

# **Local Education Agency**

## **Provider Manual**



**Iowa Department  
of Human Services**



Iowa  
Department  
of Human  
Services

Provider  
**Local Education Agency**

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

### **A. CONDITIONS OF PARTICIPATION**

Local Education Agencies (LEA) eligible to participate in the Iowa Medicaid program are the public school districts accredited by the Iowa Department of Education, the Iowa Braille and Sight-Saving School, and the School for the Deaf.

The provider must agree to remit to the Iowa Department of Human Services (DHS) an amount equal to the non-federal share of the Medicaid payment.

#### **1. Personnel**

Services shall be provided by personnel who meet standards as set forth in Iowa Department of Education rule 282 Iowa Administrative Code (IAC) Chapter 15 or 16 (256B, 34CFR300), to the extent that their certification or license allows them to provide these services. Additionally, some practitioners are required to hold a professional license.

#### **2. Records**

Providers shall maintain complete and legible clinical records documenting that the services for which a charge is made to the Medicaid program are:

- ◆ Medically necessary,
- ◆ Consistent with the diagnosis of the member's condition, and
- ◆ Consistent with professionally recognized standards of care.

The documentation for each "patient encounter" shall include the following (when appropriate):

- ◆ Complaint and symptoms, history, examination findings, diagnostic test results, assessment, clinical impression or diagnosis, plan for care, date, and identity of the observer.
- ◆ Specific procedures or treatments performed.
- ◆ Medications or other supplies.
- ◆ Member's progress, response to and changes in treatment, and revision of diagnosis.
- ◆ Information necessary to support each item of service reported on the Medicaid claim form.

**NOTE:** Time (including AM/PM) is required for services billed in units of time.



Providers of service shall maintain fiscal records in support of each item of service for which a charge is made to the program. The fiscal record does not constitute a clinical record.

Failure to maintain supporting fiscal and clinical records may result in claim denials or recoupment of Medicaid payment.

As a condition of accepting Medicaid payment for services, providers are required to provide the Iowa Medicaid program access to member medical records when requested. Providers shall make the medical and fiscal records available to the Department or its duly authorized representative on request.

Member rights of confidentiality are respected in accordance with the provisions of 42 CFR Part 431, Subpart F, and 281 IAC Chapter 41.610 (256B, 34CFR300).

## **B. COVERAGE OF SERVICES**

Medicaid payment will be made for medically necessary audiology, behavioral, medical transportation, nursing, nutrition, occupational therapy, personal assistance, physical therapy, psychologist, school-based visit, speech-language, social work, and vision services provided by a local education agency. Screening, assessment, and direct services are also covered.

### **1. Primary and Preventive School Health Services**

A school health center provides primary and preventive medical, social, mental health, and health education services designed to meet the psychosocial and physical health needs of students in the context of their family, culture, and environment. Services must be within the scope of licensure of the individual practitioner.

Student health center services, in addition to those provided by the medical home, shall be made available for the student. The student health center shall coordinate services with the student's private medical provider. Students must have a medical home. If the student does not have a medical home, the student health center will work with the student and family to establish a consistent source of medical care.





**a. Free Health Care**

School districts may not bill Medicaid for health care services that they provide free of charge to non-Medicaid students. If a school district establishes a fee schedule for billing families for health care services, the services are not considered free, and Medicaid may be billed.

**EXCEPTION:** Health care services provided under Part B of IDEA that are referenced in an Individual Education Plan (IEP) may be billed to Medicaid regardless of whether there is a charge for the service for non-Medicaid students. This includes medical transportation services that are included in the student’s IEP.

**b. Primary Health Care Services**

Primary health care services are billed to Medicaid based on whether the student is a “new patient” or an “established patient.”

Office or other outpatient (school-based) visits for the evaluation and management of a “new patient” require three components:

- ◆ A history, and
- ◆ An examination, and
- ◆ Medical decision making.

The level of the components and the expected time involved varies with the severity of the student’s problem.

<b>Severity</b>	<b>History</b>	<b>Exam</b>	<b>Decisions</b>
Self-limited or minor	Problem-focused	Problem-focused	Straight-forward
Low to moderate	Extended problem-focused	Expanded problem-focused	Straight-forward or low complexity
Moderate to high	Detailed or comprehensive	Detailed or comprehensive	Moderate or high complexity

For a student who is an “established patient,” a visit requires at least two of these three components (except when the problem is minimal and requires only a few minutes performing or supervising the service). Visits with “established patients” typically take less time.



Covered services include counseling and coordination of care with other providers or agencies, consistent with the nature of the student's problems.

**c. Preventive Services**

Preventive services are billed on the basis of the age of the student and whether the service is the initial evaluation and management of a "new patient" or the periodic re-evaluation and management of an "established patient." Covered services include:

- ◆ A comprehensive history
- ◆ A comprehensive examination
- ◆ Counseling and anticipatory guidance
- ◆ Interventions to reduce risk factors
- ◆ Ordering appropriate laboratory and diagnostic procedures

**NOTE:** Comprehensive physical examinations provided to Medicaid members must meet the requirements of the EPSDT "Care for Kids" program. See [CONTENT OF WELL CHILD EXAMINATION](#), for details.

**2. Treatment Plan Requirements for IEP Services**

All services must be specific to a Medicaid-eligible student who has an IEP.

A treatment plan is required for direct services, based on professional assessment. The treatment plan must indicate measurable goals and objectives and the type and frequency of services provided.

An updated IEP that delineates the need for ongoing services is required annually. The updated plan must:

- ◆ Include the student's current level of functioning, and
- ◆ Set new goals and objectives when needed, and
- ◆ Delineate the modified or continuing type and frequency of service.



### 3. **Audiological Services**

To be covered by Medicaid, audiological services must be provided by an audiologist licensed by the Iowa Department of Public Health.

The following services are covered when they are included in the child's IEP or are linked to a service in the IEP:

- ◆ [Audiological Screening](#)
- ◆ [Individual Audiological Assessment](#)
- ◆ [Audiological Services to an Individual](#)
- ◆ [Audiological Services in a Group](#)
- ◆ [Contracted Audiological Therapy Services](#)

#### a. **Audiological Screening**

Perform objective audiological screening in both ears using a pure-tone audiometer for age three and older:

- ◆ At a minimum of 1000, 2000, and 4000 Hz at 20 dB HL.
- ◆ If a child fails to respond at any of the frequencies in either ear, a complete audiogram or other assessment must be done.
- ◆ Use tympanometry in conjunction with pure-tone screening in young child populations (i.e., preschool, kindergarten, grade 1).

**Source:** [American Academy of Audiology Childhood Hearing Screening Guidelines, September 2011](#)

#### b. **Individual Audiological Assessment**

Individual audiological assessment includes tests, tasks, and interviews used to:

- ◆ Identify hearing loss in infants and toddlers.
- ◆ Establish the nature, range, and degree of the hearing loss.
- ◆ Make referral for medical or other professional attention for the habilitation of hearing.



**c. Audiological Services to an Individual**

Audiological service to an individual is provided in a 1:1 therapist-to-child ratio. The type and level of treatment services are an outcome of the assessment. Services may be provided directly or through case consultation. Individual services include:

- ◆ **Auditory training.** Sound discrimination tasks (in quiet noise), sound awareness, and sound localization.
- ◆ **Audiology treatment.** Services to infants and toddlers and their families, including:
  - Providing rehabilitative services to hearing-impaired children, including language habilitation, auditory training, speech-reading (lip-reading), speech conservation, and ongoing hearing evaluation.
  - Providing counseling and guidance of children and parents regarding hearing loss and the proper care and use of amplification.
  - Determining the child's need for group and individual amplification (hearing aids, auditory trainers, and other types of amplification).
  - Selecting and fitting appropriate amplification.
  - Monitoring the functioning of the child's hearing aid or other amplification.
  - Evaluating the effectiveness of amplification, adjustment or modification of hearing aids and other amplification.
  - Repairing amplification.
  - Making a recommendation for new hearing aids or other amplification.



The role of consultation is monitoring, supervising, teaching, and training professionals, paraprofessionals, and parents in the home or community environment. Consultation includes:

- ◆ Providing general information about a specific child's condition.
- ◆ Teaching special skills necessary for proper care of a specific child's hearing aid.
- ◆ Developing, maintaining, and demonstrating use and care of adaptive or assistive devices for a specific child.

**d. Audiological Services in a Group**

Audiological service provided in a group is identical in scope to the service activities listed under services to an individual, except that services are provided to a group of children.

Early ACCESS services provided to a specific child must be provided in that child's "natural environment" unless the child's goals and outcomes cannot be met in "the home or community setting where children of the same age without disabilities participate." A justification statement must be included on the IEP if service is provided in another setting.

**e. Contracted Audiological Therapy Services**

Contracted audiological therapy services include screening, assessment, and therapy services which are rendered by a qualified practitioner who is a contractor, rather than an employee, of the provider. The requirements for documentation, records maintenance, educational certification or licensure, and medical necessity remain unchanged.

**4. Behavior Services**

Behavior services consist of formal programs designed by a school psychologist, school social worker, or Iowa Medicaid health professional to prevent or correct maladaptive behavior on the part of the student. The interventions are used to change specific behaviors. They are monitored by a mental health professional, and are carried out by staff.

The behavior plan must be in a separate document from just a goal in the IEP. The plan provides a description of the behavior to be addressed and positive or negative incentives to encourage proper behavior. Direct care staff records the nature and severity of the problem behaviors and the response of the direct care staff and the student. The documentation provides the basis for evaluation and revision of the plan as necessary.



**a. Requirements for Service**

Behavior services can be covered when:

- ◆ They can reasonably be expected to improve the student's condition. At a minimum, the treatment must be designed to reduce or control the student's psychiatric symptoms to:
  - Prevent relapse or hospitalization, and
  - Improve the student's level of functioning.
- ◆ The student has the capacity to benefit from the treatment goals.
- ◆ The student does not require isolation, seclusion, elopement precautions, or restraint procedures, except for brief behavioral management.

**b. Progress Notes**

Progress notes must:

- ◆ Give a full picture of the services provided, and
- ◆ Contain a concise assessment of the student's and family progress and recommendations for revising the treatment plan as indicated by the student's condition.

Each unit of service shall be documented. A clinical service note that summarizes program participation and behavioral status and functioning can be documented weekly. At a minimum, the documentation must address the following items in order to provide a clinical description and to assure that the service conforms to the service description.

A general observation of the student's condition may include:

- ◆ The student's mental status
- ◆ Behavior
- ◆ Psychosocial skills
- ◆ The student's activity and participation in treatment
- ◆ Activities of staff
- ◆ Future plans for working with the student

Documentation of the treatment services provided to the student, the student's response (progress or lack of progress), and the staff's interaction and involvement with the student shall justify and support the continuation of services.



## 5. Health and Nursing Services

Nursing services include, but are not limited to:

- ◆ Health assessments and evaluations
- ◆ Diagnosis and planning
- ◆ Administering and monitoring medical treatments and procedures
- ◆ Consultation with licensed physicians and other health practitioners, parents, and staff regarding the child's specific health needs
- ◆ Individual health counseling and instruction
- ◆ Emergency intervention
- ◆ Other activities and functions within the purview of the Nurse Practice Act

Medicaid covers the following services when they are in the child's IEP or are linked to a service in the IEP:

- ◆ [Screening](#) (RN service only)
- ◆ [Individual Assessment](#) (RN service only)
- ◆ [Nursing Service to an Individual](#)
- ◆ [Nursing Service to a Group](#)
- ◆ [Contracted Nursing Service](#)
- ◆ [Consultation](#)
- ◆ [Nursing Care Procedures](#)

To be covered, these services must be provided by a licensed nurse or physician.

### a. Screening

Screening is the process of assessing health status through direct individual or group observation, in order to identify problems and determine if further assessment is needed.

Document referrals for evaluation or treatment services identified through the screening.



## b. Individual Assessment

“Assessment” refers to the process of health data collection, observation, analysis, and interpretation for the purpose of formulating a nursing diagnosis. The initial assessment includes:

- ◆ Determining the need, nature, frequency, and duration of treatment.
- ◆ Determining the need for coordinating with other services.
- ◆ Documenting these determinations.

Additional activities include:

- ◆ **Treatment planning.** Establishing a plan of care that includes determining goals and priorities for actions that are based on the nursing diagnosis and the intervention to implement the plan of care.
- ◆ **Monitoring of treatment implementation.** Activities designed to document whether the plan is meeting the child’s needs by demonstrating maintenance or improvement in health status.
- ◆ **Evaluation.** Activities designed to evaluate the child’s status in relation to established goals and the plan of care.

## c. Nursing Service to an Individual

Nursing services to an individual child involve executing the individual nursing interventions in the plan of care, including ongoing assessment, planning, intervention, and evaluation.

## d. Direct Nursing Service to a Group

Services to a group may include:

- ◆ **Family counseling.** This service consists of sessions with one or more family members for the purposes of effecting change within the family structure to ensure the child’s health needs are met.
- ◆ **Group counseling.** Services to a child or family provided in a group are identical in scope to the service activities listed for individuals, except that services are provided to more than one family or child at the same time. The services are designed to improve health status. The issues addressed in the group service would have to include identical medical needs.





**e. Contracted Nursing Service**

Contracted services include nursing assessment and services to an individual that are rendered by a qualified practitioner who is a contractor, rather than an employee of the agency. The requirements for documentation, records maintenance, and medical necessity remain unchanged.

**f. Consultation**

The role of consultation is to monitor, supervise, teach, and train professionals, paraprofessionals, and parents in the home or community environment. Consultation includes:

- ◆ Providing general information about a child's condition.
- ◆ Teaching special skills necessary for proper care of a child's medical needs.
- ◆ Making recommendations for enhancing a specific child's performance.
- ◆ Developing, maintaining, and demonstrating use and care of adaptive or assistive devices for a specific child.

Consultation services can include contracted services with a physician in the physician's office to obtain a specialized evaluation or reassessment.

**g. Nursing Care Procedures**

Services include, but are not limited to, immunizations, medication administration and monitoring, prescribed health procedures, and interventions identified in the IEP.

Nursing care procedures include, but are not limited to, monitoring prescribed health procedures and interventions identified in the child's IEP that are needed to participate in early intervention service.



Nursing procedures required for specialized health care under 281 Iowa Administrative Code (IAC) 41.405(256B, 34CFR300) and 281 IAC 120.16(34CFR303) include, but are not limited to:

◆ Catheterization:

- Education and monitoring self-catheterization
- Intermittent urinary catheterization
- Indwelling catheter irrigation, reinsertion, and care

◆ Feeding:

- Nutrition and history assessment
- Ostomy feeding
- Ostomy irrigation, insertion, removal, and care
- Parenteral nutrition (intravenous)
- Specialized feeding procedures
- Stoma care and dressing changes

◆ Health support systems:

- Apnea monitoring and care
- Central line care, dressing change, emergency care
- Dressing and treatment
- Dialysis monitoring and care
- Shunt monitoring and care
- Ventilator monitoring, care, and emergency plan
- Wound and skin integrity assessment, monitoring, and care

◆ Medications:

**Legal reference:** 281 IAC 41.402(3) (256B, 34CFR300) and  
281 IAC 41.405 (256B, 34 CFR300)

- Administration of medications by mouth, injection (intravenous, intramuscular, subcutaneous), oral inhalation by inhaler or nebulizer, rectum or bladder instillation, eye, ear, nose, skin, ostomy, or tube
- Ongoing assessment of medications
- Medication assessment and emergency administration

◆ Ostomies:

- Ostomy care, dressing, and monitoring
- Ostomy irrigation



- ◆ Respiratory care:
  - Oxygen monitoring and care
  - Postural drainage and percussion treatments
  - Suctioning
  - Tracheostomy tube replacement
  - Tracheostomy monitoring and care
  - Ventilator care
- ◆ Specimen collection:
  - Blood
  - Sputum
  - Stool
  - Urine
- ◆ Other nursing procedures including:
  - Bowel and bladder intervention, monitoring, and care
  - Assessing and monitoring body systems, vitals, and growth and development

## 6. **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.



## 7. Medical Supplies and Equipment

Dressings, durable medical equipment, and other supplies shall be obtained from a medical equipment dealer or pharmacy. Supplies should be incidental to the student's care, such as syringes or gloves.

Local education agencies are limited to supplies and equipment of no more than \$25 per month. To provide durable medical supplies and equipment in excess of the \$25 limit, the agency may enroll in the Medicaid program as a medical equipment and supply dealer and bill for these supplies on the CMS-1500 claim form under medical equipment and supply dealer number.

## 8. Nutrition Counseling

Providers are eligible for reimbursement of nutritional counseling (medical nutritional therapy) services provided by licensed dietitians who are employed by or have contracts with the provider when a nutritional problem or a condition of such severity exists that nutritional counseling beyond that normally expected as part of the standard medical management is warranted.

Medical conditions that can be referred to a licensed dietitian include the following:

- ◆ Inadequate or excessive growth. Examples include:
  - Failure to thrive
  - Undesired weight loss
  - Underweight
  - Excessive increase in weight relative to linear growth
  - Major changes in weight-to-height percentile or BMI for the child's age
  - Excessive appetite or hyperphagia
- ◆ Inadequate dietary intake. Examples include:
  - Formula intolerance
  - Food allergy
  - Limited variety of foods
  - Limited food resources
  - Poor appetite



- ◆ Infant or child feeding problems. Examples include:
  - Poor suck or swallow
  - Breastfeeding difficulties
  - Lack of developmental feeding progress
  - Inappropriate kinds or amounts of feeding offered
  - Limited information or skills of caregiver
  - Food aversions
  - Enteral or parenteral feeding
  - Delayed oral motor skills
- ◆ Chronic disease requiring nutritional intervention. Examples include:
  - Congenital heart disease
  - Pulmonary disease
  - Renal disease
  - Cystic fibrosis
  - Metabolic disorder
  - Diabetes
  - Gastrointestinal disease
  - Any other genetic disorders requiring nutritional intervention
- ◆ Medical conditions requiring nutritional intervention. Examples include:
  - Iron deficiency anemia
  - High serum lead level
  - Familial hyperlipidemia
  - Hyperlipidemia
  - Pregnancy
- ◆ Developmental disability. Examples include:
  - Increased risk of altered energy and nutrient needs
  - Oral-motor or behavioral feeding difficulties
  - Medication-nutrient interaction
  - Tube feedings
- ◆ Psychosocial factors. Examples include behaviors suggesting an eating disorder. Children with an eating disorder should also be referred to community resources and to their primary care provider for evaluation and treatment.

This is not an all-inclusive list. Other diagnoses may be appropriate and warrant referral to a licensed dietitian.



## **Individual Nutrition Evaluation and Assessment**

Initial evaluations and follow-up assessments document the process of comprehensive data collection, child and family observation, and analysis to determine a child's nutritional status in order to develop a plan of care. The evaluation is based on:

- ◆ Informed clinical opinion through objective food record review,
- ◆ Evaluation of the child's pattern of growth, and
- ◆ Evaluation of area of concern based on the evaluation tool used and medical nutritional therapy.

Families who are eligible for nutritional counseling through the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) must provide a statement that the need for nutritional counseling exceeds the services available through WIC. Maintain a copy of the statement in the child's record.

### **9. Occupational Therapy**

The following occupational therapy services are covered when they are in the child's IEP or are linked to a service in the IEP:

- ◆ [Occupational Therapy Screening](#)
- ◆ [Individual Occupational Therapy Assessment](#)
- ◆ [Direct Occupational Therapy Service to an Individual](#)
- ◆ [Direct Occupational Therapy in a Group](#)
- ◆ [Contracted Occupational Therapy Services](#)

Occupational therapy services may be provided by:

- ◆ An occupational therapist, licensed by the Iowa Department of Public Health (IDPH), or
- ◆ A licensed occupational therapy assistant as delegated and supervised by the licensed occupational therapist.



### **a. Occupational Therapy Screening**

Screening is the process of surveying a student through direct and indirect observation in order to identify previously undetected problems. Document the referral source and date as well as reason for screening. Screening may include, but is not limited to, the use of any of the following methods:

- ◆ Review of written information (school or medical records, teacher notes)
- ◆ Review of spoken information (interview teachers or parents)
- ◆ Direct observation (checklists, a comparison with peers)
- ◆ Formal screening tools

Need for occupational evaluation services identified through the screening must be documented as well as referrals to other providers. Screening is covered when it is linked to a service in the IEP.

### **b. Individual Occupational Therapy Assessment**

If individual evaluations are conducted, documentation of referral source and date, reason occupational therapy services are being sought, data collected, analysis and summary are necessary. Evaluation may include review of records, interview, observation, and use of formal or informal tools.

The areas of occupations (e.g., activities of daily living, social participation, work) that are successful or problematic, contexts and environments (e.g., physical, social, cultural, temporal) that support or hinder occupations, and the demands of the activities (e.g., required actions, body functions) should be included in the evaluation.

In addition, the following information about the child should be included:

- ◆ Performance skills (e.g., motor, cognitive, social, sensory-perceptual skills);
- ◆ Performance patterns (e.g., habits, routines); and
- ◆ Other factors (e.g., mental, neuromuscular, sensory, visual functions and structures).





**c. Direct Occupational Therapy Service to an Individual**

**(1) Direct Service Model**

In a direct service model, the occupational therapist works with a child or student individually. Therapy may occur in an isolated environment due to the need for instruction free from distraction or the need for specialized equipment not found in the classroom setting.

The occupational therapist or an occupational therapy assistant under the supervision of the occupational therapist is the primary provider of service and is accountable for specific treatment plan objectives for the child or student. There is not an expectation that activities will be delegated to others and carried out between therapy sessions.

The emphasis of therapy is usually on the acquisition of skills or sequences needed for a new performance during a critical learning period. The child has not achieved a level of ability that would permit transfer of skills to other environments. Often only a short interval of direct service is needed before the child can participate in a less restrictive model of service.

Typically, direct service is used when frequent program changes are needed and other personnel do not have the unique expertise to make these decisions.

Intervention sessions may include the use of therapeutic or specialized equipment that require the occupational therapist's expertise and cannot safely be used by others within the child's or the student's educational environment. The occupational therapist's professional judgment determines when a licensed occupational therapist is the only person qualified to carry out the therapy program.



## (2) Integrated Services Model

“Integrated service” is a model of therapy that combines direct child-therapist contact with consultation with others involved in the child’s program.

Emphasis is placed on the need for practice of skills and problem solving in the child’s daily routine. Integrated therapy service is provided within the child’s daily educational environment.

The process of goal achievement is shared among those involved with the child or student, including the occupational therapist, occupational therapy assistant, teacher, parents, classroom associate, and others. Intervention may include:

- ◆ Adapting functional activities, usually occurring in the student’s routine related to mobility, self-care, mealtime skills, or manipulation.
- ◆ Creating opportunities for the child or student to practice new skills.
- ◆ Dynamic positioning.
- ◆ Collaborative problem solving with others to encourage functioning and independence.
- ◆ Enhanced performance as the child develops and uses new skills.

Only the actual time spent providing service by the occupational therapist or an occupational therapy assistant under the supervision of an occupational therapist is considered therapy. Activities or follow-through performed by others cannot be called occupational therapy.



### **(3) Consultative Services Model**

In the consultative occupational therapy service model, the therapist participates in collaborative consultation with the teacher, other staff, parents, and, when appropriate, the student regarding student-specific issues as identified in the IEP goals.

Occupational therapy appears on the IEP as a support service and is associated with a specific IEP goal.

The occupational therapist's unique expertise is often needed for staff and parent training related to the IEP goal. Although the therapist is not the primary person responsible for carrying out these activities, the occupational therapist's input is typically needed to determine:

- ◆ Appropriate expectations.
- ◆ Environmental modifications.
- ◆ Assistive technology.
- ◆ Possible learning strategies.

The intervention activities, which are delegated to others, do not require the occupational therapist's expertise and should not be identified as occupational therapy.

#### **d. Direct Occupational Therapy in a Group**

Direct occupational therapy to a group includes the same models as described for direct occupational therapy service to an individual.

#### **e. Contracted Occupational Therapy Services**

Contracted occupational therapy services include screening, assessment and therapy services which are rendered by a qualified practitioner who is a contractor, rather than an employee, of the provider. The requirements for documentation, records maintenance, and medical necessity remain unchanged.



## 10. Personal Health Services

Personal health services primarily involve hands-on assistance with a student's physical dependency needs. Services are related to a student's physical requirements for activities of daily living, such as assistance with eating, bathing, dressing, personal hygiene, bladder and bowel requirements, and taking medications.

The services must be included in a treatment plan developed by the licensed health care professional, but are provided by paraprofessional staff.

Personal health services may include assistance with communication, eating, personal hygiene, mobility, bladder and bowel requirements, and medication administration. Services may include assistance with preparation of meals but do not include the cost of the meals themselves.

**NOTE:** Use billing code T1020 when services are provided for 50 percent or more of a school day.

## 11. Physical Therapy

The following physical therapy services are covered when they are in the child's or student's IEP, or are linked to a service in the IEP:

- ◆ [Physical Therapy Screening](#)
- ◆ [Individual Physical Therapy Assessment](#)
- ◆ [Direct Physical Therapy Service to an Individual](#)
- ◆ [Direct Physical Therapy Service in a Group](#)
- ◆ [Contracted Physical Therapy Services](#)

To be covered, the service must be provided either by:

- ◆ A licensed physical therapist, or
- ◆ A licensed physical therapy assistant as delegated and supervised by the licensed physical therapist.

Contracted physical therapy services include screening, assessment and therapy services that are rendered by a qualified, contracted practitioner rather than an employee of the provider. The requirements for documentation, records maintenance, and medical necessity remain unchanged.



**a. Physical Therapy Screening**

Screening is the process of surveying a student through direct and indirect observation in order to identify previously undetected problems. Document referral source and date as well as reasons for screening. Screening may include, but is not limited to, the use of any of the following methods:

- ◆ Review of written information (school or medical records, teacher notes)
- ◆ Review of spoken information (interview teachers or parents)
- ◆ Direct observation (checklists, a comparison with peers)
- ◆ Formal tools for the purpose of screening

Need for physical therapy evaluation and services identified through screening must be documented as well as referrals to other providers. Screening is covered when it is linked to a service in the IEP. Physical therapists may be involved in screening a group of children or students, but more typically, the therapist consults and provides in-service training for other personnel who regularly screen groups of children or students.

**b. Individual Physical Therapy Assessment**

An assessment by a physical therapist should consider information from each of the following areas as they affect the student's ability to meet the demands of the education program:

- ◆ Developmental motor level
- ◆ Neuromuscular and musculoskeletal components
- ◆ Functional motor skills:
  - Positioning
  - Mobility

Other areas may also be considered when they are related to the student's identified problem.



### c. **Direct Physical Therapy to an Individual**

Direct physical therapy to an individual includes services indicated in the treatment plan. Physical therapy service may be delivered through the following models:

#### **(1) Direct Service Model**

In a direct service model, the physical therapist works with a student individually. Therapy may occur in an isolated environment due to the need for instruction free from distraction or the need for specialized equipment not found in the classroom setting.

The physical therapist or a physical therapy assistant under the supervision of the physical therapist is the primary provider of service and is accountable for specific treatment plan objectives for the child or student. There is not an expectation that activities will be delegated to others and carried out between therapy sessions.

The emphasis of direct therapy is usually on the acquisition of skills or sequences needed for new performance during a critical learning period. The student has not achieved a level of ability that permits transfer of skills to other environments. Often only a short interval of direct services is needed before the child can participate in a less restrictive model of service.

Typically, direct service is used when frequent program changes are needed, and other personnel do not have the unique expertise to make these decisions.

Intervention sessions may include the use of therapeutic or specialized equipment that require the physical therapist's expertise and cannot safely be used by others within the child's or the student's educational environment. The physical therapist's professional judgment determines when a licensed therapist is the only person qualified to carry out the therapy program.



## **(2) Integrated Service Model**

The integrated service model combines direct child-therapist contact with consultation with others involved in the student's educational program. Emphasis is placed on the need for practice of motor skills and problem solving in the child's or student's daily routine. Integrated therapy service is provided within the child's or the student's daily educational environment.

The process of goal achievement is shared among those involved with the student, including the therapist, therapy assistant, teacher, parents, classroom associate, and others.

Intervention may include:

- ◆ Adapting functional activities, usually occurring in the student's routine related to mobility.
- ◆ Creating opportunities for the student to practice new motor skills.
- ◆ Dynamic positioning to promote learning.
- ◆ Collaborative problem solving with others to encourage functioning and independence.
- ◆ Enhanced performance as the child develops and uses new skills.

Only the actual time spent providing service by the physical therapist, or physical therapy assistant under the supervision of a physical therapist, is considered therapy. Activities or follow-through performed by others cannot be called physical therapy.

## **(3) Consultative Service Model**

In the consultative service model, the physical therapist participates in collaborative consultation with the teacher, other staff, parents, and when appropriate, the student regarding child- or student-specific issues as identified in the IEP goals.



Physical therapy appears on the IEP plan as a support service and is associated with a specific treatment plan goal or objective, although the physical therapist is not the primary individual responsible for carrying out these activities.

The physical therapist's unique expertise is often needed for staff and parent training related to the IEP goal. The physical therapist's input is typically needed to determine:

- ◆ Appropriate expectations.
- ◆ Environmental modifications.
- ◆ Assistive technology.
- ◆ Possible learning strategies.

The intervention activities, which are delegated to others, do not require the therapist's expertise and should not be identified as physical therapy.

**d. Direct Physical Therapy Service in a Group**

Direct physical therapy to a group includes the same models as described under [Direct Physical Therapy to an Individual](#), but is covered only when the service is in the student's IEP or linked to a service in the IEP.

**e. Contracted Physical Therapy Services**

Contracted physical therapy services include screening, assessment, and therapy services which are rendered by a qualified practitioner who is a contractor, rather than an employee, of the provider. The requirements for documentation, records maintenance, and medical necessity remain unchanged.





## 12. Psychological Services

The following psychological services are covered when they are in the IEP or are linked to a service in the IEP:

- ◆ [Psychological Screening](#)
- ◆ [Individual Psychological Assessment](#)
- ◆ [Direct Psychological Service to an Individual](#)
- ◆ [Direct Psychological Service in a Group](#)
- ◆ [Consultative Services](#)
- ◆ [Contracted Psychological Services](#)

To be covered, services must be provided by a licensed psychologist or certified school psychologist.

Contracted psychological services include individual psychological assessment and direct psychological services to an individual or in a group that are rendered by a qualified, contracted practitioner rather than an employee of the agency. The requirements for documentation, records maintenance, and medical necessity remain unchanged.

### a. Psychological Screening

Psychological screening is the process of surveying a child through direct observation or testing in order to verify problems and determine if further assessment is needed. Document referrals for evaluation or treatment services identified through the screening.

### b. Individual Psychological Assessment

“Assessment” refers to the process of collecting data for the purpose of making treatment decisions. Portions of the assessments specifically leading to psychological services (including social behavior and adaptive behavior) may be billed to Medicaid. Treatment refers to psychological services, which includes therapeutic services including the use of Applied Behavior techniques. The initial assessment includes:

- ◆ Determining the need, nature, frequency, and duration of treatment.
- ◆ Deciding the needed coordination with others.
- ◆ Documenting these activities.



Additional assessment activities include:

- ◆ **Treatment planning.** Assessment activities and procedures used to design an intervention plan.
- ◆ **Monitoring of treatment implementation.** Activities and procedures designed to document the child's improvement during treatment provision and to adjust the intervention plan as needed.
- ◆ **Treatment evaluation.** Assessment activities and procedures designed to evaluate the summary effects of an intervention after a significant period.

**c. Direct Psychological Service to an Individual**

Direct psychological services to an individual involve individual therapy and consist of supportive, interpretive, insight-oriented, and directive interventions.

**d. Direct Psychological Service in a Group**

Direct psychological services to a group include the following services:

- ◆ **Group therapy** that is designed to enhance a student's socialization skills, peer interaction, expression of feelings, etc.
- ◆ **Family therapy**, which consists of sessions with one or more family members for the purposes of effecting changes within the family structure, communication, clarification of roles, etc.

**e. Consultative Services**

Consultative service is a model of therapy where by the therapist participates in collaborative consultation with the team members regarding outcomes identified on the IEP.

The therapist's input is typically needed to train appropriate therapeutic supports (to include behavior therapy), increase plan fidelity, and determine needed changes in behavioral strategies for the child. The therapist's unique expertise may be needed for other team member training. However, the therapist's expertise is not required for the child's specific interventions used to accomplish the outcomes.



A *Functional Behavioral Assessment*, *Behavioral Intervention Plan*, and behavioral service must appear on the IEP. Since the therapist is not the primary person responsible for carrying out the interventions, at least one other person is also linked to the outcome or goal. The time the therapist will spend in collaborative consultation shall appear on the IEP.

**f. Contracted Psychological Services**

Contracted psychological services include individual psychological assessment and direct psychological services to an individual or in a group that are rendered by a qualified practitioner who is a contractor, rather than an employee, of the provider. The requirements for documentation, records maintenance, and medical necessity remain unchanged.

**13. Social Work Services**

Social work services include assessment, diagnosis and treatment services including, but not limited to:

- ◆ Administering and interpreting clinical assessment instruments.
- ◆ Completing a psychosocial history.
- ◆ Obtaining, integrating, and interpreting information about child behavior.
- ◆ Planning and managing a program of therapy or intervention services.
- ◆ Providing individual, group, or family counseling.
- ◆ Providing emergency or crisis intervention services.
- ◆ Providing consultation services to assist other service providers or family members in understanding how they may interact with a child in a therapeutically beneficial manner.

Medicaid covers the following services when they are in the child's IEP or are linked to a service in the IEP:

- ◆ [Social Work Screening](#)
- ◆ [Social Work Assessment](#)
- ◆ [Direct Services to an Individual](#)
- ◆ [Direct Services in a Group](#)
- ◆ [Contracted Services](#)

For services to be covered, they must be provided by a licensed social worker or certified school social worker.



**a. Social Work Screening**

Screening is the process of surveying a person through observation or group testing in order to verify problems and determine if further assessment is needed.

Document referrals for evaluation or treatment services identified through the screening.

**b. Social Work Assessment**

“Assessment” refers to the process of collecting data for the purpose of making treatment decisions. Portions of assessment specifically leading to social work services (including social behavioral and adaptive behavioral services) may be billed to Medicaid. Treatment refers to social work services which includes therapeutic services including the use of applied behavior techniques. These decisions may require:

- ◆ Determining the need, nature, frequency, and duration of treatment.
- ◆ Deciding the needed coordination with others.
- ◆ Documenting these activities.

Categories of treatment decisions in addition to screening are:

- ◆ **Monitoring of IEP implementation.** Activities and procedures designed to document the child’s progress during treatment provision and to adjust the treatment plan as needed.
- ◆ **Treatment evaluation.** Activities designed to evaluate the effects of an intervention after a significant period.

**c. Direct Service to an Individual**

Services to an individual involve individual therapy. This service may use any model of therapy and clinical practice.

The role of consultation is monitoring, supervising, teaching, and training professionals, paraprofessionals, and parents in the home or community environment. Consultation includes:

- ◆ Providing general information about a child’s developmental delay or condition.
- ◆ Teaching special skills necessary to meet a child’s needs.
- ◆ Making recommendations for enhancing a child’s performance.



**d. Direct Service in a Group**

Services to a group include the following therapeutic services:

- ◆ **Group therapy.** This service is designed to enhance socialization skills, peer interaction, and expression of feelings.
- ◆ **Family therapy.** This service consists of sessions with one or more family members, for the purposes of effecting changes within the family structure, communication, and clarification of roles.

Early ACCESS service provided to a specific child must be provided in that child's "natural environment" unless the child's goals and outcomes cannot be met in "the home or community setting when children of the same age without disabilities participate." A justification statement must be included on the IEP if service is provided in another setting.

**e. Contracted Services**

Contracted services include clinical assessment and services to an individual or in a group that are rendered by a qualified practitioner who is a contractor, rather than an employee, of the agency. The requirements for documentation, records maintenance, and medical necessity remain unchanged.

**14. Speech-Language Therapy**

The following speech-language services are covered when they are in the IEP or are linked to a service in the IEP:

- ◆ [Speech-Language Screening](#)
- ◆ [Individual Speech-Language Assessment](#)
- ◆ [Speech-Language Services to an Individual](#)
- ◆ [Speech-Language Therapy Service in a Group](#)
- ◆ [Contracted Speech-Language Services](#)

To be covered, services must be provided by either:

- ◆ A licensed or certified speech-language pathologist, or
- ◆ A speech pathology assistant who is supervised by a licensed speech-language pathologist.



Contracted speech-language services include screening, assessment, and therapy services that are rendered by a qualified, contracted practitioner rather than an employee of the agency. The requirements for documentation, records maintenance, and medical necessity remain unchanged.

Contracted speech-language services are covered only when provided by a licensed or certified speech-language pathologist.

**a. Speech-Language Screening**

Speech-language screening is the process of surveying an infant, toddler, or student through observation, analysis, or direct supervision by a speech-language pathologist in order to identify previously undetected speech and language problems such as:

- ◆ Articulation
- ◆ Receptive and expressive language
- ◆ Voice
- ◆ Fluency
- ◆ Oral motor functioning
- ◆ Oral structure
- ◆ Feeding

**b. Individual Speech-Language Assessment**

Individual speech-language assessment refers to the process of gathering and interpreting information through:

- ◆ Administration of tests or evaluation instruments.
- ◆ Observation.
- ◆ Record review.
- ◆ Interviews with parents, teachers, and others.

Results of the assessment may identify delay or disorder in one or more of the following areas:

- ◆ Articulation
- ◆ Language
- ◆ Fluency
- ◆ Voice
- ◆ Oral motor, feeding, or both



Based on these assessments, the needs of the infant, toddler, or student are identified, planned for, and documented, including the amount of services.

**c. Speech-Language Services to an Individual**

Speech-language services include various service delivery models, which may be used independently, in combinations, or individualized to meet the needs of the child.

The following service delivery options may be used for speech-language services:

- ◆ **Skill-building.** Skill-building is used for infants, toddlers, or students learning a new skill, needing more intensive instruction, requiring drill and practice and shaping through progressive approximation by a professionally trained speech-language pathologist. Instructional interventions include teaching of specific skills, providing drill, prompting, cueing, eliciting, modeling, reinforcing, modifying, and accommodating.
- ◆ **Integrated.** A communication skill has been trained but needs to be integrated and generalized to functional settings of the classroom, home, and community. Instructional interventions include:
  - Enhancing carryover or generalization of communication skill from skill building lever.
  - Integrating and establishing functional communication skill within the classroom, home, and community.
  - Informing teachers of expectations to use communication skill.
  - Implementing modifications or accommodations as needed to maintain the skill in classroom, home, or community.
- ◆ **Co-teaching.** Skill building and generalization are taught to the infant, toddler, or student as a combined effort between the speech-language pathologist, general or special education teacher. Instructional interventions include:
  - Pre-planning lessons by the speech-language pathologist, general or special education teacher.
  - Integrating of target communication skills for group lesson.
  - Alternating as lead instructor.
  - Rotating between small or large groups.



- ◆ **Consultative.** Skill building occurs, but a provider other than the speech-language therapist guides the meaningful change and development of the target communication skills. Activities include:
  - Regularly scheduled monitoring,
  - Writing and monitoring of goals and objectives written by the speech-language pathologist,
  - Brief demonstration teaching and materials provided by the speech-language psychologist, and
  - Maintaining ongoing evaluation of successful or unsuccessful interventions.
- ◆ **Extended-year special education (EYSE).** An extended school year for children or students who are selected based on empirical and qualitative data demonstrating that an interruption in programming will result in loss of critical skills that cannot be retaught in nine weeks or that a rare and unusual circumstance exists.
- ◆ **Home-based.** Speech-language services that are provided by a speech-language pathologist in the home of the child or to provide modeling or demonstrations to parents.
- ◆ **Hospital-based.** Speech-language services that are provided by a speech-language pathologist in a medical setting. This usually involves referral for diagnostic assessment for independent opinions or to gain additional information. It may also involve monitoring and management of speech-language disorders.
- ◆ **Itinerant home services.** Speech-language services provided to students who are temporarily unable to leave home to attend school due to illness or other disability. Various service delivery options may be used to support the child's or student's needs.
- ◆ **School-based (individual or group).** Services are provided in the child's or student's primary educational setting (classrooms), speech room or other educational setting (lunchroom, playground, art, music, gym, etc.) by a speech-language pathologist or speech pathologist assistant for IEP goals designed to remediate the child's or student's communication disorder. In some cases, the child or student may be scheduled for both individual and group speech-language services.





#### d. **Speech-Language Therapy Service in a Group**

Speech-language services include various service delivery models, which may be used independently, in combination, or individualized to meet the needs of the child or student.

The following direct service delivery options may be used for speech-language services delivered in a group:

- ◆ **Skill-building.** Skill building is used for infants, toddlers and students learning a new skill, needing more intensive instruction, requiring drill and practice and shaping through progressive approximation by a professionally trained speech-language pathologist. Instructional interventions include teaching of specific skills, providing drill, prompting, cueing, eliciting, modeling, reinforcing, modifying, and accommodating.
- ◆ **Integrated.** A communication skill has been trained but needs to be integrated and generalized to functional settings of the classroom, home, and community. Instructional interventions include:
  - Enhancing carryover or generalization of communication skills from skill building level.
  - Integrating and establishing functional communication skill within the classroom, home, and community.
  - Informing teachers of expectations to use communication skill.
  - Implementing modifications or accommodations as needed to maintain the skill in classroom, home, or community.
- ◆ **Co-teaching.** Skill building and generalization are taught to the infant, toddler, or student as a combined effort between the speech-language pathologist, general or special education teacher. Instructional interventions include:
  - Pre-planning lessons by the speech-language pathologist, general or special education teacher.
  - Integrating of target communication skills for group lesson.
  - Alternating as lead instructor.
  - Rotating between small or large groups.



- ◆ **Consultative.** Skill building occurs, but a provider other than the speech-language pathologist guides the meaningful change and development of the target communication skills. Instructional interventions include:
  - Regularly scheduled contact and monitoring.
  - Writing and monitoring of goals and objectives written by the speech-language pathologist.
  - Brief demonstration teaching and materials provided by the speech-language pathologist.
  - Maintaining ongoing evaluation of successful or unsuccessful interventions.

The following direct service delivery environments and structures models may be used for speech-language services to a group:

- ◆ **Center-based classroom for communication disorder (CM).** A class, at any level, taught by a qualified speech-language pathologist, for students with a speech-language impairment as their primary handicapping condition.

Students receive special education weighting. The curriculum is communication-based and is directed toward remediating the speech-language disorder. Classes can be either full-day or half-day programs. Special transportation may be required.
- ◆ **Communication class.** A class period taught by a speech-language pathologist. The curriculum is designed to remediate and improve speech-language skills and to augment regular classroom activities.
- ◆ **Extended-year special education (EYSE).** An extended school year for students who are selected based on empirical and qualitative data demonstrating that an interruption in programming will result in loss of critical skills that cannot be retaught in nine weeks or that a rare and unusual circumstance exists.
- ◆ **Learning center.** Six to ten students with speech-language disorders work independently in a group setting under the direction of a speech-language pathologist. The speech-language pathologist provides materials, monitoring, reinforcement, and feedback to the students, and may provide brief periods of individual instruction as needed.



- ◆ **School-based services (individual or group).** Services are provided in the child's or student's primary educational setting (classrooms), speech room or other educational setting (lunchroom, playground, art, music, gym, etc.) by a speech-language pathologist or speech pathologist assistant for IEP goals designed to remediate the child's or student's communication disorder. In some cases, the child or student may be scheduled for both individual and group speech-language services.

**e. Contracted Speech-Language Services**

Contracted speech-language services include screening, assessment, and therapy services that are rendered by a qualified practitioner who is a contractor, rather than an employee, of the agency. The requirements for documentation, records maintenance, and medical necessity remain unchanged.

**15. Transportation Services to Receive Medical Care**

To help ensure that members have access to medical care within the scope of the program, the Department reimburses for transportation to receive necessary medical care. Expenses for transportation of a student to and from the site of medical services are covered when the medical need for transportation is on the child's IEP. Transportation may be billed only once per day. The child must have received a medical service on that day.

For IEP students, medical transportation includes transportation services to a student who:

- ◆ Resides in a geographic area within which school bus transportation is not provided, or
- ◆ Requires transportation in a vehicle specially equipped or staffed to accommodate the student's special medical needs.

Escort services are a separate billable service allowed only in connection with medical transportation. Escort services for IEP students must be indicated in the IEP as assistance required for the student during transportation due to the student's physical or behavioral disability and specific needs. If an IEP student is able to ride on a regular school bus, but requires escort assistance, the transportation cost is not billable, but the escort service can be paid if it is noted on the IEP.



Calculate the number of miles from the point of origin to the service location multiplied by the cost per mile times two if return trip is provided. The total cost for that day is billed. Claims that exceed the edits must be submitted with the mileage log.

Documentation for travel must be recorded in the child's record (trip logs may be used) and must include:

- ◆ The date of service,
- ◆ The point of origin of travel (location),
- ◆ The location of service,
- ◆ Location of return travel (if provided), and
- ◆ The number of miles from the point of origin to the location of service.
- ◆ For a round trip, documentation for both ways.
- ◆ For escort services, "time in" and "time out," to support 15-minute billing units and a short description of the child's status while escorted.

Regardless of IEP ordered medical services, 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.

Iowa Medicaid Enterprise 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/>



## 16. Vision Services

Vision services include:

- ◆ Identification of the range, nature, and degree of vision loss
- ◆ Consultation with a child and parents concerning the child's vision loss and appropriate selection, fitting or adaptation of vision aides
- ◆ Evaluation of the effectiveness of a vision aide
- ◆ Orientation and mobility services

Medicaid covers the following services when they are in the child's IEP or are linked to a service in the IEP:

- ◆ [Vision Screening](#)
- ◆ [Vision Assessment](#)
- ◆ [Services to an Individual or Group](#)
- ◆ [Contracted Vision Services](#)
- ◆ [Orientation and Mobility Services](#)

For services to be covered, they must be provided by personnel who are licensed or certified to provide vision services.

### a. Vision Screening

Screening is the process of assessing vision through direct observation in order to identify problems and determine if further assessment is needed.

Documentation is required if the child is referred for evaluation or treatment services identified through the screening. Document referrals whenever they are made.

### b. Vision Assessment

Assessment refers to the process of collecting data for the purpose of making treatment decisions. These decisions may require:

- ◆ Determining the need, nature, frequency, and duration of treatment
- ◆ Determining the need for coordination with other providers
- ◆ Documenting these activities



**c. Services to an Individual or Group**

Individual intervention is designed to enhance vision or orientation and mobility skills of an individual.

Group services involve two or more persons and are designed to enhance vision or orientation and mobility skills of the group.

The role of consultation is monitoring, supervising, teaching, and training professionals, paraprofessionals, and parents in the home or community environment. Consultation includes:

- ◆ Providing general information about a child's condition.
- ◆ Teaching specific skills necessary to meet a child's needs.
- ◆ Developing, maintaining, and demonstrating use of adaptive or assistive devices for a specific child.
- ◆ Making recommendations to enhance a child's performance.

Early ACCESS service provided to a specific child must be provided in that child's "natural environment" unless the child's goals and outcomes cannot be met in "the home or community setting when children of the same age without disabilities participate." A justification statement must be included on the IEP if service is provided in another setting.

**d. Contracted Vision Services**

Contracted service includes vision assessment and direct services for an individual or group that are rendered by a qualified practitioner who is a contractor, rather than an employee, of the agency. The requirements for documentation, records maintenance, and medical necessity remain the same.

**e. Orientation and Mobility Services**

Orientation and mobility services are services provided to eligible blind or visually impaired children by qualified personnel to enable those children to attain systematic orientation to and safe movement within their environments in home and community.



The services include teaching the children as appropriate:

- ◆ Spatial and environmental concepts and use of information received by the senses (such as sound, temperature and vibrations) to establish, maintain, or regain orientation and line of travel (e.g., traveling in the direction of the caregiver's voice)
- ◆ Use of the long cane to supplement visual travel skills or as a tool for safely negotiating the environment for children with no available travel vision
- ◆ Use of remaining vision and distance, low-vision aids and other concepts, techniques, and tools

## 17. Service Exclusions

Iowa Medicaid does not cover the following services:

- ◆ Services that are provided but are not documented in the student's treatment plan or linked to a service in the IEP.
- ◆ Services rendered that are not provided directly to the eligible student or to a family member on behalf of the eligible student.
- ◆ Scheduled services that are not provided.
- ◆ Initial evaluations, re-evaluation, and IEP development. These are considered educational services.
- ◆ Services that are **solely** instructional in nature. Teaching Braille, for example, is considered an educational service.
- ◆ Consultation services that are not specific to an eligible student or are not consistent with the IEP.
- ◆ Services that are **solely** recreational in nature.
- ◆ Two Medicaid services provided simultaneously, except medical transportation and escort services.
- ◆ Services provided to students over age 20.
- ◆ Services included in plans under section 504 of the Rehabilitation Act of 1973.



### 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 older based on risk assessment

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





## 1. History and Guidance

### a. Comprehensive Health and Developmental History

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

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

- ◆ Identification of specific concerns
- ◆ Family history of illnesses
- ◆ The member's history of illnesses, diseases, allergies, and accidents
- ◆ Information about the member's social or physical environment that may affect the member's overall health
- ◆ Information on current medications or adverse reaction/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.

Parent 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](#)
- ◆ [Developmental Behavioral Online website of the American Academy of Pediatrics](#)
- ◆ [Assuring Better Child Health and Development \(ABCD\) Initiative](#)
- ◆ [National Center for Medical Home Implementation](#) 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*, Fourth Edition, Arlington, VA. This publication is available from the American Academy of Pediatrics (866) 843-2271. Click [here](#) to order.

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



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### ***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***

- ◆ 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**

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***Oral Health***

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

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***Injury Prevention***

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



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### ***Mental Health***

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

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### ***Nutrition***

- ◆ 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***

- ◆ 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**

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### ***Oral Health***

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



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### ***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

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### ***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

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### ***Nutrition***

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

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### ***Other Preventive 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





## **Suggested Health Education Topics: 13 – 21 Years**

### ***Oral Health***

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

### ***Development***

- ◆ Normal biopsychosocial changes of adolescence

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

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

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

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



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### ***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



### ***Substance Use***

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

### ***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

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

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

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



- ◆ **Speech:** Hesitation, stuttering, baby talk, lisping, and estimate of number of words in vocabulary.
- ◆ **Habits:** Bed-rocking, head-banging, tics, thumb-sucking, pica, ritualistic behavior, and use of tobacco, alcohol, or drugs.
- ◆ **Discipline:** Parental assessment of child's temperament and response to discipline, methods used and their success or failure, negativism, temper tantrums, withdraw, and aggressive behavior.
- ◆ **Schooling:** Experience with day care, nursery school, and kindergarten; age and adjustment on entry; current parental and child satisfaction; academic achievement; and school's concerns.
- ◆ **Sexuality:** Relations with members of 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 the first smear is unsatisfactory, repeat as soon as possible.



**b. Chlamydia Test**

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

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

**c. Gonorrhea Test**

Testing for gonorrhea may be done on persons with:

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

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

**d. Hemoglobin and Hematocrit**

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

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



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

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

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

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

#### **Fifth Percent Criteria for Children**

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

#### **Female (non-pregnant)**

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

#### **Male**

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

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



**e. Hemoglobinopathy Screening**

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

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

**f. Lead Testing**

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

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

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

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

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





### **g. Newborn Screening**

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

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

### **h. Tuberculin Testing**

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

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

## **3. Physical Examination**

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

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



**a. Blood Pressure**

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

The National Health, Lung and Blood Institute published blood pressure standards for children and adolescents. The standards are based on height as well as age and gender for children and adolescents from 1 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 these 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. Repeat measurements are indicated.

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



## b. Growth Measurements

### (1) Body Mass Index

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

1. Convert any fractions to decimals.

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

2. Insert the values into the formula:

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

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

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

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

### (2) Height

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

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

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



### (3) Plotting Measurements

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

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

Example:

	Year	Month	Day	
<b>Date of visit</b>	<del>93</del> 92	<del>7</del> <del>6</del> 18	<del>45</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](#)
- ◆ [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 member 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 accessed on the following web sites:

- ◆ [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 recommendation.

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 program (EDHI) website, click [here](#) or call (888) 425-4371.

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



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

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

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

- ◆ Caregiver concern\* regarding hearing, speech, language, or developmental delay (Roizen, 1999)
- ◆ Family history\* of permanent childhood hearing loss (Cone-Wesson et al., 2000; Morton & Nance, 2006).
- ◆ Neonatal intensive care of more than five days, or any of the following regardless of length of stay:
  - Extracorporeal Membrane Oxygenation (ECMO)\*
  - Assisted ventilation
  - Hyperbilirubinemia requiring exchange transfusion
  - Exposure to ototoxic medications (gentamycin and tobramycin) or loop diuretics (furosemide/lasix)(Fligor et al., 2005; Roizen, 2003).
- ◆ In-utero infections, such as CMV, \*herpes, rubella, syphilis, and toxoplasmosis (Fligor et al., 2005; Fowler et al., 1992; Madden et al., 2005; Nance et al., 2006; Pass et al., 2006; Rivera et al., 2002).
- ◆ Craniofacial anomalies, including those involving the pinna, ear canal, ear tags, ear pits, and temporal bone anomalies (Cone-Wesson et al., 2000).
- ◆ Physical finding, 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 include Waardenburg, Alport, Pendred, and Jervell and Lange-Nielson (Nance, 2003).
- ◆ Neurodegenerative disorders, \* such as Hunter syndrome, or sensory motor neuropathies, such as Friedreich ataxia and Charcot-Marie-Tooth syndrome (Roizen, 2003).
- ◆ Culture-positive postnatal infections associated with sensorineural hearing loss, \* including confirmed bacterial and viral (especially herpes viruses and varicella) meningitis (Arditi et al., 1998; Bess, 1982; Biernath et al., 2006; Roizen, 2003).
- ◆ Head trauma, especially basal skull/temporal bone fracture\* requiring hospitalization (Lew et al., 2004; Vartialnen et al., 1985; Zimmerman et al., 1993).
- ◆ Chemotherapy\* (Bertolini et al., 2004).

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

### c. **Nutritional Status**

To assess nutritional status, include:

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



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

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

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

- ◆ Measurements
  - Weight/height < 5th percentile or > 95th percentile (NCHS charts)
  - Weight/age < 5th percentile
  - Major change in weight/height percentile rank (a 25 percentile or greater shift in ranking)
  - Flat growth curve (two months without an increase in weight/age of an infant below the 90th percentile weight/age)
- ◆ Laboratory tests
  - < Hct 32.9%
  - < Hgb 11 gm/dL (6-12 months)
  - $\geq 15$   $\mu\text{g/dL}$  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, gastro-intestinal disorders, neurological disorders, or skeletal disorders



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

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

◆ Laboratory tests

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

◆ Health problems

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

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



#### **d. Vision**

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

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

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

#### **D. BASIS OF PAYMENT**

Local education agencies are reimbursed based on a fee schedule. The amount billed should reflect the actual cost of providing the services. The fee schedule amount is the maximum payment allowed.

Click [here](#) to view the fee schedule for Local Education Agencies online.

Click [here](#) for additional information on the Iowa Department of Education website.

Bill all procedures in whole units of service. Except as noted in the coding chart, 15 minutes equals one unit. Round remainders of seven minutes or less down to the lower unit and remainders of more than seven minutes up to the next unit.



## E. PROCEDURE CODES AND NOMENCLATURE

Iowa uses the HCFA Common Procedure Coding System (HCPCS). Claims submitted without a procedure code and an ICD-9 diagnosis code will be denied. Use the diagnosis code for the identified medical condition. Modifiers applicable to local education agency services are as follows:

<b><u>Modifier</u></b>	<b><u>Definition</u></b>
------------------------	--------------------------

AH	Clinical psychologist
AJ	Social worker
GN	Speech pathologist
GO	Occupational therapist
GP	Physical therapist
HO	Master's degree (use for guidance counselor)
HQ	Group setting
TD	RN
TE	LPN
TM	Individual Education Program contracted services
U9	Other health associate
UA	Audiologist

### **Vaccinations**

Medicaid immunizations must be provided under the Vaccines for Children Program (VFC). Click [here](#) to view the list of vaccines available through the VFC program, or call (800) 831-6293.

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

For VFC vaccine, bill code for vaccine administration in addition to the CPT code. The charges in box 24F should be "0." Charge the cost for the appropriate vaccine administration procedure code.

**NOTE:** Procedure code 90473 cannot be reported in conjunction with procedure code 90471. If using 90461, there will not be a payment for 90461, but it is collected for informational purposes.





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## F. BILLING POLICIES AND CLAIM FORM INSTRUCTIONS

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

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

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

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

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