Number: 800
Title: Provision of Gap-Filling Direct Care Services
Effective Date: 10/01/2022
Revision Date: 09/08/2025
Date of Last Review: 09/08/2025
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

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

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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: 09/08/2025
Date of Last Review: 09/08/2025
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. 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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3. 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: 09/08/2025
Date of Last Review: 09/08/2025
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
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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: 09/08/2025
Date of Last Review: 09/08/2025
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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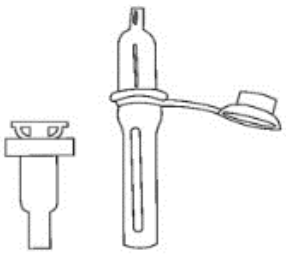
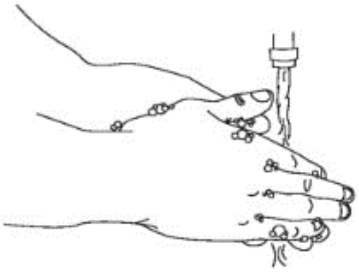
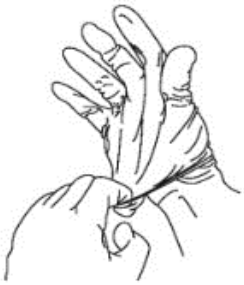


1. Lancet and collection tube.

2. Assemble equipment and supplies.

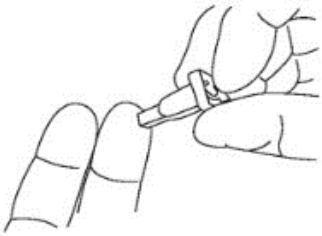


3. Perform hand hygiene (if using soap and water, dry hands with single-use towels).

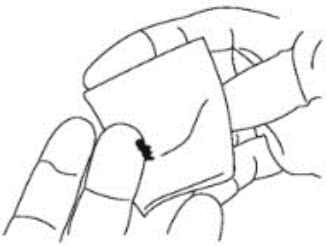


4. Put on well-fitting, non-sterile gloves.

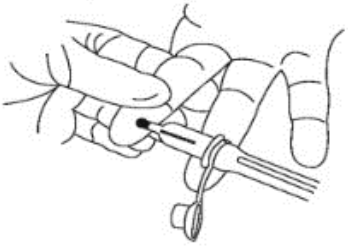
5. Select the site. Apply 70% isopropyl alcohol and allow to air dry.



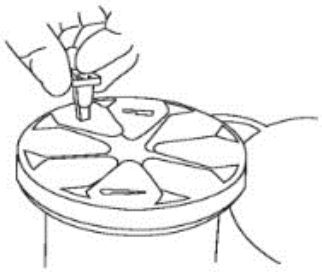
6. Puncture the skin.



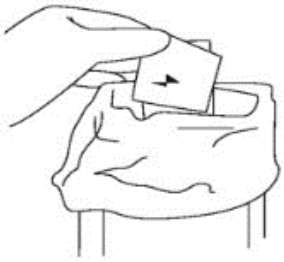
7. Wipe away the first drop of blood.



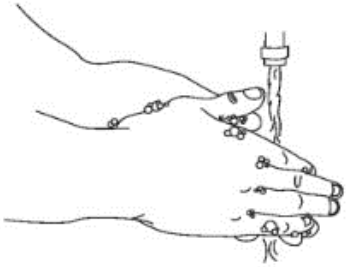
8. Avoid squeezing the finger too tightly.



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).

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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 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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Billing Codes: Collection of venous blood by venipuncture - 36415; Collection of capillary blood specimen - 36416
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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:

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
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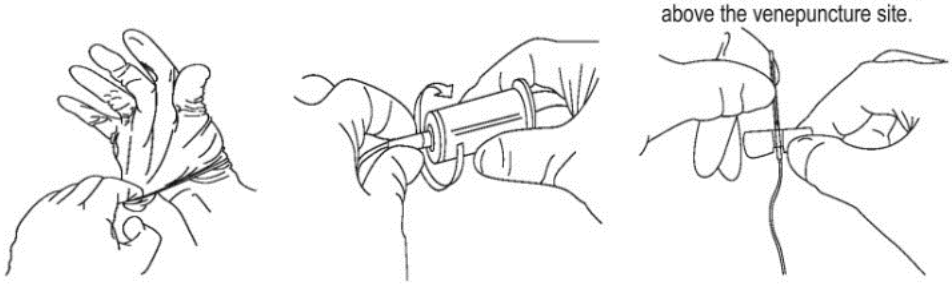
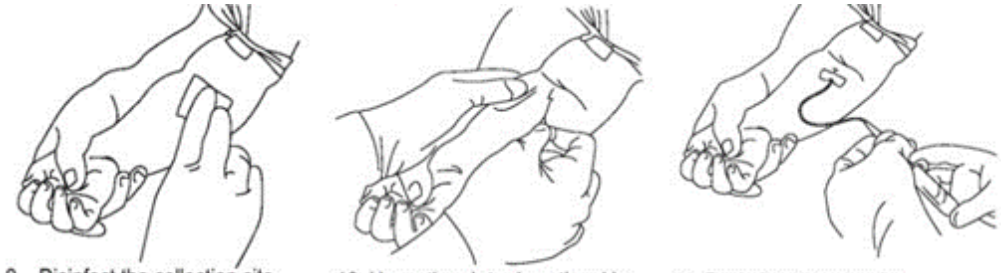
Authority: Iowa HHS Medicaid Screening Center Provider Manual

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.

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: 09/08/2025
Date of Last Review: 09/08/2025
Authority: Iowa HHS Medicaid Screening Center Provider Manual

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: 09/09/2025
Date of Last Review: 09/09/2025
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: 09/09/2025
Date of Last Review: 09/09/2025
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

Number: 806
Title: Blood Lead Evaluation and Management
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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 90460/90461).
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: 09/09/2025
Date of Last Review: 09/09/2025
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
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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.

IOWA | Health and Human Services

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: 09/09/2025
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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 Guidelines 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.

IOWA | Health and Human Services

Number: 807
Title: Blood Lead Screening, Analysis, and Handling/Conveyance
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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, note this in the narrative to see clinical chart for further details.

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 (Collection of venous blood by venipuncture), 36416 (Collection of capillary blood specimen), 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 Guidelines
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: 09/09/2025
Date of Last Review: 09/09/2025
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

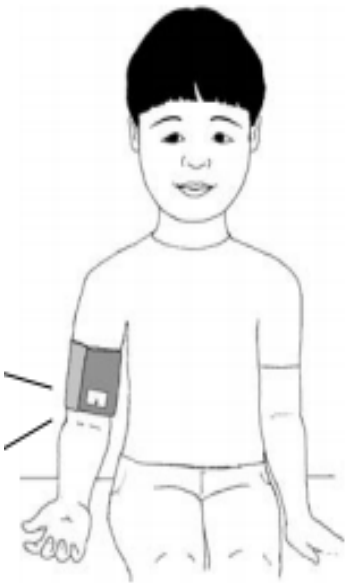
The blood pressure of children should be assessed as part of the well visit starting at 3 years of age. Children less than 3 years of age should have their BP checked under special conditions, including a history of prematurity, congenital heart disease malignancy, and other systemic illnesses. Contractors 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).

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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
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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: 09/09/2025
Date of Last Review: 09/09/2025
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/ppc/patient_care/mental_health.html (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. 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

Sources

Minnesota Child and Teen Checkups: Maternal Depression Screening.

IOWA | Health and Human Services

Number: 809
Title: Caregiver Depression Screening
Billing Code: Depression Screening - 96161
Effective Date: 10/01/2022
Revision Date: 09/09/2025
Date of Last Review: 09/09/2025
Authority: Screening Center Provider Manual

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: 09/09/2025
Date of Last Review: 09/09/2025
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

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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: 09/09/2025
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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: 09/09/2025
Date of Last Review: 09/09/2025
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: 09/10/2025
Date of Last Review: 09/10/2025
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 | Health and Human Services

Number: 301
Title: Required Policies and Procedures
Effective Date: 10/01/2022
Revision Date: 09/10/2025
Date of Last Review: 09/10/2025
Authority: Iowa Administrative Code 641-76, Iowa HHS General Conditions for Service Contracts; OCIO Information Technology Standards

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: 09/10/2025
Date of Last Review: 09/10/2025
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.

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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.

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Effective Date: 10/01/2022
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Authority: Medicaid Screening Center Manual

Billing

Use the following well-child exam codes:

1. **Initial screen (New Patient):**
   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 (Established Patient):**
   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 HHS 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: 09/11/2025
Date of Last Review: 09/11/2025
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. Code 96161.

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.

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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. Report the total time of the service (duration) for Code G0444.
2. For code 96161, report the total time of the service (duration).

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Title: Depression Screening
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Authority: Screening Center Provider Manual

Complete in the MCAH data system:

1. First and last name of service provider & credentials.
2. 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

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: 817
Title: Documentation of Services in MCAH Data System
Effective Date: 10/01/2022
Revision Date: 09/16/2025
Date of Last Review: 09/16/2025
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: 09/17/2025
Date of Last Review: 09/17/2025
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: 09/17/2025
Date of Last Review: 09/17/2025
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: 09/17/2025
Date of Last Review: 09/17/2025
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.

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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
Effective Date: 10/01/2022
Revision Date: 09/17/2025
Date of Last Review: 09/17/2025
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.

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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.

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
Effective Date: 10/01/2022
Revision Date: 09/17/2025
Date of Last Review: 09/17/2025
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
Revision Date: 09/17/2025
Date of Last Review: 09/17/2025
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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

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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). **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

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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)

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

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IOWA | Health and Human Services

Number: 825
Title: Hemoglobin/Hematocrit
Effective Date: 10/01/2022
Revision Date: 09/17/2025
Date of Last Review: 09/17/2025
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: 09/17/2025
Date of Last Review: 09/17/2025
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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Revision Date: 09/17/2025
Date of Last Review: 09/17/2025
Authority: Screening Centers Provider Manual

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 service S9123.
2. Report the total time of the service (duration) for service S9127.
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). This is an encounter code and is not based upon a timed unit. Document duration of service.
   f. 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.

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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

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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
Revision Date: 08/21/2025
Date of Last Review: 08/21/2025
Authority: Screening Centers Provider Manual

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. 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

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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.
   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.

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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.
   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.

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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 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

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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.

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

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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.

Billing

1. The VFC vaccine is used for children through the age of 18 years (at no cost to the agency or to the family).
2. Vaccines may be billed for Medicaid-enrolled children over the age of 18 years (ages 19 and 20 years).
3. If there is a shortage of the VFC vaccine, an IME Informational Letter will be provided with instructions for billing the vaccine.

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4. 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.
   a. Administration codes:
      i. Use 90460 for each vaccine administered. Submit your cost per your cost analysis. 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.
      ii. Use Code 90471 for the initial administration of the vaccine (single or combination), subcutaneous or intramuscular. Use Code 90472 for subsequent administrations of vaccine (single or combination) subcutaneous or intramuscular on the same day as Code 90471. Do not use these immunization administration codes if using 'immunization administration with counseling' (Code 90460/90461).
      iii. Use Code 90473 for the administration of one vaccine (single or combination) by intranasal or oral means. Use Code 90474 for the administration of an additional vaccine through intranasal or oral means. Do not use these immunization administration codes if using 'immunization administration with counseling' (Code 90460/90461).
      iv. Do not bill 90471 with 90473; can bill 90471 with 90474.
      v. Bill the appropriate administration code(s) (per your cost analysis) and the CPT code(s) for the VFC vaccine (at $0.00 in box 24F).

Resources
ACIP Recommendations Immunization Schedule.
CDC: Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2025
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)
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Vaccine Information Statements

Sources
CDC Pink Book, Vaccine Administration

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Billing Codes: IPV Screening for an adolescent – 96160; IPV Screening for a caregiver of a child health client - 96161
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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?

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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.

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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, document duration of service.

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: 09/18/2025
Date of Last Review: 09/18/2025
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
Revision Date: 09/18/2025
Date of Last Review: 09/18/2025
Authority: Iowa HHS Medicaid Screening Center Provider Manual

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
Iowa EPSDT Periodicity Schedule
Iowa HHS Medicaid Screening Center Provider Manual

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: 09/18/2025
Date of Last Review: 09/18/2025

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: 09/18/2025
Date of Last Review: 09/18/2025
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: 09/18/2025
Date of Last Review: 09/18/2025
Authority: Iowa HHS Medicaid Screening Center Provider Manual

Resources

Iowa HHS Medicaid Screening Center Provider Manual
Iowa EPSDT Periodicity Schedule

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: 09/18/2025
Date of Last Review: 09/18/2025
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: 09/18/2025
Date of Last Review: 09/18/2025
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. 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. Document duration of service.

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: 09/18/2025
Date of Last Review: 09/18/2025
Authority: Screening Centers Provider Manual

Resources

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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; Counseling for obesity – G0447
Effective Date: 10/01/2022
Revision Date: 09/18/2025
Date of Last Review: 09/18/2025
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
    d. Excessive increase in weight relative to linear growth

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Title: Nutrition Counseling (Medical Nutrition Therapy) & Counseling for Obesity
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    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:
    a. Increased risk of altered energy and nutrient needs
    b. Oral-motor or behavioral feeding difficulties

Number: 834
Title: Nutrition Counseling (Medical Nutrition Therapy) & Counseling for Obesity
Billing Code(s): Initial nutrition assessment & counseling – 97802; Counseling for obesity – G0447
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   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).

Billing

1. Use Code 97802: Initial nutrition assessment & counseling (15-minute unit)
2. Use Code 97803: Nutrition reassessment and counseling (15-minute unit)

Number: 834
Title: Nutrition Counseling (Medical Nutrition Therapy) & Counseling for Obesity
Billing Code(s): Initial nutrition assessment & counseling – 97802; Counseling for obesity – G0447
Effective Date: 10/01/2022
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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: 09/18/2025
Date of Last Review: 09/18/2025
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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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
Iowa EPSDT Periodicity Schedule

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: 09/18/2025
Date of Last Review: 09/18/2025
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

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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. Document duration for the service.

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: 09/18/2025
Date of Last Review: 09/18/2025
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 & 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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Title: Reportable Diseases & Conditions
Effective Date: 10/01/2016
Revision Date: 09/18/2025
Date of Last Review: 09/18/2025
Authority: Iowa Code Chapter 139A; Iowa Administrative Code [641] Chapters 1 and 11; Iowa Code Chapter 141A

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: 09/18/2025
Date of Last Review: 09/18/2025
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: 09/22/2025
Date of Last Review: 09/22/2025
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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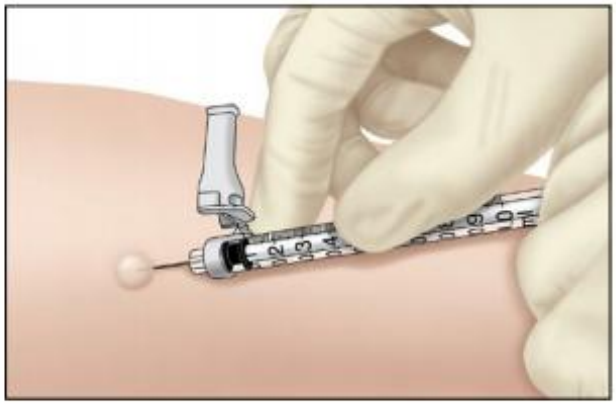
A TST requires two visits with a health care provider. On the first visit, the test is placed; on the second visit, the health care provider reads the test.

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.

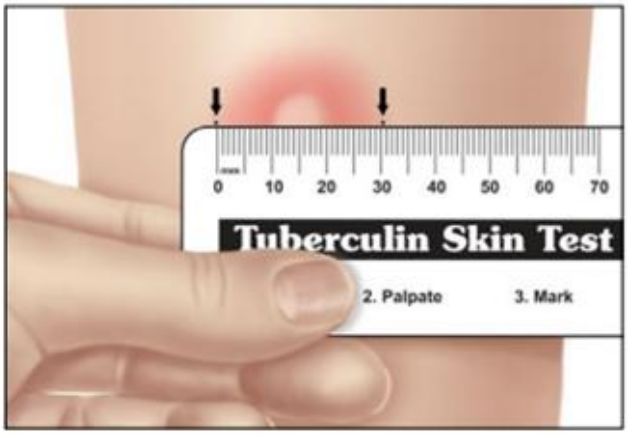
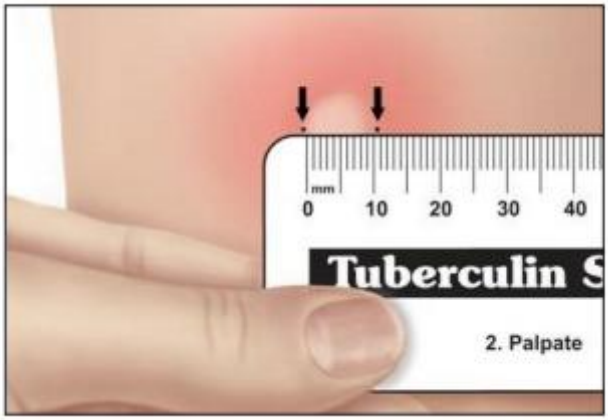


Figure 2.3
Reading the TST Correctly

- 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: 09/22/2025
Date of Last Review: 09/22/2025
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
Title: Vision Screening
Billing Code(s): Visual acuity – 99173; Instrument-based ocular screening - 99174
Effective Date: 10/01/2022
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Authority: Screening Centers Provider Manual

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

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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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: 09/22/2025
Date of Last Review: 09/22/2025

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
Revision Date: 09/22/2025
Date of Last Review: 09/22/2025

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: 09/22/2025
Date of Last Review: 09/22/2025
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
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Sources
Bright Futures, Guidelines for Health Supervision of Infants, Children and Adolescents
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Number: 861
Title: Anticipatory Guidance 11-21 years
Effective Date: 10/01/2022
Revision Date: 09/22/2025
Date of Last Review: 09/22/2025
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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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Documentation

Reimbursement for anticipatory guidance is a part of the cost and fee of the direct service or enabling service being provided.

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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/

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Number: 862
Title: Anticipatory Guidance Birth – 10 Years
Effective Date: 10/01/2022
Revision Date: 09/22/2025
Date of Last Review: 09/22/2025
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
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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.