccine doses are not valid if administered using the wrong route, and revaccination is recommended. For the most current site and route recommendations, see the CDC Pink Book, Vaccine Administration chapter.

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10. **Multiple Vaccinations:** Children and adults often need more than one vaccine at the same time. Giving more than one vaccine at the same clinical visit is preferred because it helps keep clients up-to-date. Use of combination vaccines can reduce the number of injections. Considerations when administering multiple injections include:
    a. Administer each vaccine in a different injection site. Recommended sites (i.e., vastus lateralis and deltoid muscles) have multiple injection sites. Separate injection sites by 1 inch or more, if possible, so that any local reactions can be differentiated.
    b. For infants and younger children, if more than two vaccines are being injected into the same limb, the thigh is the preferred site because of the greater muscle mass. For older children and adults, the deltoid muscle can be used for more than one intramuscular injection.
    c. Vaccines that are the most reactive and more likely to cause an enhanced injection site reaction (e.g., DTaP, PCV13) should be administered in different limbs, if possible.
    d. Vaccines that are known to be painful when injected (e.g., HPV, MMR) should be administered after other vaccines.
    e. If both a vaccine and an immune globulin (Ig) preparation are needed (e.g., Td/Tdap and tetanus immune globulin [TIG] or hepatitis B vaccine and hepatitis B immune globulin [HBIG]), administer the vaccine in a separate limb from the immune globulin.
11. **Vaccine Supply and Disposal**: Immediately after use, all syringe/needle devices should be placed in biohazard containers that are closable, puncture-resistant, leak-proof on sides and bottom, and labeled or color-coded. This practice helps prevent accidental needle stick injury and reuse. Used needles should not be recapped or cut or detached from the syringes before disposal.

Documentation

1. Document the service in the MCAH data system
2. In the ‘Comments’ field reference client’s chart, IRIS, and/or Master Index Card for full description of both the immunizations administered and counseling provided.
3. In the client's chart, IRIS, and/or Master Index Card: Documentation must adhere to requirements in IAC 441-79.3(2). Note the review of record, need for immunization, anticipatory guidance provided, provision of VIS, date of VIS, follow-up plan, and any parent/guardian concerns or questions.
4. Document immunizations in IRIS.

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Billing

1. Typically, the VFC vaccine is used for children through the age of 18 years (at no cost to the agency or to the family). Vaccines may be billed for Medicaid-enrolled children over the age of 18 years (ages 19 and 20 years). If there is a shortage of the VFC vaccine, an IME Informational Letter will be provided with instructions for billing the vaccine. Due to NCCI edits, E&M and Well Child Exam Codes (See IME Informational Letter #1219) will not pay when billed on the same date as 90460.
2. Use 90460 for each vaccine administered. Submit your cost per your cost analysis.
3. For vaccines with multiple components (combination vaccines): Report 90461 for each additional component beyond the first component in the vaccine. Submit a nominal cost for accounting of the additional components. Examples: HPV: 90460, Influenza: 90460, MMR: 90460, 90461-2 units, Tdap: 90460, 90461-2 units
4. Typically, the VFC vaccine is used for children through the age of 18 years (at no cost to the agency or to the family). Vaccines may be billed for Medicaid-enrolled children over the age of 18 years (ages 19 and 20 years).
5. Use Code 90471 for the initial administration of the vaccine (single or combination), subcutaneous or intramuscular.
6. Use Code 90472 for subsequent administrations of vaccine (single or combination) subcutaneous or intramuscular on the same day as Code 90471.
7. Use Code 90473 for the administration of one vaccine (single or combination) by intranasal or oral means.
8. Do not bill 90471 with 90473.
9. For subsequent immunization administration, use either 90472 or 90474 (as appropriate) with 90471 or 90473.
10. Do not use these immunization administration codes if using ‘immunization administration with counseling’ (Code 90460/90461).
11. Use Code 90474 for subsequent administrations of vaccine (single or combination) by intranasal or oral means on the same day as Code 90473.
12. Bill the appropriate administration code(s) and the code(s) for the VFC vaccine (at $0.00).

Resources

ACIP Recommendations Immunization Schedule.
CDC: Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2025

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Vaccine Contraindications and Precautions
CDC Epidemiology and Prevention of Vaccine-Preventable Diseases, a.k.a. the "Pink Book".
Iowa's Immunization Registry Information System (IRIS)
Immunization Action Coalition
Vaccine Information Statements

Sources

CDC Pink Book, Vaccine Administration
Iowa HHS Medicaid Screening Center Provider Manual
Iowa EPSDT Periodicity Schedule

IOWA | Health and Human Services

Number: 828
Title: Intimate Partner Violence Screening
Billing Codes: IPV Screening for an adolescent – 96160; IPV Screening for a caregiver of a child health client - 96161
Effective Date: 10/01/2022
Revision Date: 04/30/2025
Date of Last Review: 04/30/2025
Authority: Iowa HHS Medicaid Screening Center Provider Manual

Description in Brief

This is domestic violence screening using the Abuse Assessment Screen (AAS). An adolescent (Code 96160) and a caregiver of a child health client (Code 96161).

Overview

Intimate partner violence (IPV) is considered present when an intimate partner commits physical, sexual, emotional, economic, or psychological assault on the other partner through the use of a pattern of controlling behaviors, including force, coercion, threats, or intimidation. It is known by a variety of names: domestic violence, family violence, and battering.

Violence by an intimate partner is very common. It occurs in all socioeconomic groups, ages, races, ethnicities, and among those with and without disabilities. Intimate partner violence occurs in as many as 1 in 4 US households, with an estimated 5.3 million victimizations occurring annually in US women aged 18 and older. Teen dating violence is also common, with 20% to 25% of female high school students reporting physical and/or sexual abuse by a dating partner.

Policy

Ask all families about IPV. Bright Futures recommends discussing IPV at the prenatal, newborn, 1-month, 9-month, and 4-year visits and discussing interpersonal and dating violence at the middle and late adolescence health supervision visit. Consider screening caregivers at child health supervision visits when signs or symptoms raise concerns (e.g., bruising on the child or caregiver) or if the caregiver says they have a new intimate partner. Consider screening adolescents if they say they have a new intimate partner, when signs or symptoms raise concerns or during any prenatal visits. Contractors shall have an individual order from a primary care provider, or the client shall meet the criteria of the standing order signed by the medical director for the screening.

Procedure

Listen supportively but be direct in your questioning if possible. Ask in an effective and efficient manner that becomes routine for all patients.

1. **Caregiver Screening:** Assess the client or caregiver alone without a partner, the parent, or other accompanying persons in attendance**.** Try to assess with children out of the room. If this isn't practical, then ask general questions. If the caregiver gives cues that they are uncomfortable, use alternative methods of screening and discussion. Sample screening questions from Bright Futures include:
    a. Do you always feel safe in your home?

Number: 828
Title: Intimate Partner Violence Screening
Billing Codes: IPV Screening for an adolescent – 96160; IPV Screening for a caregiver of a child health client - 96161
Effective Date: 10/01/2022
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   b. Has your partner or ex-partner ever hit, kicked, or shoved you, or physically hurt you or the baby?
   c. Are you scared that you and/or other caretakers may hurt the baby?
   d. Do you have any questions about your safety at home?
   e. What will you do if you feel afraid? Do you have a plan?
   f. Would you like information on where to go or who to contact if you ever need help?
2. **Adolescent Screening:** No specific tools have been scientifically validated for screening in the pediatric practice. However, several screening tools have been shown to be effective when implemented in primary care pediatric offices, including the 4-question "Child Safety Questionnaire":
   a. Have you ever been in a relationship with someone who has hit you, kicked you, slapped you, punched you, or threatened to hurt you?
   b. Are you currently in a relationship with someone who has hit you, kicked you, slapped you, punched you, sexually abused you, or threatened to hurt you?
   c. Are you in a relationship with someone who yells at you, calls you names, or puts you down?
   d. When you were pregnant, did anyone ever physically hurt you?
3. Assure that referral resources are available as needed.
4. Assure that staff providing the service have been appropriately trained.

What Should You Do if You Identify IPV?
The health care provider's job is not to fix the problem but to provide a safe environment for disclosure and discussion of the issue, support the victim, and begin to help the victim understand their situation and to educate and address the impact of IPV. Provide referrals to social workers, local IPV support groups, shelters, mental health or counseling, or legal services.

IPV should not be considered child abuse (and, therefore, treated as a mandatory report) unless the child, themselves, was directly harmed by the perpetrator. If a health care provider believes they are required to make a mandatory report, they must inform the patient and discuss safety planning to follow best practices and follow Iowa HHS Mandatory Reporting Requirements.

Required Credentials
Must be provided by an RN or a person with at least a bachelor's degree in social work, counseling, sociology, psychology, family and community service, health or human development, health education, or individual and family studies.

IOWA | Health and Human Services

Number: 828
Title: Intimate Partner Violence Screening
Billing Codes: IPV Screening for an adolescent – 96160; IPV Screening for a caregiver of a child health client - 96161
Effective Date: 10/01/2022
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Documentation

1. Report the total time of the service (duration).
2. Complete in the MCAH data system:
    a. Service fields.
    b. First and last name of service provider & credentials.
    c. An AAS form may be completed and attached to the service.
    d. In the 'Comments' field, reference the client's chart for full detail/description/clinical record of the service provided as needed to complete the documentation. Capture:
        i. Who the domestic violence screening is for – caregiver or adolescent
        ii. Name of the screening tool, including date/version of the tool
        iii. Results/scoring interpretation of results
        iv. Client questions/concerns
        v. Referral/follow-up
3. In the client's record: Documentation must adhere to requirements in Iowa Administrative Code [441] Chapter 79.3(2).
4. Documentation for a domestic violence screen for a caregiver is located in the child's record. Follow agency protocol for confidential documentation of this service to assure safety if a medical record would be requested by individuals with legal access to the medical record such as a child's other parent or adolescent's parents.

Billing

1. Use Code 96160 if the screen is provided for an adolescent.
2. Use Code 96161 for the caregiver of a child health client. Bill under the child's Medicaid number.
3. Codes 96160 and 96161 are encounter codes and are not billed based on time.

Resources

Iowa HHS Medicaid Screening Center Provider Manual
Iowa EPSDT Periodicity Schedule
Mandatory Reporting of Domestic Violence to Law Enforcement by Health Care Providers

Sources

DHHS Child Welfare Information Gateway
Bright Futures: Performing Preventive Services - Intimate Partner Violence

IOWA | Health and Human Services

Number: 829
Title: Lipid Screening
Effective Date: 10/01/2022
Revision Date: 04/30/2025
Date of Last Review: 04/30/2025
Authority: Iowa HHS Medicaid Screening Center Provider Manual

Overview

Cardiovascular disease (CVD) is the leading cause of death and morbidity in the United States. Most of the clinical burden of CVD occurs in adulthood. However, research over the last 40 years has increasingly indicated that the process of atherosclerotic CVD begins early in life and is progressive throughout the lifespan. It has also become clear that there is an important genetic component to the disease process that produces susceptibility but that environmental factors, such as diet and physical activity, are equally important in determining the course of the disease process.

Policy

Contractors serving as a medical home shall perform a risk assessment at the following well-child visits: 24 months, and at 4, 6, 8, and 12-17 years of age. Children at high risk should be screened with a fasting lipid profile. Test all children once between 9 and 11 years and once between 17 and 21 years. For universal screening, non-fasting, non-HDL cholesterol can be used. Contractors shall have an individual order from a primary care provider, or the client shall meet the criteria of the standing order signed by the medical director for the screening.

Procedure

Risk assessment for dyslipidemia should be done at two, four, six, and eight years and between 12 and 16 years. Universal lipid screening using the non-fasting, non-HDL total cholesterol should be performed once during prepuberty (at 9 to 11 years) and once post-puberty (at 17 to 21 years) (American Academy of Pediatrics, 2011).

Risk Assessment

The following are examples of recommended risk factors that can be identified through personal and family health history and physical measurements (American Academy of Pediatrics, 2017). Some or all of these factors may be included in the risk assessment:

1. Parent, grandparent, aunt or uncle, or sibling with myocardial infarction (MI); angina; stroke; or coronary artery bypass graft (CABG), stent, or angioplasty at younger than 55 years in males and younger than 65 years in females.
2. Parent with total cholesterol ≥240 mg/dL or known dyslipidemia.
3. The patient has diabetes, hypertension, or body mass index (BMI) ≥95th percentile or smokes cigarettes.
4. The patient has a medical condition that places them at moderate or high risk for dyslipidemia.

IOWA | Health and Human Services

Number: 829
Title: Lipid Screening
Effective Date: 10/01/2022
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Laboratory Testing and Management: Ensure appropriate counseling and other follow-up based on risk assessment results (refer to the Anticipatory Guidance section below). Health care providers should use their clinical judgment and consider currently available evidence to determine what type of evaluation (including laboratory testing) may be appropriate based on the patient's age, personal and family health history, and other factors. Refer to Expert Panel on Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents Summary Report for guidance on laboratory testing and management.

Anticipatory Guidance: There is strong evidence that good nutrition starting at birth has the potential to decrease the future risk of cardiovascular disease. Breastfeeding provides sustained cardiovascular benefits. (American Academy of Pediatrics, 2011). For children and young people two years of age and older, counsel following the Dietary Guidelines for Americans. Clinical tools for nutrition and physical activity counseling are available on Let's Go!

Resources
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Sources
Minnesota Child and Teen Checkup: Dyslipidemia Risk Assessment
Expert Panel on Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents (2012)

IOWA | Health and Human Services

Number: 830
Title: Medical and Non-Medical Emergencies
Effective Date: 10/01/2022
Revision Date: 04/30/2025
Date of Last Review: 04/30/2025

Policy

Contractors shall develop emergency protocols, with input from their medical director, that reflect local resources.

Procedure

Emergency situations involving clients and/or staff may occur at any time. All contractors must have written plans for the management of on-site medical and non-medical emergencies. All staff must be familiar with these plans.

1. Medical Emergencies: At a minimum, written protocols must address:
    a. Anaphylaxis
    b. Cardiac arrest
    c. Hemorrhage
    d. Respiratory difficulties
    e. Shock
    f. Syncope
    g. Transportation in a medical emergency
    h. Vaso-vagal reactions
2. Non-Medical Emergencies: At a minimum, written protocols must address:
    a. Bomb threat guidance
    b. Chemical spill
    c. Fire
    d. Intoxicated patient or client
    e. Intruder in the building
    f. Lost or abducted child
    g. Power failure
    h. Severe weather (tornado, flood)

Resources

Kinner Medical/Emergency-Critical-Care-Pocket-Guide-7th Edition

IOWA Health and Human Services

Number: 831
Title: Medication & Allergy Documentation
Effective Date: 10/01/2022
Revision Date: 04/30/2025
Date of Last Review: 04/30/2025
Authority: Iowa HHS Medicaid Screening Center Provider Manual

Overview

An important component of documentation is medications and allergies. Client medications and allergies must be prominently documented in the clinical record and cannot be overlooked.

Definitions

1. **Current Medications:** Prescribed or over-the-counter (OTC) medications, dietary supplements, and herbal preparations the client is currently taking or frequently using, including medications used for intermittent illness (e.g., migraines or asthma).
2. **Allergies**: An adverse or significantly sensitive reaction to medications, over-the-counter, and herbal preparations or dietary supplements. This can also include significant food, material, or environmental sensitivities (e.g., peanuts, latex, and bee stings).

Policy

The client's list of current medications and allergies is reviewed, revised as necessary, and documented in the clinical record at every visit to ensure accuracy, and if allergies are reported, they are documented prominently and consistently in a highly visible location in the client's chart.

Procedure

1. At the beginning of each clinic visit, the health care provider, or designated staff, reviews the medications and allergies lists in the clinical record.
2. If there is a question regarding the accuracy of the information, enter "client states" with the medication information in the client record.
3. If the name of the medication is known but the client is unsure of the dose, "unspecified dose" may be entered in the record.
4. The health care provider reviews all entries during the visit.
5. Medications dispensed or written by the health care provider during a clinic visit are cross-checked with the allergy list prior to dispensing.
6. No matter the format of the clinical record (i.e., electronic medical record, MCAH data system, paper chart, etc.), drug allergies must be located prominently, consistently, and quickly accessible. The Joint Commission and AAAHC both require centers to place known drug allergies in a "highly visible location in the client's chart", which is commonly interpreted as the front of the chart.

IOWA Health and Human Services

Number: 831
Title: Medication & Allergy Documentation
Effective Date: 10/01/2022
Revision Date: 04/30/2025
Date of Last Review: 04/30/2025
Authority: Iowa HHS Medicaid Screening Center Provider Manual

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Sources

UC Davis Occupational Health Services Policy and Procedure - Medications and Allergies Documentation and Reconciliation

IOWA | Health and Human Services

Number: 832
Title: Mental Health Assessment
Billing Code(s): Mental Health Assessment – H0031
Effective Date: 10/01/2022
Revision Date: 04/30/2025
Date of Last Review: 04/30/2025
Authority: Screening Centers Provider Manual

Description in Brief

A mental health clinical assessment using a nationally recognized validated tool. This involves an integrated evaluation across a full range of life domains, which leads to the development of an effective, comprehensive, and individualized plan of care. It is a thorough assessment of the individual's clinical and psychosocial needs and functional level.

Overview

The identification of mental health problems can be improved by standardized screening (SAMHSA, 2012). Half of all lifetime cases of mental illness begin by early adolescence (Weitzman & Wegner, 2015). Substantial evidence shows that early mental health interventions help prevent behavior problems and poor school performance (Weitzman & Wegner, 2015).

A mental health clinical assessment involves an integrated evaluation across a full range of life domains, which leads to the development of an effective, comprehensive, and individualized plan of care using a nationally recognized, validated tool. It is a thorough assessment of the child's clinical and psychosocial needs and functional level.

Many mental health concerns in the pediatric office setting are elicited through attentive listening, as well as surveillance and screening for potential mental health issues. Surveillance is the routine elicitation of family concerns, often performed in the context of a well-child exam. Screening is the practice of using a validated instrument to evaluate a possible condition of concern.

Persistent or significant adverse childhood experiences, including persistent stress and family dysfunction, can lead to the development of behavioral and emotional problems in children. Clinical judgment has not been shown to reliably identify these problems. These issues are often correlated with familial stresses such as poverty, substance abuse, domestic violence, food and housing instability, and mental illness among family members. The AAP Preventive guidelines recommend that pediatric primary care providers assess for the presence of these stresses at every well-child visit.

The Bright Futures Pediatric Intake Form is a screening tool that can be used to determine if there are areas of concern in providing psychosocial counseling. The form includes questions about depression, substance abuse, violence, history of abuse, social support, etc.

IOWA Health and Human Services

Number: 832
Title: Mental Health Assessment
Billing Code(s): Mental Health Assessment – H0031
Effective Date: 10/01/2022
Revision Date: 04/30/2025
Date of Last Review: 04/30/2025
Authority: Screening Centers Provider Manual

Policy

A mental health assessment using an approved, standardized instrument is recommended for all visits aged 6 through 11 years and is required for ages 12 through 20 years.

Required Credentials

Licensed social worker (LISW, LMSW) or other licensed mental health professional. Qualifications for mental health assessment are instrument-specific; refer to the instrument's manual for more information. Assure that staff providing the service have been appropriately trained.

Procedure

1. The following instruments are recommended. Follow the tool's directions on use:
    a. Pediatric Symptom Checklist (PSC)
    b. Global Appraisal of Individual Needs (GAIN-SS)
2. Assure that referral resources are available. It is critical that children with identified concerns receive or be referred for specialized services. Refer the identified child to their primary care provider. After making a referral, ensure the child or family obtained services without encountering barriers and that the services were effective.

Documentation

1. Complete in the Maternal Health (MH) Child Adolescent Health (CAH) data system:
    a. First and last name of service provider & credentials.
    b. Add a "Survey" with scores to the MCAH data system.
    c. In the 'Comments' field, reference the client's chart for full detail/description/clinical record of the service provided as needed to complete the documentation. Capture:
        i. Name of the screening tool, including date/version of tool
        ii. Results/scoring
        iii. Interpretation of results
        iv. Client questions/concerns
        v. Referral/follow-up
2. Document assessment in the visit record. Document screening with the name of the instrument, the score, and anticipatory guidance based on the results given to the parent/caregiver or youth. For positive results, document referral and follow-up plan.

Billing

Code H0031 - Mental health assessment by a non-physician. This is an encounter code and is not billed based on time.

IOWA | Health and Human Services

Number: 832
Title: Mental Health Assessment
Billing Code(s): Mental Health Assessment – H0031
Effective Date: 10/01/2022
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Date of Last Review: 04/30/2025
Authority: Screening Centers Provider Manual

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Sources

American Academy of Pediatrics. (2025, February). Recommendations for Preventive Pediatric Health Care. Retrieved from Bright Futures/American Academy of Pediatrics
CDC. (2013). Mental Health Surveillance among Children United States, 2005-2011. MMWR, 62(2), 1-35.
MMB. (2019). Children's Mental Health Inventory and Benefit-Cost Analysis. Retrieved February 17, 2021
SAMHSA. (2012, April). Identifying Mental Health and Substance Use Problems of Children and Adolescents: A Guide for Child-Serving Organizations.
U.S. Preventive Services Task Force. (2016, November). Screening for Depression in Children and Adolescents: USPSTF Recommendation Statement.
Bright Futures: Performing Preventive Services - History, Observation and Surveillance
Weitzman, C., & Wegner, L. (2015). Promoting Optimal Development: Screening for Behavioral and Emotional Problems. Pediatrics, 135(2), 385-395.
Minnesota Child and Teen Checkups: Mental Health Screening
California Chapter of the American Academy of Pediatrics - Surveillance, Screening and Psychosocial Assessment for Behavioral Health Concerns

IOWA Health and Human Services

Number: 834
Title: Nutrition Counseling (Medical Nutrition Therapy) & Counseling for Obesity
Billing Code(s): Initial nutrition assessment & counseling – 97802; Nutrition reassessment and counseling – G0447
Effective Date: 10/01/2022
Revision Date: 05/01/2025
Date of Last Review: 05/01/2025
Authority: Iowa HHS Medicaid Screening Center Provider Manual

Description in Brief

1. Medical nutrition therapy:
    a. Initial nutrition assessment and intervention, face-to-face with the individual
    b. Nutrition reassessment and intervention, face-to-face with the individual
2. Counseling for obesity: This is face-to-face behavioral counseling for obesity.

Overview

Title V Medicaid Screening Centers are eligible for reimbursement of nutrition counseling (medical nutrition therapy) services provided by licensed dietitians who are employed by or have contracts with the provider when a nutrition problem or a condition of such severity exists that nutrition counseling beyond that which is normally expected as part of the standard medical management is warranted. Additionally, Screening Centers are eligible for reimbursement of counseling for obesity. This must be conducted as face-to-face behavioral counseling and be provided by a licensed dietitian or an RN.

Policy

Nutrition and obesity will be assessed at every well-child visit. Refer to "Algorithm for the Assessment and Management of Childhood Obesity in Patients 2 Years and Older" from the AAP Institute for Healthy Childhood Weight. Provide anticipatory guidance and intervention as needed. Contractors shall have an individual order by a primary care provider, or the client shall meet the criteria of the standing order signed by the medical director for medical nutrition therapy, nutrition counseling or counseling for obesity.

Required Credentials

Nutrition counseling (AKA Medical nutrition therapy) must be provided by a licensed dietitian. Counseling for obesity must be provided by a licensed dietitian or an RN.

Procedure

Medical nutrition therapy is used for medically necessary therapeutic nutrition services beyond those provided through the WIC program. Assure that the criteria for providing this service are met. Medical conditions that can be referred to a licensed dietitian include the following (this is not an all-inclusive list. Other diagnoses may be appropriate and warrant referral to a licensed dietitian.):

1. Inadequate or excessive growth. Examples include:
    a. Failure to thrive
    b. Undesired weight loss
    c. Underweight

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   d. Excessive increase in weight relative to linear growth
   e. Major changes in weight-to-height percentile or Body Mass Index (BMI) for the child's age
   f. Excessive appetite or Hyperphagia.
2. Inadequate dietary intake. Examples include:
   a. Formula intolerance
   b. Food allergy
   c. Limited variety of foods
   d. Limited food resources
   e. Poor appetite
3. Infant or child feeding problems. Examples include:
   a. Poor suck or swallow
   b. Breastfeeding difficulties (which may be referred to a certified lactation consultant (CLC))
   c. Lack of developmental feeding progress
   d. Inappropriate kinds or amounts of feeding offered
   e. Limited information or skills of caregiver
   f. Food aversions enteral or parenteral feeding
   g. Delayed oral motor skills
4. Chronic disease requiring nutrition intervention. Examples include:
   a. Congenital heart disease
   b. Pulmonary disease
   c. Renal disease
   d. Cystic fibrosis
   e. Metabolic disorder
   f. Diabetes
   g. Gastrointestinal disease
   h. Any other genetic disorders requiring nutrition intervention.
5. Medical conditions requiring nutrition intervention. Examples include:
   a. Iron deficiency anemia
   b. High serum lead level
   c. Familial hyperlipidemia
   d. Hyperlipidemia
   e. Pregnancy
6. Developmental disability. Examples include:

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   a. Increased risk of altered energy and nutrient needs
   b. Oral-motor or behavioral feeding difficulties
   c. Medication-nutrient interaction
   d. Tube feedings.
7. Psychosocial factors. Examples include behaviors suggesting an eating disorder. Children with an eating disorder should also be referred to community resources and to their primary care provider for evaluation and treatment.

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

1. Informed clinical opinion through objective food record review
2. Evaluation of the child's pattern of growth
3. Evaluation of area of concern based on the evaluation tool used and medical nutrition therapy.

Documentation
Nutrition Counseling (AKA Medical nutrition therapy)

1. This is face-to-face behavioral counseling for nutrition counseling.
2. Must be provided by a licensed dietitian.
3. Time in and time out are required for this service.
4. In the MCAH Database, the first and last name of the service provider & credentials are required.
5. In the client's record, the documentation must adhere to requirements in Iowa Administrative Code [441] Chapter 79.3(2).

Counseling for Obesity

1. This is face-to-face behavioral counseling for obesity.
2. Must be provided by a licensed dietitian or an RN.
3. Time in and time out are required for this service.
4. In the MCAH Database, the first and last name of the service provider & credentials are required.
5. In the client's record, the documentation must adhere to requirements in Iowa Administrative Code [441] Chapter 79.3(2).

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Number: 834
Title: Nutrition Counseling (Medical Nutrition Therapy) & Counseling for Obesity
Billing Code(s): Initial nutrition assessment & counseling – 97802; Nutrition reassessment and counseling – G0447
Effective Date: 10/01/2022
Revision Date: 05/01/2025
Date of Last Review: 05/01/2025
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Billing

1. Use Code 97802: Initial nutrition assessment & counseling (15-minute unit)
2. Use Code 97803: Nutrition reassessment and counseling (15-minute unit)
3. For 15-minute units:
   8-22 minutes = 1 unit
   23-37 minutes = 2 units
   38-52 minutes = 3 units
   53-67 minutes = 4 units
4. For Codes 97802 and 97803, a minimum of 8 minutes must be provided to bill the service.
5. Code G0447: Counseling for Obesity

Resources

Iowa HHS Medicaid Screening Center Provider Manual
Iowa EPSDT Periodicity Schedule
Iowa Administrative Code [441] Chapter 79.3(2).

IOWA Health and Human Services

Number: 835
Title: Nutrition Status Evaluation
Effective Date: 10/01/2022
Revision Date: 05/01/2025
Date of Last Review: 05/01/2025
Authority: Iowa HHS Medicaid Screening Center Provider Manual

Overview

Nutritional status affects every pediatric patient's response to illness. Good nutrition is important for achieving normal growth and development. Nutritional assessment, therefore, should be an integral part of the care for every pediatric patient. Routine screening measures for abnormalities of growth should be performed on all pediatric patients. Those patients with chronic illness and those at risk for malnutrition should have detailed nutritional assessments done. Components of a complete nutritional assessment include a medical history, nutritional history including dietary intake, physical examination, anthropometrics (weight, length or stature, head circumference), and biochemical tests of nutritional status. The use of age, sex, and disease-specific growth charts is essential in assessing nutritional status and monitoring nutrition interventions. The importance of accurate measurements using trained personnel and appropriate equipment cannot be overemphasized.

Policy

Nutritional Status Evaluation is a service that is required to be provided as part of the screening examination.

Procedure

1. At every well-child visit, assess nutrition and obesity. Refer to "Algorithm for the Assessment and Management of Childhood Obesity in Patients 2 Years and Older" from the AAP Institute for Healthy Childhood Weight. And:
    a. Provide anticipatory guidance.
    b. Provide intervention as needed.
2. Assess the nutritional status of the child:
    a. Assure accurate measurements of height and weight. If any of the following apply, consider referral for medical evaluation:
        i. height or weight is above the 95th percentile or below the 5th percentile (See Clinical Growth Charts)
        ii. Greater than a 25% change in height/weight percentile rank
        iii. BMI for age is greater than 95th percentile or less than 5th percentile (for 24 months or older)
        iv. Flat growth curve:
            1. For ages 0-12 months: two months without an increase in weight per age of an infant below the 90th percentile weight per age.
            2. For ages 12-36 months: Two months without an increase in weight per age of a child below the 90th percentile weight per age.

Number: 835
Title: Nutrition Status Evaluation
Effective Date: 10/01/2022
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Authority: Iowa HHS Medicaid Screening Center Provider Manual

3. For ages 3-10 years: Six months without an increase in weight per age of a child below the 90th percentile weight per age.

b. If age-appropriate, screen for iron deficiency anemia (see EPSDT Periodicity Schedule under Hemoglobin and Hematocrit for suggested screening ages).
   i. If any of the following lab tests are below the values for the child's age, consider referral for medical evaluation:

Age	HCT %	HGB gm/dL
0-12 months	32.9%	< 11 (6-12 months)
1-2 years	32.9	11.0
2-5 years	33.0	11.1
5-8 years	34.5	11.4
8-10 years	35.4	11.9

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

c. Discuss dietary practices with parent and/or child to identify:
   i. Diets that are deficient or excessive in one or more nutrients
   ii. Food allergy, intolerance, or aversion

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iii. Inappropriate dietary alterations
iv. Unusual eating habits (such as extended use of bottle feedings, pica, or abnormal behaviors intended to change body weight)

d. Discuss health issues that may exist with the child, including but not limited to:
i. Chronic disease requiring a special diet
ii. Physical handicap or developmental delay that may alter nutrition status
iii. Metabolic disorder
iv. Substance use or abuse
v. Family history of hyperlipidemias
vi. Any behaviors intended to change body weight, such as self-induced vomiting, binging, and purging, use of laxatives or diet pills, skipping meals on a regular basis, excessive exercise

3. Complete physical examination, including dental, with special attention to such general features as pallor, apathy, and irritability. If any of the following apply, consider referral for medical evaluation:
   a. Abnormality of any of the following which indicates poor nutrition: hair, skin or nails, eyes, teeth or gums
   b. Disorders of the thyroid or parotid glands, gastrointestinal disorders, neurological disorders, or skeletal disorders
4. Assess for high-risk cardiovascular disease at 24 months and at 4, 6, 8, and 12-17 years of age. Children at high risk should be screened with a fasting lipid profile. See “Lipid Screening” Policy/Procedure for more information on screening and testing.

Resources
Iowa HHS Medicaid Screening Center Provider Manual
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Sources
Expert Panel on Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents. U.S. Department of Health and Human Services, October 2012.
Mascarenhas MR, Zemel B, Stallings VA. Nutritional assessment in pediatrics. Nutrition. 1998 Jan;14(1):105-15. doi: 10.1016/s0899-9007(97)00226-8. PMID: 9437695.

IOWA Health and Human Services

Number: 837
Title: Psychosocial Counseling
Billing Code(s): Mental health services, not otherwise specified – H0046
Effective Date: 10/01/2022
Revision Date: 05/01/2025
Date of Last Review: 05/01/2025
Authority: Screening Centers Provider Manual

Description in Brief

This is a psychosocial counseling service.

Overview

Psychosocial counseling is provided after a psychosocial concern has been identified (see Policy 832 Mental Health Assessment) to address emotional, situational, and developmental stressors. It is provided in a confidential setting to individuals or families. The goal is to reduce identified risk factors to achieve positive outcomes and optimal child development by reducing distress and enhancing coping skills.

Policy

Psychosocial counseling will be offered to clients and/or families where a psychosocial concern has been identified. If psychosocial counseling is not available by the Maternal Health (MH) or Child and Adolescent Health (CAH) Contractor, the client will be referred for services. Contractors shall have an individual order by a primary care provider, or the client shall meet the criteria of the standing order signed by the medical director for psychosocial counseling.

Required Credentials

Must be provided by a person with at least a bachelor's degree in social work, counseling, sociology, psychology, family counseling, or an RN.

Procedure

Psychosocial counseling follows the screening and assessment process (see Policy 832 Mental Health Assessment) and bases the components of planning, intervention, and closure on the findings of the screening and assessment.

1. **Planning**: a joint process of counseling and goal setting by the health care provider and client, which results in the development of the counseling service plan.
2. **Intervention**: the process of counseling an individual or family during one or more sessions to support the process of overcoming environmental, emotional, or social problems that are affecting the health and well-being of the individual or family members. Intervention includes a follow-up session to assure resolution of issues, reduction of risks, completion of tasks, and/or referrals.
3. **Closure:** the process of determining with the client what progress has been made toward the goals and evaluating the need for further counseling services. Upon discontinuing

Number: 837
Title: Psychosocial Counseling
Billing Code(s): Mental health services, not otherwise specified – H0046
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psychosocial counseling services, a closing summary will be completed indicating the reason for closure, the progress achieved, and any continuing service needs.

4. Appropriate referrals will be made as needed for additional services and/or complicated cases.

Documentation

1. Report the total time of the service (duration).
2. Complete in the MCAH data system:
    a. First and last name of service provider & credentials.
    b. In the 'Comments' field, reference the client's chart for full detail/description/clinical record of the service provided.
3. In the client's record: Documentation must adhere to requirements in Iowa Administrative Code [441] Chapter 79.3(2).

Billing

1. Code H0046 Mental health, not otherwise specified.
2. This is an encounter code and is not billed based on time.

Resources

Iowa HHS Medicaid Screening Center Provider Manual
Iowa EPSDT Periodicity Schedule
Iowa Administrative Code [441] Chapter 79.3(2)

Sources

Bright Futures: Performing Preventive Services - History, Observation and Surveillance
California Chapter of the American Academy of Pediatrics - Surveillance, Screening and Psychosocial Assessment for Behavioral Health Concerns

IOWA | Health and Human Services

Number: 839
Title: Reportable Diseases & Conditions
Effective Date: 10/01/2016
Revision Date: 05/01/2025
Date of Last Review: 05/01/2025
Authority: Iowa Code Chapter 139A; Iowa Administrative Code [641] Chapters 1 and 11; Iowa Code Chapter 141A

Overview

A notifiable disease is any disease or condition that is required by law to be reported to Iowa HHS. The collation of information allows Iowa HHS to monitor the disease and provides early warning of possible outbreaks.

Policy

Maternal Health (MH) and Child and Adolescent Health (CAH) Contractors will comply with the reporting requirements for infectious diseases and conditions as outlined on the Iowa HHS Center for Acute Disease Epidemiology (CADE) Disease Information and Reportable Communicable Diseases and Infectious Conditions webpages.

Required Credentials

MD, DO, ARNP, PA, RN, lab personnel

Procedure

CADE routinely monitors over 45 diseases as well as unusual occurrences of disease (outbreaks). To report diseases immediately, use the 24/7 disease reporting phone hotline: 1-800-362-2736. Diseases can be reported through the following:

1. Iowa Disease Surveillance System (IDSS)
2. Secure fax: (515) 281-5698
3. Phone: 1-800-362-2736
4. Mail: CADE, Lucas State Office Building, 321 E. 12th Street, Des Moines, IA 50319-0075
5. Iowa Disease Reporting Card

Outbreak Reporting

IMMEDIATELY report to the department outbreaks of any kind, diseases that occur in unusual numbers or circumstances, unusual syndromes, or uncommon diseases. Outbreaks may be infectious, environmental, or occupational in origin and include food-borne outbreaks or illnesses secondary to chemical exposure (e.g., pesticides, anhydrous ammonia).

Bioterrorism Reporting

IMMEDIATELY report diseases, syndromes, poisonings, and conditions of any kind suspected or caused by a biological, chemical, or radiological agent or toxin when there is reasonable suspicion that the disease, syndrome, poisoning, or condition may be the result of a deliberate act such as terrorism.

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Examples of these include (but are not limited to) anthrax, mustard gas, sarin gas, ricin, tularemia and smallpox.

Reportable Diseases

Reportable diseases, required timelines for reporting, and how to report are found here.

Documentation

Iowa Disease Reporting Card

Resources

CDC: Notifiable Infectious Disease Data Tables
Iowa Code Chapter 139A
Iowa Administrative Code [641] Chapter 1
Iowa Administrative Code [641] Chapter 11
Iowa Code Chapter 141A

Sources

Iowa Disease Reporting Card
Center for Acute Disease Epidemiology
Reportable Communicable Diseases and Infectious Conditions

IOWA Health and Human Services

Number: 840
Title: Standing Orders
Effective Date: 10/01/2022
Revision Date: 05/01/2025
Date of Last Review: 05/01/2025
Authority: 21 U.S. Code § 823

Overview

Standing orders are written protocols approved by a physician or other authorized practitioner that allow qualified health care professionals (who are eligible to do so under state law, such as registered nurses) to assess the need for and administer direct care, such as vaccine administration, to patients meeting criteria. Qualified healthcare professionals must also be eligible by state law to administer certain medications, such as epinephrine, under standing orders should a medical emergency (rare event) occur.

Having standing orders in place streamlines practice workflow by eliminating the need to obtain an individual physician's order to vaccinate each patient. Standing orders are straightforward to use. The challenge is to integrate them into the practice setting so they can be used to their full potential. This process requires some preparation up front to assure everyone in the practice understands the reasons why standing orders are being implemented, their role in the implementation of the standing order, and their responsibilities in using standing orders.

Policy

Standing orders are permitted to be used in Maternal Health (MH) and Child and Adolescent Health (CAH) programs for direct care services in compliance with state scope of practice laws. If standing orders are used in the clinical setting, they must be reviewed and approved annually by the agency medical director. Staff implementing standing orders must receive training on said orders, including relevant emergency procedures.

Required Credentials

MD, DO, and ARNP are able to create and sign standing orders for clinical staff. RNs, LPNs, and CMAs are able to implement standing orders within their scope of practice.

Procedure

Standing orders should be specific to the population served, the direct care service being provided, and the clinical setting in which they are being implemented. There are many templates available for standing orders. Some are specific to a direct care service, such as immunization administration standing orders from the Immunization Action Coalition. However, if using this type of standing orders, make sure they come

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from reputable sources, reflect current practices, and are applicable to the population served.

If a new standing order must be written, use a standard format for all standing orders across a practice. Be sure to address these issues:

1. Explain clearly who is responsible for each task;
2. Include the date the standing order was written or when it was last reviewed;
3. Describe the patient group to whom the order applies, including any contraindications; and
4. Provide the generic name of any medication or vaccine included in a standing order, the exact dosage, and the route of administration. Follow the Institute for Safe Medication Practices guidelines to avoid error-prone abbreviations, symbols, and dose designations.

Resources

Institute for Safe Medication Practices guidelines to avoid error-prone abbreviations, symbols, and dose designations.
Immunization Action Coalition: Standing Orders Templates for Administering Vaccines

Sources

Family Practice Management Journal: Developing Standing Orders to Help Your Team Work to the Highest Level (June 2018)

IOWA | Health and Human Services

Number: 841
Title: Tuberculosis Risk Assessment & Testing
Billing Code(s): Intradermal TB test, including TB skin test – 86580; TB, cell mediated immunity measurement of gamma interferon antigen response -86480
Effective Date: 10/01/2022
Revision Date: 05/02/2025
Date of Last Review: 05/02/2025
Authority: Screening Centers Provider Manual

Description in Brief

1. IGRA: Blood test for TB (not a skin test)
2. Tuberculosis test using a Mantoux tuberculin skin test (TST)

Overview

Tuberculosis (TB) disease in children under 15 years of age (also called pediatric TB) is a public health problem of special significance because it is a marker for recent transmission of TB. Also of special significance, infants and young children are more likely than older children and adults to develop life-threatening forms of TB disease (e.g., disseminated TB and TB meningitis). Among children, the greatest numbers of TB cases are seen in children less than 5 years of age and in adolescents older than 10 years of age.

Policy

Contractors will complete a risk assessment for exposure to tuberculosis (TB) at well-child visits ages 1, 6, 12 & 24 months and annually starting at age 3 years. TB testing for latent TB infection (LTBI) (either IGRA or TST, depending on age) will be conducted for children who screen as high-risk. Contractors shall have an individual order from a primary care provider, or the client shall meet the criteria of the standing order signed by the medical director for the screening.

Required Credentials

Tuberculin Skin Tests (TSTs) should be performed, read, and recorded by health care workers trained in the administration and interpretation of TSTs. A licensed, trained health care worker can draw TB blood tests. A licensed health care provider (physician, nurse practitioner, physician assistant) must complete result interpretation and follow-up.

Procedure

Risk Assessment

1. Use the risk assessment tool below to identify asymptomatic children (persons under 18 years) who require testing for latent TB infection (LTBI).
2. Test for LTBI using a Mantoux tuberculin skin test (TST) or an Interferon-Gamma Release Assay blood test (IGRA) (e.g., QuantiFERON®-TB Gold or T-SPOT®), unless an appropriately documented,[1,2] negative test dated within the past 90 days or appropriately documented positive test result is available.
3. IGRAs are preferred for people who have received the bacille Calmette-Guerin (BCG)[3] vaccine (commonly given to children outside of the United States).

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4. Repeat testing should only be done in persons who previously tested negative and have new risk factors since their last assessment. If the initial negative screening test occurred prior to 6 months of age, repeat testing should occur at age 6 months or older.
5. A negative TST or IGRA does not rule out active TB disease.
6. For persons with TB symptoms,[4] abnormal chest x-ray consistent with TB disease, or a positive TST or IGRA, Medical homes shall evaluate for active TB disease by obtaining a chest x-ray, symptom screen, performing a physical exam and if indicated,[5] sputum testing (i.e., AFB smears, cultures and nucleic acid amplification). Contact the Iowa HHS TB Control Program at 515-281-7504 or 515-281-8636 for more information and recommendations.

Check the appropriate risk factor boxes below. LTBI testing is recommended for persons with any of the following risk factors.

Risk Factor	Yes	No
Close contact with someone with infectious TB disease		
Birth, travel, or residence in a country with a high TB rate (e.g., any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe)		
Immunosuppression, current or planned – includes but is not limited to HIV infection, organ transplant recipient, treated with TNF-alpha antagonist (e.g., infliximab, etanercept), steroid use equivalent to prednisone ≥15 mg/day for ≥1 month, other immunosuppressive medication use		
Resident of a high-risk congregate setting (e.g., correctional facility, health care facility, homeless shelter, refugee camp)		

[1] TST documentation must include the date of the test (i.e., month, day, year), the number of millimeters of induration (if no induration, document “0” mm) and interpretation (i.e., positive or negative).

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[2] IGRA documentation should include the date of the test (i.e., month, day, year), the qualitative results (i.e., positive, negative, indeterminate, or borderline), and the quantitative assay (i.e., Nil, TB, and Mitogen concentrations or spot counts).
[3] BCG vaccination is not a contraindication for TST or IGRA testing; disregard BCG history when interpreting test results.
[4] Cough that lasts 3 weeks or longer, chest pain, coughing up blood, weakness or fatigue, weight loss, no appetite, chills, fever, or sweating at night.
[5] Sputum testing is indicated for all patients with chest x-ray findings compatible with TB regardless of TST or IGRA results or certain TB symptoms. Please consult with a TB expert.

Screening with TB Blood Test (IGRA):
The American Academy of Pediatrics (AAP) Red Book (2018-2021) indicates interferon-gamma release assay (IGRA) as the primary TB screening test for clients aged 2 years and older (American Academy of Pediatrics, 2018). For more information, refer to the CDC's IGRAs – Blood Tests for TB Infection (www.cdc.gov).

TB blood tests, IGRAs detect the presence of *M. tuberculosis* infection by measuring the immune response to TB proteins in whole blood. TB blood tests may be used to identify people who are likely to benefit from LTBI treatment, including people who are or will be at increased risk of progression to TB disease if infected with *M. tuberculosis*. The two TB blood tests that are commercially available and approved by the U.S. Food and Drug Administration (FDA) as aids in diagnosing *M. tuberculosis* infection are the QuantiFERON®-TB Gold Plus (QFT-Plus) and the T-Spot® TB test (T-Spot).

Conducting a TB Blood Test:
To conduct a TB blood test, a client's blood samples are mixed with antigens and controls. If a person has *M. tuberculosis* infection, the blood cells in the sample will recognize the antigens and release IFN-γ in response. Health care workers should be properly trained on how to conduct a TB blood test. In general, health care workers should read the instructions from the manufacturer and follow the steps below:

1. Confirm arrangements for testing in a qualified laboratory
2. Arrange for delivery of the blood sample to the laboratory within the time the laboratory specifies to ensure testing of samples containing viable blood cells
3. Draw a blood sample from the client according to the test manufacturer's instructions
4. Schedule a follow-up appointment for the client to receive test results
5. Provide follow-up evaluation and treatment as needed based on test results

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Interpreting TB Blood Test Results:
Qualitative results are reported as positive, negative, indeterminate, invalid, or borderline. Quantitative results are reported as numerical values. Quantitative results may be useful for clinical decision-making in combination with the client's risk factors. Health care workers should consider each TB blood test result and its interpretation along with other epidemiologic, historical, physical, and diagnostic findings. Regardless of test results, if a client has signs and symptoms of TB disease or is at high risk for developing TB disease, the client should receive further evaluation.

False-Positive TB Blood Test Results:
Errors in running and interpreting the test can decrease the accuracy of TB blood tests and lead to false-positive results. Therefore, it is important to perform the test according to the manufacturer's instructions.

False-Negative TB Blood Test Results:
Some people have a negative TB blood test result even though they are infected with *M. tuberculosis*. False-negative results can be caused by many things. For example, false-negative TB blood test results may occur if the TB infection occurred within 8 weeks of testing because it can take 2 to 8 weeks after being infected with *M. tuberculosis* for the body's immune system to mount a response detectable by the test. Thus, negative TB blood test results for contacts of persons with infectious TB disease should be confirmed with a repeat test 8 to 10 weeks after their last exposure to TB. Clients with untreated, advanced HIV infection (or AIDS) or advanced immunosuppression, such as sepsis, can also have false negative results. The following are other factors that can cause a false-negative TB blood test result:

1. Incorrect blood sample collection
2. Incorrect handling of the blood collection tubes
3. Incorrect performance of the assay

Screening with Mantoux Tuberculin Skin Test (TST):
TST, also called the Mantoux tuberculin skin test, is an acceptable alternative for Contractors not serving as a medical home. TSTs are recommended for children under 2 years of age. A positive TST at any age is considered valid. For children 6 months of age and older, a negative TST is considered valid. TSTs may be used for children < 6 months of age; however, a negative TST result in a child of this age is unreliable. Iowa HHS recommends repeating an initial negative TST in an infant after the child reaches 6 months of age.

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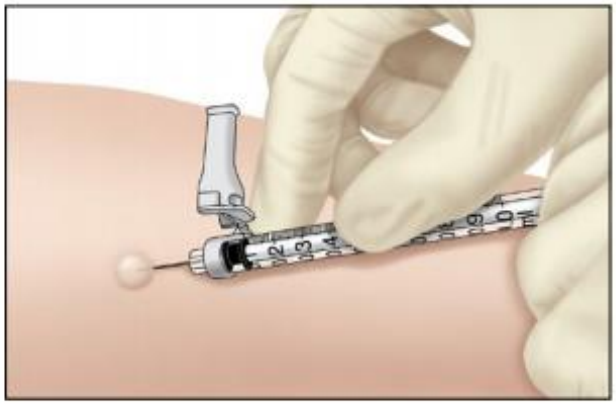
A TST requires two visits with a health care provider. On the first visit, the test is placed; on the second visit, the health care provider reads the test.

Administering the TST:
The TST is performed by intradermal injection of 0.1 ml of PPD containing 5 tuberculin units into the volar surface of the forearm. The injection should be made intradermally (just beneath the surface of the skin) with a disposable 27-gauge tuberculin syringe with the needle bevel facing upward. This should produce a discrete, pale elevation of the skin (a wheal) 6 mm to 10 mm in diameter (Figure 2.2). Institutional guidelines regarding universal precautions for infection control (e.g., the use of gloves) should be followed.

Figure 2.2
Administering the Mantoux TST



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Reading the TEST:
A health care worker trained to read TEST results should assess the reaction 48 to 72 hours after the injection. Reactions to PPD usually begin 5 to 6 hours after injection, reach a maximum of 48 to 72 hours, and subside over a period of a few days. However, positive reactions often persist for up to 1 week or longer. Health care workers should not ask clients to read their own skin test. The TST is read by palpating the site of injection to find an area of induration (firm swelling). The diameter of the indurated area should be measured across the forearm (Figure 2.3). Erythema (redness) should not be measured (Figure 2.4). Induration, even those classified as negative, should be recorded in millimeters. If no induration is found, “0 mm” should be recorded.

Figure 2.4
Reading the TST Incorrectly

- The erythema is being measured.
- This is INCORRECT.
- The incorrect example to the right measures 30 mm.

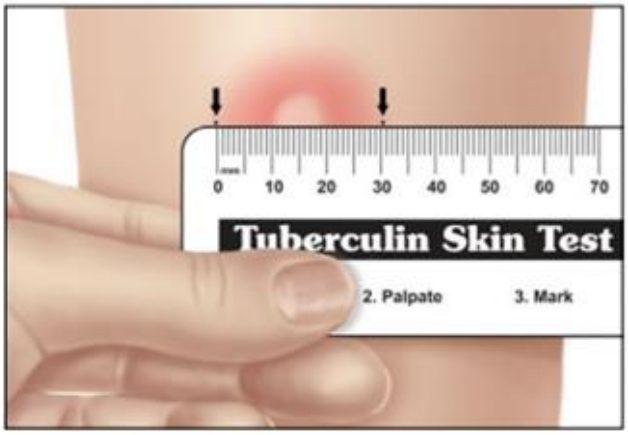
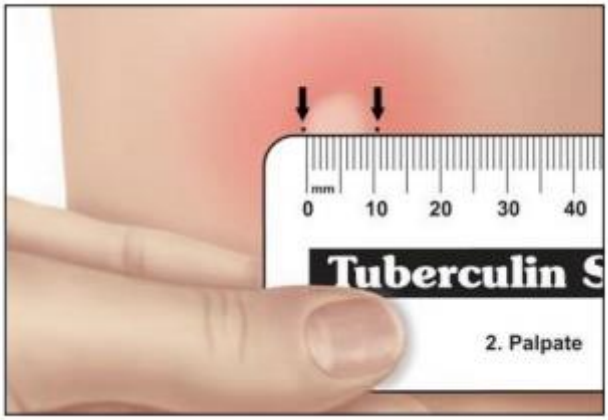


Figure 2.3
Reading the TST Correctly

- Only the induration is being measured.
- This is CORRECT.
- The correct example to the right measures 10 mm.



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Interpreting the TEST:
Interpreting TST Reactions Interpretation of TST reactions depends on the measurement of induration in millimeters and the person's risk of TB infection or progression to TB disease if infected.

Table 2.6
Interpreting the TST Reaction

 5 or more millimeters	 10 or more millimeters	 15 or more millimeters
An induration of **5 or more millimeters** is considered positive for • People living with HIV • Recent contacts of people with infectious TB disease • People who have fibrotic changes on a chest radiograph • Patients with organ transplants • Other immunosuppressed patients (e.g., patients on prolonged therapy with corticosteroids equivalent to/ greater than 15 mg per day of prednisone or those taking TNF-α antagonists)	An induration of **10 or more millimeters** is considered positive for • People born in countries where TB disease is common, including Mexico, the Philippines, Vietnam, India, China, Haiti, and Guatemala • People who abuse drugs or alcohol • Mycobacteriology laboratory workers • People who live or work in high-risk congregate settings (e.g., nursing homes, homeless shelters, or correctional facilities) • People with certain medical conditions that place them at high risk for TB (e.g., silicosis, diabetes mellitus, severe kidney disease, certain types of cancer, or certain intestinal conditions) • People with a low body weight (<90% of ideal body weight) • Children younger than 5 years of age • Infants, children, and adolescents exposed to adults in high-risk categories	An induration of **15 or more millimeters** is considered positive for • People with no known risk factors for TB

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TST False-Positive Reactions:
The TST is a valuable tool, but it is not perfect. Several factors can lead to false-positive or false-negative skin test reactions. Infection with nontuberculous mycobacteria can sometimes cause a false-positive reaction to the TST. Another cause of a false-positive reaction is bacille Calmette Guérin (BCG), a vaccine for TB disease that is rarely used in the United States. People who have been vaccinated with BCG may have a positive reaction to the TEST even if they do not have a TB infection. A false-positive reaction may also occur if an incorrect antigen is used or if the results are not measured or interpreted properly.

TST False-Negative Reactions:
Some people have a negative reaction to the TEST even though they have been infected with *M. tuberculosis*. A false-negative reaction can be caused by many things. If a client has a negative TST, but the health care provider suspects active TB disease and/or latent TB infection, contact the Iowa HHS TB Control Program for more information and recommendations.

Documentation
1. Report the total time of the service (duration).
2. Complete in the MCAH data system:
    a. First and last name of service provider & credentials.
    b. In the 'Comments' field, reference the client's chart for full detail/ description/ clinical record of the service provided.
    c. Attach the TB risk assessment
3. In the client's record: Documentation must adhere to requirements in IAC 441-79.3(2).

Billing
1. Code 86480: Tuberculosis test, cell-mediated immunity measurement of gamma interferon antigen response (IGRA). See Policy 805 Blood Draws for billing information on the blood draw needed to complete an IGRA.
2. Code 86580: Tuberculosis test using a Mantoux tuberculin skin test (TST).

Resources
Iowa HHS Medicaid Screening Center Provider Manual
Iowa EPSDT Periodicity Schedule

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Sources

CDC Core Curriculum on Tuberculosis: What the Clinician Should Know
CDC Tuberculosis: Testing & Diagnosis
Iowa Department of Public Health: TB Control Program
Minnesota Child and Teen Checkups: TB Risk Assessment

IOWA | Health and Human Services

Number: 842
Title: Vision Screening
Billing Code(s): Visual acuity – 99173; Instrument-based ocular screening - 99174
Effective Date: 10/01/2022
Revision Date: 05/02/2025
Date of Last Review: 05/02/2025
Authority: Screening Centers Provider Manual

Description in Brief

1. Screening test of visual acuity, quantitative, bilateral. The screening test used must employ graduated visual acuity stimuli that allow a quantitative estimate of visual acuity (e.g., Snellen chart). Code 99173
2. Instrument-based Ocular Screening (using an approved instrument). Code 99174

Overview

Vision screening remains an important component of regular well-child visits. A newborn's vision is mostly blurry, but the visual system develops over time and is fully formed in the teen years. Childhood vision screenings may provide early detection of vision disorders and opportunities for subsequent treatment.

The difference between a vision screening and a comprehensive eye exam is that a comprehensive eye exam diagnoses eye disease. A child shall be referred for an eye exam if a child fails the vision screen or a concern is noted. In addition, if a parent or client reports vision complaints or observes abnormal visual behavior or is at risk of developing eye problems (infants born prematurely, etc.), has a learning disability, developmental delay, neuropsychological condition, or behavior issue.

Required Vision Screening: Iowa law requires that the parent or guardian of a child enrolled in kindergarten or third grade ensure that evidence of a child's vision screening is submitted to the school in which the child is enrolled. This may be submitted in electronic form or hard copy or electronically through the Iowa Immunization Registry Information System (IRIS).

Vision screening can be performed in several settings, including a healthcare provider's office. The vision screening can be done up to one year prior to the child's enrollment in kindergarten or third grade or no later than 6 months after enrollment.

A resource for vision screenings in Iowa is the Iowa KidSight Program; a joint project of the Lions Clubs of Iowa and the Department of Ophthalmology & Visual Sciences at the University of Iowa Stead Family Children's Hospital, dedicated to enhancing the early detection and treatment of vision impairments in young children (target population 6 months of age through kindergarten) in Iowa communities through screening and public education.

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Number: 842
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Policy

Vision will be assessed at each well-child visit. Vision screening will be completed as part of a well-child visit following the Iowa Periodicity Schedule, with a referral for an eye exam by an ophthalmologist when needed. Contractors shall have an individual order by a primary care provider, or the client shall meet the criteria of the standing order signed by the medical director for the screening.

Required Credentials

MD, DO, ARNP, PA, RN, LPN, or CMA

Procedure

Assess risk at every visit; obtain a history to elicit evidence of any visual difficulties from parents. Vision screening is conducted during the newborn period, between 6-12 months, and at 3, 4, 5, 6, 8, 10, 12, and 15 years of age.

Newborn- 12 months: Click here to view the full scope of pediatric vision screening as stated by the American Academy of Ophthalmology. A doctor or other trained health professional examines an infant's eyes to check for basic indicators of eye health. The screening includes testing for:

1. a "red reflex" (like seeing red eyes in a flash photograph). If the bright light shone in each eye does not return a red reflex, more testing may be needed.
2. blink and pupil response
3. visual inspection of the eye
4. check for healthy eye alignment and movement
5. blink and pupil response

12 to 36 months: Between 12 and 36 months, check for healthy eye development, including amblyopia (lazy eye). If there is a problem, refer to an ophthalmologist.

3 to 6 years: Between 3 and 6 years, a child's vision and eye alignment should be checked. The screening test of visual acuity shall be quantitative and bilateral. The screening test must employ graduated visual acuity stimuli that allow a quantitative estimate of visual acuity (e.g., Snellen chart) or be an instrument-based ocular screening using a Medicaid-approved instrument. Visual acuity (sharpness of vision, like 20/20 for example) should be tested as soon as the child is old enough to read an eye chart (Snellen eye chart if able to distinguish letters or picture eye chart if not). Refer the child for further evaluation if they show signs of any of the following:

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Title: Vision Screening
Billing Code(s): Visual acuity – 99173; Instrument-based ocular screening - 99174
Effective Date: 10/01/2022
Revision Date: 05/02/2025
Date of Last Review: 05/02/2025
Authority: Screening Centers Provider Manual

1. Struggles to read the eye chart
2. misaligned eyes (strabismus)
3. "lazy eye" (amblyopia)
4. refractive errors (myopia, hyperopia, astigmatism)
5. or another focusing problem

5 years and older: At 5, the child is screened for visual acuity and alignment. Nearsightedness (myopia) is the most common problem in this age group. More information is available from the Iowa Child Vision Screening Program.

Documentation

1. Report the total time of the service (duration).
2. Complete in the MCAH data system the first and last name of the service provider & credentials.
3. In the client's record: Documentation must adhere to requirements in Iowa Administrative Code [441] Chapter 79.3(2).

Billing

1. Use Code 99173 for visual acuity
2. Use Code 99174 for instrument-based ocular screening
3. Medicaid does not allow billing for an online vision screen.

Resources

Iowa EPSDT Periodicity Schedule
Iowa Child Vision Screening Program
Iowa Administrative Code [441] Chapter 79.3(2)

Sources

Bright Futures, Guidelines for Health Supervision of Infants, Children and Adolescents
Iowa HHS Medicaid Screening Center Provider Manual
Iowa EPSDT Periodicity Schedule
American Academy of Ophthalmology

IOWA | Health and Human Services

Number: 843
Title: CAH Administration of Direct Care Services in Early Care and Education Settings
Billing Code(s): Various
Effective Date: 10/01/2022
Revision Date: 05/02/2025
Date of Last Review: 05/02/2025

Overview

Because young children in Iowa often spend significant amounts of time in Early Care and Education (ECE) settings, these settings may come to mind as a gap-filling direct care site to facilitate preventive care in young children. Parents may even request services be provided at childcare to decrease barriers to accessing health care in a medical home and/or to avoid having to be present for care that can be distressing to parent and child, such as blood draws and immunizations. There may be times when local boards of health need to conduct procedures in an ECE setting due to communicable disease outbreaks or emergency situations as part of their public health authority. The intent and focus of the Child and Adolescent Health (CAH) program is to build high-quality systems for preventive care using a medical home model. The Caring for Our Children Guiding Principles also support a medical home model. “Young children should receive optimal medical care in a family-centered medical home. Cooperation and collaboration between the medical home and caregivers/ teachers lead to more successful outcomes” (Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs, xix).

ECE settings must be a place where infants and children feel safe and secure, experience nurturing, bonding, and enjoyment, and build trusting relationships with adults to promote early brain development, emotional regulation, and positive mental health (Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs, xix).

Painful, scary, invasive, and/or procedures requiring the child’s movement to be restricted include but are not limited to, capillary or venous blood draws, immunizations, and infant growth measurements.

Early Care and Education settings include center and/or home-based childcare, preschool, daycare, Head Start, Early Head Start, and before/after school programs.

Policy

Painful and/or scary procedures, including but not limited to immunizations and blood draws, shall not be administered in Early Care and Education settings through the CAH program.

Childcare providers/staff shall not be requested or allowed to hold or restrain a child during a procedure/service.

Contractors are required to receive permission from the State Title V program prior to providing **any** direct care services to children in Early Care and Education settings through the CAH Program (vision screening, developmental screening, etc.).

IOWA | Health and Human Services

Number: 843
Title: CAH Administration of Direct Care Services in Early Care and Education Settings
Billing Code(s): Various
Effective Date: 10/01/2022
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If a Contractor seeks an Exception to Policy for a compelling reason to provide painful or scary procedures in an Early Care and Education setting, the parent/legal guardian **must be** present for the procedure.

Procedure

CAH programs may provide gap-filling direct health care services near the ECE setting with parents present to facilitate access to approved gap-filling preventive health care. CAH programs providing gap-filling direct health care services shall provide those services at times that are convenient for families. CAH programs may provide enabling services onsite in the ECE setting to assist families with accessing medical homes.

Sources

American Academy of Pediatrics, American Public Health Association, National Resource Center for Health and Safety in Child Care and Early Education. Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs. 4th ed. Itasca, IL: American Academy of Pediatrics; 2019

IOWA | Health and Human Services

Number: 860
Title: Anticipatory Guidance
Effective Date: 10/01/2022
Revision Date: 04/22/2025
Date of Last Review: 04/22/2025
Authority: Iowa EPSDT Periodicity Schedule

Overview

EPSDT encourages healthcare providers to offer practical and contemporary health information to parents before significant physical, emotional, and psychological milestones. This guidance will help parents anticipate impending changes and take action to maximize their child's developmental potential and identify their child's special needs.

Policy

At each screening visit, provide anticipatory guidance appropriate for the child's age and stage of development.

Procedure

Child and Adolescent Health (CAH) Contractors should develop criteria for anticipatory guidance based on the service provided, the age of the client, and concerns identified during the visit. These criteria are written and available to all clinical service providers. Anticipatory guidance follows public health principles and utilizes best practices provided by a variety of sources (i.e., AAP, Bright Futures, CDC, Zerotothree.org, etc.).

Anticipatory guidance is an essential component of screening services. Providing age-appropriate anticipatory guidance to parents and youth at each screening visit is designed to:

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

Anticipatory guidance must be age-appropriate, culturally competent, and geared to the particular child's medical, developmental, dental, and social circumstances.

Anticipatory guidance recommended topics are included in Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, Fourth Edition. Bright Futures is supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration, and Maternal and Child Health Bureau. It is published by the American Academy of Pediatrics.

The HHS Screening Centers Provider Manual contains lists of suggested anticipatory guidance topics and age-related topics recommended for discussion at screenings. These are guidelines only. They do not require the inclusion of topics that are inappropriate for the child nor limit topics that are appropriate for the child. Additional resources:

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- Bright Futures: A joint project of the Maternal and Child Health Bureau and the American Academy of Pediatrics, these offer comprehensive health supervision guidelines and tools, including recommendations on immunizations, routine health screenings, and anticipatory guidance. Bright Futures also offers free parent handouts and other resources.
- Zero to Three: Materials for parents and providers, including child development handouts for parents that discuss development from the child's perspective.
- Ages and Stages: A series of downloadable brochures on child development based on age from Iowa State University. These brochures are also available in a Spanish version.
- Essentials for Parenting Toddlers and Preschoolers: This CDC website provides information and materials to help parents develop strong, stable and nurturing relationships with their children.

Resources
Iowa EPSDT Periodicity Schedule

Sources
Bright Futures, Guidelines for Health Supervision of Infants, Children and Adolescents
Iowa HHS Medicaid Screening Center Provider Manual
Iowa EPSDT Periodicity Schedule

IOWA | Health and Human Services

Number: 861
Title: Anticipatory Guidance 11-21 years
Effective Date: 10/01/2022
Revision Date: 04/22/2025
Date of Last Review: 04/22/2025
Authority: Screening Center Provider Manual

Overview

Anticipatory guidance (or preventive counseling) is the advice health care professionals provide clients, parents, and caregivers during a visit that addresses problems that could occur in the future. Age-appropriate topics such as nutrition, injury prevention, behavior management, developmental guidance, sex education, and general health education may all be covered during every visit.

Adolescents and young adults in the U.S. are the least likely age group to access preventive health care, so every visit is a vital opportunity for preventive care and anticipatory guidance. Adolescents are interested and very willing to talk with health care providers about selected screening topics and anticipatory guidance, especially when completed within a private, confidential environment (Oregon Pediatric Improvement Partnership, 2015).

Policy

Anticipatory guidance regarding the child's health must be provided as part of every child and adolescent health service. Anticipatory guidance supports health and development and prevents injury and illness as the child grows older. Anticipatory guidance must be age-appropriate, culturally competent, and geared to the particular child's medical, developmental, dental, and social circumstances.

Required Credentials

Anticipatory guidance is provided by a licensed health care provider (MD, DO, ARNP, PA, or RN).

Procedure

Strengths-based counseling is focused on the youth's competencies, healthy behaviors, relationships, community engagement, self-confidence, and decision-making. Providing anticipatory guidance with a strengths-based approach can promote healthy adolescent choices, independence, and involvement in their own health care, as well as decrease risky behaviors (Duncan, 2012).

The effectiveness of anticipatory guidance can be maximized through motivational interviewing, awareness of and respect for the youth's and family's culture and values, and using plain language. Providers should also be aware of consent and confidentiality laws for youth (summary of minor consent statutes in Iowa).

Anticipatory guidance topics should be individualized and prioritized according to the questions and concerns brought by the youth or parent/guardian, as well as gleaned from the health history and physical exam. As an additional resource, the Minnesota Title V Child and Teen Checkup program

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has developed an Adolescents and Young Adults (AYA) Health Questionnaire to facilitate meaningful 1:1 conversations between providers and adolescents/young adults.

Bright Futures offers significant detail on anticipatory guidance topics for adolescents at Bright Futures: Performing Preventive Services - Anticipatory Guidance. Anticipatory guidance specifically for late adolescents/young adults, ages 18-24, can be found at the following AMCHP resource. Other key topics for anticipatory guidance include:

1. **Adolescent Development**:
    a. Sharing the Ten Tasks of Adolescent Development (http://hr.mit.edu) with parents and young people can put the young person's changing needs and behaviors in perspective.
    b. The Bright Futures, 4th ed. provides recommendations for anticipatory guidance by topic and age (Hagan J.F., 2017), including promoting healthy sexual development and sexuality (www.brightfutures.aap.org).
    c. Resources to support adolescent mental health (www.hhs.gov) include a variety of healthy development topics and resources.
2. **Healthy Relationships**: Relationships are foundational to helping young people discover their strengths and make positive contributions to their communities. Encourage parents to set routines and developmentally appropriate expectations, provide positive reinforcement of desired behaviors, and encourage independence (Glascoe, 2010).
    a. Healthy and safe relationships (www.loveisrespect.org)
    b. Ages and Stages: Teen (www.healthychildren.org)
3. **Healthy Lifestyle**:
    a. Parent Information: Teens (Ages 12-19) (www.cdc.gov)
    b. Nutrition and Fitness: Healthy Active Living for Families (www.healthychildren.org)
    c. Internet safety, social media, and screen time: Family Media Plan (www.healthychildren.org)
    d. Sleep: How much sleep do I need? (www.kidshealth.org)
4. **Injury Prevention**:
    a. Safety tips for preteens 10-14 years (www.safekids.org) and teens 15-19 years (www.safekids.org)
    b. Teen Drivers (www.cdc.gov)
    c. Preventing Children's Sports Injuries (www.kidshealth.org)
5. **Illness Prevention:**
    a. Vaccines for Your Children (www.cdc.gov)
    b. Sexually Transmitted Infections (STIs): Prevention (www.cdc.gov)

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Revision Date: 04/22/2025
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Authority: Screening Center Provider Manual

Documentation

Reimbursement for anticipatory guidance is a part of the cost and fee of the direct service or enabling service being provided.

Resources

Screening Center Provider Manual
Iowa EPSDT Periodicity Schedule

Sources

Minnesota Child and Teen Checkups: Anticipatory Guidance: 11-20 Years
Bright Futures: Performing Preventive Services - Anticipatory Guidance
Duncan, P. (2012). Improvement in adolescent screening and counseling rates for risk behaviors and developmental tasks. Pediatrics, 130(5), e1345-1351.
Glascoe, F. a. (2010). Parenting behaviors, perceptions, and psychosocial risk: Impacts on young children's development. Pediatrics, 125(2), 313-319.
Oregon Pediatric Improvement Partnership. (2015, July). Adolescent Well-Visits: An integral strategy for achieving the Triple Aim. Retrieved from https://www.oregon.gov/

IOWA | Health and Human Services

Number: 862
Title: Anticipatory Guidance Birth – 10 Years
Effective Date: 10/01/2022
Revision Date: 04/22/2025
Date of Last Review: 04/22/2025
Authority: Screening Center Provider Manual

Overview

Anticipatory guidance (or preventive counseling) is the advice health care professionals provide clients, parents, and caregivers during a visit that addresses problems that could occur in the future. Age-appropriate topics such as nutrition, injury prevention, behavior management, developmental stimulation, sex education, and general health education may all be covered during every visit.

Parents and guardians who receive anticipatory guidance information report more confidence as caregivers, were more likely to use positive parenting strategies, and were less likely to report feeling worried about the development of their child in the areas that anticipatory guidance was discussed with them (Bethell, Peck, & Schor, 2001).

Policy

Anticipatory guidance regarding the child's health must be provided as part of every well-child visit. Anticipatory guidance supports health and development and prevents injury and illness as the child grows older. Anticipatory guidance must be age-appropriate, considerate of family culture, and geared to the particular child's medical, developmental, dental, and social circumstances.

Required Credentials

Anticipatory guidance should be provided by a licensed health care provider (MD, DO, ARNP, PA, or RN).

Procedure

High-priority topics of anticipatory guidance should be part of the face-to-face conversation with the client/family. Handouts can supplement this in-person guidance, keeping in mind the family's language and literacy needs. Focus anticipatory guidance topics on:

1. Questions and concerns brought by the child and the parent/caregivers,
2. Findings from the child's health history and physical exam and
3. Age-appropriate health promotion and illness or injury prevention (refer to helpful links below).

Motivational interviewing, awareness of and respect for the family's culture and values, and using plain language all improve the effectiveness of anticipatory guidance.

Bright Futures offers significant detail on anticipatory guidance topics at Bright Futures: Performing Preventive Services - Anticipatory Guidance. Additionally, Iowa Family Support Network provides many resources that can be found here. Other key topics for anticipatory guidance include:

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1. **Healthy Relationships**: Positive relationships are the foundation for healthy social-emotional, physical, and cognitive development. Encourage parents to set routines and developmentally appropriate expectations (Glascoe, 2010).
    a. Early Development and Well-Being (www.zerotothree.org)
    b. Search Institutes Developmental Relationship and Developmental Assets Frameworks (www.search-institute.org)
    c. Positive Parenting Tips (www.cdc.gov)
    d. Ages and Stages (www.healthychildren.org)
2. **Healthy Lifestyle:** An active lifestyle and healthy behaviors are important for optimal development and lifelong beneficial habits.
    a. Healthy Living for Families (www.healthychildren.org)
    b. We Can! EatPlayGrow (www.nhlbi.nih.gov)
    c. MyPlate (www.choosemyplate.gov)
    d. Children's Oral Health (www.cdc.gov)
    e. All About Sleep (www.kidshealth.org)
3. **Injury Prevention:** Keeping children safe is a critical role of parenting.
    a. Protect the Ones You Love: Child Injuries are Preventable (www.cdc.gov)
    b. Safe Kids Worldwide Safety Tips (www safekids.org)
    c. Household Safety Checklists (www.kidshealth.org)
    d. Safe to Sleep (www.safetosleep.nichd.nih.gov or Iowa SIDS Foundation)
    e. Preventing Abusive Head Trauma (The Period of Purple Crying website)
    f. Preventing Children's Sports Injuries (www.kidshealth.org)
4. **Illness Prevention:** Children have close and prolonged contact with others, especially in settings such as daycare, preschools, and schools, which puts them at higher risk of contracting illness.
    a. Germ Prevention Strategies (www.healthychildren.org)
    b. Vaccines and Immunizations (www.cdc.gov)
    c. When to Call Your Pediatrician (www.healthychildren.org)

Documentation
Reimbursement for anticipatory guidance is a part of the cost and fee of the direct service or enabling service being provided.

Resources
Iowa HHS Medicaid Screening Center Provider Manual
Iowa EPSDT Periodicity Schedule

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Number: 862
Title: Anticipatory Guidance Birth – 10 Years
Effective Date: 10/01/2022
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Date of Last Review: 04/22/2025
Authority: Screening Center Provider Manual

Sources

Bright Futures: Performing Preventive Services - Anticipatory Guidance
Minnesota Child and Teen Checkups - Anticipatory Guidance: Birth - 10 Years
Bethell, C., Peck, C., & Schor, E. (2001). Assessing Health System Provision of Well-Child Care: The Promoting Health Development Survey. Pediatrics, 1084-1094.
Glascoe, F. a. (2010). Parenting behaviors, perceptions, and psychosocial risk: Impacts on young children's development. Pediatrics, 125(2), 313-319.

Number: 901
Title: Maternal and Child & Adolescent Oral Health Services
Effective Date: 10-1-2016
Revision Date: 10-1-2022
Date of Last Review:
Authority: Iowa Code §135.15; Iowa Administrative Code 641 IAC 50, 641 IAC 76; Social Security Act Title V Sec 506 [42 USC 706]

Policy

Maternal Health and Child & Adolescent Health Contractors are responsible for improving the availability and quality of services to improve oral health for infants, children, adolescents, and pregnant women.

Procedure

Through the core public health functions of assessment, policy development, and assurance, Contractors work to develop comprehensive oral health service systems by:

1. Building public health services and systems,
2. Providing enabling services to assure access to dental care, and
3. Providing gap-filling direct dental services.

Contractors provide these services based on community needs assessment and as specified in the approved application plan on file with the Iowa Department of Public Health (IDPH or Department).

Contractors must provide services with consideration given to the MCH Pyramid levels, with the strongest emphasis on the base of the pyramid activities. See Policy 102 Purpose and Framework of the CAH Program.

Examples of **Public Health Services and Systems** activities regarding oral health include:

1. Surveying dental offices to identify oral health care accessibility in the service area
2. Establishing regular, personal contact with dentists to advocate for children, pregnant people and families
3. Developing referral tracking systems with local dental offices
4. Educating and training physicians on oral health
5. Conducting MCAH staff training to develop oral health education, care coordination, and referral protocols
6. Establishing relationships with school health staff to assure oral health education and prevention services
7. Developing and presenting oral health information for the board of health
8. Participating in the local Community Health Needs Assessment and Health

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Improvement Plan (CHNA-HIP) process
9. Conducting strategic planning with local oral health coalitions and other forums to assess community oral health needs
10. Planning and implementing activities with community partners, such as “Give Kids a Smile Day”
11. Organizing open mouth surveys
12. Providing oral health education for Head Start parents or prenatal classes
13. Providing oral screenings at a community event (e.g. health fair)
14. Providing oral screenings for open-mouth surveys
15. Providing gap-filling screenings for children unable to meet the school dental screening requirement
16. Promoting the importance of oral health
17. Sharing oral health information with local organizations that have an interest in the health of women and children
18. Meeting with childcare providers to evaluate and implement oral health programs
19. Coordinating the school dental screening requirement with local boards of health, schools, and providers
20. Promoting early oral health care through hospital delivery centers, pediatricians, and/or obstetricians/gynecologists

Examples of **Enabling** activities regarding oral health include:
1. Dental care coordination
2. Outreach to dentists to accept referrals
3. Referrals to dentists, medical providers, and community resources
4. Translation/interpretation services
5. Arranging transportation services for clients
6. Outreach and enrollment assistance for public or private dental insurance
7. Assuring health literacy of materials created

Examples of **Gap-Filling Direct Services** are found in Policy 905.

Bureau of Oral and Health Delivery System (OHDS) staff within the Department are available upon request to provide consultation and technical assistance for Contractors.

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Title: Maternal and Child & Adolescent Oral Health Services
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Date of Last Review:
Authority: Iowa Code §135.15; Iowa Administrative Code 641 IAC 50, 641 IAC 76; Social Security Act Title V Sec 506 [42 USC 706]

Sources

- Iowa Code §135.15
- Iowa Administrative Code 641 IAC 50 (135)
- Iowa Administrative Code 641 IAC 76 (135)
- Social Security Act Title V Section 506 [42 USC 706]

IOWA | Health and Human Services

Number: 902
Title: The I-Smile™ Program
Effective Date: 10-1-2016
Revision Date: 10-1-2022
Date of Last Review:
Authority: Iowa Code § 135.15; Iowa Administrative Code 441 IAC 84, 641 IAC 50, 641 IAC 76

Overview

In 2005, the Iowa legislature mandated that Medicaid-enrolled children aged 12 and younger have a designated dental home and be provided with dental screenings and preventive services as identified in the oral health standards under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. The I-Smile™ program was developed in response to this mandate and serves as the comprehensive program to improve the oral health of Iowa children and pregnant women.

Good oral health allows children the ability to eat well, grow and thrive, concentrate on learning, feel positive about their appearance, and improve social interactions, thus contributing to overall well-being and reducing future dental and medical costs. To assure the oral health of Iowa's at-risk children, I-Smile™ is the oral health component of the Child and Adolescent Health (CAH) program and is a collaborative partner program for the Maternal Health (MH) program to assure oral health during pregnancy.

I-Smile™ connects children and families with dental, medical, and community resources to ensure a lifetime of health and wellness. The Department provides funding for I-Smile™ to CAH Contractors through an application process.

Policy

Each CAH Contractor must have an Iowa-licensed dental hygienist serving as the ***I-Smile™ Coordinator*** for its Collaborative Service Area (CSA). The I-Smile™ Coordinator must work at least 32 hours a week on activities to build local public health system capacity and to ensure the provision of enabling and population-based oral health services. The I-Smile™ Coordinator is the single point of contact for oral health activities in each CSA and is included on the Key Personnel Form for CAH Contractors. The I-Smile™ Coordinator is also required to collaborate with the MH Contractor for the CSA. I-Smile™ Coordinators must participate in educational meetings as determined by the Department.

Each CAH Contractor must have an Iowa-licensed registered dental hygienist (RDH) or registered dental assistant (RDA) to serve as the ***Direct Dental Service Planner*** (DDSP). The DDSP assists the I-Smile™ Coordinator by planning and coordinating direct dental services provided by the Contractor. The DDSP may also provide direct dental services. Additional staffing for oral health services must be sufficient to

adequately reflect the CSA needs, including the number of at-risk children and the size of the CSA.

Each MH Contractor must ensure collaboration between the I-Smile™ Coordinator and the local MH Program Coordinator/program staff. This will include meeting with the I-Smile™ Coordinator four times a year, ensuring MH staff are trained prior to providing direct dental services, and developing oral health protocols.

Procedure

The I-Smile™ Coordinator, with assistance from the CAH Project Director and other applicable staff, is responsible for developing and implementing program activities within the CSA. Activities will be developed annually and submitted as part of the CAH program application process. I-Smile™ activities must be based on the needs of the CSA; all counties must be regularly assessed to determine available resources and gaps in oral health services.

The I-Smile™ Coordinator is responsible for implementing the following **I-Smile™ strategies**. Each strategy listed includes examples of activities. More detail is found in the most current I-Smile™ Coordinator Handbook.

1. Develop and build local partnerships in the community to increase awareness about oral health. Consider entities such as:
   a) Local public health organizations
   b) Dental and medical providers
   c) School nurses and administrators
   d) WIC program
   e) Head Start
   f) Businesses
   g) Civic and other community organizations
   h) Food banks
   i) Faith-based organizations
2. Address oral health issues of county residents through linkage with local boards of health.
   a) Provide I-Smile™ program updates to each local board of health
   b) Participate in the local Community Health Needs Assessment and Health Improvement Plan (CHNA-HIP) process

c) Assist with the school screening audit process and report to the local board(s) of health
d) Assist in assessment, policy development, and assurance of local oral health initiatives

3. Establish dental referral networks using outreach visits to dental offices.
   a) Promote age 1 dental visits
   b) Encourage participation in Medicaid and Hawki and/or taking vouchers
   c) Offer training on seeing very young children to help ensure that young children have access to a dentist
   d) Develop relationships with dentists and dental office staff

4. Ensure dental care coordination and referral services for families to facilitate dental visits for regular preventive and restorative care.
   a) Establish a dental referral list (e.g. dentists who accept Medicaid, dentists who see young children, dentists who see new patients)
   b) Assist clients with locating dentists and scheduling appointments
   c) Remind clients that periodic oral screenings or exams are due
   d) Counsel clients about the importance of keeping appointments
   e) Provide follow-up to assure that oral health care was received
   f) Arrange support services such as transportation, child care or translation/interpreter services
   g) Assist families with finding payment sources for dental care
   h) Reinforce anticipatory guidance and oral health education
   i) Link families to other medical and community services (e.g., immunizations, WIC)

5. Conduct program planning and regular needs assessments.
   a) Participate in community health planning and needs assessments
   b) Review, monitor, and use qualitative and quantitative data to share the I-Smile™ story with local partners and policymakers
   c) Use local data to develop annual work plans

6. Develop and maintain protocols and provide training to ensure competency of direct care, informing, and care coordination CAH staff regarding oral health.
   a) Develop protocols – step-by-step descriptions – about how Contractor staff and subcontractors will provide dental care coordination and direct dental services

b) Review protocols at least annually and update them as needed based on program or policy changes or for quality improvement
c) Provide annual education and training for care coordination and informing staff to ensure an understanding of the importance of oral health and early and regular dental care and the need to link families to preventive and restorative care
d) Provide training about dental insurance options, including the Hawki dental-only plan
e) Train all direct service staff each year on the use of the I-Smile™ risk assessment, proper techniques, infection control, and appropriate oral health education topics

7. Collaborate with the Maternal Health Contractor within the CSA to improve oral health and birth outcomes for low-income women, as well as ensure optimal oral health for their infants.
   a) Offer training or assistance to assure appropriate and quality dental care coordination
   b) Train direct care staff about providing gap-filling direct dental services

8. Provide outreach visits to medical providers to ensure they are aware of oral health as part of overall health.
   a) Train non-dental medical providers, such as physicians, nurse practitioners, registered nurses, and physician's assistants, to provide oral screenings, fluoride varnish applications, and education as appropriate within the provider's scope of practice
   b) Provide I-Smile™ referral information and patient education materials to hospitals, free clinics, and medical offices

9. Promote oral health, creating awareness and sharing oral health messages.
   a) Use social media, newspaper ads, and other communication avenues
   b) Develop and distribute oral health promotion and educational materials within communities
   c) Participate in community events and meetings to incorporate oral health within health and social initiatives

10. Ensure the provision of gap-filling preventive dental services for underserved children by direct service staff, including implementation of the I-Smile™ @ School program.
    a) Oral screenings

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Title: The I-Smile™ Program
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b) Fluoride varnish applications
c) Silver diamine fluoride applications
d) Dental sealants
e) Oral hygiene instruction

The Direct Dental Service Planner (DDSP) assists the I-Smile™ Coordinator by planning and coordinating direct dental services (including I-Smile™ @ School) by:

1. Organizing direct service provider schedules;
2. Setting up locations/direct service sites;
3. Ordering supplies;
4. Distributing and collecting forms (e.g., consent forms); and
5. Ensuring accurate data entry.

Other responsibilities should include providing preventive services, providing care coordination, and completing documentation and data entry.

Refer to the most recent I-Smile™ Coordinator Handbook for additional information.

Sources

- Iowa Code §135.15
- Iowa Administrative Code 441 IAC 84
- Iowa Administrative Code 641 IAC 50 (135)
- Iowa Administrative Code 641 IAC 76 (135)

Number: 903
Title: The I-Smile™ @ School Program
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Revision Date: 10-1-2022
Date of Last Review:
Authority: Iowa Code § 135.15; Iowa Administrative Code 441 IAC 84; 641 IAC 50, 641 IAC 76; 42 CFR 441, Subpart B

Overview

A dental sealant is a tooth-colored material applied to the pit-and-fissure surfaces of posterior teeth. Sealants prevent future tooth decay by providing a physical barrier that keeps food debris and decay-causing bacteria from collecting in the pits and grooves of vulnerable teeth.

A school-based sealant program is an evidence-based approach that uses teams of dental providers (which may include dentists, dental hygienists, and/or dental assistants) to apply dental sealants for at-risk children in schools. Iowa's program is called I-Smile™ @ School.

Policy

CAH Contractors must administer I-Smile™ @ School in all eligible schools within the collaborative service area (CSA). To avoid duplication of services, the I-Smile™ @ School program will not be implemented in schools served by other non-IDPH school-based sealant programs. I-Smile™ @ School provides preventive dental services for second and third-grade children in schools with 40% or greater free/reduced lunch rate participation and/or those eligible for Community Eligibility Provision (CEP).

Procedure

I-Smile™ @ School is a component of I-Smile™, incorporating components of all three levels of the MCH pyramid.

The I-Smile™ Coordinator will assure the implementation of the I-Smile™ @ School program through oversight of the Direct Dental Service Planner (DDSP).

To ensure that all I-Smile™ @ School guidelines are followed and requirements are met, the DDSP will:

1. **Assess School Eligibility:** Annually assess the eligibility of all elementary and junior high/middle schools in the service area. This annual assessment includes a review of free/reduced lunch rates and a determination of schools served by other programs.
2. **Complete the Program Workbook:** As part of the annual CAH application

process, complete the I-Smile™ @ School Program Workbook.

3. **Implement the Program:**
    a. Partner with local schools (e.g., schedule dates and distribute forms).
    b. Use appropriate staff (Iowa-licensed dental hygienists, dental assistants, dentists when indicated).
    c. Assure provision of direct services (screening, risk assessment, sealants, and fluoride varnish) to students with consent in participating schools (regardless of payer source).
    d. Ensure that the minimum number of students have been screened each year (as determined by the Department).
    e. Offer students in second and third grades the program services. Grades 1, 4, 5, 6, 7, and 8 may also be served. Contractors may request an exception to the policy if additional grades are anticipated (e.g., kindergarten or 9th grade).
    f. Provide classroom education, as able.

4. **Follow Program Guidelines:**
    a. Use appropriate equipment, supplies, techniques, and procedures.
    b. Use I-Smile™ @ School outreach and promotion materials as directed throughout the project period.
    c. Use standardized forms and materials.
    d. Assure billing of services provided to Medicaid-enrolled students.
    e. Assure provision of care coordination for children/adolescents identified with dental treatment needs by referring students to dental offices for care, assisting families in making appointments, assisting families in finding payment sources for care, and educating families about the need for good oral health and regular care.
    f. Assure use of Medicaid Administrative Funds (MAF) for dental care coordination services provided for Medicaid-enrolled children, when applicable.
    g. Assure data entry of all services and consent tracking into the Department's MCAH data system.
    h. Attend meetings as required by the Department.

For more information, see the most current I-Smile @ School School-Based Oral Health Programs handbook.

Number: 903
Title: The I-Smile™ @ School Program
Effective Date: 10-1-2016
Revision Date: 10-1-2022
Date of Last Review:
Authority: Iowa Code § 135.15; Iowa Administrative Code 441 IAC 84; 641 IAC 50, 641 IAC 76; 42 CFR 441, Subpart B

Sources

- Iowa Code §135.15
- Iowa Administrative Code 441 IAC 84
- Iowa Administrative Code 641 IAC 50 (135)
- Iowa Administrative Code 641 IAC 76 (135)
- 42 CFR 441, subpartB

Number: 904
Title: Oral Health Funding
Effective Date: 10-1-2016
Revision Date: 10-1-2022
Date of Last Review:
Authority: Iowa Code § 135.15; Iowa Administrative Code 641 IAC 76, 641 IAC 50; Social Security Act Title V Section 506 [42 USC 706]

Policy

MH and CAH Contractors shall use available funding for appropriate activities to improve the availability and quality of services to improve oral health for infants, children, adolescents, and pregnant women according to Department guidelines.

Procedures

CH Dental Funding (CAH)

CAH contractors shall use CH Dental grant funds for:

1. Costs of activities to build public health system capacity that provide support for developing and maintaining comprehensive oral health service systems in communities;
2. Costs associated with provision of preventive direct dental services provided by Contractor staff (dental hygienists, nurses, nurse practitioners, physician assistants) for children and adolescents eligible for Title V; and/or
3. Reimbursement, at Medicaid approved rates, to local dentists providing a limited level of preventive and/or restorative dental services for children and adolescents eligible for Title V (dental vouchers). See Policy 919 Child &Adolescent Health Dental Vouchers for Treatment Provided by Dentists.

CH Dental funding cannot be used to support direct dental services provided within federally qualified health center (FQHC) dental clinics.

See Policy 106 Child & Adolescent Health Program Eligibility & Voluntary Participation regarding Title V eligibility requirements.

I-Smile™ Funding (CAH)

CAH contractors shall use I-Smile™ grant funds for the following:

1. Costs associated with building public health systems capacity, including assurance of population-based oral health services and non-billable enabling services, to develop local systems to assure dental access for Medicaid-enrolled

Number: 904
Title: Oral Health Funding
Effective Date: 10-1-2016
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Date of Last Review:
Authority: Iowa Code § 135.15; Iowa Administrative Code 641 IAC 76, 641 IAC 50; Social Security Act Title V Section 506 [42 USC 706]

children; and

2. Costs associated with maintaining a dental hygienist as the I-Smile™ Coordinator, responsible for implementing the Contractor's I-Smile™ project activities and ensuring integration and completion of I-Smile™ strategies as part of the oral health program plan.

I-Smile™ funds cannot be used for any costs associated with the provision of direct dental services, including salaries of direct service staff for the time spent providing direct services or purchase of supplies for direct dental services.

I-Smile™ @ School Funding (CAH)

Based on Department guidelines, CAH Contractors shall use I-Smile™ @ School grant funds for:

1. Costs associated with implementing a school-based sealant program (including planning, personnel, supplies, travel) within schools at 40% or greater free/reduced lunch participation and/or eligibility for the Community Eligibility Provision (CE) designation based on Iowa Department of Education data.

No more than 20% of I-Smile™ @ School grant funds may be used for time spent by staff to provide direct dental care. For the purposes of the I-Smile™ @ School Program, direct service costs only include personnel time spent providing oral screenings and application of sealant and/or fluoride varnish (e.g., time "in the mouth").

Funds may be used for costs associated with providing oral health classroom education to second and third grade students.

Other funds may be used (e.g., from local organizations, private foundations) to serve schools with lower than 40% free/reduced lunch rates. See Policy 903 I-Smile™ @ School Program.

Maternal Oral Health Funding (MH)

There is no oral health-specific grant funding for MH contractors. However, Title V MH grant funds shall be used for activities to build public health services and systems

Number: 904
Title: Oral Health Funding
Effective Date: 10-1-2016
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Date of Last Review:
Authority: Iowa Code § 135.15; Iowa Administrative Code 641 IAC 76, 641 IAC 50; Social Security Act Title V Section 506 [42 USC 706]

related to oral health and enabling services. Funding may also be used to provide direct dental services for Title V-eligible clients.

Hawki and Medicaid Billing/Reimbursement for Direct Dental Services (CAH and MH)

When direct dental services are provided for Hawki or Medicaid-enrolled infants, children, adolescents, and/or pregnant women, MH and CAH Contractors shall bill the client's assigned dental Prepaid Ambulatory Health (PAHP) plan. See Policy 601 Managed Care Organizations and Prepaid Ambulatory Health Plans.

Contractors must bill their established costs, determined via their cost analysis report. The MCAH Cost Analysis Report must be submitted to the Department at the beginning of each multi-year project period and as needed after. See Policy 503 Cost Analysis.

Reimbursement for Dental Care Coordination Services (CAH and MH)

MH and CAH Contractors must bill their use of Medicaid Administrative Funds (MAF) to the Department for time spent providing dental care coordination services to Medicaid-enrolled clients. See Policy 408 Medicaid Administrative Funds Billing.

Other Funding Sources (CAH and MH)

Contractors are encouraged to seek other funds (e.g., foundations, Early Childhood Iowa, community grants) to enhance oral health service systems. Possible use of these supplemental funds may include reimbursing dentists for treatment of eligible clients; contracting with a dental hygienist or nurse to provide oral screenings and fluoride varnish for clients not enrolled on Medicaid; oral health promotion; and purchasing oral health supplies for clients.

Sources

- Iowa Code §135.15
- Iowa Administrative Code 641 IAC 76 (135)
- Iowa Administrative Code 641 IAC 50 (135)
- Social Security Act Title V Section 506 [42 USC 706]

Number: 905
Title: Maternal Health Client Enrollment as Oral Health Only
Effective Date: 10-1-2016
Revision Date: 10-1-2022
Date of Last Review:
Authority: Iowa Code § 135.15; Iowa Administrative Code 641 IAC 76, 641 IAC 50, Social Security Act Title V Section 506 [42 USC 706]

Policy

Maternal Health (MH) Contractors may enroll a client as “oral health only” if the client declines other MH program services, yet oral health services and assistance are needed.

“Oral health only” clients must be enrolled and discharged on the same day unless follow-up services are needed.

Procedure

Full enrollment in the MH program should always be encouraged, but in these situations described, it is not required.

Sources

- Iowa Code §135.15
- Iowa Administrative Code 641 IAC 76 (135)
- Iowa Administrative Code 641 IAC 50 (135)
- Social Security Act Title V Section 506 [42 USC 706]

Number: 906
Title: Dental Care Coordination
Effective Date: 10-1-2016
Revision Date: 10-1-2022
Date of Last Review:
Authority: Iowa Code § 135.15; Iowa Administrative Code 641 IAC 76, 641 IAC 50; Social Security Act Title V Section 506 [42 USC 706]

Policy

Maternal Health (MH) and Child & Adolescent Health (CAH) Contractors must ensure dental care coordination and referral services are provided for Title V-eligible and/or Medicaid-enrolled clients to facilitate dental visits for regular preventive and restorative care. See Policy 703 Care Coordination.

CAH Contractors will:

1. Promote the benefits of preventive oral health care,
2. Provide the names and locations of participating dentists,
3. Encourage families to establish regular dental visits beginning at age 1,
4. Inform families about available payment sources for oral health care and
5. Ensure dental care coordination services for children are provided based on Iowa's EPSDT dental periodicity schedule found here.

MH and CAH Contractors will ensure that all staff who provide dental care coordination are trained using the Department's Dental Care Coordination Protocol, which outlines procedures based on the MH and CAH oral health risk assessments.

MH Contractors will assess pregnant women regarding their access to oral health care and methods to pay for dental care. Medicaid presumptive eligibility determinations are provided for pregnant women who have no health insurance. See Policy 704 Presumptive Eligibility for Medicaid and Hawki.

Medicaid Administrative Funds (MAF) must be used to pay for time spent providing dental care coordination for Medicaid-enrolled children and pregnant women. See Policy 408 Medicaid Administrative Funds Billing. Title V funds may be used to pay for dental care coordination provided for Title V-eligible children and pregnant women. See Policy 106 Child & Adolescent Health Program Eligibility & Voluntary Participation. Other funds (e.g., ECI, I-Smile™ @ School) may be used, as appropriate, to pay for time spent providing dental care coordination for clients.

Procedure

Contractors will develop and annually review policies and procedures (protocols) for providing dental care coordination.

Dental care coordination is provided in person or by phone. If provided by text or email, a response must be documented for the interaction to be considered care coordination.

Number: 906
Title: Dental Care Coordination
Effective Date: 10-1-2016
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Date of Last Review:
Authority: Iowa Code § 135.15; Iowa Administrative Code 641 IAC 76, 641 IAC 50; Social Security Act Title V Section 506 [42 USC 706]

Dental care coordination must be provided to maternal health clients or the parents/guardians of children needing assistance.

Contractors shall review data for quality and appropriateness of care coordination provided and use findings to identify gaps or issues in care coordination protocols and adjust as needed.

Examples of dental care coordination activities include:

1. Assisting clients with locating dentists
2. Assisting with scheduling dentist appointments
3. Reminding clients that periodic oral screenings or exams are due
4. Counseling clients about the importance of keeping appointments
5. Providing follow-up to assure that oral health care was received
6. Arranging support services such as transportation, child care, or translation/interpreter services
7. Assisting families with finding payment sources for dental care
8. Reinforcing anticipatory guidance and oral health education
9. Linking families to other medical and community services (e.g., immunizations, WIC)

Dental care coordination may be provided on the same day as a direct dental service (e.g., oral screening) and documented in the MCAH data system as care coordination. However, the reimbursement/payment source for the direct service is considered to include the time spent providing care coordination when done on the same day.

Documentation

Contractors must enter all documentation for care coordination within the MCAH Data System. If provided on the same day as a direct service, indicate “other” as the payment source for the care coordination time.

See Policy 703 Care Coordination.

Sources

- Iowa Code §135.15
- Iowa Administrative Code 641 IAC 76 (135)
- Iowa Administrative Code 641 IAC 50 (135)
- Social Security Act Title V Section 506 [42 USC 706]

Number: 907
Title: Direct Dental Services Provided by Contractor
Effective Date: 10-1-2016
Revision Date: 10-1-2024
Date of Last Review:
Authority: Iowa Code § 135.15; Iowa Administrative Code 441 IAC 84, 641 IAC 76, 641 IAC 50; Social Security Act Title V Section 506 [42 USC 706]

Overview

Data shows that Maternal Health (MH) and Child & Adolescent Health (CAH) clients are more likely to face challenges accessing care from dentists than from medical providers. As a result, gap-filling direct dental services are an important way for MH and CAH Contractors to help clients prevent dental disease.

Policy

CAH Contractors must provide direct dental services for children ages 0-2 years. CAH Contractors must also provide direct dental services as part of I-Smile @ School in eligible schools within the Collaborative Service Area (CSA). See Policy 903 The I-Smile @ School Program.

Direct dental services may be provided for other children and adolescents through age 20, based on local needs and data that indicate children lack access to dental care and prevention.

MH and CAH direct dental services must be provided according to Department protocols and provider scope of practice regulations. Refer to Policy 917 Supervision of Dental Hygienists Working in Public Health and Policy 918 Supervision of Dental Assistants Working in Public Health.

Training for MH and CAH direct service staff must be provided by the CSA I-Smile Coordinator using HHS-approved training materials. Documentation of training for non-dental staff, including a list of personnel trained, must be completed on Department-provided forms and submitted to the Department's Oral Health (OH) staff.

Contractors must assure that consent is obtained prior to performing oral health services for MH and CAH clients.

An oral screening must always be completed on a client prior to the provision of fluoride varnish, dental sealants, silver diamine fluoride, prophylaxes, or radiographs.

Referrals for regular dental care and dental care coordination services must be provided for pregnant women and children receiving direct dental services by a Contractor.

Direct dental services and care coordination must be documented in the client's health record, including the MCAH data system.

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Number: 907
Title: Direct Dental Services Provided by Contractor
Effective Date: 10-1-2016
Revision Date: 10-1-2024
Date of Last Review:
Authority: Iowa Code § 135.15; Iowa Administrative Code 441 IAC 84, 641 IAC 76, 641 IAC 50; Social Security Act Title V Section 506 [42 USC 706]

Procedure

It is recommended that direct dental services be provided by a dental hygienist employed or contracted by the Contractor. However, based on needs assessment and workforce availability, registered nurses, nurse practitioners and physician assistants who are employed or contracted may also provide direct dental services, if trained by the I-Smile Coordinator for the CSA.

Direct dental services that MH and CAH Contractors may provide are listed as follows. Allowable providers for each service are also included.

Service	Allowable providers	Contractor	Additional Policy
Oral screening	RDH, RN, ARNP, PA	MH, CAH	908, 909
Risk assessment	RDH, RN, ARNP, PA	MH, CAH	908, 909
Fluoride varnish application	RDH, RN, ARNP, PA	MH, CAH	911
Dental sealant application	RDH	MH, CAH	912
Silver diamine fluoride application	RDH	MH, CAH	913
Prophylaxis	RDH	MH, CAH	914
Radiograph	RDH	MH, CAH	914
Oral hygiene instruction	RDH, RN, ARNP, PA	MH, CAH	922
Nutritional counseling for the control of dental disease	RDH, RN, ARNP, PA	MH, CAH	920
Tobacco counseling for the control of dental disease	RDH, RN, ARNP, PA	MH	921
Interpretation services		MH, CAH	709

Number: 907
Title: Direct Dental Services Provided by Contractor
Effective Date: 10-1-2016
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Date of Last Review:
Authority: Iowa Code § 135.15; Iowa Administrative Code 441 IAC 84, 641 IAC 76, 641 IAC 50; Social Security Act Title V Section 506 [42 USC 706]

Providers Key: RDH - registered dental hygienist; RN - registered nurse; ARNP - advanced registered nurse practitioner; PA - physician assistant; RD – registered dietitian

Consent for Oral Screenings: *Active consent is recommended and encouraged for oral screenings*; passive consent is allowable for an oral screening. Active consent means that the client or parent/guardian of a minor (child under age 18 and unmarried) indicates consent for the oral screening and signs and dates the program consent form. Passive (or "opt-out") consent allows a service to be provided unless the parent/guardian has actively declined the service after being notified that the service will be provided. Contractors are responsible for assuring that all required documentation/information is obtained for the purposes of data entry into the Department MCAH Data System.

Consent for All Other Direct Dental Services: *Active consent is required for fluoride varnish applications, sealant applications, silver diamine fluoride applications, prophylaxes, and radiographs*. Active consent means that the client or parent/guardian of a minor (child under age 18 and unmarried) indicates consent for each service and signs and dates the program consent form. Standardized consent forms are available from the Oral Health (OH) staff. Contractors may develop consent forms based on the HHS OH template, which must be approved by OH staff prior to using. Specific consent for use of silver diamine fluoride must be obtained from parents/guardians; forms are available from HHS OH staff.

Combined CAH/oral health or MH/oral health consent forms may be used. Specific oral health services offered by the contractor must be included on the combined consent forms. Contractors must assure that all information required on the oral health consent template is captured within the client medical record.

Signed consent forms are valid for one year.

Contractors may accept a signed consent form that has been faxed or an electronic signature that has been sent via email. Verbal consent over the phone is not acceptable when providing direct services.

Number: 907
Title: Direct Dental Services Provided by Contractor
Effective Date: 10-1-2016
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Authority: Iowa Code § 135.15; Iowa Administrative Code 441 IAC 84, 641 IAC 76, 641 IAC 50; Social Security Act Title V Section 506 [42 USC 706]

Contractors with questions about the necessity of obtaining consent, the person authorized to provide consent, or the adequacy of a consent form are encouraged to contact their agency or private legal counsel to obtain advice on such issues. Refer to Policy 302 Client Records and Policy 304 Client Consent for Services.

***Release of Confidential Information**: Confidential information may only be shared with a signed authorization for release,* unless otherwise specifically authorized by law. All paper and electronic client records that include information on the identity, assessment, diagnosis, prognosis and services provided to specific individuals or families are considered confidential information. See Policy 305 Confidentiality.

A separate release of information form and consent form are required for all oral health services provided. However, when direct dental services are provided in a school setting or any time a parent/guardian is not present, a combined consent/release of information form may be used. In this instance, two signatures must be obtained on the form – one for consent and one authorizing release of information.

The Department's OH section provides templates for consent, release of information and screening forms that include minimum requirements. Contractors may develop agency-specific forms based on the HHS OH template. Forms must be approved by the oral health consultant prior to use.

Documentation

Screening Form documentation must include:

1. Name of client
2. Date of birth
3. Medicaid number, if applicable
4. Date of service
5. Place of service
6. Medical and dental history
7. Findings from the oral screening
8. Dental codes/services provided
9. Duration of service

Number: 907
Title: Direct Dental Services Provided by Contractor
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Authority: Iowa Code § 135.15; Iowa Administrative Code 441 IAC 84, 641 IAC 76, 641 IAC 50; Social Security Act Title V Section 506 [42 USC 706]

10. Oral health education provided, including with whom you spoke
11. Products recommended or dispensed
12. First and last name of provider and credentials
13. Signature/signature log

Sources

- Iowa Code §135.15
- Iowa Administrative Code 441 IAC 84
- Iowa Administrative Code 641 IAC 76 (135)
- Iowa Administrative Code 641 IAC 50 (135)
- Social Security Act Title V Section 506 [42 USC 706]

IOWA Health and Human Services

Number: 908
Title: Child & Adolescent Health Oral Screening and Risk Assessment
Billing Codes: D0190, D0601, D0602, D0603
Effective Date: 10-1-2016
Revision Date: 10-1-2022
Date of Last Review:
Authority: Iowa Code § 135.15, 641 IAC 50, Medicaid Screening Center Provider Manual

Overview

Tooth decay is one of the most common chronic conditions of childhood in the United States. Untreated tooth decay can cause pain and infections that may lead to problems with eating, speaking, playing, and learning.

Oral screenings of Child & Adolescent Health (CAH) clients can identify oral health anomalies or diseases, such as untreated tooth decay, gum disease, developmental problems, and trauma. Oral screening findings help to identify a client's risk level for future dental disease using the I-Smile™ Risk Assessment. The risk assessment provides guidance for Contractors regarding the appropriate education, care coordination, and immediacy regarding referral to a dentist of each client screened.

Policy

CAH Contractors must follow Department guidelines and procedures when providing oral screenings.

An I-Smile™ Decay Risk Assessment, provided by the Department, must be completed on each CAH client receiving an oral screening. The I-Smile™ risk assessment establishes a child's level of risk for tooth decay as low, moderate or high.

Screenings may be provided by Iowa-licensed dental hygienists, registered nurses, advanced registered nurse practitioners, or physician assistants.

All Contractor staff who provide oral screenings must be trained by the CSA I-Smile™ Coordinator prior to providing the service. Documentation of the training of non-dental staff must be on file with the Bureau of Oral and Health Delivery Systems, using forms provided by the Department.

A referral to a dentist must be completed for all clients screened.

Procedure

Oral screenings may be provided at locations where at-risk, low-income infants, children and adolescents may be found, such as WIC clinics, Head Start classrooms, preschools, daycares, and schools.

IOWA Health and Human Services

Number: 908
Title: Child & Adolescent Health Oral Screening and Risk Assessment
Billing Codes: D0190, D0601, D0602, D0603
Effective Date: 10-1-2016
Revision Date: 10-1-2022
Date of Last Review:
Authority: Iowa Code § 135.15, 641 IAC 50, Medicaid Screening Center Provider Manual

Dental explorers cannot be used to complete oral screenings. Visual assessment is sufficient. Using a dental explorer may transfer decay-causing bacteria from one tooth to another or cavitate a demineralized area. The only exception to this requirement is within I-Smile™ @ School; dental explorers are allowed but not required.

A lighting source must be used to complete an oral screening, such as a penlight, headlamp, or lighted mirror.

An oral screening includes a medical/dental history and an oral evaluation. For CAH clients, medical or dental history information that cannot be obtained through an interview with the parent or guardian should be collected through the (parent not present) consent form.

To complete an oral screening:

1. Review Client's Medical History: The medical history consists of:
    a. Name of child's primary care provider
    b. Frequency of medical visits for a well-child/adolescent exam
    c. Immunization status
    d. Current medications used (e.g. those with sugar or those that cause dry mouth, enlarged gingiva, or bleeding)
    e. Allergies
2. Review Client's Dental History: The dental history consists of:
    a. Name of child's dentist
    b. Current or recent oral health problems or injuries
    c. Parental concerns related to child's oral health
    d. Frequency of dental visits
    e. Home care (frequency of brushing, flossing or other oral hygiene practices)
    f. Feeding/snacking habits (exposure to sugar/carbohydrates)
    g. Use of fluoride by child (water source, use of fluoridated toothpaste or other fluoride products)
    h. Parent or sibling decay history
3. Evaluate Client's Soft Tissue
    a. Gum redness or bleeding
    b. Swelling or lumps

Number: 908
Title: Child & Adolescent Health Oral Screening and Risk Assessment
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c. Trauma or injury

4. Evaluate Client's Hard Tissue
    a. Suspected decay
    b. White spot lesions (demineralized areas) near the gumline
    c. Visible plaque
    d. Stained fissures of primary molars
    e. Enamel defects
    f. History of decay (presence of fillings or crowns)
    g. Trauma or injury

To complete the I-Smile™ Decay Risk Assessment, review the oral screening indicators listed in the first column of the risk assessment form. Assign the appropriate risk level according to the "highest" oral screening indicator identified (high, moderate, or low).

Documentation

The client chart must include documentation that the oral screening and risk assessment were provided, including the duration of each service. The services must also be entered in the Department's MCAH data system completing all required fields including the primary payer who is paying for the service. (e.g., Hawki – Delta Dental, Title V, Title XIX - FFS, Title XIX PAHP - Delta Dental or MCNA)

Billing

When provided to Hawki or Medicaid-enrolled clients, the oral screening and risk assessment must be billed to the appropriate Prepaid Ambulatory Health Plan (PAHP) or Iowa Medicaid (for those not enrolled with a dental plan). Use codes D0190 and D0601, D0602, or D0603 to bill.

Sources

- Iowa Code §135.15
- Iowa Administrative Code 641 IAC 50 (135)
- Medicaid Screening Center Provider Manual

IOWA | Health and Human Services

Number: 909
Title: Maternal Health Oral Screening and Risk Assessment
Billing Codes: D0190, D0601, D0602, D0603
Effective Date: 10-1-2016
Revision Date: 10-1-2024
Date of Last Review:
Authority: Iowa Code § 135.15; Iowa Administrative Code 641 IAC 50, 641 IAC 76; Medicaid Maternal Health Center Provider Manual

Overview

A healthy mouth is essential for a healthy pregnancy. Diet and hormonal changes that occur during pregnancy may increase a woman's risk for developing tooth decay and gum disease. Oral infections can affect the health of the mother and her baby. Contractors can have a positive impact on improving the health of Maternal Health (MH) clients and their babies by including risk assessments and oral screening services.

Oral screenings of MH clients can identify oral health anomalies or diseases, such as untreated tooth decay, gum disease, developmental problems, and trauma. Oral screening findings help to identify a client's risk level for future dental disease, using the Oral Health Risk Assessment for Maternal Health. The risk assessment provides guidance for Contractors regarding the appropriate education, care coordination, and immediacy needed regarding referral to a dentist of each client screened.

Policy

MH Contractors must follow Department guidelines and procedures when providing oral screenings.

An Oral Health Risk Assessment for Maternal Health contractors is provided by the Department, and must be completed on each MH client receiving an oral screening. The risk assessment establishes a client's level of risk for tooth decay and/or gum disease as low, moderate or high.

Screenings may be provided by Iowa-licensed dental hygienists, registered nurses, advanced registered nurse practitioners, or physician assistants.

Contractor staff who provide oral screenings must be trained by the CSA I-Smile Coordinator prior to providing the service. Documentation of the training of non-dental staff must be on file with the HHS OH section, using forms provided by the Department.

Contractors must refer all clients screened to a dentist.

MH Contractors that provide full prenatal care services are required to include oral screening for their clients.

1. At least one screening must be completed during the prenatal visit schedule.

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Title: Maternal Health Oral Screening and Risk Assessment
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Date of Last Review:
Authority: Iowa Code § 135.15; Iowa Administrative Code 641 IAC 50, 641 IAC 76; Medicaid Maternal Health Center Provider Manual

2. If a client has not seen a dentist following the initial screening, a second screening is required and can be completed postpartum, if needed.

Procedure

Oral screenings may be provided at locations where at-risk, pregnant women may be found, such as WIC clinics.

Dental explorers cannot be used to complete oral screenings. Visual assessment is sufficient. Using a dental explorer may transfer decay-causing bacteria from one tooth to another or cavitate a demineralized area.

A lighting source must be used to complete an oral screening, such as a penlight, headlamp, or lighted mirror.

An oral screening includes a medical/dental history and an oral evaluation.

To complete an oral screening:

1. Review Client's Medical History: The medical history consists of:
    a. Name of primary care provider
    b. Frequency of medical visits
    c. Pertinent medical conditions (e.g. pregnancy due date, prenatal care, nausea/vomiting, gestational diabetes, heart murmur)
    d. Current medications used (e.g. those with sugar or those known to cause dry mouth, enlarged gingiva, or bleeding)
    e. Allergies
    f. Tobacco, alcohol or drug use
2. Review Dental History: The dental history consists of:
    a. Name of dentist
    b. Current or recent oral health problems or injuries
    c. Frequency of dental visits
    d. Home care (frequency of brushing, flossing or other oral hygiene practices)
    e. Feeding/snacking habits (exposure to sugar/carbohydrates)
    f. Fluoride use (water source, use of fluoridated toothpaste or other fluoride products)

Number: 909
Title: Maternal Health Oral Screening and Risk Assessment
Billing Codes: D0190, D0601, D0602, D0603
Effective Date: 10-1-2016
Revision Date: 10-1-2024
Date of Last Review:
Authority: Iowa Code § 135.15; Iowa Administrative Code 641 IAC 50, 641 IAC 76; Medicaid Maternal Health Center Provider Manual

3. Soft Tissue Evaluation: The soft tissue evaluation consists of:
    a. Gum redness, bleeding or exudate
    b. Swelling or lumps
    c. Trauma or injury
    d. Gingival recession
4. Hard Tissue Evaluation: The hard tissue evaluation consists of:
    a. Suspected decay
    b. White spot lesions (demineralized areas) near the gumline
    c. Visible plaque, calculus (tartar) or stain
    d. Enamel defects
    e. Decay history (presence of fillings or crowns)
    f. Trauma or injury
    g. Loose or missing teeth

To complete the Oral Health Risk Assessment for Maternal Health, review the oral screening indicators listed in the first column of the risk assessment form. Assign the appropriate risk level according to the “highest” oral screening indicator identified (high, moderate, or low).

Some MH clients are eligible to be enrolled as “oral health only” clients. See 905 Maternal Health Client Enrollment as “Oral Health Only”.

Documentation

The client chart must include documentation that the oral screening and risk assessment were completed, including the duration of each service. The services must also be entered in the Department’s MCAH data system completing all required fields including the primary payer who is paying for the service (e.g., Hawki – Delta Dental, Title V, Title XIX - FFS, Title XIX PAHP – Delta Dental or MCNA).

Number: 909
Title: Maternal Health Oral Screening and Risk Assessment
Billing Codes: D0190, D0601, D0602, D0603
Effective Date: 10-1-2016
Revision Date: 10-1-2024
Date of Last Review:
Authority: Iowa Code § 135.15; Iowa Administrative Code 641 IAC 50, 641 IAC 76; Medicaid Maternal Health Center Provider Manual

Billing

When provided to Hawki or Medicaid-enrolled clients, the oral screening and risk assessment must be billed to the appropriate Prepaid Ambulatory Health Plan (PAHP) or Iowa Medicaid (for those not enrolled with a dental plan). Use codes D0190 and D0601, D0602, or D0603 to bill.

Sources

- Iowa Code §135.15
- Iowa Administrative Code 641 IAC 76 (135)
- Iowa Administrative Code 641 IAC 50 (135)
- Medicaid Maternal Health Center Provider Manual

Number: 910
Title: Dental Referrals
Effective Date: 10-1-2016
Revision Date: 10-1-2024
Date of Last Review:
Authority: Iowa Code § 135.15, 641 IAC 50, Medicaid Provider Manuals (Screening Center & Maternal Health Center)

Policy

Maternal Health (MH) and Child & Adolescent Health (CAH) clients must be referred to a dentist for routine care and/or dental treatment.

Procedure

For clients contacted by mail, email, or phone, emphasize the importance of regular and routine dental care from a dentist and offer assistance with a referral.

For clients receiving an oral screening, use the appropriate (I-Smile or MH) risk assessment to determine the referral need.

1. CAH: Inform parent/guardian of the need for a dental exam within six months of an infant's first erupted tooth or by the age of one. Children of any age that are identified with an oral health problem, such as suspected decay, injury, pain, gum inflammation, or abscess, must be referred to a dentist for treatment.
2. MH: Inform MH clients of the importance of regular and routine dental care from a dentist. MH clients should visit a dentist at least once during pregnancy. A MH client identified with an oral health problem such as suspected decay, injury, pain, gum inflammation, or abscess, must be referred to a dentist for treatment.

Documentation

Document a dental referral in the MCAH data system and in a client's hard copy chart (when applicable).

Sources

- Iowa Code §135.15
- Iowa Administrative Code 641 IAC 50 (135)
- Medicaid Screening Center Provider Manual
- Medicaid Maternal Health Center Provider Manual

Number: 911
Title: Fluoride Varnish Application
Billing Code: D1206
Effective Date: 10-1-2016
Revision Date: 10-1-2024
Date of Last Review:
Authority: Iowa Code § 135.15, 641 IAC 50

Overview

Fluoride varnish is a resin-based product that when painted on teeth by a dental or other health care professional, protects the teeth from tooth decay. During application, the varnish forms a thin sticky layer on the tooth which hardens on contact with saliva. Fluoride is then absorbed into the enamel of the tooth. The varnish holds a high concentration of fluoride in a small amount of material in close contact with the teeth for many hours until it is brushed off. Fluoride varnishes must be reapplied at regular intervals with at least four applications per year for optimal effectiveness.

Fluoride varnish is highly effective in preventing decay and re-mineralizing white spot lesions (early tooth decay). It is recommended for use on at-risk children as soon as teeth begin to erupt. It can also be highly effective in preventing tooth decay in pregnant women. The benefits of fluoride varnish make it extremely useful within public health programs. The absorption time into tooth enamel is much longer than for traditional fluoride gels and foams.

Application of fluoride varnish is recommended three to four times a year for Maternal Health (MH) and Child & Adolescent Health (CAH) clients. Because of the rapid hardening of the varnish and the small amount used, the risk of ingestion and toxicity of fluoride varnish is extremely low, making it safe for very young children and pregnant women.

Policy

MH and CAH contractors will ensure the application of fluoride varnish when possible for clients who receive an oral screening,

Fluoride varnish application is limited for use in conjunction with an oral screening and must be provided according to the Department’s fluoride varnish protocol.

Fluoride varnish application must be documented in the MCAH Data System and the client record including the product used and fluoride concentration.

MH and CAH direct service staff must receive training from the I-Smile Coordinator prior to providing fluoride varnish applications for clients.

IOWA Health and Human Services

Number: 911
Title: Fluoride Varnish Application
Billing Code: D1206
Effective Date: 10-1-2016
Revision Date: 10-1-2024
Date of Last Review:
Authority: Iowa Code § 135.15, 641 IAC 50

Procedure

Within the MH and CAH programs, fluoride varnish may be applied by an Iowa-licensed dentist, licensed dental hygienist, licensed physician, registered nurse, advanced registered nurse practitioner, and/or physician assistant. Healthcare professionals must function within their scope of practice or licensure.

The criteria for application of fluoride varnish include any of the following:

1. Presence of suspected tooth decay
2. Presence of white spot lesions
3. Presence of visible plaque
4. History of decay (fillings or crowns)
5. Low socio-economic status

To apply fluoride varnish:

1. Adhere to current I-Smile infection control guidelines.
2. Assemble supplies, including disposable 2x2 gauze sponges, fluoride varnish (single use dosage with applicator), a toothbrush (optional), and paper towels or disposable bib.
3. Wipe teeth with gauze to remove excess plaque or debris.
4. Eliminate excess saliva/moisture from the area using gauze. Work a quadrant at a time, for ease of maintaining a dry, isolated area.
5. Apply a thin layer of varnish to all surfaces of teeth, including the chewing and interproximal surfaces. Avoid applying on large, open decay where there may be pulpal involvement.

Following application, it recommended that the client eat only soft foods for at least two hours, not drink hot liquids or use alcohol-based mouth rinses for at least six hours, not brush or floss for at least 4-6 hours, and wait until the following day for normal brushing and flossing.

Once varnish is applied, it will set quickly upon contact with saliva. Teeth may appear discolored temporarily until the varnish is brushed off.

Repeat fluoride varnish applications at 3-4 month intervals for moderate or high-risk clients and at 6-month intervals for low-risk clients.

Storage: Store varnish in a safe location at room temperature. Store out of the reach of children.

Number: 911
Title: Fluoride Varnish Application
Billing Code: D1206
Effective Date: 10-1-2016
Revision Date: 10-1-2024
Date of Last Review:
Authority: Iowa Code § 135.15, 641 IAC 50

Documentation

The client chart must include documentation that the fluoride varnish was provided, including the product used, concentration, and duration of the service. The service must also be entered in the

Department's MCAH data system completing all required fields including the primary payer who is paying for the service (e.g., Hawki – Delta Dental, Title V, Title XIX - FFS, Title XIX PAHP – Delta Dental or MCNA).

Billing

When provided to Hawki or Medicaid-enrolled clients, the fluoride varnish service must be billed to the appropriate Prepaid Ambulatory Health Plan (PAHP) or Iowa Medicaid (for those not enrolled with a dental plan). Use code D1206 to bill.

Sources

- IDPH Fluoride Varnish Protocol
- Iowa Code §135.15
- Iowa Administrative Code 641 IAC 50 (135)

Number: 912
Title: Dental Sealants
Billing Code: D1351
Effective Date: 10-1-2016
Revision Date: 10-1-2024
Date of Last Review:
Authority: Iowa Code § 135.15; Iowa Administrative Code 650 IAC 10, 641 IAC 50

Overview

A dental sealant is a resin that prevents tooth decay when applied and “cured” to the chewing surface of posterior teeth. Using dental sealants is an important public health preventive service for low-income, uninsured and/or underinsured children and adolescents, particularly when placed on permanent molar teeth.

The teeth most at risk of decay, and therefore most in need of sealants, are the first and second permanent molars. For optimal prevention, the molars should be sealed as soon as possible after the teeth have sufficiently erupted, around ages 6-8 and 12-14 years. Permanent premolars may also benefit from sealants; application on those teeth can be determined on an individual basis. Although sealing primary molars is a Medicaid-billable service, this should be limited to children whose age and behavior will allow an optimal application procedure to ensure sealant retention.

Policy

Child & Adolescent Health (CAH) Contractors are required to participate in the I-Smile @ School program, per eligibility guidelines, to apply dental sealants to the posterior teeth of second and third-graders in eligible schools. See Policy 903 I-Smile @ School Program. CAH Contractors are also encouraged to apply dental sealants to the posterior teeth of age-appropriate clients in other settings if possible.

Iowa-licensed dentists and dental hygienists are allowed to apply dental sealants. The use of dental assistants is recommended. Dental assistants must be registered with the Iowa Dental Board. Registered nurses may also assist with the application of sealants. Hygienists and assistants must use public health supervision. See Policy 917 Supervision of Dental Hygienists Working in Public Health and 918 Supervision of Dental Assistants Working in Public Health.

Laypeople may help with documentation and/or transfer of students.

Procedure

CAH clients must first have an exam from a dentist or an oral screening from a dentist or a dental hygienist to determine which teeth will benefit from the application of dental

Number: 912
Title: Dental Sealants
Billing Code: D1351
Effective Date: 10-1-2016
Revision Date: 10-1-2024
Date of Last Review:
Authority: Iowa Code § 135.15; Iowa Administrative Code 650 IAC 10, 641 IAC 50

sealants. The hygienist's public health supervision agreement must include oral screenings to determine sealant application.

Based on the findings from the exam or screening, a dentist or dental hygienist may apply dental sealants. A dental hygienist must practice under public health supervision of a dentist, with a collaborative agreement that includes sealant application.

See the most current I-Smile @ School School-Based Oral Health Programs handbook for additional guidance.

Periodic retention checks are recommended for quality assurance, according to Department protocols.

Documentation

The client chart must include documentation that the dental sealant(s) was provided, including the product used, tooth number(s), and duration of the service. The service must also be entered in the Department's MCAH data system, completing all required fields, including the primary payer who is paying for the service (e.g., Hawki – Delta Dental, Title V, Title XIX - FFS, Title XIX PAHP – Delta Dental or MCNA).

Billing

When provided to Hawki or Medicaid-enrolled clients, the dental sealant service must be billed to the appropriate Prepaid Ambulatory Health Plan (PAHP) or Iowa Medicaid (for those not enrolled with a dental plan). Use code D1351 to bill (or D1353 to bill for a replacement sealant).

- **Sources**
- Iowa Code §135.15
- Iowa Administrative Code 650 IAC 10
- Iowa Administrative Code 641 IAC 50 (135)

Number: 913
Title: Silver Diamine Fluoride
Billing Code: D1354
Effective Date: 10-1-2018
Revision Date: 10-1-2024
Date of Last Review:
Authority: Iowa Code § 135.15; 641 IAC 50, 650 IAC 10

Overview

Silver diamine fluoride (SDF) is a topical treatment that can arrest some tooth decay and prevent future decay. It is particularly beneficial for at-risk children and adults seen in public health settings. SDF can stop the disease process, reducing the immediate need for restorative treatment that is sometimes difficult for families served by the CAH program to obtain.

SDF cannot be used on pregnant or nursing women.

Policy

Child & Adolescent (CAH) Contractors are required to offer silver diamine fluoride (SDF) applications when appropriate for children with untreated tooth decay.

Within CAH programs, only employed or contracted Iowa-licensed dental hygienists are allowed to apply for SDF. Use of SDF must be included on a hygienist's public health supervision agreement, which requires both the hygienist and dentist to complete an Iowa Dental Board-approved training.

An oral screening must be provided prior to SDF application. If an area of tooth decay is identified that is appropriate for use of SDF, the hygienist must receive specific written (active) consent from the parent/guardian to apply the SDF.

If written consent for SDF is not possible on the day of screening, SDF must be provided within 30 days of the documented screening. If the application cannot be done within 30 days, another fully documented screening must be completed prior to the SDF application.

Application of SDF must be provided according to the Department's silver diamine fluoride protocol.

Procedure

The primary indications for use of SDF for a CAH client are to stabilize uncontrolled tooth decay for clients at moderate or high risk of experiencing new lesions and to treat decayed lesions for clients with limited or no access to restorative dental care.

Number: 913
Title: Silver Diamine Fluoride
Billing Code: D1354
Effective Date: 10-1-2018
Revision Date: 10-1-2024
Date of Last Review:
Authority: Iowa Code § 135.15; 641 IAC 50, 650 IAC 10

To apply silver diamine fluoride:

1. Adhere to OH section consent requirements and infection control guidelines.
2. Assemble supplies, including a tray, plastic-lined tray cover, plastic-lined patient bib, petroleum jelly, cotton-tipped applicator, 2x2 gauze sponges, silver diamine fluoride, disposable dappen dish, and micro brush applicator.
3. Wear gloves to open the bottle of SDF and place one drop in the dappen dish (one drop will treat up to five surfaces).
4. Clean the area where SDF will be applied if needed. (toothbrushing is sufficient)
5. Use the cotton-tipped applicator to apply petroleum jelly to client's lips and soft tissue near the application site and dry teeth with 2x2 gauze.
6. Dip the micro brush into the SDF, and remove excess against the dapper dish.
7. Apply to a lesion for 2-3 minutes.
8. If it is not possible to maintain a dry field or keep the SDF in contact for 2-3 minutes, apply for at least one minute and then apply fluoride varnish over the area.
9. Rinse with water, if desired.
10. Gather all materials used and hold inside the palm of one gloved hand. Remove the glove, inside out, wrapping it around the materials and other glove. Dispose of in a garbage bag.

Avoid contacting SDF with gingiva, mucosa, skin, countertops, and clothing.

Use caution in areas of demineralization because it will darken if applied with SDF.

If using fluoride varnish for the client, apply SDF prior to fluoride varnish application.

Following application, recommend that the client not eat or drink for at least 30 minutes and not brush their teeth for at least one hour.

Remind client and/or parent/guardian that the treated area will increase in darkness over the next week and an examination from a dentist is needed. Complete the Department-provided information flyer to the parent/guardian to share with a dentist.

Repeat SDF applications at 3-4 month intervals, as needed.

Number: 913
Title: Silver Diamine Fluoride
Billing Code: D1354
Effective Date: 10-1-2018
Revision Date: 10-1-2024
Date of Last Review:
Authority: Iowa Code § 135.15; 641 IAC 50, 650 IAC 10

Documentation

The client chart must include documentation that SDF was provided, including the product used, tooth number(s) and duration of the service. The service must also be entered in the Department's MCAH data system completing all required fields including the primary payer, who is paying for the service (e.g., Hawki – Delta Dental, Title V, Title XIX - FFS, Title XIX PHP – Delta Dental or MCNA).

Documentation must also include verification that the specific consent was obtained.

Billing

When provided to Hawki or Medicaid-enrolled clients, the SDF service must be billed to the appropriate Prepaid Ambulatory Health Plan (PAHP) or Iowa Medicaid (for those not enrolled with a dental plan). Use code D1354 to bill.

Sources

- IDPH Silver Diamine Fluoride Protocol
- Iowa Code §135.15
- Iowa Administrative Code 641 IAC 50 (135)
- Iowa Administrative Code 650 IAC 10

Number: 914
Title: Prior Approval to Provide Prophylaxes and Radiographs
Billing Codes: D1120, D1110, D0274, D0272, D0270
Effective Date: 10-1-2016
Revision Date: 10-1-2024
Date of Last Review:
Authority: Iowa Code § 135.15, Iowa Administrative Code 650 IAC 10, 641 IAC 50

Policy

Prior approval from the Department's Oral Health section is required in order for Maternal Health (MH) and Child & Adolescent Health (CAH) programs to offer and provide prophylaxes and/or radiographs. The basis for providing either service must be linked to a community needs assessment.

Periodontal assessment must be part of a prophylaxis service.

Due to the threat of bleeding associated with prophylaxis, a detailed medical history must be completed to evaluate a client's risk for bacterial endocarditis or other blood-related conditions. This would include, but not be limited to, a client who has a heart murmur, takes anticoagulant medications or is immune suppressed.

Prophylaxes and radiographs may only be provided by a dentist or a dental hygienist. Dental hygienists must work under public health supervision, and the collaborative agreement must include the guidelines for prophylaxis and/or radiograph services.

Contractors must have standing orders in place with a dentist(s) who will receive and review radiographs.

See Policy 917 Supervision of Dental Hygienists Working in Public Health.

Procedure

Contact your oral health consultant within the Department to request prior approval to provide prophylaxis and/or radiograph services.

Documentation

The client chart must include documentation that the prophylaxis and/or radiograph(s) were provided, including the duration of the service(s). The service must also be entered in the Department's MCAH data system, completing all required fields, including the primary payer, who is paying for the service (e.g., Hawki – Delta Dental, Title V, Title XIX - FFS, Title XIX PAHP – Delta Dental or MCNA).

Number: 914
Title: Prior Approval to Provide Prophylaxes and Radiographs
Billing Codes: D1120, D1110, D0274, D0272, D0270
Effective Date: 10-1-2016
Revision Date: 10-1-2024
Date of Last Review:
Authority: Iowa Code § 135.15, Iowa Administrative Code 650 IAC 10, 641 IAC 50

Billing

When provided to Hawki or Medicaid-enrolled clients, the prophylaxis and/or radiograph service must be billed to the appropriate Prepaid Ambulatory Health Plan (PAHP) or Iowa Medicaid (for those not enrolled with a dental plan). Use code(s) D1120, D1110, 0274, 0272, or 0270.

Sources

- Iowa Code §135.15
- Iowa Administrative Code 650 IAC 10
- Iowa Administrative Code 641 IAC 50 (135)

IOWA | Health and Human Services

Number: 915
Title: Hawki and Medicaid Billable Direct Dental Services
Billing Code(s): See below
Effective Date: 7-1-2021
Revision Date: 10-1-2024
Date of Last Review:
Authority: Iowa Code § 135.15, Iowa Administrative Code 441 IAC 84; 42 CFR 441, subpart B

Policy

Maternal Health (MH) and Child & Adolescent Health (CAH) Contractors must bill Hawki, Medicaid or the Prepaid Ambulatory Health Plans (PAHPs) for direct dental services provided to enrolled clients.

MH and CAH Contractors must bill their actual cost for providing direct dental services. See Policy 503 Cost Analysis.

The following table lists the Hawki and Medicaid-billable dental services. Those that are only allowable to be provided by dental hygienists are noted as such.

Code and Service Description	Frequency
D0120 Periodic oral evaluation by a dentist.	Every 6 months
D0150 Initial oral evaluation by a dentist	1 time per patient; also allowed when provider has not seen patient within a 3-year period
D0190 Oral screening by a non-dentist	Every 6 months
D0601 Caries risk assessment and documentation, with a finding of low risk by a dentist, dental hygienist or nurse	Every 6 months with screening/evaluation
D0602 Caries risk assessment and documentation, with a finding of moderate risk by a dentist, dental hygienist or nurse	Every 6 months with screening/evaluation
D0603 Caries risk assessment and documentation, with a finding of high risk by a dentist, dental hygienist or nurse	Every 6 months with screening/evaluation
D0270 Bitewing radiograph – single film (hygienist only)	1 time in 12-month period
D0272 Bitewing radiograph – two films (hygienist only)	1 time in 12-month period

IOWA | Health and Human Services

Number: 915
Title: Hawki and Medicaid Billable Direct Dental Services
Billing Code(s): See below
Effective Date: 7-1-2021
Revision Date: 10-1-2024
Date of Last Review:
Authority: Iowa Code § 135.15, Iowa Administrative Code 441 IAC 84; 42 CFR 441, subpart B

Code and Service Description	Frequency
D0274 Bitewing radiograph – four films (hygienist only)	1 time in a 12-month period
D1110 Prophylaxis, adult – age 13 and over (hygienist only)	Every 6 months
D1120 Prophylaxis, child – age 12 and under (hygienist only)	Every 6 months
D1206 Topical application of fluoride varnish	4 times a year
D1310 Nutritional counseling for the control and prevention of oral disease (may be provided by a dietitian)	Every 6 months
D1320 Tobacco counseling for the control and prevention of oral disease	Every 6 months
D1330 Oral hygiene instruction	Every 6 months
D1351 Sealant - per tooth (hygienist only) ● Permanent premolars, molars, and primary molars ● Children through 18 years of age or those with a physical or mental disability	Every 6 months
D1353 Replacement sealant – per tooth (hygienist only)	One year after placement by CAH Contractor; 1 time every 3 years
D1354 Interim caries arresting medicament application – per tooth (hygienist only) ● Conservative treatment of an active, non-symptomatic carious lesion by topical application of silver diamine	Twice a year

Number: 915
Title: Hawki and Medicaid Billable Direct Dental Services
Billing Code(s): See below
Effective Date: 7-1-2021
Revision Date: 10-1-2024
Date of Last Review:
Authority: Iowa Code § 135.15, Iowa Administrative Code 441 IAC 84; 42 CFR 441, subpart B

fluoride without mechanical removal of sound tooth structure	
D9990 Certified translation or sign-language services ● In-person interpretation ● Staff employed or contracted for interpretation	Once per day per client

Procedure

Enroll as a provider with each PAHP. See Policy 601 Managed Care Organizations and Prepaid Ambulatory Health Plans.

Use the Medicaid Eligibility Verification System (ELVS) to verify client eligibility for services. Reference the MCAH data system to determine if a service may be provided based on Medicaid/Hawki frequency requirements and the client's designated PAHP. Verification must be completed in the month of the service.

See Policy 907 Direct Dental Services Provided by Contractor.

Follow the Contractor's established billing protocol.

Sources

- Iowa Code §135.15
- Iowa Administrative Code 441 IAC 84
- Iowa Administrative Code 441
- 42CFR 441.B

Number: 916
Title: School Dental Screening Requirement
Effective Date: 10-1-2016
Revision Date: 10-1-2024
Date of Last Review:
Authority: Iowa Code § 135.17, Iowa Administrative Code 641 IAC 51

Overview

All children entering kindergarten and ninth grade in an Iowa public or accredited non-public elementary or high school must provide the school with proof of a dental screening using Department-approved forms.

The purpose of the dental screening requirement is to improve the oral health of Iowa's children. The dental screenings:

1. Facilitate early detection and referral for treatment of dental disease;
2. Reduce the incidence, impact, and cost of dental disease;
3. Inform parents and guardians of their children's dental problems;
4. Encourage the establishment of effective oral health practices early in life;
5. Promote the importance of oral health as an integral component of preparation for school and learning and
6. Contribute to statewide surveillance of oral health.

Policy

I-Smile Coordinators (within Child & Adolescent Health programs) must assist schools, families, and local boards of health to assure compliance with the dental screening requirement, including annual audits.

Procedure

Local assistance by I-Smile Coordinators may include:

1. Distributing dental screening certificates and information to schools and dental offices and at community outreach events;
2. Ensuring the provision of gap-filling dental screenings in schools and/or other public health settings for children who are unable to receive a screening from a dentist;
3. Ensuring care coordination to help children receive screening and/or restorative care from a dentist;
4. Training non-dental health care professionals to provide screenings in compliance with program requirements;
5. Working with schools and local board(s) of health to audit screening certificates; and

Number: 916
Title: School Dental Screening Requirement
Effective Date: 10-1-2016
Revision Date: 10-1-2024
Date of Last Review:
Authority: Iowa Code § 135.17, Iowa Administrative Code 641 IAC 51

6. Compiling local school screening data to share with the local board(s) of health and other partners.

Resource

- IDPH School Dental Screenings

Sources

- Iowa Code § 135.17
- Iowa Administrative Code 641 IAC 51(135)

Number: 917
Title: Supervision of Dental Hygienists Working in Public Health
Effective Date: 10-1-2016
Revision Date: 10-1-2022
Date of Last Review:
Authority: Iowa Code § 135.15, Iowa Administrative Code 650 IAC 10

Policy

All Iowa-licensed dental hygienists employed or contracted by Maternal Health (MH) and Child & Adolescent Health (CAH) Contractors to provide direct dental services must have public health supervision from a dentist. This allows hygienists to provide services in public health settings without patients first being examined by a dentist.

Hygienists may provide educational and program administrative services without supervision.

Procedure

To work under public health supervision, a dental hygienist must have an active Iowa license and a minimum of one year of clinical experience. A collaborative agreement between a dentist and hygienist is required, outlining the services that can be provided, locations where services will be provided, and standing orders for the services. A current template for public health supervision agreements may be found on the Department website.

If a hygienist's public health supervision agreement includes the use of silver diamine fluoride (SDF), both the hygienist and dentist must complete an Iowa Dental board-approved training prior to entering into the agreement.

The hygienist must submit a copy of the final, signed collaborative public health supervision agreement to the Department's Bureau of Oral and Health Delivery Systems (OHDS). Dental hygienists and their supervising dentist are responsible for reviewing the agreement biennially to assure that information is current. If updates are needed, a revised agreement must be sent to OHDS. An addendum may be requested from OHDS to add sites and/or services to the agreement on file.

Each dental hygienist who has rendered services under public health supervision must annually complete and file a report of those services provided during a calendar year with OHDS. Each year, OHDS staff will provide instructions and a report form to be used by hygienists with active agreements on file.

Public health supervision agreements are required to include information about maintaining dental records of services provided by the hygienist and where the records are to be located. Because services will be provided as part of the MH and CAH

Number: 917
Title: Supervision of Dental Hygienists Working in Public Health
Effective Date: 10-1-2016
Revision Date: 10-1-2022
Date of Last Review:
Authority: Iowa Code § 135.15, Iowa Administrative Code 650 IAC 10

programs, records must be maintained by Contractors and not at different locations. See Policy 302 Client Records.

Dentists providing public health supervision for hygienists are not required to provide future dental treatment for patients served by a hygienist.

Sources

- Iowa Code §135.15
- Iowa Administrative Code 650 IAC 10

Number: 918
Title: Supervision of Dental Assistants Working in Public Health
Effective Date: 10-1-2016
Revision Date: 10-1-2022
Date of Last Review:
Authority: Iowa Administrative Code 650 IAC 20

Policy

All Iowa-registered dental assistants employed or contracted by Maternal Health (MH) and Child & Adolescent Health (CAH) Contractors to provide intraoral and/or extraoral direct services must have public health supervision from a dentist. This allows assistants to provide services in designated public health settings. Assistants may provide care coordination and/or administrative services without supervision.

Procedure

A dental assistant must be registered in Iowa and have a minimum of one year of clinical practice experience to work under public health supervision of a dentist. A collaborative agreement between a dentist and assistant is required that includes the services that can be provided, where services will be provided, and standing orders for the services. A current template for public health supervision agreements may be found on the Department website.

The dental assistant must submit a copy of the final, signed collaborative agreement to the Department's Bureau of Oral and Health Delivery Systems (OHDS) and the Iowa Dental Board. Each dental assistant and dentist are responsible for reviewing the agreement biennially to assure that information is current. If updates are needed, a revised agreement must be sent to OHDS and the Iowa Dental Board. An addendum may be requested from OHDS to add sites and/or services to the agreement on file.

Each dental assistant who has rendered services under public health supervision must annually complete and file a report of services provided under public health supervision for a calendar year with OHDS. Each year, OHDS staff will provide instructions and a report form to be used.

Sources

- Iowa Administrative Code 650 IAC 20

IOWA | Health and Human Services

Number: 919
Title: Dental Vouchers for Treatment Provided by Dentists
Effective Date: 10-1-2016
Revision Date: 10-1-2024
Date of Last Review:
Authority: Iowa Code § 135.15, Iowa Administrative Code 641 IAC 76, 641 IAC 50, Social Security Act Title V Sec 506 [42 USC 706]

Policy

Child & Adolescent (CAH) Contractors may use CH Dental funds to reimburse dentists (via "dental vouchers") for a limited number of basic preventive and restorative dental services, at Medicaid approved rates, for CAH clients enrolled in Title V. CH Dental funds **cannot** be used to support direct care services provided within Federally Qualified Health Center (FQHC) dental clinics.

Contractors that use CH Dental funds to reimburse dentists for services must have a written agreement with those dentists.

Procedure

Client eligibility for Title V must be assessed. See Policy 106 CAH Eligibility and Voluntary Participation.

Agreements with dentists should include:

1. A list of the reimbursable dental procedures and the reimbursement amounts for those procedures;
2. If the Contractor has determined a maximum amount that will be allowed per child per voucher, include the amount allowed without prior authorization;
3. Information on how a dental office may request an "exception" for procedures not currently on the list;
4. Clarification that voucher reimbursement is accepted as payment in full and the patient/family is not responsible for additional costs; and
5. I-Smile Coordinator contact information.

Contractors may create a "dental voucher" system to use for reimbursement of dental services for eligible clients. The voucher may be given to a family to provide a participating dental office, indicating that the Contractor will reimburse the dental office for allowable treatment costs (using CH Dental funds).

Each year, Contractors receive an updated list of pre-authorized codes and reimbursement levels from the Oral Health (OH) Section. Reimbursement rates are based on the most current Medicaid and/or Prepaid Ambulatory Health Plan (PAHP) fee schedule.

Number: 919
Title: Dental Vouchers for Treatment Provided by Dentists
Effective Date: 10-1-2016
Revision Date: 10-1-2024
Date of Last Review:
Authority: Iowa Code § 135.15, Iowa Administrative Code 641 IAC 76, 641 IAC 50, Social Security Act Title V Sec 506 [42 USC 706]

Payment protocols must be based on Medicaid guidelines for dentists. Refer to the Medicaid Dental Services Provider Manual.

CH Dental funds/dental vouchers cannot be used to pay for direct services provided within FQHC dental clinics.

Oral Health staff may grant exceptions to use CH Dental funds for services that are not on the pre-authorized list of codes. To request an exception, Contractors must complete the Department's *Title V Voucher Exception to Policy Request* form and submit to assigned OH consultant.

The I-Smile Coordinator will be notified by OH staff of the final decision.

Documentation

For any client receiving care from a dentist that is reimbursed with CH Dental funds, "dental voucher" must be indicated as a service for that client in the Department MCAH Data System.

CAH Contractors must enter all voucher data into the MCAH data system by the 30th of the month following the end of each fiscal quarter (January 30, April 30, July 30 and October 30). The data includes: the number of children who saw a dentist using CH Dental funds, the number of dental procedures provided by dentists and the total amount of treatment dollars reimbursed to dentists per quarter.

Sources

- Iowa Administrative Code 641 IAC 76 (135)
- Social Security Act Title V Sec 506 [42 USC 706]
- Medicaid Dental Services Provider Manual

IOWA | Health and Human Services

Number: 920
Title: Nutritional Counseling
Billing Code: D1310
Effective Date: 10-1-2016
Revision Date: 10-1-2022
Date of Last Review:
Authority: Iowa Code § 135.15, 641 IAC 50

Overview

Oral health education, including nutritional counseling, is an integral service provided by MH and CAH contract agencies. It is important that MH and CAH clients understand how carbohydrates contribute to dental disease and thus can affect overall health.

Policy

MH and CAH contractors will provide nutritional counseling for the control and prevention of oral disease for clients when appropriate.

Provision of nutritional counseling must be documented in the MCAH data system and the client record.

MH and CAH direct service staff must receive training from the I-Smile™ Coordinator prior to providing nutritional counseling for clients.

Procedure

Within the MH and CAH programs, nutritional counseling for the control and prevention of oral disease may be provided by an Iowa-licensed dentist, licensed dental hygienist, licensed physician, registered nurse, advanced registered nurse practitioner, physician assistant, and/or dietitian. Healthcare professionals must function within their scope of practice or licensure.

For CAH contractors providing nutritional counseling, the following age-appropriate oral health topics may also be included for parents/caregivers and older children:

- Decay process
- Dental disease risks associated with certain foods and beverages, including bottle and sippy cup habits
- Dental disease risks associated with certain medications (e.g. seizure medications, those that cause dry mouth, or sugary cough syrups used for an extended time)

For MH contractors providing nutritional counseling, the following oral health topics may also be included:

- Decay process
- Dietary habits, including inappropriate snacking and soda pop consumption

Documentation

The client chart must include documentation that the nutritional counseling was provided, the duration of the service, and who received the counseling. Client-specific

notes must be included in the documentation that clearly demonstrates why the counseling was provided and supports the duration of the service.

The service must also be entered in the Department's MCAH data system, completing all required fields, including the primary payer who is paying for the service (e.g., Hawki – Delta Dental, Title V, Title XIX - FFS, Title XIX PAHP – Delta Dental or MCNA).

Billing

When provided to Hawki or Medicaid-enrolled clients, the counseling service must be billed to the appropriate Prepaid Ambulatory Health Plan (PAHP) or Iowa Medicaid (for those not enrolled with a dental plan). Use code D1310 to bill.

Sources

- Iowa Code §135.15
- Iowa Administrative Code 641 IAC 50 (135)

IOWA | Health and Human Services

Number: 921
Title: Tobacco Counseling
Billing Code: D1320
Effective Date: 10-1-2016
Revision Date: 10-1-2022
Date of Last Review:
Authority: Iowa Code § 135.15, 641 IAC 50

Overview

Tobacco counseling for the control and prevention of oral disease is an important component of services provided to both maternal health clients and adolescents. It is important for clients to understand that tobacco use can lead to oral disease and healthy teeth and gums contribute to overall health.

Policy

MH and CAH contractors will provide tobacco counseling for the control and prevention of oral disease for clients when appropriate.

The provision of tobacco counseling must be documented in the MCAH data system and the client record.

MH direct service staff must receive training prior to providing tobacco counseling for clients. The online training, *Treating Tobacco Use During Pregnancy*, must be taken, and course completion must be documented with the I-Smile™ Coordinator. The training can be found at the following link:

- https://quitlogixeducation.org/iowa/

CAH direct service staff may find additional courses for adolescents at the same link. Training is not required prior to providing tobacco counseling for the control and prevention of oral disease for adolescents, as it is not a billable service.

Procedure

Tobacco counseling for the control and prevention of oral disease may be provided by an Iowa-licensed or registered dentist, dental hygienist, physician, nurse, advanced registered nurse practitioner, and/or physician assistant. Healthcare professionals must function within their scope of practice or licensure.

For MH contractors providing tobacco counseling may include the following oral health topics in addition to the information provided in the tobacco cessation training:

- Pregnancy gingivitis related to tobacco use
- Tobacco associated risks of periodontal disease and link to pre-term labor
- Systemic implications of oral diseases linked to tobacco use
- Oral cancer linked to tobacco use

For CAH contractors providing tobacco counseling may include the following oral health topics:

Number: 921
Title: Tobacco Counseling
Billing Code: D1320
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- Systemic implications of oral diseases linked to tobacco use
- Oral cancer linked to tobacco use

Documentation

The client chart must include documentation that the counseling was provided, the duration of the service, and who received the counseling. Client-specific notes must be included in the documentation that clearly demonstrates why the counseling was provided and supports the duration of the service.

The service must also be entered in the Department's MCAH data system, completing all required fields, including the primary payer who is paying for the service (e.g., Hawki – Delta Dental, Title V, Title XIX - FFS, Title XIX PAHP – Delta Dental or MCNA).

Billing

Billing is **only** available for MH contractors. When provided to Hawki or Medicaid-enrolled MH clients, the counseling service must be billed to the appropriate Prepaid Ambulatory Health Plan (PAHP) or Iowa Medicaid (for those not enrolled with a dental plan). Use code D1320 to bill. Tobacco counseling is not a billable service for CAH contractors.

Sources

- Iowa Code §135.15
- Iowa Administrative Code 641 IAC 50 (135)

IOWA | Health and Human Services

Number: 922
Title: Oral Hygiene Instruction
Billing Code: D1330
Effective Date: 10-1-2016
Revision Date: 10-1-2022
Date of Last Review:
Authority: Iowa Code § 135.15, 641 IAC 50

Overview

Oral hygiene instruction is an integral component of the services provided by MCAH contract agencies. Helping clients understand how to keep teeth and gums healthy is an important component of overall health.

Policy

MH and CAH contractors will provide oral hygiene instruction for clients when appropriate. Oral hygiene instruction must include a hands-on demonstration of oral hygiene techniques, along with the importance of brushing with fluoridated toothpaste at least twice a day for 2 minutes each time.

The provision of oral hygiene instruction must be documented in the MCAH data system and the client record.
MH and CAH direct service staff must receive training from the I-Smile™ Coordinator prior to providing oral hygiene instruction for clients.

Procedure

Within the MH and CAH programs, oral hygiene instruction may be provided by an Iowa-licensed or registered dentist, dental hygienist, physician, nurse, advanced registered nurse practitioner, and/or physician assistant. Healthcare professionals must function within their scope of practice or licensure.

For CAH contractors, the required hands-on demonstration of brushing and possibly flossing may also include the following educational topics for parents/caregivers and older children:

- Importance of baby teeth
- First dental visit by age 1 and periodic visits based on the client's risk assessment
- Proper daily cleaning and monthly "Lift the Lip" techniques
- Risks associated with certain foods and beverages, including bottle and sippy cup habits
- Importance of topical fluoride exposure
- Non-nutritive sucking (fingers or pacifier)
- Teething/eruption patterns
- Dental disease risks associated with certain medications (e.g. seizure medications, those that cause dry mouth, or sugary cough syrups used for an extended time)

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- Oral piercing
- Tobacco use

For MH contractors, the required hands-on demonstration of brushing and possibly flossing may also include the following educational topics for their pregnant clients:

- Home care (e.g. brushing twice a day for 2 minutes)
- Dietary habits, including inappropriate snacking and soda pop consumption
- Pregnancy gingivitis
- Morning sickness
- Risks of periodontal disease and link to pre-term labor
- Systemic implications of oral diseases
- Fluoride
- Transfer of decay-causing bacteria from mother to child
- Infant oral health care

Documentation

The client chart must include documentation that the oral hygiene instruction was provided, the duration of the service, and who received the counseling. Client-specific notes must be included in the documentation that clearly demonstrates why the counseling was provided and supports the duration of the service.

The service must also be entered in the Department's MCAH data system, completing all required fields, including the primary payer who is paying for the service (e.g., Hawki – Delta Dental, Title V, Title XIX - FFS, Title XIX PAHP – Delta Dental or MCNA).

Billing

When provided to Hawki or Medicaid-enrolled clients, oral hygiene instruction must be billed to the appropriate Prepaid Ambulatory Health Plan (PAHP) or Iowa Medicaid (for those not enrolled with a dental plan). Use code D1330 to bill.

Sources

- Iowa Code §135.15
- Iowa Administrative Code 641 IAC 50 (135)