

# Physician Services Provider Manual





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## **CHAPTER III. PROVIDER-SPECIFIC POLICIES**

### **A. Physicians Eligible to Participate**

All physicians (doctors of medicine and osteopathy) licensed to practice in Iowa are eligible to participate in the Medicaid program. Physicians in other states are also eligible to participate, providing they are duly licensed in that state.

A record of past and current General Letters outlining the content changes to this chapter is available online at: [http://dhs.iowa.gov/sites/default/files/Phys\\_GL.pdf](http://dhs.iowa.gov/sites/default/files/Phys_GL.pdf).

### **B. Coverage of Physician Services**

The Iowa Medicaid Enterprise (IME) has established and, as needed, revises standards governing care for which payment will be made and has formulated general policies and procedures to be followed. Payment will be approved for all reasonable and necessary medical services and supplies, subject to the exclusions and limitations set forth in this chapter.

#### **1. Care for Kids (EPSDT)**

The U.S. Department of Health and Human Services requires that the Medicaid program place special emphasis on early and periodic screening and diagnosis for children to ascertain physical and mental problems and provide treatment for conditions discovered. In Iowa, this program is called "Care for Kids."

When a child is due for a Care for Kids screening examination, the Department issues a reminder. The child's parent makes the appointment for the screening.

If a child is being examined for a preschool physical or pre-camp physical, provide all components of the screening examination and bill for a Care for Kids screen, if the child has not been screened according to the recommended screening schedule. Inter-periodic screens are also a covered service under Medicaid.

## 2. Routine Physical Examination

A routine physical examination is one performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury. When billing these routine examinations, use the appropriate diagnosis.

- ◆ For children under 21 years of age, payment will be approved for early and periodic Care for Kids examinations. This includes all well-baby and routine physical examinations for children. Payment will be made for an annual routine physical examination for children in foster care for whom the Department assumes financial responsibility. See [Care for Kids \(EPSDT\)](#).
- ◆ Payment will be approved for all children and disabled adults for a required school or camp examination. For a person age 21 and over, enter the type of examination on the claim form. Sports physicals (including Special Olympics physicals) are not covered by Medicaid. If the examination is for a child, provide and bill for a Care for Kids screening examination.
- ◆ Physical examinations in connection with a prescription for birth control medications and devices are payable. Payment will be approved for a physical examination, a pelvic examination and any other diagnostic procedure deemed necessary by the physician. For members age 20 and under, use the EP modifier. (This does not replace a comprehensive Care for Kids examination.)
- ◆ Pap smears are payable as preventative medical services for adults age 21 and over. For members age 20 and under, use the EP modifier. (This does not replace a comprehensive Care for Kids examination.)
- ◆ For adults age 21 and over, payment will be made for an examination which is required as a condition of employment or training approved by the Department. This includes the PROMISE JOBS program. Enter "work program" on the claim form for these situations.
- ◆ Payment will be made for an examination made for initial and annual certifications of the need for nursing home placement, as required by regulations of the Iowa Department of Inspections and Appeals. Make an entry in the "Statement of Services" section of the claim indicating "NF initial certification" or "NF annual certification."
- ◆ Payment will be made for the examination to establish the need for care in a residential care facility on admission and annually thereafter. Enter "RCF exam" on the claim form.



- ◆ Payment will be made for a routine physical examination for refugees who have newly settled in Iowa. Payment will be made for only one such examination per person. These refugees will have a *Medical Assistance Eligibility Card*.
- ◆ The Department's county office will notify the physician concerning eligibility of the refugee for a routine physical examination. The entry "refugee examination" must be shown on the claim form for persons age 21 and over. For persons age 20 and under, bill the procedure for an early and periodic Care for Kids screening exam.

Use the appropriate preventive medicine codes for persons age 21 and over (new or established patients) only when the service rendered is a payable Medicaid service.

### **3. Services of Auxiliary Personnel**

Payment will be approved to the physician for services rendered by auxiliary personnel employed by the physician and working under the physician's direct personal supervision, when such services are performed incident to the physician's professional services.

Auxiliary personnel are nurses, advanced registered nurse practitioners, physician's assistants, psychologists, social workers, audiologists, occupational therapists, and physical therapists. An auxiliary person is considered to be an employee of the physician if the following conditions are met:

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

In the office, "direct personal supervision" means the physician must be present in the same office suite, not necessarily the same room, and be available to provide immediate assistance and direction.

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

Nurse-midwives certified under the Iowa law are exempt from the requirement for direct personal supervision. Physician's assistants and advanced registered nurse practitioners certified under Iowa law are also exempt from this requirement. They may render service in the office setting, a hospital or a nursing facility without the physician being present. However, the physician must still be available by telephone to provide supervision and direction if required.

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

Licensed dietitians employed by or under contract with physicians may provide nutritional counseling services to members age 20 and under. Payment will be made to the employing physician.

In all cases, claims for services rendered by the auxiliary personnel must be submitted in the name of the employing physician. For modifier codes to be used in submitting claims, see [Procedure Codes And Nomenclature](#). Payment will be made to the physician.

### **C. Content of Well Child Examination**

A well child examination must include at least the following:

- ◆ Comprehensive health and developmental history, including an assessment of both physical and mental health development. This includes:
  - A developmental assessment.
  - An assessment of nutritional status.
- ◆ A comprehensive unclothed physical examination. This includes:
  - Physical growth.
  - A physical inspection, including ear, nose, mouth, throat, teeth, and all organ systems, such as pulmonary, cardiac, and gastrointestinal.
- ◆ Appropriate immunizations according to age and health history as recommended by the Iowa Department of Public Health.
- ◆ Health education, including anticipatory guidance.
- ◆ Hearing and vision screening.

- ◆ Appropriate laboratory tests. These shall include:
  - Hematocrit or hemoglobin.
  - Lead toxicity screening for all children ages 12 to 72 months.
  - Tuberculin test, when appropriate.
  - Hemoglobinopathy, when appropriate.
  - Serology, when appropriate.
- ◆ Oral health assessment with dental referral for children over age 12 months and based on risk assessment.

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

## **1. History and Guidance**

### **a. Comprehensive Health and Developmental History**

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

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

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

## **b. Developmental Screening**

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

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

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

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

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

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

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

- ◆ Collect information on the child’s or adolescent’s usual functioning, as reported by the child, parents, teacher, health professional, or other familiar person.
- ◆ Incorporate and review this information in conjunction with other information gathered during the physical examination.

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

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

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

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

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

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

For further information on developmental screening, see:

- ◆ [Care for Kids Provider website](#)
- ◆ [Addressing Early Childhood Emotional and Behavioral Problems by the American Academy of Pediatrics](#)
- ◆ [Assuring Better Child Development and Health \(ABCD\) Electronic Resource Center of the National Academy for State Health Policy](#)
- ◆ [National Center of Home Initiatives for Children with Special Needs website of the American Academy of Pediatrics](#)

### **c. Health Education/Anticipatory Guidance**

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

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

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

Anticipatory guidance and health education recommended topics are included in the *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, Third Edition, Arlington, VA. This publication is available from the National Center for Education in Maternal and Child Health (703) 356-1964, (888) 434-4MCH, or click <https://brightfutures.aap.org>.

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

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

#### ***Oral Health***

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

#### ***Injury Prevention***

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

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### ***Mental Health***

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

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### ***Nutrition***

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

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### ***Other Preventive Measures***

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



## **Suggested Health Education Topics: 2 – 5 Years**

### ***Oral Health***

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|--|---|
| <ul style="list-style-type: none"> <li>◆ Oral care: parental tooth brushing and flossing when the teeth touch, monthly “lift the lip”</li> <li>◆ Teething and tooth eruption</li> <li>◆ Importance of baby teeth</li> <li>◆ Regular dental visits</li> <li>◆ Non-nutritive sucking (thumb, finger, and pacifier)</li> <li>◆ Feeding and snacking habits: exposure to carbohydrates and sugars</li> </ul> | <ul style="list-style-type: none"> <li>◆ Appropriate use of bottle and breast feeding</li> <li>◆ Use of sippy cup</li> <li>◆ Use of sugary medications</li> <li>◆ Early childhood carries, gingivitis</li> <li>◆ Dental injury prevention</li> <li>◆ Fluoride exposure: toothpaste, water, topical fluoride, and supplements</li> <li>◆ Sealants on deciduous molars and permanent six-year molars</li> </ul> |
|--|---|

### ***Injury Prevention***

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|--|--|
| <ul style="list-style-type: none"> <li>◆ CPR training</li> <li>◆ Booster car seat</li> <li>◆ Burns and fire</li> <li>◆ Farm hazards: manure pits, livestock, corn cribs, grain auger, and grain bins</li> <li>◆ Dangers of accessible chemicals</li> <li>◆ Importance of protective helmets</li> <li>◆ Machinery safety</li> <li>◆ No extra riders on tractor</li> <li>◆ Play equipment</li> </ul> | <ul style="list-style-type: none"> <li>◆ Purchase of bicycles</li> <li>◆ Put up warning signs</li> <li>◆ Restricted play areas</li> <li>◆ Street danger</li> <li>◆ Teach child how to get help</li> <li>◆ Toys</li> <li>◆ Tricycles</li> <li>◆ Walking to school</li> <li>◆ Water safety</li> <li>◆ Gun storage</li> </ul> |
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### ***Mental Health***

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|---|--|
| <ul style="list-style-type: none"> <li>◆ Adjustment to increasing activity of child</li> <li>◆ Balancing home, work, and school</li> <li>◆ Helping children feel competent</li> </ul> | <ul style="list-style-type: none"> <li>◆ Child care</li> <li>◆ Sibling rivalry</li> <li>◆ Managing emotions</li> </ul> |
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***Nutrition***

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

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***Other Preventive Measures***

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

## **Suggested Health Education Topics: 6 – 12 Years**

### ***Oral Health***

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

### ***Injury Prevention***

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

### ***Mental Health***

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

### ***Nutrition***

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

### ***Other Preventive Measures***

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

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

### ***Oral Health***

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

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### ***Development***

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- ◆ Normal biopsychosocial changes of adolescence

### ***Gender Specific Health***

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

### ***Health Member Issues***

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

### ***Injury Prevention***

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

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### ***Nutrition***

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

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### ***Personal Behavior and Relationships***

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

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### ***Substance Use***

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

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### ***Other Prevention Measures***

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

#### d. **Mental Health Assessment**

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

- ◆ The child's **life-style**, home situation, and "significant others."
- ◆ A **typical day**: How the child spends the time from getting up to going to bed.
- ◆ **Religious and health beliefs** of the family relevant to perceptions of wellness, illness, and treatment, and the child's outlook on the future.
- ◆ **Sleep**: Amount and patterns during day and at night; bedtime routines; type and location of bed; and nightmare, terrors, and somnambulating.
- ◆ **Toileting**: Methods of training used, when bladder and bowel control attained, occurrence of accidents or of enuresis or encopresis, and parental attitudes.
- ◆ **Speech**: Hesitation, stuttering, baby talk, lispings, and estimate of number of words in vocabulary.
- ◆ **Habits**: Bed-rocking, head-banging, tics, thumb-sucking, pica, ritualistic behavior, and use of tobacco, alcohol, or drugs.
- ◆ **Discipline**: Parental assessment of child's temperament and response to discipline, methods used and their success or failure, negativism, temper tantrums, withdraw, and aggressive behavior.
- ◆ **Schooling**: Experience with day care, nursery school, and kindergarten; age and adjustment on entry; current parental and child satisfaction; academic achievement; and school's concerns.
- ◆ **Sexuality**: Relations with members of the opposite sex; inquisitiveness regarding conception, pregnancy, and girl-boy differences; parental responses to child's questions and the sex education parents have offered regarding masturbation, menstruation, nocturnal emissions, development of secondary sexual characteristics, and sexual urges; and dating patterns.

- ◆ **Personality:** Degree of independence; relationship with parents, siblings, and peers; group and independent activities and interests, congeniality; special friends (real or imaginary); major assets and skills; and self-image.

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

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

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

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

- ◆ Tools that provide a general screen for psychosocial problems or risk in children and adolescents, such as the *Pediatric Symptom Checklist* (Jellinek et al., 1988, 1999).
- ◆ Tools that screen for specific problems, symptoms, and disorders, such as the *Conners' Rating Scales for ADHD* (Conners, 1997) and the *Children's Depression Inventory* (Kovacs, 1992).

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

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

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

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



## **2. Laboratory Tests**

### **a. Cervical Papanicolaou (PAP) Smear**

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

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

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

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

### **b. Chlamydia Test**

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

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

### **c. Gonorrhea Test**

Testing for gonorrhea may be done on persons with:

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

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

#### **d. Hemoglobin and Hematocrit**

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

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

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

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

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

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

**Fifth Percent Criteria for Children**

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

**Female (non-pregnant)**

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

**Male**

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

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

**e. Hemoglobinopathy Screening**

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

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

**f. Lead Testing**

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

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

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

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

Click [here](#) to access the Statewide Plan for Childhood Lead Testing and Case Management of Lead-Poisoned Children which contains a Poisoning Risk Questionnaire on page 44. Use this questionnaire to decide whether to use the high risk or low risk blood lead testing schedule, or use the high risk testing schedule for all children. Do **not** assume that all children are at low risk. The lead testing and follow up protocols are also located at this link.

**g. Newborn Screening**

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

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

**h. Tuberculin Testing**

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

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

### **3. Physical Examination**

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

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

#### **a. Blood Pressure**

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

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

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

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

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

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

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

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

## **b. Growth Measurements**

### **(1) Body Mass Index**

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

1. Convert any fractions to decimals.

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

2. Insert the values into the formula:

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

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

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

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

Children with a BMI equal to or greater than the 95th percentile are considered overweight.

**(2) Height**

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

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

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

**(3) Plotting Measurements**

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

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

Example:

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

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

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

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

Common errors result from:

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

#### **(4) Recumbent Length**

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

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

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

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

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



## **(6) Weight**

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

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

### **c. Head Circumference**

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

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

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

### **d. Oral Health Screening**

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

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

- ◆ Complete or update the dental history:
  - Current or recent dental problems, including pain or mouth injuries

- Name of dentist
- Date of child's last dental visit or length of time since last dental visit
- ◆ Medical and dental history:
  - Current or recent medical conditions
  - Current medications used
  - Allergies
  - Name of child's physician and dentist
  - Frequency of dental visits
  - Use of fluoride by child (source of water, use of fluoridated toothpaste or fluoride products)
  - Current or recent dental problems or injuries, including parental concerns
  - Home care (frequency of brushing, flossing, or other oral hygiene practices)
  - Exposure to sugar, carbohydrates (snacking and feeding habits, use of sugary medications)
- ◆ Oral evaluation
  - Hard tissue:
    - Suspected decay
    - Demineralized areas (white spots)
    - Visible plaque
    - Enamel defects
    - Sealants
    - Decay history (fillings, crowns)
    - Stained fissures
    - Trauma or injury
  - Soft tissue:
    - Gum redness or bleeding
    - Swelling or lumps
    - Trauma or injury
- ◆ Provide age-appropriate oral health education to the parent or guardian. Education should be based on the findings of the oral health screening.

- ◆ Refer children to a dentist for:
  - Complete dental examination annually by 12 months and periodic exams semiannually based on risk assessment
  - Obvious or suspected dental caries
  - Pain or injury to the oral tissue
  - Difficulty chewing

#### **4. Other Services**

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

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

##### **a. Immunization**

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

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

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

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

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

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

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

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

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

#### **b. Hearing**

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

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

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

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

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

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

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

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

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

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

- ◆ Physical findings, such as white forelock, associated with a syndrome known to include a sensorineural or permanent conductive hearing loss (Cone-Wesson et al., 2000).
- ◆ Syndromes associated with hearing loss or progressive or late-onset hearing loss,\* such as neurofibromatosis, osteopetrosis, and Usher syndrome (Roizen, 2003). Other frequently identified syndromes including Waardenburg, Alport, Pendred and Jervell and Lange-Nielson (Nance, 2003).
- ◆ Neurodegenerative disorders,\* such as Hunter syndrome, or sensory motor neuropathies, such as Friedreich ataxia and Charcot-Marie-Tooth syndrome (Roizen, 2003).
- ◆ Culture-positive postnatal infections associated with sensorineural hearing loss,\* including confirmed bacterial and viral (especially herpes viruses and varicella) meningitis (Arditi et al., 1998; Bess, 1982; Biernath et al., 2006; Roizen, 2003).
- ◆ Head trauma, especially basal skull/temporal bone fracture\* requiring hospitalization (Lew et al., 2004; Vartialnen et al., 1985; Zimmerman et al., 1993).
- ◆ Chemotherapy\* (Bertolini et al., 2004).

### c. **Nutritional Status**

To assess nutritional status, include:

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

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

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

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

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

## (2) Medical Evaluation Indicated (1-10 years)

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

### ◆ Measurements

- Weight/length < 5th percentile or > 95th percentile for 12-23 months
- BMI for age < 5th percentile or > 95th percentile for 24 months and older
- Weight/age < 5th percentile
- Major change in weight/height percentile rank (a 25 percentile or greater shift in ranking)
- Flat growth curve:

Age	Indicator
12 to 36 months	Two months without an increase in weight per age of a child below the 90th percentile weight per age.
3 to 10 years	Six months without an increase in weight per age of a child below the 90th percentile weight per age.

### ◆ Laboratory tests

Age	HCT %	HGB gm/dL
1 up to 2 years	32.9	11.0
2 up to 5 years	33.0	11.1
5 up to 8 years	34.5	11.4
8 up to 10 years	35.4	11.9

### ◆ Health problems

- Chronic disease requiring a special diet
  - Metabolic disorder
  - Family history of hyperlipidemias
  - Physical handicap or developmental delay that may alter nutritional status
- ◆ Physical examination: Abnormality of any of the following which indicates poor nutrition: hair, skin or nails, eyes, teeth or gums, disorders of the thyroid or parotid glands, gastrointestinal disorders, neurological disorders, or skeletal disorders



### (3) Medical Evaluation Indicated (11-21 years)

Use these criteria for referring adolescents for further medical evaluation of nutritional status:

◆ Laboratory tests

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

◆ Health problems

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

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

#### **d. Vision**

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

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

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

#### **D. Prescription Drugs**

Payment will be made for drugs as prescribed below when prescribed by a legally qualified practitioner (which includes physician, dentist, podiatrist, physician assistant, therapeutically certified optometrist, or advanced registered nurse practitioner).

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

Click [here](#) to view the ***Prescribed Drugs Manual*** for coverage of prescription drugs.

##### **1. Injected Medication Covered Services**

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

- ◆ HCPCS code
- ◆ NDC
- ◆ Units of service

**NOTE:** When billing an "unlisted" J code (otherwise known as a "dump" code), in addition to the three bulleted items directly above, the provider should also indicate the charge for the injection.

When the above information is not provided, claims potentially will be denied. To the extent a physician participates in the 340B program, proper billing is as per instruction in [Informational Letter \(IL\) 2243](#). The provider should include the NDC for the drug if billing under the 340B program where the UD modifier is appended.

## 2. **Injected Medication Non-Covered or Limited Services**

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

- ◆ **Injections not indicated for treatment of a particular condition.**

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

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

- ◆ **Injections not for a particular illness.** Payment will not be approved for an injection if administered for a reason other than the treatment of a particular condition, illness or injury.

**NOTE:** Prior authorization is required before employing an amphetamine or legend vitamin by injection. Click [here](#) to view the ***Prescribed Drugs Manual*** for additional information.

- ◆ **Method of injection not indicated.** Payment will not be approved when injection is not an indicated method of administration according to accepted standards of medical practice.

- ◆ **Allergenic extract injection.** Claims from suppliers of allergenic extract materials provided the member for self-administration will be allowed according to coverage limits in effect for this service.

- ◆ **Excessive injections.** Basic standards of medical practice provide guidance as to the frequency and duration of injections. These vary and depend upon the required level of care for a particular condition. The circumstances must be noted on the claim before additional payment can be approved.

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

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

## **E. Hospital Care**

Payment will be made for inpatient hospital care as medically necessary. There are no specific limits on the number of days of inpatient care for which Medicaid payment will be approved, as long as that care is medically necessary in the individual case.

If the IME Medical Services Unit determines the care is not medically necessary, the member, physician, or hospital can request a reconsideration of the decision by filing a written request for reconsideration with the IME Medical Services Unit within 365 days from the date of the hospital's remittance notice. The aggrieved party can appeal a denial by the IME Medical Services Unit for reconsideration to the Department.

No waiver days will be allowed.

### **1. Review of Claims for Inpatient Hospital Care**

The IME Medical Services Unit will randomly select a sample of inpatient hospital claims from Iowa and bordering states' hospitals. Claims will be reviewed for the appropriateness of admission, readmission, transfer, discharge, DRG assignment, coding, invasive procedures, and quality of care. The IME Medical Services Unit will also profile claim data, review results, and identify DRGs and procedures that may be targeted for retrospective review.

### **2. Review of Specific Admissions**

Admissions to physical rehabilitation units and swing bed/lower level of care require preadmission and continued stay review/approval by the IME Medical Services Unit.

### **3. Use of Emergency Room**

Payment will be approved for use of an emergency room providing at least one of the following conditions is met:

- ◆ The member is evaluated or treated for a medical emergency, accident, or injury.
- ◆ The member's evaluation or treatment results in a utilization review committee approval for inpatient hospital admission.
- ◆ The member is referred by a physician.
- ◆ The member is suffering from an acute allergic reaction.
- ◆ The member is experiencing acute, severe respiratory distress.
- ◆ The member is experiencing any other acute or severe symptoms, which by the "prudent layperson" standard, would lead the member or member's family members or caretakers to believe the member is suffering from an emergent or life-threatening episode.

## **F. Surgery**

### **1. Same-Day Surgery**

Payment will not be made for inpatient hospital care for certain surgical procedures which can ordinarily be performed safely and effectively in the hospital outpatient department, physician's office, or other setting. In the absence of justifying information, claims for inpatient care for the procedures will be denied. The reviews for necessity are part of the retrospective hospital review process. Exceptions will be made when medical documentation justifying the medical necessity for inpatient care in the individual case is provided to the IME Medical Services Unit. If the IME Medical Services Unit concurs that inpatient care is necessary, then payment for the care will be approved. If adequate justifying documentation is not presented for a given member's inpatient admission under these circumstances, then payment of the hospital claim for inpatient care will be denied.

### **2. Surgical Assistance**

Payment will be made for each surgical assistant fee. For multiple surgical assists for the same member in the same operating session, payment will be made with the multiple surgery methodology (100 percent, 50 percent, 25 percent, 25 percent, etc.).

For a physician, the surgical code must be billed using an 80 modifier (payment is 16 percent of the surgical fee). For a physician assistant, the surgical code must be billed using an AS modifier (payment is 65 percent of the physician surgical assist fee). The assistant at surgery claim must be submitted on a separate claim form from the primary surgeon's bill.

### **3. Pre-Procedure Review**

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

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

The following sections explain:

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

**a. Procedures Subject to Review**

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

	<b>Hospital Use Only: <u>ICD-10</u></b>		<b>Physician and Ambulatory Surgical Center Use Only: <u>CPT-4</u></b>
Bone marrow transplant	30230G0	30260G0	38240
	30230G1	30260G1	38241
	30233G0	30263G0	
	30233G1	3E03005	
	30240G0	3E03305	
	30240G1	3E04005	
	30243G0	3E04305	
	30243G1	3E05005	
	30250G0	3E05305	
	30250G1	3E06005	
	30253G0	3E06305	
	30253G1	30263G1	



	<b>Hospital Use Only: ICD-10</b>	<b>Physician and Ambulatory Surgical Center Use Only: CPT-4</b>
Stem cell transplant	30230AZ	30243X0
	30230Y0	30243X1
	30233AZ	30250X0
	30233Y0	30250X1
	30240AZ	30253X0
	30240Y0	30253X1
	30243AZ	30260X0
	30243Y0	30260X1
	30250Y0	30263X0
	30253Y0	30263X1
	30260Y0	3E03005
	30263Y0	3E03305
	30230Y1	3E04005
	30233Y1	3E04305
	30240Y1	3E05005
	30243Y1	3E05305
	30250Y1	3E06005
	30253Y1	3E06305
	30260Y1	30230G0
	30263Y1	30233G0
	30230X0	30240G0
	30230X1	30243G0
	30233X0	30250G0
	30233X1	30253G0
	30240X0	30260G0
	30240X1	30263G0
	Heart transplant	02YA0Z0 02YA0Z1 02YA0Z2
Liver transplant auxiliary	0FY00Z0 0FY00Z1 0FY00Z2	47135
Other transplant of liver	0FY00Z0 0FY00Z1 0FY00Z2	47135 47136



	<b>Hospital Use Only:</b> <b><u>ICD-10</u></b>	<b>Physician and Ambulatory Surgical Center Use Only:</b> <b><u>CPT-4</u></b>
Lung transplant: ◆ Unilateral transplant ◆ Bilateral transplant	0BYK0Z0      0BYG0Z2 0BYK0Z1      0BYH0Z0 0BYK0Z2      0BYH0Z1 0BYL0Z0      0BYH0Z2 0BYL0Z1      0BYJ0Z0 0BYL0Z2      0BYJ0Z1 0BYF0Z0      0BYJ0Z2 0BYF0Z1      0BYM0Z0 0BYF0Z2      0BYM0Z1 0BYG0Z0      0BYM0Z2 0BYG0Z1	32851 32852 32853 32854
Pancreas	0FYG0Z0 0FYG0Z1 0FYG0Z2	48160 48554
Combined heart/lung	<b>Requires two ICD-10 procedure codes.</b>  <b>One from heart codes:</b> 02YA0Z0 02YA0Z1 02YA0Z2  <b>And one from respiratory codes:</b> 0BYM0Z0 0BYM0Z1 0BYM0Z2	33935
Laparoscopic bariatric procedures	0DB64Z3      0D1647L 0D16479      0D164JB 0D1647A      0D164JL 0D164J9      0D164KB 0D164JA      0D164KL 0D164K9      0D164ZB 0D164KA      0D164ZL 0D164Z9      0DQ64ZZ 0D164ZA      0DV64CZ 0D1647B	43644 43645 43770 43772 43773 43774 43775 43775

	<b>Hospital Use Only:</b> <b><u>ICD-10</u></b>		<b>Physician and Ambulatory Surgical Center Use Only:</b> <b><u>CPT-4</u></b>
Bariatric procedures, other than laparoscopic	0DB60ZZ	0DBB0ZZ	43842
	0DB63ZZ	0F190Z3	43843
	0DB67ZZ	0TRB07Z	43845
	0D1607A	0D190Z9	43846
	0D160JA	0D190ZA	43847
	0D160KA	0D190ZB	
	0D160ZA	0D194Z9	
	0D1687A	0D194ZA	
	0D168JA	0D194ZB	
	0D168KA	0D198Z9	
	0D168ZA	0D198ZA	
	0D160K9	0D198ZB	
	0D160Z9	0D1A0ZA	
	0D16879	0D1A0ZB	
	0D168J9	0D1A4ZA	
	0D168K9	0D1A4ZB	
	0D168Z9	0D1A8ZA	
	0DV63ZZ	0D1A8ZB	
	0DV64DZ	0D1A8ZH	
	0DV64ZZ	0D1B0ZB	
0DV67ZZ	0D1B4ZB		
0DV68ZZ	0D1B8ZB		
0DB90ZZ	0D1B8ZH		
Bariatric procedures, revisions/ removals	0DQ60ZZ		43771
	0DQ63ZZ		43772
	0DQ64ZZ		43774
	0DQ67ZZ		43848
	0DQ68ZZ		43860
	0DW643Z		43865
	0DW64CZ		43886
	0DP643Z		43887
	0DP64CZ		43888
	3E0G3GC		

**b. Review Process**

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

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

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

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

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

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

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

**c. Procedure Review Obtained Following Discharge**

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

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

**4. Preoperative and Postoperative Visits**

Iowa Medicaid's global surgical days are consistent with Medicare's 0-10-90 global surgical package. Iowa Medicaid follows Medicare's definition of preoperative and postoperative days. Preoperative days begin on the day of surgery for minor procedures and the day before surgery for major procedures.

Postoperative days either do not apply or begin 10 days immediately following the day after surgery for minor procedures and 90 days immediately following the day of surgery for major surgery. The global surgery period for procedures with a Medicare Physician Fee Schedule (MPFS) Global Surgery Indicator of "YYY" and "MMM" are determined by the carrier.

**EXCEPTION:** Endoscopic procedure reimbursement does not include preoperative and postoperative visits.

**5. Abortions**

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

- ◆ The attending physician certifies in writing, on the basis of professional judgment, that continuing the pregnancy would endanger the life of the pregnant woman.

Federal funding is available in these situations only if the woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed.

- ◆ The attending provider certifies in writing, on the basis of provider's professional judgment, that the fetus is physically deformed, mentally deficient or afflicted with a congenital illness and states the medical indications for determining the fetal condition.
- ◆ The pregnancy is the result of rape that:
  - Was reported to a law enforcement agency or public or private health agency, which may include a family physician, and
  - Was reported within 45 days of the date of the incident, and
  - The report contains the name, address, and signature of the person making the report. An official of the agency must also certify in writing.
- ◆ The pregnancy is the result of incest that:
  - Was reported to a law enforcement agency or public or private health agency, which may include a family physician, and
  - Was reported within 150 days of the incident, and
  - The report contains the name, address, and signature of the person making the report. An official of the agency or physician must so certify in writing.

**a. Certification Regarding Abortion, Form 470-0836**

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

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

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

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

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

The reason for the abortion must be identified on form 470-0836, *Certification Regarding Abortion*. This form must be attached to the claim for payment, along with the following documentation:

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

**b. Covered Services Associated With Non-Covered Abortions**

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

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

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

**c. Non-Covered Services**

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

- ◆ Physician and surgical charges for performing the abortion. These charges include the usual, uncomplicated preoperative and postoperative care and visits related to performing the abortion.
- ◆ Hospital or clinic charges associated with the abortion. This includes:
  - The facility fee for use of the operating room.
  - Supplies and drugs necessary to perform the abortion.
- ◆ Charges associated with routine, uncomplicated preoperative and postoperative visits by the member.
- ◆ Physician charges for administering the anesthesia necessary to induce or perform an abortion.
- ◆ Charges for laboratory tests performed before performing the non-covered abortion to determine the anesthetic or surgical risk of the member (e.g., CBC, electrolytes, blood typing).
- ◆ Drug charges for medication usually provided to or prescribed for a member who undergoes an uncomplicated abortion. This includes:
  - Routinely provided oral analgesics.
  - Antibiotics to prevent septic complication of abortion and Rho-GAM (an immune globulin administered to RH-negative women who have an abortion).
- ◆ Charges for histo-pathological tests performed routinely on the extracted fetus or abortion contents.
- ◆ Uterine ultrasounds performed immediately following an abortion.

## 6. Cosmetic Surgery

Cosmetic, reconstructive, or plastic surgery or expenses incurred in connection with such surgeries is not covered under the Medicaid program except when required for the prompt (i.e., as soon as medically feasible) repair of accidental injury, for the improvement of or return to the original functioning of a congenitally malformed body member, or for revision of disfiguring and extensive scarring related to neoplastic surgery. In such latter cases, surgery becomes primarily reconstructive, as opposed to merely cosmetic.

For the purposes of this program, cosmetic, reconstructive, or plastic surgery is surgery which can be expected primarily to improve physical appearance or which is performed primarily for psychological purposes, or which restores form but which does not correct or materially improve bodily functions. However, when a surgical procedure primarily restores function, whether or not there is also a concomitant improvement in physical appearance, the surgical procedure does not fall within the provisions of this policy.

When it is determined that a cosmetic, reconstructive, or plastic surgery procedure does not qualify for coverage under the program, all related services and supplies, including any institutional costs, are also excluded. However, an important distinction in this regard is that if a given member incurs some medical condition, such as an infection (or similar condition) following cosmetic surgery, then payment would be made for treating the infection or similar condition.

While coverage under the program is generally not available for cosmetic, reconstructive or plastic surgery, under certain limited circumstances payment for otherwise covered services and supplies may be provided in connection with cosmetic, reconstructive, or plastic surgery as follows:

- ◆ Correction of a congenital anomaly.
- ◆ Restoration of body form following an accidental injury.
- ◆ Revision of disfiguring and extensive scars resulting from neoplastic surgery.

Generally, coverage is limited to those cosmetic, reconstructive or plastic surgery procedures provided no later than 12 months subsequent to the related accidental injury or surgical trauma. However, special consideration or exception will be given to cases involving children who may require a growth period or for other medically necessary and appropriate reasons involving adults.



Cosmetic, reconstructive, or plastic surgery performed in connection with certain conditions is specifically excluded. These conditions are:

- ◆ Dental congenital anomalies, such as absent tooth buds, malocclusion, and similar conditions.
- ◆ Procedures related to transsexualism, hermaphroditism, gender identity disorders, or body dysmorphic disorders.
- ◆ Cosmetic, reconstructive, or plastic surgery procedures performed primarily for psychological reasons or as a result of the aging process.
- ◆ Breast augmentation mammoplasty, surgical insertion of prosthetic testicles, penile implants procedures, and surgeries for the purpose of sex reassignment.

Following is a partial list of cosmetic, reconstructive, or plastic surgery procedures which are not covered under the program (this list is for example purposes only and is not considered all inclusive):

- ◆ Any procedure performed for personal reasons, to improve the appearance of an obvious feature or part of the body which would be considered by an average observer to be normal and acceptable for the member's age or ethnic or racial background
- ◆ Cosmetic, reconstructive, or plastic surgical procedures which are justified primarily on the basis of a psychological or psychiatric need
- ◆ Augmentation mammoplasties
- ◆ Face lifts and other procedures related to the aging process
- ◆ Reduction mammoplasties, unless there is medical documentation of intractable pain not amenable to other forms of treatment as the result of increasingly large pendulous breasts
- ◆ Panniculectomy and body sculpture procedures, unless there is medical documentation of chronic back or abdominal pain, intertriginous skin infections or dermatitis, impaired ambulation, or difficulty with activities of daily living not amenable to at least six months of conservative treatment
- ◆ Repair of sagging eyelids, unless there is demonstrated and medically documented significant impairment of vision
- ◆ Rhinoplasties, unless there is evidence of accidental injury occurring within the past six months which resulted in significant obstruction of breathing
- ◆ Chemical peeling for facial wrinkles
- ◆ Dermabrasion of the face

- ◆ Revision of scars resulting from surgery or a disease process, except disfiguring and extensive scars resulting from neoplastic surgery
- ◆ Removal of tattoos
- ◆ Hair transplants
- ◆ Electrolysis
- ◆ Sex reassignment
- ◆ Penile implant procedures
- ◆ Insertion of prosthetic testicles

## 7. Hysterectomies

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

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

This statement may be added to either the surgery consent form, written on the claim form, or on a separate sheet of paper. The member or her representative receiving the explanation must sign the statement.

The following language is satisfactory for such a statement:

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

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

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

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

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

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

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

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

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

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

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

This includes C-sections when there is a reasonable expectation a hysterectomy will be performed, such as in the event of an acreta.

## 8. Organ Transplants

Payment will be made only for the following organ and tissue transplant services when medically necessary. For those transplants requiring preprocedure review/approval, such will be noted.

- ◆ Kidney, cornea, skin, and bone transplants.
- ◆ Allogeneic bone marrow transplants (also known as Allogeneic "stem cell" transplants) for the treatment of the conditions listed below. Allogeneic bone marrow transplants require preprocedure review/approval.
  - Aplastic anemia,
  - Severe combined immunodeficiency disease (SCID),

- Wiskott-Aldrich syndrome,
- Follicular lymphoma,
- Fanconi anemia,
- Paroxysmal nocturnal hemoglobinuria,
- Pure red cell aplasia,
- Amegakaryocytosis/congenital thrombocytopenia,
- Beta thalassemia major,
- Sickle cell disease,
- Hurler's syndrome (mucopolysaccharidosis type 1 [MPS-1]),
- Adrenoleukodystrophy,
- Metachromatic leukodystrophy,
- Refractory anemia,
- Agnogenic myeloid metaplasia (myelofibrosis),
- Familial erythrophagocytic lymphohistiocytosis and other histiocytic disorders,
- Acute myelofibrosis,
- Diamond-Blackfan anemia,
- Epidermolysis bullosa, or
- The following types of leukemia:
  - ◊ Acute myelocytic leukemia,
  - ◊ Chronic myelogenous leukemia,
  - ◊ Juvenile myelomonocytic leukemia,
  - ◊ Chronic myelomonocytic leukemia,
  - ◊ Acute myelogenous leukemia, and
  - ◊ Acute lymphocytic leukemia.
- ◆ Autologous bone marrow transplants (also known as Autologous "stem cell" transplants) for treatment of the conditions listed below. Autologous bone marrow transplants require preprocedure review/approval.
  - Acute leukemia,
  - Chronic lymphocytic leukemia,
  - Plasma cell leukemia,
  - Non-Hodgkin's lymphomas,
  - Hodgkin's lymphoma,
  - Relapsed Hodgkin's lymphoma,
  - Lymphomas presenting poor prognostic features,
  - Follicular lymphoma,
  - Neuroblastoma,
  - Medulloblastoma,
  - Advanced Hodgkin's disease,
  - Primitive neuroendocrine tumor (PNET),
  - Atypical/rhabdoid tumor (ATRT),
  - Wilms' tumor,
  - Ewing's sarcoma,

- Metastatic germ cell tumor, or
- Multiple myeloma.
- ◆ Liver transplants for members with extrahepatic biliary atresia or any other form of end-stage liver disease. **EXCEPTION:** Coverage is not provided for members with a malignancy extending beyond the margins of the liver or those with persistent viremia.

Liver transplants require pre-procedure review by the IME Medical Services Unit and are payable only when performed in a facility that meets the requirements of 441 IAC 78.3(10).

- ◆ Heart transplants for persons with inoperable congenital heart defects, heart failure, or related conditions. Artificial hearts and ventricular assist devices as a temporary life-support system until a human heart becomes available for transplants are covered. Artificial hearts and ventricular assist devices as a permanent replacement for a human heart are not covered.

Heart-lung transplants are covered where bilateral or unilateral lung transplantation with repair of a congenital cardiac defect is contraindicated. Heart transplants, heart-lung transplants, artificial hearts, and ventricular assist devices described above require pre-procedure review by the Iowa Medicaid Enterprise Medical Services Prior Authorization Unit. Covered heart transplants are payable only when performed in a facility that meets the requirements of 441 IAC 78.3(10).

- ◆ Lung transplants for members having end-stage pulmonary disease. Lung transplants require pre-procedure review by the IME Medical Services Unit and are payable only when performed in a facility that meets the requirements of 441 IAC 78.3(10). Heart-lung transplants are covered consistent with the criteria listed above under heart transplants.
- ◆ Pancreas transplants for person with type I diabetes mellitus, as follows:
  - Simultaneous pancreas-kidney transplants and pancreas after kidney transplants are covered.
  - Pancreas transplants alone are covered for persons exhibiting any of the following:
    - ◇ A history of frequent, acute and severe metabolic complications (e.g., hypoglycemia, hyperglycemia, or ketoacidosis) requiring medical attention.
    - ◇ Clinical problems with exogenous insulin therapy that are so severe as to be incapacitating.

- ◇ Consistent failure of insulin-based management to prevent acute complications.

Pancreas transplants require pre-procedure review by the IME Medical Services Unit.

**NOTE:** See current rules 441 IAC 78.1(20) for a complete listing of currently covered transplants and related provisions.

Donor expenses incurred directly in connection with a covered transplant are payable. Expenses incurred for complications that arise with respect to the donor are covered only if they are directly and immediately attributed to surgery. Expenses of searching for a donor are not covered.

## 9. Sterilizations

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

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

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

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

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

An “institutionalized” member is one who is:

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

The same revision of federal regulations provide that payment may be made through the Medicaid program for the sterilization of a member aged 21 or over when the consent form is signed, who is mentally competent and

noninstitutionalized in accordance with the above definitions under certain conditions.

**a. Requirements**

The following conditions must be met:

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

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

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

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

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

The elements of explanation which must be provided are:

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

- An offer to answer any inquiries concerning the proposed procedure.

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

## **G. Related Services**

### **1. Ambulance Services**

Medicaid will pay for ambulance transportation by an approved ambulance service to a hospital or skilled nursing facility only when transportation by any other means could endanger the member's health.

In order to receive payment, the provider must document the medical necessity of this transport on the run report. It is the responsibility of the ambulance supplier to furnish complete and accurate documentation to demonstrate that the ambulance service being furnished meets the medical necessity criteria.

Payment will be approved subject to the following conditions:

- ◆ The member must be transported to the nearest hospital with appropriate facilities.
- ◆ The member may be transported from one hospital to another only if there is a valid documented medical reason for transporting the member to the second hospital. The member's personal preference is not a valid medical reason for ambulance transport.

#### **a. Medical Necessity**

The Medical Review Unit in the office of the IME is responsible for determining the ambulance service was medically necessary and that the condition of the member precluded any other method of transportation.

#### **(1) Cases Not Requiring Confirmation of Physician**

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

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

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

## **(2) Cases Requiring Confirmation of Physician**

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

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

In these and similar cases, the IME may find it necessary to request information from the ambulance company (who may in turn request it from the physician) to determine medical necessity and whether payment of a claim should be approved or denied.

The IME may request assistance in supplying the information to determine if ambulance service can be covered by Medicaid.

### **b. Non-Covered Services**

Payment will **not** be approved for the following:

- ◆ A routine trip to return the member home, when the member had been transported to the hospital.
- ◆ An ambulance trip to a funeral home.
- ◆ Transfer from a hospital that has appropriate facilities and staff for treatment to another hospital. Examples include transfers to accommodate member or family preference to receive care by a personal physician or in a particular facility.
- ◆ Transportation from one private home to another.

- ◆ Transportation of a member from home or a nursing facility to a hospital outpatient department, unless it is established that there was an emergency or the trip was otherwise medically necessary.
- ◆ Transportation of a member from home or a nursing facility to a hospital outpatient department for treatment that could have been performed elsewhere (such as the member's home or nursing home).
- ◆ Transportation of a member from home or a nursing facility to a physician's office or a free-standing or hospital-based clinic and back for routine medical care.
- ◆ Transportation of a member to University Hospitals in Iowa City, unless it is established that the University Hospitals is the nearest hospital with facilities necessary to take care of the member.
- ◆ Transportation of an ambulatory member.
- ◆ Transportation to receive services of a specific physician, unless medical necessity is established.
- ◆ Transportation of, but not transfer of, an inpatient to another hospital or provider. If it is necessary to transport (but not transfer) the member to another hospital or provider for treatment, with the member remaining an inpatient at the originating hospital after that treatment, the originating hospital shall bear all costs incurred by that member for:
  - The medical treatment furnished to the member by the other provider, and
  - The ambulance transportation between the originating hospital and the other provider.

## 2. Home Health Agency Services

Home health agencies are eligible to participate in the Medicaid program providing they are certified to participate in the Medicare program (Title XVIII of the Social Security Act). Medicare-certified agencies are eligible to provide the following Medicaid services:

- ◆ Home health agency intermittent services. Services are for members of all ages, but are limited by the intermittent policy. See Chapter III. [Home Health Services](#), [Home Health Services Program](#).

- ◆ Private-duty nursing and personal care services under the early and periodic screening, diagnosis, and treatment authority. These services are only for members aged 20 and under and are covered when they are medically necessary, appropriate, and exceed intermittent policy. See Chapter III. [Home Health Services](#), [Private-Duty Nursing and Personal Care Services](#).

Payment for supplies will be approved when the supplies are incidental to the member's care, e.g., syringes for injections, and do not exceed \$15 per month. Dressings, durable medical equipment, and other supplies shall be obtained from a durable medical equipment dealer or pharmacy.

Payment will be made both for restorative service as in the Medicare program and also for maintenance service. Restorative therapy must be reasonable and necessary to the treatment of the member's illness, injury, or disabling condition. The expected restorative potential must be practical and in relation to the extent and duration of the treatment.

Generally, maintenance therapy means services to a member whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This includes members with long-term illnesses or disabling condition whose status is stable rather than post-hospital.

### **3. Interpreter Services**

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

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

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

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

#### **a. Documentation of the Service**

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

- ◆ Interpreter's name or company,

- ◆ Date and time of the interpretation,
- ◆ Service duration (time in and time out), and
- ◆ Cost of providing the service.

#### **b. Qualifications**

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

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

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

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

#### **4. Private-Duty Nurses**

No payment will be made for services of a private-duty nurse, except under EPSDT home health agency services.

#### **5. Services of Physical Therapists in Independent Practice**

Payment will be approved for services rendered by a physical therapist subject to the conditions in effect in the Medicare program for restorative physical therapy. Medicare provides coverage for the services of a physical therapist in independent practice when furnished in the therapist's office or the member's home. The physical therapist must meet licensing and other standards for participation in Medicare to qualify as a participating independently practicing physical therapist in the Medicaid program.

## **6. Transportation Services to Receive Medical Care**

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

When a member needs transportation or reimbursement for transportation, the member must contact the broker 72 business hours in advance for approval and scheduling. Modes of transportation may include: bus tokens, volunteer services, mileage reimbursement, or other forms of public transportation.

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

## **H. Basis of Payment For Physician Services**

### **1. Payment for Anesthesiologist Services**

Anesthesia services coded (ASA codes) 00100 through 01999 are reimbursed by multiplying the sum of the base units (assigned to the ASA code converted to minutes) and the time (in minutes) used in providing the anesthesia by a Medicaid reimbursement conversion factor.

Intrathecal narcotic for labor and delivery, codes 62320 and 62322, is reimbursed from a fee schedule.

The American Society of Anesthesiologists states that "...anesthesia time begins when the anesthesiologist begins to prepare the member for the induction of anesthesia in the operating room or in an equivalent area and ends when the anesthesiologist is no longer in personal attendance; that is, when the patient may be safely placed under post-operative supervision." Indicate time as the number of minutes.

Placement of an arterial line or a central venous pressure catheter is reimbursed separately from the anesthesia services provided when the base unit for the ASA code is less than 20 units (300 base minutes when converted from units to minutes). If the base unit for the ASA code is 20 (300 base minutes) or greater, the anesthesia preparation reimbursement includes placement of an arterial line or central venous pressure catheter.

Services of CRNAs employed by a physician can be billed either by the employing physician or by the CRNA, if enrolled as a Medicaid provider.

For CRNAs enrolled as Medicaid providers, instructions for billing are described in the CRNA provider manual. The CRNA's reimbursement can be paid to the employing physician even though the CRNA has a separate provider number. Such an arrangement can be made through the provider enrollment section of the IME.

To bill for employed CRNAs, use the following modifiers:

- ◆ Use the modifier "QZ" when the CRNA provides anesthesia with no medical direction from an anesthesiologist.
- ◆ Use the modifier "QX" when the CRNA provides anesthesia with medical direction from an anesthesiologist.

**NOTE:** When the physician provides anesthesia, use the modifier "AA."

**NOTE:** "Medical direction" is defined as an anesthesiologist providing medical direction from the operating suite. A physician who is not an anesthesiologist (for example, a surgeon, urologist, family practice physician, etc.) is not eligible to receive reimbursement for medical direction of anesthesia.

## **2. Payment for Continuous Epidural Analgesia**

All physician specialties providing continuous epidural analgesia are reimbursed on a flat fee basis using CPT code 62326 (continuous injection of analgesic substance, diagnostic or therapeutic; epidural, lumbar, or caudal). Use this code both for pain management and for maternity-related anesthesia.

There is no reimbursement of anesthesia codes (base units plus time) for continuous epidural analgesia. The claim form must show one unit. Only one physician will be reimbursed for the continuous epidural analgesia procedure.

For maternity-related anesthesia, the delivery physician may bill for the epidural only if the physician administers the anesthesia from the beginning of the delivery to the end. If the delivering physician introduces the epidural catheter and then calls in an anesthesiologist to complete the anesthesia, only the anesthesiologist may bill for the epidural.

Management of the epidural analgesia after the placement of the continuous epidural analgesia line is included in the reimbursement.



### 3. Payment for Family Planning Services

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

Family planning services include the following:

- ◆ Examination and tests which are necessary before prescribing family planning services.
- ◆ Contraceptive services. (Sterilization procedures **must meet the informed consent requirements** as outlined in [Consent for Sterilization, Form 470-0835 or 470-0835S.](#))
- ◆ Supplies for family planning, including such items as an IUD, a diaphragm, or a basal thermometer.

Services performed for abortions, childbirth, or the treatment of an illness or injury that have a secondary family planning relationship **are not considered as family planning services**. Do not mark these claims as family-planning-related.

Reversals of sterilization procedures are not covered procedures.

If the member has eligibility under the Iowa Family Planning Program both the diagnosis and the procedure code for the service must be on the approved list of family planning services. Click [here](#) to view the list.

### 4. Payment for Home Health Agency Services

For home health agency services, use ICD-10-CM for member diagnoses and applicable CPT codes for procedures to be performed for the home health plan of care.

The Department has established a fee schedule with advice and consultation from the Iowa Medical Society and the Iowa Osteopathic Medical Association. Physicians will be reimbursed the lower level of customary charges and the fee schedule amount.

### 5. Payment for Obstetrical Services

Please refer to the [Maternity Billing Guide](#) on the IME website under NCCI.

## **6. Payment for Osteopathic Manipulation Therapy**

Medicaid recognizes five levels of procedure codes for osteopathic manipulation therapy, as described in current CPT and HCPCS coding manuals. See [PROCEDURE CODES AND NOMENCLATURE](#). Claims using these codes must include a diagnosis directly relating to a musculoskeletal disorder.

An evaluation and management service may be billed in addition to the osteopathic manipulation therapy when an evaluation and management services is also provided. Use modifier "25" with the evaluation and management code.

## **7. Payment for Treatment of Chronic Renal Disease**

Payment will be made on the same basis as Medicare for services associated with treatment of chronic renal disease. This includes physician's services, hospital care, renal transplantation, and hemodialysis, whether performed on an inpatient or outpatient basis.

Some patients under age 65 are eligible for Medicare if they need treatment for chronic renal disease. If these persons are also eligible for Medicaid, Medicaid payment will be made for Medicare deductibles and coinsurance.

## **I. Procedure Codes and Nomenclature**

Claims submitted without a procedure code and appropriate ICD-10-CM diagnosis code will be denied.

Iowa uses the HCFA Common Procedure Coding System (HCPCS). HCPCS codes divided into three levels. Level 1 is the current CPT-4 codes. Level 2 codes are specifically designed regional five-digit codes beginning with letters A through V. Level 3 codes are specifically designed local codes beginning with letters W through Z. (Most of the local codes have been replaced due to HIPAA requirements.)

In certain instances, two-digit modifiers are applicable. They should be placed after the five-position procedure code. Modifiers are found in CPT-4.

### **1. Injections**

Physicians are reimbursed separately for injections and for the administration of injections. Use current CPT or HCPCS national Level 2 codes for injections. If a specific code cannot be identified, refer to “not otherwise classified” codes, such as J3490. When using an “unspecified” code, the NDC number and description of the drug, including the strength and the dosage, is required.

Immunizations are usually given in conjunction with a medical service. When an immunization is the only service performed, then list a minimal service in addition to the injection. Immunization procedures include the supply of related materials.

Medicaid immunizations must be provided under the Vaccines for Children Program (VFC). Click [here](#) to view vaccines available through the VFC program.

When a child receives a vaccine outside of the VFC schedule, Medicaid will provide reimbursement.

Bill the appropriate vaccine administration codes for the vaccine administration in addition to the CPT code for the vaccine.

### **2. Medical Supplies**

Click [here](#) to view the current physician fee schedule for covered and payable medical supplies.

### 3. Nursing Home Visits

Click [here](#) to view the current physician fee schedule for covered and payable nursing home services.

### 4. Obstetrical Services

#### a. Risk Assessment

<u>Code</u>	<u>Description</u>
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96160	Completion of <a href="#">Medicaid Prenatal Risk Assessment, form 470-2942</a> .
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#### b. Delivery, Antepartum, and Postpartum Care

See the current physician fee schedule for covered and payable codes. However, please see below for instructions regarding billing the following procedure codes:

Bill 59425 when four to six antepartum care visits are provided **and** delivery services are **not** also provided.

Bill 59426 when seven or more antepartum care visits are provided **and** delivery services are **not** also provided.

### 5. Optical Services - Professional Services and Materials

Refer to CPT manual or the physician fee schedule for procedure codes related to professional service.

### 6. Psychiatric Services

Covered psychiatric services include the following:

- ◆ Interview or examination
- ◆ Psychological testing
- ◆ Individual psychotherapy
- ◆ Family therapy
- ◆ Group psychotherapy
- ◆ Billing notes

Service will be reimbursed on the basis of time. Enter the number of units in the **Units** column, with one unit equal to the time shown in the description for the procedure code.

Round the units of service to the nearest unit. For example, 1 hour and 7 minutes of individual psychotherapy is rounded to 1 hour; and 1 hour and 8 minutes is rounded to 1 hour and 15 minutes.

Payment for group therapy is based on the actual number of persons who comprise the group, **but not less than six**. For example, if eight persons comprise the group, payment will be based on this number. However, if the group consists of four persons, payment will nevertheless be based on six persons. Enter the number of people in the group as a two-digit modifier directly after the procedure code.

## **J. Billing Policies and Claim Form Instructions**

Claims for physicians are billed on federal form CMS-1500, *Health Insurance Claim Form*.

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

The Billing Manual can be located online at:  
<http://dhs.iowa.gov/sites/default/files/All-IV.pdf>