



# Health Watch/Early and Periodic Screening, Diagnosis, and Treatment Provider Manual

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## Section 1: Introduction

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### Overview

The information in this supplemental provider manual is specifically for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services provided to Indiana Health Coverage Programs (IHCP) members younger than 21 years old. In Indiana, the federally mandated EPSDT Program is referred to as the HealthWatch/EPSDT Program. Specific rules about HealthWatch/EPSDT services can be found in Indiana Administrative Code (IAC) *405 IAC 5-15* (<http://www.state.in.us/legislative/iac/>). Details provided in the applicable IAC rules are not repeated in this manual except to clarify or to expand on procedural issues.

The *IHCP Provider Manual* (available on the IHCP Web site at <http://www.indianamedicaid.com/ihcp/Publications/manuals.htm>) contains detailed information about billing for services on a medical claim form; or see the *Companion Guide: 837 Professional Claims and Encounters Transactions* for information about using the 837P electronic transaction to bill. Instructions for institutional and dental claim forms can be found at the same location. However, billing requirements for EPSDT services are outlined in this supplemental provider manual.

### Contact Information

For complete contact information regarding all the IHCP programs and services, refer to the *Indiana Health Coverage Programs Quick Reference* available from the IHCP Web site at [http://www.indianamedicaid.com/ihcp/Misc\\_PDF/Quick\\_Reference.pdf](http://www.indianamedicaid.com/ihcp/Misc_PDF/Quick_Reference.pdf) or in all IHCP Provider Monthly Newsletters. The quick reference is updated on a regular basis to reflect any changes in program or service information.



## Section 2: Program Eligibility

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### Introduction

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, referred to as HealthWatch and/or EPSDT in Indiana, is a preventive healthcare program designed to improve the overall health of eligible infants, children, and adolescents. Special emphasis is given to **early detection** and treatment of health issues because these efforts can reduce the risk of more costly treatment or hospitalization that can result when detection is delayed. HealthWatch/EPSDT services are available to Indiana Health Coverage Programs (IHCP) members from birth to 21 years old (subject to the limitations of each benefit package). Individuals enrolled in Hoosier Healthwise Package C are eligible for these services; however, treatment may be subject to benefit limitations. EPSDT is a required component of care for all Medicaid recipients in this age range (birth to 21 years).

The Indiana Family Helpline assists individuals who need help scheduling appointments and making transportation arrangements to HealthWatch/EPSDT services. The toll-free number for the Indiana Family Helpline is 1-800-433-0746.

*Care Select* participants can consult their care management organization (CMO) for assistance with appointment scheduling and arranging transportation. Hoosier Healthwise risk-based managed care (RBMC) participants can consult their managed care organization (MCO) for assistance with appointment scheduling and arranging transportation.

Notices reminding individuals they may be due for HealthWatch/EPSDT screens are routinely mailed to RBMC and *Care Select* participants in the month prior to their birthday.

*Note: HealthWatch/EPSDT services may be subject to benefit limitations. The IHCP Provider Manual gives more detailed information about limitations. The IHCP Provider Manual is available on the IHCP Web site at <http://www.indianamedicaid.com/ihcp/Publications/manuals.htm>.*

### Hoosier Healthwise

The goals of the Hoosier Healthwise managed care program are to:

- Ensure access to primary and preventive care services
- Improve access to all necessary healthcare services
- Encourage quality, continuity, and appropriateness of medical care
- Provide medical coverage in a cost-effective manner

To accomplish these objectives, the Family and Social Services Administration (FSSA) has contracted with the managed care organizations (MCOs): Anthem, Managed Health Services (MHS), and MDwise, Inc., to manage the care of eligible members and ultimately improve their quality of care and health outcomes.

To learn more about these MCOs, please visit any of the following Web sites:

- Anthem: [www.anthem.com](http://www.anthem.com)
- MHS: [www.managedhealthservices.com](http://www.managedhealthservices.com)
- MDwise: [www.mdwise.org](http://www.mdwise.org)

See Table 2.1 for a breakdown of Hoosier Healthwise benefits.

Table 2.1 – Hoosier Healthwise Benefit Packages

Benefit Package	Coverage
Package A – Standard Plan	Full coverage
Package B – Pregnancy Coverage	Pregnancy-related and urgent care services only
Package C – Children’s Health Plan	Preventive, primary and acute care service for children younger than 19 years old

Members enrolled with a primary medical physician (PMP) in the RBMC network are also enrolled with an MCO that coordinates most medical services. Members enrolled in Hoosier Healthwise Package E are **not** linked to a PMP and remain in fee-for-service (FFS) for emergency care only.

If a member who is eligible for package A, B, or C fails to make a PMP selection within 30 days of being determined or redetermined eligible, a PMP is assigned to the member through the auto-assignment process.

The State implemented Open Enrollment in the Hoosier Healthwise program in three geographic phases in 2009. The final phase was implemented September 1, 2009. Prior to implementation, members could change MCOs at any time. Under Open Enrollment, members can only change health plans at the following times:

- Anytime during their first 90 days enrolled with a new health plan
- Annually during their open enrollment period
- Anytime there is “just cause” (for example, quality of care concerns)

Contracted MCOs assume financial risk for developing and managing a healthcare network that arranges for or provides Hoosier Healthwise covered services. The State pays the MCO a monthly capitation fee for each enrolled member. MCOs submit shadow claims to HP using claim data.

A current list of MCOs is maintained on the IHCP Web site at <http://www.indianamedicaid.com/ihcp/HoosierHealthwise/content/links.asp#Managed%20Care%20Organizations>.

## Care Select

The goals of *Care Select* are:

- To improve the member’s health status
- To enhance quality of life
- To improve client safety, client autonomy, and adherence to treatment plans
- To control fiscal growth

To accomplish these goals, the State focuses on the following objectives:

- Development of treatment regimens for chronic illnesses conforms to evidence-based guidelines.
- Primary care providers are able to incorporate knowledge of functional assessments, behavioral changes, self-care strategies, and methods of addressing emotional or social distress into overall patient care.
- Care is less fragmented and more holistic (for example, care addresses the physical and behavioral care needs as well as considers medical and social needs), and communication increases across settings and providers.
- Members will have greater involvement in their care management.

To accomplish these objectives, FSSA has contracted with two care management organizations (CMOs), MDwise, Inc. and ADVANTAGE Health Solutions<sup>SM</sup>, to manage the care of eligible members and ultimately improve the quality of care and health outcomes for the members.

To learn more about MDwise, visit [www.mdwise.org](http://www.mdwise.org). To learn more about ADVANTAGE, visit [www.advantageplan.com](http://www.advantageplan.com).

Individuals in the *Care Select* program, include children receiving adoptive services; aged, blind, and disabled enrollees; members in the Waiver Program; and Medicaid for Employees with Disabilities (M.E.D.), as well as wards and foster children.

Services that will not be covered under the *Care Select* program include Medicare Medicaid dually eligible, Qualified Medicare Beneficiary (QMB), specified low-income Medicare beneficiary (SLMB), members in the hospice program, undocumented aliens, AID to Recipient in County Homes (ARCH), members enrolled in the 590 Program, and members enrolled in the Breast and Cervical Cancer Treatment Services Programs.

## Primary Medical Providers

Physicians enrolled in the IHCP as Hoosier Healthwise or *Care Select* PMPs provide preventive and primary medical care through an ongoing member-to-PMP relationship, as well as authorization and referral for most medically necessary specialty services.

The PMP or designee must be available 24 hours a day, seven days a week and must assume management of the member's health and medical needs.

A Hoosier Healthwise or *Care Select* PMP must be a physician:

- In General Practice

**OR**

- Specializes in one of the following:
  - Family Practice
  - General Pediatrics
  - General Internal Medicine
  - Obstetrics and Gynecology (OB/GYN)

Primary care physicians in any setting are eligible to be PMPs and can serve as the PMP for any member within their normal scope of practice. In *Care Select*, specialists may also serve as PMPs.

Enrollees have 60 days to self-select a PMP. If enrollees do not self-select within 60 days, they are auto-assigned to a PMP (auto-assignment is a federal requirement for Medicaid managed care).

Members are auto-assigned to one of the five standard PMP provider types. Members are linked to specialists on a self-selection or previous PMP based on member/PMP history. Enrollees can change their PMP at any time.

Physicians enrolled in Hoosier Healthwise with dual specialties in internal medicine and pediatrics may also enroll as PMPs upon submitting documentation of training in both specialties. Physicians who enroll agree to be listed as PMPs in the provider listing.

Physicians interested in becoming PMPs have the opportunity to contact one of the MCOs, CMOs, or MAXIMUS for additional information. When physicians decide to enroll as a PMP, they are required to sign either a contract addendum to the *IHCP Provider Agreement* to enroll in the *Care Select* network, or a contract with an MCO to participate in the RBMC network.

## Service Provision

PMPs are expected to personally provide or authorize most primary and preventive care services as a case management function. All PMP referrals or authorizations must be documented in the patient's medical record. For those medical services that do not require PMP authorization, members may gain access through self-referral or PMPs may assist members in accessing services by providing information on specialists or other available resources.

The PMP is responsible for providing or authorizing most primary and preventive care services. These services, called PMP services, include but are not limited to the following:

- Physician services
- Hospital inpatient and outpatient services
- Some ancillary services

*Note: PMPs furnishing services to Hoosier Healthwise or Care Select members, regardless of the delivery system, participate in the HealthWatch/EPSDT program.*

PMPs are not required to provide or authorize the following *self-referral services*:

- Services for the treatment of a true medical emergency
- Family planning services, using the appropriate diagnosis and procedure code combinations
- Dental services by a provider enrolled with a dental type and specialty (except surgical services)
- Chiropractic services
- Podiatry services
- Vision care services (except surgical services)
- Human immunodeficiency virus (HIV)/acquired immune deficiency syndrome (AIDS) targeted case management services
- Transportation services
- Pharmacy services
- Individualized education plan (IEP) services furnished by schools
- Behavioral health by type and specialty

Self-referral services and other PMP-authorized services are to be billed to the appropriate delivery system (HP for *Care Select* or FFS, and the MCOs for RBMC).

The following services are always billed FFS to and paid by HP in accordance with IHCP regulations:

- Dental services rendered by providers enrolled in the IHCP in a dental specialty, which includes the following:
  - Endodontist
  - General dentistry practitioner
  - Oral surgeon
  - Orthodontist
  - Pediatric dentist
  - Periodontist
  - Pedodontist
  - Prosthodontist
- Services provided by a school as part of a student's IEP

## Program Financing

Under *Care Select*, PMPs assume no financial risk and receive an administration fee per month for every enrolled member. Reimbursement for services provided to *Care Select* members follows the standard IHCP fee schedules, and providers rendering services to *Care Select*-enrolled members should continue to bill the IHCP.

Under RBMC, PMPs negotiate reimbursement with the contracted MCO. Most claims for members enrolled in the RBMC delivery system must be submitted to the member's MCO. Claims submitted to the IHCP for services covered under the MCO capitation are denied by the IHCP. Dental services submitted on the dental claim form or the 837D electronic transaction, psychiatric residential treatment facility (PRTF) and Medicaid Rehabilitation Option (MRO) mental health services by mental health provider type and specialty and school corporation services are carved out from managed care and subject to IHCP guidelines. For this reason, all providers must verify member eligibility and PMP assignment prior to rendering services.

## PMP Authorization and Prior Authorization

All PMP services not provided by the member's PMP must be referred or authorized by the PMP in *Care Select* through the use of a certification code. This is different from prior authorization (PA) by the health plan network, which may be required for some PMP and self-referral services. *Care Select* PA is obtained from ADVANTAGE Health Solutions. *Care Select* member PA should be obtained from the CMO for members assigned to their organization at the time of the request. PMP referral, authorization, and PA for services may follow different requirements in RBMC. Contact the appropriate MCO for instructions for PMP referral, authorization, and PA. RBMC carve-out services may require PA.

A referral is a request for PMP-approved services from another provider. The PMP specifies which services are covered with this referral. The referral must be documented in the patient's medical record. However, no referral forms are required. In some instances, patients can refer themselves without a PMP authorization. The following self-referral services do not require PMP authorization:

- Podiatric services
- Chiropractic
- Transportation
- Family planning (using appropriate diagnosis and procedure code combinations)
- Vision care by specialty (except surgeries)

- Dental care by specialty (except surgeries)
- Behavioral health by type and specialty
- HIV/AIDS case management
- IEP services furnished by schools
- Services for treatment of a true emergency
- Pharmacy services

*Note: To comply with IHCP PA requirements to complete PA requests for members in the Care Select delivery system according to IHCP policies, the listed services do not require PMP authorization. Providers rendering care to RBMC-enrolled members must refer to the member's MCO for any additional policies specific to that RBMC network.*

## For More Information about Managed Care Networks

For more information about the *Care Select* delivery system, call the *Care Select* Helpline at 1-866-963-7383. This helpline is available to answer provider and member questions about the *Care Select* managed care program.

For information about the Hoosier Healthwise RBMC plans, call the MCO available in your region.

For a complete list of contact information, refer to the *Indiana Health Coverage Programs Quick Reference* available on the IHCP Web site at [http://www.indianamedicaid.com/ihcp/Misc\\_PDF/Quick\\_Reference.pdf](http://www.indianamedicaid.com/ihcp/Misc_PDF/Quick_Reference.pdf) or in the IHCP Provider Monthly Newsletters.

## Non-Managed Care Members

If a member is not enrolled in *Care Select* or Hoosier Healthwise RBMC delivery system, any IHCP provider can provide services to them.

Any provider enrolled in the IHCP, licensed to perform an unclothed physical exam and provide the components listed in the [Screening Components and Higher Reimbursement](#) subsection of this manual, is eligible to offer HealthWatch/EPSDT screens for infants, children, and adolescents. **There is no requirement that an IHCP provider must accept new patients.** Providers may choose to offer screens to only those IHCP patients assigned to their practice or currently being seen in their office.

Providers must assist in setting appointments on behalf of HealthWatch participants who need diagnostic services or follow-up treatment as a result of the screen. These additional services require PMP authorization when performed by a provider other than the PMP.

If assistance is needed to locate a specialist enrolled in the IHCP for referral purposes, contact the Indiana Family Helpline at the Indiana State Department of Health (ISDH) at 1-800-433-0746.

## Section 3: HealthWatch and EPSDT Information

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### HealthWatch Screening Examinations

Ensuring that all children in the Indiana Health Coverage Programs (IHCP) receive age-appropriate, comprehensive, preventive services is the primary goal of the HealthWatch/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. Components of the screening and the recommended frequency of the screenings are listed in the [HealthWatch/EPSDT Periodicity and Screening Schedule](#) found in *Appendix A*. The periodicity schedule follows guidelines set by the American Academy of Pediatrics (AAP) and contains footnotes to clarify screening components. Additional information concerning risk factors is included in this manual.

### Screening Components and Higher Reimbursement

According to IAC [405 IAC 5-15-2](#), a screening, or any portion of a screening, is not required when lack of medical necessity is documented. To provide quality assurance for participants in the HealthWatch program and claim a higher level of reimbursement for EPSDT screens, the following components of the screen must be **provided and documented**:

- Health and developmental history, including assessment of physical and mental health development
- Unclothed physical exam
- Nutritional assessment
- Developmental assessment
- Vision observation at each screen and direct referral to an optometrist or ophthalmologist starting when objective screen methods indicate a referral is warranted (the objective screen is not separately billable)
- Hearing observation at each screen and objective testing with audiometer at 4 years old, administered or referred (the simple hearing observation screening is not separately billable)
- Dental observation at each screen; direct referral to a dentist starting at 24 months old
  - Dental referrals may be made as early as 12 months old when indicated.
- Laboratory tests, including blood lead level assessment appropriate for age and risk factors
- Immunizations administered or referred, if needed at time of the screen
- Health education, including anticipatory guidance

For further information on billing guidelines for receiving higher reimbursement, see the [Examination Procedure and Diagnosis Codes](#) and [Reimbursement](#) sections.

### General Billing Information

**HealthWatch/EPSDT providers must adhere to billing and screening procedures to participate in this program.** To claim the higher rate of reimbursement for HealthWatch/EPSDT screens, providers must furnish all components of the EPSDT examination in accordance with the [HealthWatch/EPSDT Periodicity and Screening Schedule](#) in *Appendix A*, document services performed/referred, and include all applicable diagnosis codes (up to four) on the medical claim form

if sending on paper, or 837P transaction if submitting electronically, for each EPSDT screening exam. Indiana does not require providers to bill EPSDT screens on a separate EPSDT medical claim form when submitting claims on paper or in an 837P transaction, if submitting electronically.

To ensure adherence to EPSDT requirements, the IHCP will monitor the following:

- Timely screening as recommended by the *HealthWatch/EPSDT Periodicity and Screening Schedule* and the immunization schedule in *Appendix A*
  - Timely administration of immunizations
  - Hematocrit/hemoglobin testing
  - Blood lead testing
  - Urinalysis
  - Audiometric testing
- Children receiving follow-up treatment for diagnosed conditions

## Specific Billing Procedures

HealthWatch/EPSDT claims are billed on a professional medical claim form if sending on paper or 837P transaction if submitting electronically. A sample of the *CMS-1500* claim form is available in [Appendix C](#). The *CMS-1500* claim form and the 837 professional transaction are currently used for submission of medical claims. Refer to [Chapter 8](#) of the *IHCP Provider Manual* or the [Companion Guide: 837 Professional Claims and Encounters Transaction](#) for complete directions for claim submissions. Also, refer to Web interChange for the ability to submit claims online.

The following billing procedures must be followed to permit correct and prompt reimbursement. Every claim for a HealthWatch/EPSDT visit must be coded with the following:

- The appropriate patient examination code (99381-99385, and 99391-99395) must be included on the first detail line of the medical claim form if sending on paper or 837P transaction if submitting electronically
- The preventive health diagnosis code, **V20.2**, must be used as the **primary** diagnosis.
- Physicians are strongly encouraged to include all applicable diagnosis codes (up to four) and procedure codes on the medical claim form if sending on paper, or on the 837P transaction if submitting electronically, for each HealthWatch/EPSDT visit.

The appropriate EPSDT documentation must be kept in the patient's record and the appropriate Current Procedural Terminology (CPT®) codes and V20.2 (for the initial or established patient exam) must be billed.

*Note: When patient exams are billed in conjunction with the V20.2 diagnosis code as the primary diagnosis code, the screen components must have been provided. See [Appendix B](#) for examples of the most frequently occurring diagnoses among HealthWatch/EPSDT patients.*

## Examination Procedure and Diagnosis Codes

Providers are required to use specific examination codes, classified as *initial* or *established*, based on the age of the member. **Providers are strongly encouraged to include all appropriate codes and to**

**use the preventive health diagnosis code V20.2 as the primary diagnosis code when a HealthWatch/EPSDT screen is billed.** The primary diagnosis code (V20.2) must be indicated with the diagnosis cross-reference code of 1 in box 24 E of the medical claim form if sending on paper, or 837P transaction if submitting electronically, for the procedure code billed. The procedure codes are shown in Table 3.1.

Table 3.1 – Procedure Codes

Age	Initial Patient Exam	Established Patient Exam
Less than 1 year	99381	99391
1 to 4 years	99382	99392
5 to 11 years	99383	99393
12 to 17 years	99384	99394
18 to 20 years	99385	99395

Any other applicable diagnosis code(s) must be indicated in the other positions in item 21 on the medical claim form if sending on paper, or 837P transaction if submitting electronically, and cross-referenced accordingly in item 24E.

### **Reimbursement**

Enhanced reimbursement for the initial patient exam is limited to the first HealthWatch/EPSDT screen performed by a screening provider during the participant's lifetime. If additional claims are received for initial screening from the same provider, reimbursement is allowed at the resource-based relative value scale (RBRVS) rate on file for the billed CPT code, not the higher EPSDT rate.

Initial and established EPSDT exams are reimbursed when submitted with V20.2 as the primary diagnosis, and are subject to the 30 office visits per year limitation without prior authorization (PA). **Claims submitted with charges other than the designated amounts for screening exams are paid at the HealthWatch/EPSDT rate or the charged amount, whichever is lower.** Examinations that do not contain the screening components or that are not well child visits by this definition can be billed using the appropriate CPT code for those visits. If the preventive evaluation and management (E/M) codes are used, V20.2 should not be used as the primary diagnosis.

Claims submitted using any patient exam procedure codes listed in Table 3.1 are billed in conjunction with **the V20.2 diagnosis code as the primary diagnosis code** to identify that all EPSDT screening components have been provided. For services provided to EPSDT eligible members that do not qualify as full screening examinations, use the appropriate office visit codes for the services rendered. Appropriate documentation of the services provided or referred must be included in the patient's medical records.

### **Periodicity and Immunization Schedule**

The [HealthWatch/EPSDT Periodicity and Immunization Schedule](#) is found in *Appendix A*.

### **Immunization and Screen Billing Procedures**

Providers must report on the medical claim form if sending on paper, or 837P transaction if submitting electronically, all screenings and immunizations administered during HealthWatch/EPSDT visits. Providers should follow the [HealthWatch/EPSDT Periodicity and Screening Schedule](#) (see *Appendix A*) and provide or arrange for all the appropriate services for each child at each age level in a timely

manner and complete the medical claim form if sending on paper, or 837P transaction if submitting electronically, properly. The IHCP closely monitors all claims submitted to ensure that appropriate procedures are provided and to give the provider feedback concerning age-specific HealthWatch/EPSDT service delivery.

### **HealthWatch/EPSDT Codes**

[Appendix B](#) includes a list of routinely used HealthWatch/EPSDT codes.

### **Third-Party Liability**

Federal regulations allow for the bypass of third-party liability (TPL) claim edits when HealthWatch/EPSDT screening procedures are submitted for payment to IHCP and the Medicaid managed care organizations. The CPT procedure codes identified in this section and in [Appendix B](#) are routinely billed for HealthWatch/EPSDT services. **These codes are not subject to TPL edits when submitted in conjunction with the primary diagnosis code V20.2.**

### **Prior Authorization**

For information about services that require IHCP PA, consult the IHCP's Covered Services and Limitations Rule, *405 IAC 5* and [Chapter 6](#) of the *IHCP Provider Manual*. The *IHCP Provider Manual* is available on the IHCP Web site at [www.indianamedicaid.com/ihcp/Publications/manuals.htm](http://www.indianamedicaid.com/ihcp/Publications/manuals.htm). For authorization of services provided under a managed care program, consult the specific managed care organization (MCO) or managed care entity (MCE) for requirements.

### **Vaccines for Children**

The federal Vaccines for Children (VFC) Program makes available, at no cost to providers, certain vaccines for administration to IHCP members ages 18 years old and younger (including those 18 and under enrolled in Package C). Effective July 1, 1998, IHCP **reimbursement for vaccines available through the VFC Program is limited to the VFC vaccine administration fee**. The VFC vaccine administration fee is a maximum of \$8 (payment is made at the lower charge of \$8 or the submitted charge).

The VFC Program supplies VFC-enrolled healthcare providers with free vaccines to be administered to children 18 years old and younger who meet one or more of the following:

- Enrolled in Medicaid
- No health insurance
- An American Indian or Alaskan native, as identified by the parent or guardian
- Underinsured, for example, the child has health insurance that does not cover immunizations
  - Underinsured patients are eligible to receive VFC vaccines only at a Federally Qualified Health Center (FQHC) or rural health clinic (RHC).

The VFC Program is for uninsured children. The Office of Medicaid Policy and Planning (OMPP), the Children's Health Insurance Program (CHIP), and Indiana State Department of Health (ISDH) worked together to open the VFC Program to children in all of the Medicaid, *Care Select*, and Hoosier Healthwise benefit packages. Currently, the VFC Program offers free vaccines against the following diseases:

- Diphtheria
- Hemophilus influenza type b
- Hepatitis A
- Hepatitis B
- Influenza
- Measles
- Mumps
- Rubella
- Pertussis
- Poliomyelitis
- Rotavirus
- Tetanus
- Varicella
- Pneumococcal
- Meningococcal
- Human Papillomavirus (HPV)

IHCP providers are encouraged to participate in the VFC Program. If a provider chooses not to participate in the VFC Program, the practitioner must provide appropriate vaccine referrals, follow up with the patient, and document the immunization history. If a Hoosier Healthwise or *Care Select* PMP does not choose to participate in the VFC Program, the provider must have a procedure in place, such as a memorandum of collaboration (MOC), to ensure that children under the provider's care are adequately and appropriately immunized.

### **General VFC Billing Information**

For vaccines available through the VFC Program and provided to members 18 years and younger, the IHCP limits reimbursement to the fee for vaccine administration only. See [Table 3.2](#) for procedure codes for VFC-available vaccines.

*Note: For vaccines **not** available through the VFC and for vaccines administered to IHCP members older than 18 years old, IHCP providers should bill a vaccine administration code in addition to the CPT code to obtain reimbursement.*

For details about reimbursement under the risk-based managed care (RBMC) delivery system, call the appropriate MCO. For questions on collaborative agreements for vaccine referrals to health departments or nurse clinics, contact the Hoosier Healthwise Helpline at 1-800-889-9949 and select Option 3. For *Care Select*, contact provider services at 1-866-963-7383, Option 0.

To bill the IHCP for VFC vaccine administration use **V20.2** as the primary diagnosis and the correct procedure code for the specific vaccine administered (do not bill the separate code for administration) and claim no more than the VFC vaccine administration fee in effect on the date of service. IHCP reimbursement for VFC vaccine administration is the lesser of the provider's submitted charge for VFC vaccine administration or \$8.

For reporting immunizations with non-VFC vaccines, the IHCP permits only one administration fee per VFC vaccine administration. For combined vaccines, bill the correct code for the combined vaccine and charge only one vaccine administration fee. If the only service performed is vaccine administration, providers cannot bill for an office visit. Providers can bill an office visit in conjunction with vaccine administration only when a significant, separately identifiable service is performed at the same visit.

Table 3.2 – Procedure Codes for VFC-Available Vaccines

Procedure Code	Vaccines
90645	HIB, HBOC
90647	HIB, PRP-OMP
90648	HIB, PRP-T
90649	Human Papillomavirus (HPV)
90655	Influenza, split virus, admin to children 6-35 months for intramuscular use, preservative free
90656	Influenza, split virus, admin to children 3 years and above for intramuscular use, preservative free.
90657	Influenza, split virus, admin to children 6-35 months for intramuscular use
90658	Influenza, split virus, admin to children 3 years and above for intramuscular use.
90660	Flumist
90669	Pneumococcal conjugate, polyvalent
90700	DTaP
90702	DT
90707	MMR
90713	Inactivated Polio Vaccine (EIPV)
90716	Varicella
90718	Td
90721	DTaP-HIB
90723	DTaP-Hep B-IPV, brand name Pedirix
90744	HEP B-Ped
90745	HEP B-Adolescent
90748	HEP B-Ped-HIB combination, brand name Comvax
90733	Meningococcal Vaccine, SC (menactra)
90734	Meningococcal Vaccine, IM (menactra)

To enroll and participate in the VFC Program:

- Call the ISDH office at (317) 233-7704 in the Indianapolis local area, or toll-free at 1-800-701-0704 and request VFC provider enrollment forms.
- Complete and mail the provider enrollment forms.
- Receive appropriate training and technical assistance.
- Order vaccine periodically, as needed, and maintain appropriate vaccine supply records.

## **Forms for Vaccines for Children (VFC)**

### **Patient Eligibility Screening Record**

#### **Children & Hoosiers Immunization Registry Program (CHIRP) Users**

The patient eligibility screen used to screen patients for VFC eligibility has been changed to a pop-up window that appears before each administered shot. This screen includes a selection for Hoosier Healthwise eligible children. Providers interested in creating a CHIRP account should contact 1-888-227-4439.

#### **Non-CHIRP Users**

The patient eligibility screen record that many providers use to screen patients for VFC eligibility includes a box to indicate Hoosier Healthwise Package C eligible children. As with the VFC Program, providers may use this form for screen or may incorporate it into existing clinic forms.

### **Vaccine Accountability Tally Sheet**

Because vaccines are provided by different funding sources, ISDH must report separately the number of doses administered to VFC children and children enrolled in Hoosier Healthwise Package C. There are two methods available.

#### **CHIRP Users**

Those providers using CHIRP Inventory Management and recording all VFC-administered shots in CHIRP do not have to complete the Vaccine Accountability Tally Sheets. All patient-administered vaccines need to be entered into CHIRP by the 10th of the month following when the vaccines were administered. Providers interested in creating a CHIRP account should contact 1-888-227-4439.

*Note: Providers marking administered doses as historical must still complete Vaccine Accountability Tally Sheets.*

*Providers using imports that **do not** include VFC eligibility must still complete Vaccine Accountability Tally Sheets.*

#### **Non-CHIRP Users**

Providers must submit the Vaccine Accountability Tally Sheet to the ISDH monthly, by the 10th of the month following the month in which administered. This form must be submitted via fax to (317) 234-3163. These forms will not be accepted by mail.

## **Vaccine Storage**

Providers are not required to store VFC vaccine in separate storage units but do need to maintain physically separate inventories for vaccine stock from the VFC Program and vaccine stock from private or other designated vaccines.

Refer to the Centers for Disease Control (CDC) Web site for complete and up-to-date vaccine management and storage requirements at <http://www.cdc.gov/vaccines/pubs/vac-mgt-book.htm>. Temperatures for refrigerators and freezers containing vaccine should be verified and documented two times daily.

Providers are required to keep accurate records and agree to provide appropriate storage for each vaccine.

## **Contact Information**

Direct questions concerning VFC provider enrollment, patient eligibility for VFC, and vaccine orders and distribution, to the ISDH at:

**Indiana Immunization Program  
Indiana State Department of Health  
2 North Meridian Street  
Indianapolis, IN 46204  
Telephone (317) 233-7704 or 1-800-701-0704  
Fax (317) 233-3719**

Contact Customer Assistance at (317) 655-3240 from within the Indianapolis local area or toll-free at 1-800-577-1278 outside the Indianapolis area with questions about IHCP FFS billing and reimbursement for VFC vaccines. Contact the patient's MCO with questions about VFC vaccine administration and reimbursement under the RBMC network.

## **Vaccine Stock Availability**

On occasion, the VFC codes may be temporarily removed from the table if they are not available and at that time, all non-VFC billing guidelines apply. When a specific vaccine becomes available again, it will be added to the table with the appropriate start date. Refer to banner pages for information on vaccine stock availability.

Some vaccines, such as those for influenza and meningococcal disease, have not been available in all areas or quantities during the seasons to be limited to the \$8 administration. To guarantee that all IHCP children receive these immunizations as needed, providers should bill according to the source of the vaccine stock. If administered from private stock, bill according to usual and customary charges (UCC) for reimbursement at Medicaid rate on file. If using VFC stock, bill at \$8 per immunization.

## **Third-Party Liability Billing**

Vaccines administered to VFC-eligible children can be billed directly to the appropriate delivery system (HP or the MCO) when the primary diagnosis is V20.2. These vaccines need not be billed to the primary insurance company. Providers should not experience TPL issues with the children enrolled in Hoosier Healthwise Package C. If information is obtained that identifies a primary insurance for children enrolled in Hoosier Healthwise Package C, contact the following:

**HP Third Party Liability**  
**Telephone: (317) 488-5046 or 1-800-457-4510**  
**Fax (317) 488-5217**

### **Billing Vaccines Other Than VFC**

For vaccines not available through the VFC Program, and for vaccines administered to patients older than 18 years old, the IHCP calculates the maximum allowable reimbursement based on the current average wholesale price (AWP) for the procedure code, plus \$2.90 for vaccine administration to cover the costs of supplies and staff time associated with giving the injection. The IHCP maximum allowable amount corresponds to the dose in the narrative description for the procedure code. In cases where there is no dose specified in the narrative, the reimbursement rate is set by the contractor that is responsible for updating the rates based on what corresponds to a typical dose for that particular code. Providers are notified through bulletin or banner page articles about reimbursement rates for codes with no dose specified.

*Note: New injectable drugs covered under the IHCP that cannot be billed with an existing CPT or Healthcare Common Procedure Coding System (HCPCS) code because there has not been a specific code assigned, should be billed using an appropriate nonspecific CPT or HCPCS code.*

Only use a nonspecific CPT or HCPCS code when there is no code available with a narrative that accurately describes the drug being administered or the drug's route of administration. **Drugs billed with a nonspecific code are manually priced, and therefore must be submitted on a paper claim.** Nonspecific codes are reimbursed based on the AWP for the National Drug Code (NDC) indicated, multiplied by the number of units administered. All medical claims billed with a nonspecific code must indicate the appropriate NDC and dose administered. Claims submitted without this information are denied.

### **Immunizations and Screenings**

The procedure codes listed in Table 3.3 are the codes commonly used to bill for HealthWatch/EPSDT services, immunizations, and screening tests.

Table 3.3 – Procedure Codes Commonly Reported for Immunizations and Screens

<b>Code</b>	<b>Code Definition</b>
81000	Urinalysis
85660	Sickle Cell test
86580	TB Mantoux
86701	HIV-1
86689	HIV Antibody Confirmatory Test (for example, Western Blot)
90645	Hemophilus influenza B, HbOC conjugate
90647	Hemophilus influenza B, PRP-OMP conjugate
90648	Hemophilus influenza B, PRP-T conjugate
90669	Pneumococcal conjugate, polyvalent
90700	DTaP
90701	DTP

Code	Code Definition
90702	Tetanus-Diphtheria
90707	MMR
90713	Polio-IPV
90716	Varicella (chicken pox)
90718	Tetanus-Diphtheria (adults)
90720	DTP-Hib
90721	DTaP-Hib
90744	Hepatitis B, newborn to 11 years
90746	Hepatitis B, 20 years and older
90747	Hepatitis B, dialysis or immuno-suppressed patient, any age
92551	Audiometric testing
99173	Screening test of visual acuity
90657	Influenza, split virus, given to ages 6-35 months dosage
90658	Influenza, split virus, 3 years and above

### Diagnosis Codes

To receive appropriate reimbursement, all procedure codes must be accompanied by a diagnosis code. For a HealthWatch/EPSDT visit, screen, or immunization, **diagnosis code V20.2** (Routine Infant or Child Health Check), **must be used as the primary diagnosis code. These codes are not subject to TPL edits when submitted in conjunction with the primary diagnosis code V20.2.**

Include all applicable diagnosis and procedure codes on all claims for HealthWatch/EPSDT examinations.

### Billing for HealthWatch/EPSDT Visits and Office Visits at the Same Time

If a patient is evaluated and treated for a problem during the same visit as a HealthWatch/EPSDT annual exam or well child service, the problem-oriented exam can be billed separately accompanied by the 25 modifier (separate significantly identifiable E/M service). The problem must require additional moderate level evaluation to qualify as a separate service on the same date. The IHCP does not currently require that the charge be reduced, as is required by Medicare. The provider can bill UCC. IHCP reimbursement is allowed at the lesser of the submitted charge or the maximum fee for each code. However, the total billed charge must not be more than the provider charges for similar services provided to private-pay patients.

### Missed Appointment Procedures

Members who miss HealthWatch/EPSDT appointments or follow-up appointments must be identified and their names forwarded to the member's MCO, the Hoosier Healthwise Helpline, or the Hoosier Healthwise benefit advocate (BA). Refer to the *Indiana Health Coverage Programs Quick Reference* for contact information. The quick reference is available on the IHCP Web site at

[http://www.indianamedicaid.com/ihcp/Misc\\_PDF/Quick\\_Reference.pdf](http://www.indianamedicaid.com/ihcp/Misc_PDF/Quick_Reference.pdf). Member services from each of these entities follow up with the members.

Providers should begin referring all Hoosier Healthwise members with missed appointments to the member services for the appropriate MCO. Providers should begin referring all *Care Select* members with missed appointments to the *Care Select* Helpline at 1-866-963-7383.

Claim submission for missed appointments is not required. These claims are used for data gathering only; no reimbursement is made for missed appointments.

## Federally Qualified Health Centers and Rural Health Clinics

### Claims Submitted with Place of Service 50, 72, 11, 12, or 31

For FFS claims submitted with a place of service (POS) of 50, 72, 11, 12, or 31, providers **must use** the *T1015* encounter code and CPT or HCPCS codes. The claim logic compares the CPT or HCPCS codes used to a list of valid CPT/HCPCS codes approved by the OMPP. If the claim contains *T1015* and one of the allowable procedure codes from the encounter criteria, the CPT or HCPCS codes correctly deny for EOB 6096 – *The CPT/HCPCS code billed is not a valid encounter*. The encounter rate (*T1015*) reimburses according to the UCC established by Myers and Stauffer from the provider-specific rate on the provider file. The provider should not resubmit CPT or HCPCS codes that were denied for *EOB 6096 – The CPT/HCPCS code billed is not a valid encounter*.

If one of the CPT or HCPCS codes billed is not on the list of allowable procedure codes from the encounter criteria for place of service 72, 11, 12, or 31, the claim denies for *EOB 4124 – FQHC and RHC services must be billed according to the prospective payment system (PPS) reimbursement methodology*. Claims that deny for *EOB 4124* should not be resubmitted for payment.

FFS claims submitted with a place of service 72, 11, 12, or 31, with CPT or HCPCS codes that do not have the *T1015* present on the claims deny for *EOB 4121 – T1015 must be billed with a valid CPT/HCPCS code*. These claims can be resubmitted with the *T1015* properly included.

Only one encounter per IHCP member, per provider, per day is allowed unless the diagnosis code differs. Valid encounters with differing diagnosis codes for a member that exceeds the allowed one encounter per day can be submitted to the IHCP for manual processing.

### Fee-for-Service Claims Submitted with Place of Service 20-26

Claims submitted with a place of service 20-26 will reimburse each line item detail at the current rate for that CPT or HCPCS code. It is not necessary to include the *T1015* encounter code on claims with place of service 20-26. These services are considered non-FQHC/RHC services provided by the valid provider in a setting other than an RHC or FQHC setting.

### Dental Claims for RHCs and FQHCs

Dental claims for RHCs and FQHCs should continue to be billed on a dental claim form if sending on paper, or 837D transaction if submitting electronically, using Current Dental Terminology (CDT<sup>®</sup>) codes. The *T1015* encounter code should not be included on the dental claim form if sending on paper, or 837D transaction if submitting electronically. Dental claims reconcile to the provider-specific PPS rate monthly by Myers and Stauffer and wrap-around payments are made at that time. Additionally, year-end settlements reconcile the provider-reported data to paid dental claims. These reimbursements continue until such time that a national CDT dental code is established to act as an all-inclusive code on the dental claim form if sending on paper, or 837D transaction if submitting electronically. Refer to

[Companion Guide: 837 Dental Claims Transactions](#) for complete information about submitting electronic transactions.

### **Risk-Based Managed Care**

Claims for members in a Hoosier Healthwise RBMC plan should continue to be billed in the current manner to the applicable MCO. The T1015 encounter code should not be included on these claims. All MCO claims reconcile to the provider-specific PPS rate monthly by Myers and Stauffer and wrap-around payments are made at that time. Additionally, year-end settlements reconcile the provider-reported data to the MCO-reported data. These reimbursements continue until such time that the MCOs adapt the systems to the PPS methodology.

### **Care Select**

Claims submitted for members currently in the *Care Select* managed care continue to include all PMP information on the *CMS-1500* claim form or the 837P electronic transaction. PMP information is required on the *CMS-1500* claim form in the following fields:

- 17 – PMP name
- 17a – PMP’s nine-digit IHCP provider number
- 19 – PMP’s two-digit certification code

Refer to [Companion Guide: 837 Professional Claims and Encounters Transactions](#) for complete information about electronic transactions.

### **Billing Parameters**

All TPL, patient liability, and copayments continue to apply as appropriate, unless billed with the primary diagnosis code of V20.2. Previous TPL payments and spend-down apply to the total amount due. All Medicare crossover claims are excluded from the PPS logic as well as the new crossover reimbursement methodology, and continue to pay coinsurance and deductible amounts.

### **Valid Encounter Codes**

Refer to Myers and Stauffer’s Web site at <http://in.msle.com/> for a complete listing of CPT and HCPCS codes that meet the criteria for a valid encounter. The list is revised on an annual basis.

## Section 4: Required HealthWatch/EPSDT Referrals and Screenings

HealthWatch/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) providers are responsible for making the following required referrals at indicated ages or when screening results indicate a problem:

- Dental, vision, and hearing
- Lead screening

### Dental Observation and Screening

Refer children for dental services beginning at 24 months old or as early as 6 months old, if indicated. Refer to the *Indiana Health Coverage Programs EPSDT Dental Periodicity Schedule* in Table 4.1 for timings of required screenings.

An oral screening should be included as part of each HealthWatch/EPSDT physical exam. **This service is not separately billable.** This EPSDT screening component includes an assessment of the following:

- Palate, cheeks, tongue, and floor of mouth
- Dental ridges (including erupting teeth)
- Gums for evidence of infection, bleeding, and inflammation
- Malformation or decay of erupting teeth
- Need for daily fluoride intake
- Need for dental referral regardless of age for a complete examination of all hard and soft tissues within the oral cavity

Poor oral health has been related to decreased school performance, poor social relationships, and less success later in life.

Table 4.1 – Indiana Health Coverage Programs EPSDT Dental Periodicity Schedule, adapted from the American Academy of Pediatric Dentistry (AAPD)

	6-12 months	12-24 months	2-6 years	6-12 years	>12 years
Clinical oral examination <sup>1,2</sup> to include:	■	■	■	■	■
Assess oral growth and development <sup>3</sup>	■	■	■	■	■
Caries-risk assessment <sup>4</sup>	■	■	■	■	■
Anticipatory guidance/counseling <sup>6</sup>	■	■	■	■	■
Injury prevention counseling <sup>7</sup>	■	■	■	■	■

	6-12 months	12-24 months	2-6 years	6-12 years	>12 years
Counseling for nonnutritive habits <sup>8</sup>	■	■	■	■	■
Counseling for speech/language development	■	■	■		
Substance abuse counseling				■	■
Counseling for intraoral/perioral piercing				■	■
Assessment for pit and fissure sealants <sup>9</sup>			■	■	■
Transition to adult dental care			■	■	■
Radiographic assessment <sup>5</sup>	■	■	■	■	■
Prophylaxis and topical fluoride <sup>4,5</sup>	■	■	■	■	■
Assessment and treatment of developing malocclusion			■	■	■
Assessment and/or removal of third molars				■	■

<sup>1</sup> First examination at the eruption of the first tooth and no later than 12 months. Repeat every six months or as indicated by child's risk status/susceptibility to disease.

<sup>2</sup>Includes assessment of pathology and injuries

<sup>3</sup>By clinical examination

<sup>4</sup>Must be repeated regularly and frequently to maximize effectiveness

<sup>5</sup>Timing, selection, and frequency determined by child's history, clinical findings, and susceptibility to oral disease

<sup>6</sup>Appropriate discussion and counseling should be an integral part of each visit for care.

<sup>7</sup>Initially play objects, pacifiers, car seats; then, when learning to walk, sports and routine playing, including the importance of mouth guards

<sup>8</sup>At first, discuss the need for additional sucking: digits versus pacifiers; then, the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.

<sup>9</sup>For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption

### Required Dental Referral

*Note: In addition to the oral examination, a referral to a dentist must be a part of every screen, beginning at 24 months of age and continuing through 20 years old.*

Dental referrals can be made as early as 6 months old, if indicated. Children should visit the dentist every six months after the first referral to receive preventive dental care. The first examination by a dentist can reveal decay, unerupted or missing teeth, and the need for prophylaxis or treatment.

## Vision Observation and Screening

Each HealthWatch/EPSTD screen must include a visual observation with an external eye examination and routine testing for visual acuity. This visual observation is a component of an EPSTD screening exam and **is not separately billable**.

Undetected vision problems occur in 5-10 percent of preschool children. The most serious of these problems is amblyopia, a loss of visual acuity and binocular vision that becomes irreversible after 5 years old.

### Required Vision Referral

Vision referrals must be made when objective screen methods indicate a referral is warranted. Refer to the *Indiana Medicaid Periodicity Schedule* in [Table 4.2](#) for timings of required screenings.

#### External Examination

External examination should include general inspection of the lids and eyeballs, noting prominence, size, and position, as well as growths, inflammations, discharge, or vascular injection. Forward protrusion (exophthalmos) or retraction (enophthalmos) of the globe should be noted.

#### Visual Acuity – Infants

Visual acuity is difficult to evaluate in infants. Providers should observe whether an infant follows a light or a bright attractive toy in different directions of gaze. Each eye should be tested separately. If the infant fails to respond to such testing, the provider should observe the pupillary responses for reaction to direct light stimulus.

Infants can be tested by alternately covering each eye. If visual acuity is poor in one eye, the infant resists actively when the good eye is covered and vision is disturbed, but is much less affected when the eye with decreased vision is covered.

#### Visual Acuity – Children 36-59 Months

The most direct way to detect amblyopia (monocular decreased vision) in 3- and 4-year-old children is to assess monocular visual acuity. Recommended tests include Lea symbols, or tumbling E charts, because they allow screening of younger children. Isolated optotypes with surround bars are also acceptable. Stereopsis testing is recommended to detect strabismus as an amblyopiogenic factor.

### Vision Referral Standards

*External Area:* Abnormalities that cannot be adequately evaluated and treated by the screening physician should be referred to a specialist for further evaluation.

*Acuity:* Refer to the Chronology of Visual Development in [Table 6.2](#). Any marked deviation from these guidelines is a basis for referral to a specialist for further evaluation.

Children already wearing glasses should be tested with their glasses. If they pass, record measurement and nothing further needs be done. If they fail, refer for reevaluation to the eye practitioner who prescribed the lenses.

A child may be referred if parental complaints warrant a referral. Generally, sitting close to the television, without other complaints and with normal acuity, is **not** a reason for referral. Children failing a test for hyperopia can be referred for additional diagnosis and treatment.

Table 4.2 – Periodicity Schedule for HealthWatch/ EPSTD Vision Observation and Screening

Age of Child	Subjective (S) or Objective (O)	Services Required or Recommended
Up to 3 years	S	Visual observation with an external eye examination; subjective screening by history. Refer child to an appropriate specialist if abnormality suspected.
3 to 5 years	O	Annual objective screening test by a standard testing method. If warranted, refer child to an appropriate specialist.
6, 8, 14, 16, and 20 years	S	Visual observation with an external eye examination; subjective screening by history. Refer child to an appropriate specialist if abnormality suspected.
10, 12, and 18 years	O	Objective screening test by a standard testing method. If warranted, refer child to an appropriate specialist.

### **Hearing Observation and Screening**

Refer any newborns identified under the universal newborn hearing screening (UNHS) program to First Steps. Children between the ages of newborn to 3 years old may qualify for services through First Steps. For more information about the First Steps Program, visit the First Steps Web site at <http://www.in.gov/fssa/ddrs/2633.htm>.

Refer children 4 years and older for additional testing and treatment to an audiologist when screening results identify a possible hearing deficit.

### **Newborn Hearing Screening**

The most critical period for learning language is the first two years of life. If hearing problems are not detected until after this time, lost ground in language development may never fully be regained. Screening tests that vary according to age must be part of the HealthWatch/EPSTD screen. The early detection of hearing loss is an urgent duty of any physician caring for young children.

Currently, two methods are available to conduct newborn hearing screening that possesses a high degree of sensitivity and specificity. These are the auditory brainstem response (ABR) and Evoked Otoacoustic Emissions (OAE).

The hospital is required to complete a second screening test if newborn fails the first screening. All cases requiring follow-up are to be referred by the hospital to the local First Steps' System Point Of Entry (SPOE). These referrals may need to be coordinated by First Steps to service providers, or may only require that First Steps monitor the follow-up services coordinated by the hospital. Diagnostic testing is to be conducted only after failure to pass two screening tests.

*Note: UNHS is designed to identify infants, ensure appropriate follow-up intervention, and collect information on the evidence of hearing loss using the initial guidance package published by the Indiana State Department of Health (ISDH).*

*For further information, contact the ISDH at (317) 234-3358.*

## Infant Hearing Screening

Noisemakers can be used to screen infant's hearing. High frequencies can be tested with a squeaky toy or small bell, and middle frequencies with a rattle or piece of tissue paper. While the infant is distracted with a visual stimulus, such as a toy or brightly colored object, the noisemaker is sounded outside the field of vision. Normal responses are as follows:

- At 4 months, there is a widening of the eyes, a cessation of previous activity, and possibly a slight turning of the head in the direction of the sound.
- At 9 months or older, the child should usually be able to locate sound, whether it comes from above or below.

Many hearing tests can give **falsely normal results**, such as banging pots together or hearing a low flying airplane. Most children with significant hearing deficits have residual hearing and respond to very loud noises. However, they are educationally and socially deaf if they cannot hear normal speech sounds.

## Hearing Screening of Older Children

At age 3, a child can begin to be tested with a pure tone audiometer. However, the HealthWatch/EPSTDT Program does not require an audiometric screening until the child reaches 4 years old. If the child is unable to cooperate, the test can be deferred until the next exam. Deferral should be documented due to inability to cooperate in the patient record.

Hearing screening must be done with an audiometer or audioscope. Providers that do not wish to perform the objective hearing screen can refer the child to an audiologist for screening.

Hearing tests are given by the Department of Education in grades one, four, seven, and 10. Several schools also test kindergarten children. These screening efforts should not be duplicated unless the child is at risk and the situation warrants rescreening. **Screening results from the school, or verbal confirmation by the parent, should be documented in the patient's medical records.**

## Referral Standards

When you suspect or have confirmed a chronic hearing deficit, an appropriate referral should be arranged to do precise testing. If the hearing deficit is confirmed, the patient should be referred to an otolaryngologist for examination in an attempt to determine the cause of the hearing loss.

## Lead Screening

Lead poisoning is preventable. The key to successful prevention is to educate parents with young children about the potential sources of lead poisoning. Children from 9 months to 6 years are at greatest risk for elevated blood lead levels.

ISDH, through the Indiana Childhood Lead Poisoning Prevention Program (ICLPPP), monitors lead poisoning in Indiana's children. ICLPPP has identified the following four steps to a successful lead poisoning prevention program:

- Early identification of children with excessive lead absorption through screening programs
- Treatment of children with abnormal blood lead levels
- Prompt termination of further excessive lead exposure (environmental investigation and abatement)
- Intensive parent and public education about lead poisoning

The following items place a child at risk for lead poisoning:

- Children with high incidence of hand-to-mouth activity, such as thumb sucking or nail biting
- Children with a history of Pica (a medical disorder characterized by a craving for nonfood items such as peeling paint, dirt, cigarette butts, and so forth)
- Children living in housing constructed **prior to 1978**, who may be exposed to lead pipes or lead-based paints
- Children living in or frequently visiting poorly maintained housing units constructed prior to the 1960s or who are exposed to other hazardous lead sources (such as children of lead industrial workers)
- Children living in older homes that are being restored
- Children with poor nutritional status (increased fat, decreased calcium, iron, and other nutrients) are predisposed to enhance lead absorption in the intestines
- Children with a previously elevated blood lead level
- Children with signs and symptoms of lead poisoning
- Painted household surfaces such as cribs, window sills, toys, doors, radiators, or fallen paint chips, flaking areas, and holes in the walls
- Lead water pipes
- Soil, dirt, and dust inside and outside a dwelling
- Imported brands of plastic mini-blinds
- Paper, newsprint, magazine pages, and metallic wrapping paper
- Playground equipment with chipped lead-based paint
- Water wells
- Industrial crayons, batteries, rubber, electronic devices, printed material (yellow and orange inks or oil colors may contain lead chromate), cans, varnishes, shellac, and paints on containers
- Unglazed food containers or pottery that have been lead glazed, lead alloyed, plated, or soldered
- Fungicides, insecticides, cosmetics, and various medications, which can contain lead carbonate
- Cigarette butts, decorative candle wicks, and matches, which can contain lead acetate
- Burning painted lumber and battery casings, which can place lead in the air
- Folk remedies, such as greta and azarcon used to treat diarrhea or gastrointestinal upset, which can contain substantial amounts of lead

The Office of Medicaid Policy and Planning (OMPP) recommends that blood samples drawn for lead screening labs be sent to the ICLPPP to ensure that testing is done on atomic absorption spectrophotometers (AAS) and to ensure that the results are known to the ICLPPP. The following are the three ICLPPP laboratories:

- Vanderburgh County Department of Health
- Marion County Department of Health
- Indiana State Department of Health, located in Marion County

To find out where to send blood samples or for information on the ICLPPP, contact ICLPPP at (317) 233-1250, a local health department, or the Indiana Family Helpline at 1-800-433-0746.

Providers that use the ICLPPP’s postage-paid kit cannot bill IHCP a conveyance fee for conveying samples to the lab.

Providers that send blood samples to ISDH/ICLPPP laboratories for testing can still use code 36415 – *Venipuncture/finger stick*, to indicate that blood draws were made. The distinction must be made by diagnosis to differentiate between individuals being tested to rule out lead screening and those that have been diagnosed or are being treated for lead poisoning.

When forwarding blood samples to ISDH/ICLPPP, include the PMP provider number and authorization code for members of the *Care Select* delivery system on the paperwork accompanying the sample. If the member is enrolled in an MCO in the RBMC delivery system, include the MCO PMP authorization and referral information.

Providers that send blood samples to private labs for testing should use the codes in Table 4.3, when appropriate.

Table 4.3 – Provider Billing for Blood Samples sent to Private Labs

Code	Code Definition
36415	Venipuncture/finger stick
99000	Conveyance fee for sending blood samples from provider’s office*
99001	Conveyance fee for sending samples other than from provider’s office*

\* Can only be submitted if the provider incurs an expense associated with the conveyance.

The OMPP wants to ensure that all Medicaid children between 9 months and 6 years are tested for lead poisoning, and that children with elevated lead levels are identified and provided the recommended follow-up treatment. A blood lead screening must be performed at the 9-month or 12-month visit and again at the 24-month visit. If a child is at high risk, a blood lead screening should be initiated at the 6-month visit. Subsequent screenings are required for at-risk patients. **When a subsequent blood lead screening is performed, use the exposure diagnosis code (V15.86) in addition to the primary diagnosis code of V20.2.**

*Note: The lead exposure diagnosis code (V15.86) should only be used when children are diagnosed as lead exposed.*

The coverage and reimbursement rate for code 83655 is expanded to include tests administered using filter paper and handheld testing devices in the office setting.

Table 4.4 – Codes for Lead Testing

Procedure Code	Description
83655 U1	Assay of lead, using filter paper
83655 U2	Assay of lead, using handheld testing device
83655	Assay of lead (venous blood)

*\*Note: Coverage and reimbursement of 83655 are not being changed.*

## **Indiana's First Steps Program**

Indiana's First Steps early intervention system is a comprehensive, family-centered, community-based program that provides early intervention services to infants and young children with disabilities and who are at risk for developmental delays. The First Steps Program can provide a multidisciplinary evaluation and assessment for referred children. The First Steps Program is not income-based.

Families who are eligible to participate in the Indiana First Steps Program include any children, ages birth to 3 years old who:

- Are experiencing developmental delays
- Have a diagnosed condition that has a high probability of resulting in a developmental delay
- Are at risk of having substantial developmental delay because of biological risk factors

An individual family service plan (IFSP) is developed by parents and professionals to identify services that would achieve the best possible result for the child and the family. The IFSP then becomes the road map for the services the family and their child will receive.

All infants and toddlers are entitled to evaluation to determine eligibility, ongoing assessment, and case management. The following services are specifically listed in the regulations. If appropriate for the child and family, they are included in the family's IFSP:

- Audiology
- Case management/service coordination
- Family training, counseling, and home visits
- Health services necessary to enable the infant or toddler to benefit from the early intervention services
- Medical services only for diagnostic and evaluation purposes
- Nursing services
- Nutrition services
- Occupational therapy
- Physical therapy
- Psychological services
- Social work services
- Special instruction
- Speech-language pathology
- Transportation (direct and related costs of travel)

Although most First Steps agencies can provide all the early intervention services needed by children with developmental delays, IHCP members have the freedom of choice of providers for IHCP-covered services. Families can choose to receive IHCP-covered services from a provider not affiliated with the First Steps Program.

In addition to the services children and their families can receive, it is important to get children with suspected or diagnosed developmental delays enrolled in the First Steps program for the following two special reasons:

- To enable eligible children and their families to receive early intervention services based on an IFSP
- To enable eligible children and their families to receive transitioning services when the child turns 3 years old and the Department of Education is then responsible for providing services for these children, if eligible, through an Individual Education Plan (IEP).

Contact 1-800-441-STEP for more information about the First Steps Program.

Services authorized by First Steps for children who are not enrolled in the IHCP and some Children's Special Health Care Services (CSHCS) are billable only to First Steps. Non-First Steps services billed for IHCP member follow normal protocol for each delivery system.

## **Children's Special Health Care Services (CSHCS)**

CSHCS serves persons from birth to 21 years old. CSHCS provides a basic service package and a limited service package to help meet the needs of CSHCS clients. The basic service package for medically and financially eligible children includes primary care, such as preventive care, immunizations, and sick-child care. It also includes routine dental care and the provision of prescription medication.

Individuals can be enrolled in IHCP and CSHCS if they qualify for both programs. The EPSTDT services must first be billed to the IHCP network (fee-for-service or RBMC) to which the child is assigned before submitting the claim to CSHCS. If the child is also enrolled in First Steps and First Steps covers the service, providers should bill First Steps and First Steps will coordinate billing the IHCP and CSHCS.



## Section 5: Documentation Resources

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Documentation for the HealthWatch/Early and Periodic Screening, Diagnosis, and Treatment (EPSTD) screen may be incorporated into the documentation routinely kept for well child check-ups. However, when the patient receives HealthWatch/EPSTD screen components or when the patient is referred elsewhere to receive components, it is imperative that the patient health record reflects the components that were given and also the components, if any, that were referred elsewhere. If a child needs more frequent screening than recommended by the periodicity schedule, inter-periodic screens may be performed. Inter-periodic office visits and EPSTD screening exams are covered by the Indiana Health Coverage Programs (IHCP) up to the 30-office visit maximum per individual, per year.

Review [Chapter 2](#) and [Chapter 8](#) of the *IHCP Provider Manual* for information about billing non-EPSTD office visits and the office visit benefit limitation. Additional office visits, other than EPSTD screening exams, must be billed with appropriate Evaluation and Management (E/M) procedure codes for visits that are not full HealthWatch/EPSTD screens and **should not be billed using V20.2** as the primary diagnosis, so that they are reimbursed accordingly. If present and applicable, commercial insurance should be billed first.

The following examples indicate some tools available for physician's use in simplifying documentation of HealthWatch/EPSTD screen components in medical records.

### **Bright Futures**

Bright Futures is a national health promotion initiative dedicated to the principle that every child deserves to be healthy and that optimal health involves a trusting relationship between the health professional, the child, the family, and the community as partners in health practice.

For complete information about Bright Futures at Georgetown University, visit the Web site at <http://www.brightfutures.org/> or contact them at:

**Bright Futures at Georgetown University**  
**Box 571272**  
**Washington, DC 20057-1272**  
**Telephone: (202) 784-9772**  
**Fax: (202) 784-9777**  
**E-mail: [BrightFutures@ncemch.org](mailto:BrightFutures@ncemch.org)**

The following information can be obtained at the Bright Futures Web site:

- Pocket guide to encounter
- Growth chart
- Activity book (coloring book for children)
- Encounter Form for Health Professionals (Guidelines for Health Supervision of Infants, Children, and Adolescents)
- Guidelines for Health Supervision

### **Indiana State Department of Health**

The Indiana State Department of Health (ISDH) uses the *Recommendations for Preventive Pediatric Health Care* for the care of children who are receiving competent parenting, have no manifestations of any major health problems, and are growing and developing in satisfactory fashion. These guidelines

represent a consensus by the Committee of Practice and Ambulatory Medicine in consultations with the national committees and sections of the American Academy of Pediatrics (AAP) (<http://aappolicy.aappublications.org/cgi/content/full/pediatrics%3b105/3/645>). For more information, contact:

**Maternal and Child Health Services  
Indiana State Department of Health  
2 North Meridian Street, Section 7C  
Indianapolis, IN 46204  
Telephone: 1-800-433-0746  
Fax: (317) 233-1299**

### ***American Academy of Pediatrics***

The Committee on Practice and Ambulatory Medicine publishes the Academy's preventive care guidelines "Recommendations for Preventive Pediatric Health Care." Also known as the periodicity schedule, the guidelines set forth recommendations for the periodicity of the well-child visits and the types of screens and health assessments that should be conducted at each visit.

If you have any questions, please contact the Council on Community Pediatrics toll-free at 1-800-433-9016. Click the following link to visit their Web site at <http://www.aap.org>.

### ***Centers for Disease Control and Prevention, National Center for Health Statistics***

A detailed medical growth chart designed for each age group is available from the Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS). The CDC can be contacted in one of the following ways:

**National Center for Health Services (NCHS)  
Division of Data Services  
3311 Toledo Road  
Hyattsville, MD 20782  
Telephone: (301) 458-4636  
Web site: <http://www.cdc.gov/growthcharts>  
E-mail: [nchsquery@cdc.gov](mailto:nchsquery@cdc.gov)**

Providers are also encouraged to periodically check the CDC/NCHS Web page at <http://www.cdc.gov/nchs> for announcements and updates about distribution and training materials.

## Section 6: Recommended Screening Techniques

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### Family and Medical History Documentation

The history of the patient is an important factor in making a proper assessment of the patient's health. The HealthWatch/Early and Periodic Screening, Diagnosis, and Treatment (EPSTD) screening physician has the responsibility of obtaining a family and medical history as part of the HealthWatch/EPSTD screening examination.

The categories that should be covered during the history-taking portion of the HealthWatch/EPSTD screen are outlined below. Modifications should be made that are appropriate for the age and gender of the child. Significant findings should be noted on the child's medical record.

The following is a suggested outline for the health and development history and/or database:

- Reason for visit
- Initial observations of parent, child, and family interactions and identification of caregivers
- Perinatal history (this child)
  - *Pregnancy*: Prenatal care including trimester when initiated; habits, including use of drugs, alcohol, tobacco; illnesses; accidents; hospitalizations; planned or unplanned
  - *Birth*: Description of labor and delivery; anesthesia; complications; location of birth; full term or premature (gestational age of child)
  - *Neonatal*: Condition at birth; measurements; nursery course; length of stay; complications or problems; treatment; breast or bottle fed
- Nutritional status
  - Questions related to feeding or food habits to elicit nutritional risk
  - Review the following: height for age and weight for height, laboratory tests, and findings on health history and physical examination
- Developmental history
- Medical history
- Body systems review
- Family health history

Make a notation of the presence of diseases such as the following in maternal and paternal families: hypertension, heart disease, stroke, obesity, cystic fibrosis, allergy, asthma, emphysema, tuberculosis, diabetes mellitus, kidney disease, arthritis, cancer, anemia, hemoglobin disorder, mental retardation, seizures, mental illness, migraine, congenital anomalies, hereditary or familial conditions, sexually transmitted disease, and substance use or abuse.

- Psychosocial and lifestyle history
- Child's mental and emotional health
- Family household and environment

## Assessment of Physical and Mental Health Development

### Physical Examination

*Note: A complete and unclothed physical exam must be given each time a HealthWatch/EPSDT screen is performed.*

All areas of a routine general physical exam are included in the HealthWatch/EPSDT screen. Because federal and state Medicaid requirements emphasize certain areas of the examination, a [HealthWatch/EPSDT Periodicity and Screening Schedule](#) (Appendix A) has been developed outlining these areas and showing what age of the certain procedures must be completed. The information contained in this section suggests various screening techniques and standards for referral if further evaluation or treatment is needed as a result of the HealthWatch/EPSDT screen.

The following protocol is suggested when performing a HealthWatch/EPSDT exam:

- Measurements
- Height
- Weight
- Weight for height
- Head circumference (birth through 2 years)
- Blood pressure (from 3 years)
- General physical examination and review of the following systems:
  - Parent, child, and physician interaction
  - General appearance and behavior
  - Nutrition and growth
  - Skin and hair
  - Head
  - Face
  - Eyes
  - Ears
  - Nose, mouth, and throat
  - Teeth and gums
  - Musculoskeletal system
  - Neck
  - Lymph nodes
  - Cardiovascular system
  - Respiratory system
  - Gastrointestinal system
  - Urogenital system
  - Endocrine system
  - Nervous system
  - Other

Suspect or positive findings should be summarized and discussed with the parent and child and a plan of care developed.

## Height, Weight, Head Circumference

Guidelines for obtaining measurements:

- *Weight is required at each visit for all ages.* Infants and small children should be weighed on a table model beam scale. Older children who can stand without support can be weighed on a floor model beam scale. Scales should be balanced prior to weighing and should be checked and adjusted for accuracy according to the manufacturer's specifications.
- *Height is required at each visit for all ages.* Infants and children as old as 2 years old and children with low birth weight, failure to thrive, or certain developmental disorders, or who cannot stand, should be measured supine on a firm surface using a fixed headboard and footboard when possible. For older children who are able to stand without support, use a nonstretchable measuring tape fixed to a true vertical surface.
- *Head circumference* must be measured at every visit for infants and children through 2 years old.
  - Measure the head with a cloth, steel, or disposable paper tape
  - Apply the tape around the head from the supraorbital ridges anteriorly to the posterior point (usually the external occipital protuberance) giving the maximum circumference
- *Standards for further evaluation or referral:* Refer to the Centers for Disease Control and Prevention (CDC), National Center for Health Statistics' (NCHS) percentile standards. If significant deviation is present, conduct further evaluation and, if necessary, make a referral. These growth charts are available from the CDC NCHS Web site at <http://www.cdc.gov/growthcharts/>.

## Blood Pressure

Blood pressure must be checked at every screening visit for all children 3 years of age and older. However, blood pressure can be taken on younger children if a provider decides it is appropriate:

- Take the blood pressure with the appropriate sized pediatric or adult cuff
- Record the reading in the patient chart

*Standards for Further Evaluation or Referral:* Refer to current percentile charts published by the American Academy of Pediatrics (AAP) for the normal blood pressure for various ages. Any significant deviation is a basis for further evaluation and, if necessary, referral. The AAP Web site is located at <http://www.aap.org/>.

## Vision Screening

Table 6.1 provides testing procedures and passing criteria for these commercially available tests.

Table 6.1 – Testing Procedures

Function to be Evaluated	Type of Test	Specific Test	Recommended Testing Procedures	Passing Criteria
Stereopsis	Random dot stereogram	Random Dot E	<p>Test distance = 40 cm (630 arcsec)</p> <p>All testing, including pretesting, should be performed binocularly with the polarized glasses on.</p> <p>Pretest – Test child’s ability to perform test by having child identify the location of the three-dimensional E on four of five trials (E on left or right; above or below).</p> <p>Test procedure – Test child’s ability to identify the location for the stereo E. Tester should use five presentations, varying location in a nonsystematic manner.</p>	Child must locate stereo E on four of five presentations. *

\*From a statistical perspective, it would be ideal to require a child pass five of five trials because the probability of achieving this criterion by simply guessing is less than 5 percent. In reality, many children will have difficulty attending consistency for five trials. Therefore, four of five correct passing criteria are considered acceptable, even though the probability of passing by chance is 16.5 percent.

## Vision

Refer to an appropriate vision or eye specialist any patient exhibiting a marked deviation from the chronology of visual development in Table 6.2.

Table 6.2 presents the level of visual development that should be attained at each age.

Table 6.2 – Chronology Of Visual Development

Age	Level of Development
Birth	Awareness of light and dark and closes eyelids in bright light.
Neonatal	Rudimentary fixation on near object (three to 30 inches).
2 weeks	Transition fixation, usually monocular, at a distance of roughly three feet.
4 weeks	Follows large, conspicuously moving objects.
6 weeks	Moving objects evoke binocular fixation briefly.
8 weeks	Follows moving objects with jerky eye movements. Convergence beginning to appear.
12 weeks	Visual following now a combination of head and eye movements and convergence improving. Enjoys light objects and bright colors.

Age	Level of Development
16 weeks	Inspects own hands. Fixates immediately on a one-inch cube brought within one to two feet of eye. Vision 20/300 to 20/200 (6/100 to 6/70)
20 weeks	Accommodative convergence reflexes all organizing. Visually peruse lost rattle. Shows interest in stimuli more than three feet away.
24 weeks	Retrieves a dropped one-inch cube, can maintain voluntary fixation of stationary object even in the presence of competing moving stimulus, and hand-eye coordination appearing.
26 weeks	Will fixate on a string.
28 weeks	Binocular fixation clearly established.
36 weeks	Beginning of depth perception.
40 weeks	Marked interest in tiny objects and tilts head backward to gaze up. Vision 20/200 (6/70)
52 weeks	Fusion beginning to appear. Discriminate simple geometric forms (squares and circles). Vision 20/180 (6/60)
12 – 18 months	Looks at pictures with interest.
18 months	Convergence well established and localization of distance is crude - runs into large objects.
2 years	Accommodation well developed. Vision 20/40 (6/12)
3 years	Convergence smooth and fusion improving. Vision 20/30 (6/9)
4 years	Vision 20/20 (6/6)

### **Audiological High Risk Register**

The following are considered audiological high risk register (HRR):

- Neonates (birth to 28 days) who fall into one or more of the 10 risk criteria identified by the Joint Committee on Infant Hearing (1990) are considered at risk for hearing impairment and should receive audiologic screening. The factors frequently referred to as the HRR are:
  - Family history of congenital or delayed onset childhood sensorineural impairment
  - Congenital infection known or suspected to be associated with sensorineural hearing impairment such as toxoplasmosis, syphilis, rubella, cytomegalovirus, and herpes
  - Craniofacial anomalies, including morphologic abnormalities of the pinna and ear canal, absent philtrum, low hairline, and so forth
  - Birth weight less than 1,500 grams (less than 3.3 lbs.)
  - Hyperbilirubinemia at a level exceeding indication for exchange transfusion
  - Ototoxic medications, including, but not limited to, the aminoglycosides, used for more than five days (such as, gentamicin, tobramycin, kanamycin, streptomycin) and loop diuretics used in combination with aminoglycosides
  - Bacterial meningitis
  - Severe depression at birth, which may include infants with Appearance, Pulse, Grimace, Activity, Respiration (APGAR) scores of 0-3 by five minutes or those who fail to initiate spontaneous respiration by 10 minutes or those with hypotonia persisting to 2 hours of age
  - Prolonged mechanical ventilation for a duration equal to or greater than 10 days, such as persistent pulmonary hypertension
  - Stigmata or other findings associated with a syndrome to include sensorineural hearing loss, such as Wardenburg or Usher's Syndrome

- Infants (29 days to 2 years)
  - Parent or caregiver concerns about hearing, speech, or developmental delay
  - Bacterial meningitis
  - Neonatal risk factors that may be associated with progressive sensorineural hearing loss, such as cytomegalovirus, prolonged mechanical ventilation, and inherited disorders
  - Head trauma, especially with either longitudinal or transverse fracture of the temporal bone
  - Stigmata or other findings associated with syndromes known to include sensorineural hearing loss, such as Wardenburg or Usher’s Syndrome
  - Ototoxic medications including, but not limited to, the aminoglycosides used for more than five days, such as, gentamicin, tobramycin, kanamycin, streptomycin, and loop diuretics used in combination with aminoglycosides
  - Children with neurodegenerative disorders such as neurofibromatosis, myoclonic epilepsy, Friedreich’s Ataxia, Huntington’s Chorea, Werdnig-Hoffman Disease, Tay-Sach’s Disease, Charcot-Marie Tooth Disease, any metachromatic leukodystrophy, or any infantile demyelinating neuropathy
- Screening test failures
  - Infants who fail any of the office screening tests described above should be given more sensitive tests to clarify hearing status.
- Suggestive symptoms in infants
  - Concerned parents – Most mothers of deaf children have some suspicion of the problem by the time the child is 6 months old and sometimes earlier. When the parent suspects hearing impairment, a reliable hearing test should be given.
  - Not awakening to sound – A normal sleeping infant sometimes awakens to sounds in other parts of the house. If this has not happened, the mother should be asked to be alert for it and report it at the next HealthWatch/EPSTDT visit. If it does not occur, the child requires referral.
- Speech delays
  - Before any child is labeled as having mental retardation, autism, auditory agnosia, or a developmental speech delay, a valid hearing test is required. Verbal communication depends on hearing. If the patient is old enough to cooperate with pure tone audiometry and the results are normal, referral to an audiologist is not needed. Referral to an audiologist should be preceded by otoscopic examination.

Table 6.3 – Periodicity Schedule for HealthWatch/EPSTDT Hearing Observation and Screening

Age of Child	Subjective (S), Objective (O), or Required (R)	Services Required or Recommended
Newborn	R	Newborn hearing screening via fully automated auditory brain stem response, if available.
Newborn	R	All patients considered to be at risk for hearing deficit are to be screened at this time.
Under 12 months	S	Subjective screening, by history and/or other infant screening techniques; refer child to an appropriate hearing specialist, if warranted.
12 months through 4 years	O	As early as possible, perform an objective screening using a standard testing method. Refer those at risk or suspected of hearing deficit to a specialist.

Age of Child	Subjective (S), Objective (O), or Required (R)	Services Required or Recommended
4 to 5 years	R	Audiometric screening with an audiometer or audioscope (child may be referred to an audiologist for screening); refer child at risk or suspected of hearing deficit to an appropriate specialist.
4, 8, 14, 16, and 20 years	S	Subjective screening by history and/or other method; refer child with suspected hearing deficit to an appropriate specialist.
10, 12, and 18 years	O	Objective hearing screening by a standard testing method; (hearing tests are given by the Indiana Dept. of Education in grades 1, 4, 7, and 10 - several schools also test kindergarten students). <b>Do not duplicate school screenings unless the child is considered at risk and rescreening is warranted.</b>

Refer to the high-risk register for categories of patients often associated with unsuspected hearing loss.

## Dental Observation and Screening

Table 6.4 – Periodicity Schedule for HealthWatch/EPSTDT Dental Observation and Screening

Age of Child	Subjective (S) or Required (R)	Services Required or Recommended
Younger than 12 months	S	Direct referral to a dentist for medically appropriate services, if warranted by injury, disease, congenital abnormality, or other cause.
12 to 24 months	S	Direct referral to a dentist, if medically appropriate.
24 months	R	Direct referral to a dentist for examination, preventive dental care, and anticipatory guidance.
24 months through 20 years	R	Regular dental assessments at intervals defined by the dentist (approximately every six months) for the individual patient. Assessment should include examination, preventive dental care, and anticipatory guidance.

For information about the prevention of baby bottle tooth decay, please contact the Indiana State Department of Health (ISDH) by mail at the following address:

**Indiana State Department of Health  
2 N. Meridian St.  
Indianapolis, IN 46204**

## Newborn Screening

Newborn screenings are tests to be given at the earliest feasible time for the detection of the following disorders:

- Phenylketonuria
- Hypothyroidism
- Hemoglobinopathies, including sickle cell anemia
- Galactosemia
- Maple Syrup urine disease
- Homocystinuria
- Inborn errors of metabolism that resulting in mental retardation
- Congenital adrenal hyperplasia
- Biotinidase deficiency
- Disorders detected by tandem mass spectrometry or other technologies with the same or greater detection capabilities as tandem mass spectrometry, if the state determines that the technology is available for use by a laboratory designated under the applicable Indiana law

All blood samples are collected by the hospital on a filter paper card that must also contain information to identify the infant, the infant's physician as provided by the mother, the time of birth, the time of the first feeding, and time of the blood draw. The blood sample is sent to the Indiana University (IU) Laboratory. IU is contracted by the ISDH to perform the laboratory analysis for newborn screening. There is a charge from the IU Laboratory to the hospital for the initial test, but **if a retest is needed there is no additional charge** by the IU Laboratory. If the IU Laboratory requests further testing in the form of serum or whole blood collection, that testing is provided at no charge. The IU Laboratory indicates in the letter to the physician whether additional testing of serum or whole blood is indicated.

*Note: IHCP providers using laboratories other than the IU Laboratory to perform newborn screening analysis should discontinue this practice immediately.*

Use of laboratories other than IU increases newborn screen costs unnecessarily. To ensure that the IU Laboratory performs all newborn screening, all newborn screening should be coordinated through the ISDH. Providers must determine whether valid newborn screening test results have been obtained for the infant. If a valid test has been obtained for the infant and the test results were normal, no further testing is required. The newborn screening process is complete.

If a re-screen is needed because the first screen was invalid, or if additional testing of serums is needed because test results were abnormal, or if there is no record that newborn screening was done, providers should call ISDH to work out the best method of accomplishing newborn screening. Generally, ISDH recommends that the infant be taken back to the birth hospital to have that hospital perform newborn screening or rescreening. However, providers should consult with ISDH on how best to proceed with newborn screening when there is an invalid or abnormal test. If additional information is needed, contact the following:

**Indiana State Department of Health  
Newborn Screening Program  
2 N. Meridian St., Suite 700  
Indianapolis, IN 46204  
Telephone: (317) 233-1270 or 1-888-815-0006  
Fax: (317) 234-2995**

Because newborns can be released from hospitals prior to the 48 hours needed to obtain valid newborn screen results, an increasing number of newborns require a second screen. Families are generally asked to bring the newborn back to the birth hospital as an outpatient or the hospital requests that a nurse make a follow-up visit to obtain the sample for newborn screening. In either case there is a potential that the hospital could bill the IHCP separately for newborn screening that is already included in the diagnosis-related group (DRG) that the IHCP pays for the newborn hospitalization.

Hospitals are not permitted to bill the IHCP separately for newborn screenings. There are occasions when hospitals are requested to perform newborn screening for newborns born in another Indiana hospital. For example, when distance precludes a trip to the birth hospital, the infant should be taken to the nearest hospital with birthing facilities so that newborn screening can be completed. To prevent the second hospital from being charged by the IU Laboratory for the second screen, the hospital must indicate on the filter paper card, in the space provided, the name of the birth hospital and the submitting hospital. The IU Laboratory attempts to match the infant's second screen with the first screen so that the hospital is not charged. If the infant's name or birth date has been changed, the original name and date of birth must be included in the information sent to the IU Laboratory to facilitate a match.

Newborn screening results must be recorded in the patient record for infants younger than 1 year old.



## Section 7: Anticipatory Guidance

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### Overview

Health education is a required component of screening services and includes anticipatory guidance. At the outset, the physical and/or dental screening provides the initial context for providing health education. Health education and counseling to both parents (or guardians) and children are required and designed to assist in understanding what to expect in terms of the child's development. Health education provides information about the benefits of healthy lifestyles and practices as well as accident and disease prevention.

### Dental

#### ***Dental Anticipatory Guidance for Parents***

Parents should be counseled on the importance of taking care of their baby's teeth. Teeth are susceptible to decay as soon as they appear in the mouth. Brushing the teeth can be done as soon as they appear.

Among the many dental conditions affecting children, dental caries (tooth decay) is the preeminent concern in the context of Medicaid services because of their substantial prevalence in the low-income population. Tooth decay continues to be the single most common chronic disease among U.S. children, despite the fact that it is highly preventable through early and sustained home care and regular professional preventive services.

Dental caries generally are considered to be reversible or capable of being arrested in the earliest stages through a variety of proven interventions. Beyond the early stages, the decay process generally tends to advance and become more difficult and costly to repair the longer it remains untreated. Therefore, treatment initiated early in the course of dental caries development will almost always be easier for both child and dentist, less expensive, and more successful than treatment begun at a later time.

Dental care is one of the most commonly unmet treatment needs in children. Lower-income children have more untreated dental disease than more affluent children who obtain care on a regular periodic basis. Reasons for this disparity include the fact that low-income children are more likely to experience dental disease and frequently only access care on an episodic or urgent basis when decayed teeth cause pain or swelling.

See [Section 4](#) of this manual for detailed recommendations regarding the periodicity of professional dental services for children. The American Academy of Pediatric Dentistry (AAPD) periodicity schedule outlines the recommended content and periodicity of developmental assessments, clinical examinations, diagnostic tests including radiographic assessments, counseling and prevention activities, and periodic reevaluations. These recommendations generally call for procedures to be repeated at six-month intervals or as indicated by individual patient's needs or risk for disease.

## **Preventing Baby Bottle Tooth Decay**

Information printed by the Indiana State Department of Health (ISDH) about baby bottle tooth decay can be obtained at the following location:

**Indiana State Department of Health**  
**Oral Health**  
2 N. Meridian St., Section 7G  
Indianapolis, IN 46204  
E-mail: [oralhealth@isdh.state.in.us](mailto:oralhealth@isdh.state.in.us)  
Web site: <http://www.in.gov/isdh/18717.htm>

Or call the Indiana Family Helpline at 1-800-433-0746.

## **Developmental and Behavioral Assessment**

### **Assessing Development**

Developmental assessment is an ongoing process; therefore, it is to be completed as part of each HealthWatch/Early and Periodic Screening, Diagnosis, and Treatment (EPSTDT) screen. It consists of a range of activities to determine whether the child's development progress is within a typical range of achievement according to age and cultural background. **Parents should be able to give an accurate history of the child's development; however, a developmental assessment is required.** For regular patients, an ongoing recording in the child's chart of developmental milestones may be sufficient to make a judgment about developmental progress.

### **Children Younger Than 5 Years Old**

For children younger than 5 years old, [Table 7.1](#) depicts milestones for motor language and social development. Every child develops at his or her own, unique rate. These milestones are meant to demonstrate typical developmental stages:

- *Motor skills:* Although practice of motor movements has a slight influence on the rate of development, maturation usually plays a much greater role. The newborn infant can perform a number of motor movements mainly of a reflex type.  
  
Motor development involving the hands tends to proceed along a definite sequential course. The child first looks from the hand to the object and then attempts to grasp objects with two hands. Grasping with the palm of the hand is learned first, using the ulnar side of the hand initially and later the radial side. Eventually, grasping with the thumb and index finger is mastered.
- *Social activity and behavior:* Questions should be asked to determine how the child relates to family and peers and whether there is any noticeable deviation in any behavior. Observe for similar behavior in the office.
- *Speech development:* Attention should be paid to the child's speech pattern to see whether it is appropriate for the child's age. Language remains the best predictor of future intellectual endowment and should serve as the common denominator comparing its rate of development with other areas including gross motor, problem solving, adaptive, and social skills. If a provider decides during the screening process that further evaluation is needed, then one of the standard speech and language tests may be given.
- *Developmental tests:* After observing the child in the various areas of development, the provider may decide that a more in-depth evaluation is needed. The provider can elect to use an objective

developmental screening test and receive additional reimbursement. Developmental testing is recommended from 6 months through 4 years old.

If a developmental delay is a concern, a referral to First Steps for children birth to 3 years old is recommended. Additional information concerning the First Steps program is located in the [Indiana's First Steps Program](#) section of this manual, or you can use the following information to contact *First Steps*.

**Bureau of Child Development Services**  
**402 West Washington Street, Room W. 386**  
**Indianapolis, IN 46204-2739**  
**Telephone: (317) 233-6092**  
**1-800-441-STEP (1-800-441-7837)**  
**(Indiana Residents Only)**  
**Fax: (317) 234-6701**  
**E-mail your questions or comments to: [FirstStepsWeb@fssa.in.gov](mailto:FirstStepsWeb@fssa.in.gov)**

See [Appendix D: Children's Programs in Indiana](#) for additional information and resources for young children.

Table 7.1 – Developmental Milestones – Language Skills

Age	Gross Motor	Visual Motor	Language	Social
1 month	Raises head slightly from prone, makes crawling movements, lifts chin up	Has tight grasp, follows to midline	Alerts to sound (for example, by blinking, moving, startling)	Regards face
2 months	Holds head in midline, lifts chest off table	No longer clenches fists tightly, follows objects past midline	Smiles after being stroked or talked to	Recognizes parent
3 months	Supports on forearms in prone, holds head up steadily	Holds hands open at rest, follows in a circular fashion	Coos (produces long vowel sounds in musical fashion)	Reaches for familiar people or objects, anticipates feeding
4 to 5 months	Rolls front to back, back to front, sits well when propped, supports on wrists and shifts weight	Moves arms in unison to grasp, touches cube placed on table	Orients to voice, 5 months – turns head toward bell, says “ah goo,” razzing	Enjoys looking around environment
6 months	Sits well supported, puts feet in mouth in supine position	Reaches with either hand, transfers, uses raking grasp	Babbles, 8 months – “dada/mama” indiscriminately	Recognizes strangers
9 months	Creeps, crawls, cruises, pulls to stand, pivots when sitting	Uses pincer grasp, probes with forefinger, holds bottle, finger feeds	Imitates sounds, waves bye-bye. 10 months “dada/mama” discriminatory. 11 months – uses one word	Starts to explore environment, plays pat-a-cake

Age	Gross Motor	Visual Motor	Language	Social
12 months	Walks alone	Throws objects, uses hand to release or let go of toys, uses mature pincer grasp	Follows one-step command with gesture, uses two words, 14 months – uses three words	Imitates actions, comes when called, cooperates with dressing
15 months	Creeps upstairs, walks backwards	Builds tower of two blocks in imitation of examiner, scribbles in imitation	Follows one-step command without gesture, uses four to six words and immature jargonizing (runs several unintelligible words together)	
18 months	Runs, throws toy from standing without falling	Turns two to three pages at a time, fills spoon and feeds himself or herself	Knows seven to 20 words, points to one body part when named, uses mature jargonizing (includes intelligible words in jargonizing)	Copies parent in tasks (such as, sweeping, dusting) and plays in company of other children
21 months	Squats in play, goes up steps	Builds tower of five blocks, drinks well from cup	Points to three body parts, uses two-word combinations. Points to five body parts	Asks to have food and to go to the toilet
24 months	Walks up and down steps without help	Turns pages one at a time; removes shoes, pants, and so forth; imitates stroke	Uses 50 words, two-word sentences, and three pronouns, names objects in pictures	Parallel play
30 months	Jumps with both feet off floor, throws ball overhand	Unbuttons, holds pencil in adult fashion, differentiates, horizontal and vertical line	Uses pronouns “I, you, me” discriminately	Tells first and last names when asked, gets a drink without help
3 years	Pedals tricycle, can alternate feet when going up stairs	Dresses and undresses partially, dries hands if reminded, draws a circle	Uses three-word sentences, uses plurals, past tense, knows all pronouns, minimum 250 words	Participates in group play; shares toys; takes turns; plays well with others; knows full name, age, and sex

Age	Gross Motor	Visual Motor	Language	Social
4 years	Hops, skips, alternates feet going downstairs	Buttons clothing fully, catches ball	Knows colors, says song or poem from memory, asks questions	Tells tall tales, plays cooperatively with a group of children
5 years	Skips, alternating feet; jumps over low obstacles	Ties shoes, spreads with knife	Prints first name, asks what a word means	Plays competitive games, abides by rules, likes to help in household tasks

*Note: This information comes from: Capute, AJ and Blehl, RF: Pediatr. Clin. North Am 20:3-25, 1973; Capute, AJ, et al.: Dev Med Child Neurol. In Press. 194: Capute. AJ and Accarco, PJ: Clin Pediatr 17: 847-853f, 1978.*

## Assessing Behavior and Mental Health

The federal EPSDT mandate requires regularly scheduled screens of all Medicaid-enrolled children to identify physical and mental health problems. To make early identification of behavioral and emotional problems easier and cost-effective for busy physicians, a screening questionnaire as part of routine primary care can be used to facilitate early recognition. Many regularly used tools are available in English and Spanish.

### Adolescent Maturation

Evaluation or referral to an appropriate specialist is indicated if the female patient has not reached the second stage of breast development by 13 years old or menarche by 16 years old.

Evaluation or referral to an appropriate specialist is indicated if the male patient has not reached the second stage of genitalia maturation by 13.5 years old.

### Pelvic Exams

Sexually active adolescents should be considered at risk for abnormal cervical cytology because it appears that early age of intercourse increases the risk for infection with human papillomavirus. Screening at yearly intervals is recommended through adolescence.

### STD Screening

All sexually active adolescents must be considered at high risk for most sexually transmitted diseases (STDs).

### Specific Tests

The most sensitive and specific tests for Chlamydia and gonorrhea are those involving deoxyribonucleic acid (DNA) or ribonucleic acid (RNA) amplification [ligase chain reaction (LCR) and polymerase chain reaction (PCR)]. Informed consent must be obtained from the individual. These tests are not an acceptable or reliable way to determine if an adolescent is sexually active.

Samples must be obtained from the endocervix or endourethra. Culture of urine for these organisms is unsatisfactory.

Antigen detection (ELISA or direct fluorescent antibody) for Chlamydia or gonorrhea is less sensitive than other methods.

Asymptomatic pyuria (WBC) can be detected using dipsticks for leukocyte esterase. Among sexually active adolescents, the likelihood of infection with an STD is increased when leukocyte esterase is detected. Subsequent evaluation to identify the etiology of the pyuria is indicated. Chlamydia urethritis must be considered when leukocyte esterase is identified in the urine of adolescent males.

## **HIV Testing**

Common HIV tests use protein products of the virus to detect antibodies produced by the infected host. The two antibody tests used most commonly are:

- Enzyme-Linked ImmunoSorbent Assay (ELISA)
- Western Blot

These tests are not 100 percent sensitive and require the production of antibody by the host and the absence of cross-reaching antibodies. Newer methodologies have been developed to divide HIV-1 tests into several groups:

- Virus culture techniques
  - Peripheral blood mononuclear cells (PBMC) co-culture for HIV-1 isolation
  - Quantitative cell culture
  - Quantitative plasma culture
- Antibody detection tests
- Antigen detection tests
- Viral genome amplification tests
- Immune function tests

False positive ELISA reactions generally result from cross-reaching antibodies, such as those against class II human leukocyte antigens that are most often observed in multiparous women or in a person who has received multiple units of transfused blood. A common misconception is that a false positive ELISA will always be corrected by the confirmatory Western Blot test.

The most important parameter when interpreting HIV tests is the positive predictive value. The probability of a positive test result occurring in a truly infected individual is critically dependent on the prevalence of HIV infection of the population tested. In testing HIV drug users from a major U.S. city in which the seroprevalence is 50 percent, the positive predictive value would approach 100 percent. Conversely, in screening female schoolteachers from a rural area where the seroprevalence is 0.01 percent, 50 percent of the women testing positive would have a false positive result. The likelihood of two false negative tests (ELISA and Western Blot) is very low, even in areas where seroprevalence is low.

## **Additional Coding Guidelines**

Table 7.2 lists codes that a provider might indicate on the claim for a HealthWatch/EPSDT visit or an associated lab service.

Table 7.2 – Additional Codes

Code	Code Definition
87076	GC culture
86592	VDRL
87110	Chlamydia
88150	PAP Smear

Providers should always use the most appropriate codes when submitting claims for services rendered.

## Substance Abuse Screening

Urine testing to establish drug abuse seems a tempting and objective means of overcoming the problems of denial, unreliable histories, and the less-than-clear-cut signs and symptoms. However, there are problems of sensitivity and specificity in urine screens. False negatives occur because of innocent confounding substances. The physician's role in substance abuse screening, through obtaining a history of the patient, is identification and referral.

## Anticipatory Guidance

At each screening visit, provide age-appropriate anticipatory guidance concerning such topics as the following:

- Auto safety – Car seats, seat belts, air bags, positioning young or lightweight children in the backseat
- Recreational safety – Helmets and protective padding, playground equipment
- Home hazards – Poisons, accidental drowning, weapons, matches and lighters, staying at home alone, use of detectors for smoke, radon gas, and carbon monoxide
- Exposure to sun and secondhand smoke
- Alcohol and tobacco use
- Substance abuse
- Adequate sleep, exercise and nutrition, including eating habits and disorders
- Sexual activity
- Peer pressure
- Immunization and blood testing as required

### **Anticipatory Guidance Regarding Lead Poisoning for Pregnant Women and Children 6 Years Old or Younger**

Pamphlets for use in offices, *Lead – Is Your Child at Risk?*, can be obtained from the ISDH by calling the Family Helpline at 1-800-433-0746.



## Section 8: Ruling Out Specific Conditions

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### Elevated Blood Lead

#### **Interpretation of Blood Lead Test Results and Follow-up Activities**

Interpretation of blood lead test results and follow-up of activities are grouped into different classes. Classifications of the child are based on blood lead concentration and listed below. Blood lead concentration is measured in micrograms of lead per deciliter of blood (ug/dl).

Table 8.1 – Blood Lead Concentration

Class	Blood Lead Concentration (ug/dl)	Comment
I	< or = 9	A child in Class I is not considered to be lead-poisoned.
IIA	10-14	A child in Class IIA may need to be re-screened more frequently.
IIB	15-19	A child in Class IIB should receive nutritional and educational intervention and be rescreened within one month. If the blood lead level persists in this range, environmental investigation and intervention should be done.
III	20-44	A child in Class III should receive environmental evaluation, remediation, and a medical evaluation. A child in this class may need pharmacologic treatment of lead poisoning. Rescreen the child within one week.
IV	45-69	A child in Class IV will need both medical and environmental interventions, including chelation therapy within 48 hours.
V	> or = 70	A child with Class V lead poisoning is a <b>medical emergency</b> . Medical and environmental management must begin <b>immediately</b> .

The Office of Medicaid Policy and Planning (OMPP) encourages providers to work with the Indiana Childhood Lead Poisoning Prevention Program (ICLPPP) and submit blood lead samples to one of the following laboratories:

- Vanderburgh County Department of Health
- Marion County Department of Health
- Indiana State Department of Health, located in Marion County

To find out where to send blood samples and for information on the ICLPPP, contact a local health department or the Indiana Family Helpline at 1-800-433-0746.

### Sickle Cell Anemia

Early detection of sickle cell is important, because oral prophylactic penicillin should be started by 2 months old to prevent life-threatening infections. Children with sickle cell should be immunized as

recommended by the American Academy of Pediatrics (AAP) immunization schedule. They should also receive pneumococcal vaccine at 2 years old.

For more information about sickle cell anemia, contact the Indiana Family Helpline at 1-800-433-0746.

## Tuberculosis

Information published by the AAP indicates that the most reliable tuberculosis control program is based on aggressive, expedient contact investigations, rather than routine skin test screening. The AAP recommends that all routine pediatric healthcare evaluations include assessment of risk of exposure to tuberculosis.

*Note: Only children deemed to have increased risk of exposure to persons with tuberculosis should be considered for tuberculin (Mantoux) skin testing.*

The frequency of such skin testing should be according to the degree of risk of acquiring tuberculosis infection, as detailed below. Routine tuberculin skin testing of children with no risk factors residing in low prevalence communities is not indicated.

Children for whom immediate skin testing is indicated:

- Children with contacts to persons with confirmed or suspected infectious tuberculosis, including contact to family members or associates in jail or prison in the last five years
- Children with radiographic or clinical findings suggesting tuberculosis
- Children immigrating from endemic areas, such as, Asia, Africa, the Middle East, and Latin America
- Children with travel histories to endemic countries or significant contact with indigenous persons from such countries

Children who should be tested annually for tuberculosis:

- Children infected with human immunodeficiency virus (HIV)
- Incarcerated adolescents

Children who should be tested every two to three years:

- Children exposed to the following individuals who are HIV-infected: homeless residents of nursing homes, institutionalized adolescents or adults, users of illicit drugs, incarcerated adolescents or adults, and migrant farm workers

Children who have no risk factors but who reside in high prevalence regions and children whose histories for risk factors are incomplete or unreliable should be considered for tuberculin (Mantoux) skin testing at 4 to 6 years old and 11 to 16 years old. The decision to test should be based on the local epidemiology of tuberculosis in conjunction with advice from regional tuberculosis control officials.

Family investigation is indicated whenever a tuberculin skin test result of a parent converts from negative to positive (indicating recent infection). Children of healthcare workers are not at increased risk of acquiring tuberculosis infection unless the workers tuberculin skin test results convert to positive or the workers have diagnoses of tuberculosis disease.

The skin test interpretation guidelines for indurations of 5, 10, and 15mm in diameter remain appropriate for decisions about contact investigations, tuberculosis control measures, and preventive therapy.

## Iron Deficiency Anemia

The purpose of screening for anemia is to uncover correctable nutritional anemia such as iron deficiency anemia.

### Standards for Further Evaluation

Diagnosis of anemia should be based on the doctor's evaluation of the child and a blood test. Children with 10 grams of hemoglobin or less (or a hematocrit of 30 percent or less) should be further evaluated for anemia.

For providers using charts to evaluate hemoglobin or hematocrit normals, it should be emphasized that average or mean Hb/B1 for age is not the level to determine anemia, but rather two standard deviations below the mean value.

Table 8.2 depicts the mean hematologic values for full-term infants, children, and adults and Table 8.3 provides the mean hematologic values for low-birth-weight infants.

Table 8.2 – Mean Hematologic Values for Full-Term Infants, Children, and Adults\*

Age	Hemoglobin (g/dl)	Hematocrit (%)	RBC 4 (10/UL)	MCV 3 (um)	MCH (pg)	MCHC (g/dl)
Birth (cord blood)	1.7 ± 1.8	52.0 ± 5	4.64 ± 0.5	113 ± 6	37 ± 2	33 ± 1
1 day	19.4 ± 2.1	58.0 ± 7	5.30 ± 0.5	110 ± 6	37 ± 2	33 ± 1
2-6 days	19.8 ± 2.4	66.0 ± 8	5.40 ± 0.7	122 ± 14	37 ± 4	30 ± 3
14-23 days	15.7 ± 1.5	52.0 ± 5	4.92 ± 0.6	106 ± 11	32 ± 3	30 ± 2
24-37 days	14.1 ± 1.9	45.0 ± 7	4.35 ± 0.6	104 ± 11	32 ± 3	31 ± 3
40-50 days	12.8 ± 1.9	42.0 ± 6	4.10 ± 0.5	103 ± 11	31 ± 3	30 ± 2
2-2.5 months	11.4 ± 1.1	38.0 ± 4	3.75 ± 0.5	101 ± 10	30 ± 3	30 ± 2
3-3.5 months	11.2 ± 0.8	37.0 ± 3	3.88 ± 0.4	95 ± 9	29 ± 3	30 ± 2
5-7 months	11.5 ± 0.7	38.0 ± 3	4.21 ± 0.5	91 ± 9	27 ± 3	30 ± 2
8-10 months	11.7 ± 0.6	39.0 ± 2	4.35 ± 0.4	90 ± 8	27 ± 3	30 ± 1
11-13.5 months	11.9 ± 0.6	39.0 ± 2	4.44 ± 0.4	88 ± 7	27 ± 2	30 ± 1
1.5-3 years	11.8 ± 0.5	39.0 ± 2	4.45 ± 0.4	87 ± 7	27 ± 2	30 ± 2
5 years	12.7 ± 1.0	37.0 ± 3	4.65 ± 0.5	80 ± 4	27 ± 2	34 ± 1
10 years	13.2 ± 1.2	39.0 ± 3	4.80 ± 0.5	81 ± 6	28 ± 3	34 ± 1
Men	15.5 ± 1.1	46.0 ± 3.1	5.11 ± 0.38			
Women	13.7 ± 1.0	40.9 ± 3	4.51 ± 0.36			
Men and women				90.1 ± 4.8	30.2 ± 1.8	33.7 ± 1.1

\* Mean + or - 1 Standard Deviation (SD)

*Note: This information is from Johnson TR How Growing Up Can Alter Lab Values in Pediatric Laboratory Medicine, Diag Med (Special Issue) 1982, 5 13-18.*

Table 8.3 – Mean Hematologic Values for Low-Birth-Weight Infants\*

Weight and Gestational Age at Birth	Age of Testing	Hemoglobin (g/dl)	Hematocrit (%)	Reticulocytes
<1.500 g. 28-32 weeks	3 days	17.5 ± 1.5	54 ± 5	8.0 ± 3.5
	1 week	15.5 ± 1.5	48 ± 5	3.0 ± 1.0
	2 weeks	13.5 ± 1.1	42 ± 4	3.0 ± 1.0
	3 weeks	11.5 ± 1.0	35 ± 4	-----
	4 weeks	10.0 ± 0.9	30 ± 3	6.0 ± 2.0
	6 weeks	8.5 ± 0.5	25 ± 2	11.0 ± 3.5
	8 weeks	8.5 ± 0.5	25 ± 2	8.5 ± 3.5
	10 weeks	9.0 ± 0.5	28 ± 3	7.0 ± 3.0
1.500-2.000 g. 32-36 weeks	3 days	19.0 ± 2.0	59 ± 6	6.0 ± 2.0
	1 week	16.5 ± 1.5	51 ± 5	3.0 ± 1.0
	2 weeks	14.5 ± 1.1	44 ± 5	2.5 ± 1.0
	3 weeks	13.0 ± 1.1	39 ± 4	-----
	4 weeks	12.0 ± 1.0	36 ± 4	3.0 ± 1.0
	6 weeks	9.5 ± 0.8	28 ± 3	6.0 ± 2.0
	8 weeks	9.5 ± 0.5	28 ± 3	5.0 ± 1.5
	10 weeks	9.5 ± 0.5	29 ± 3	4.5 ± 1.5
2.000-2.500 g. 36-40 weeks	3 days	19.0 ± 2.0	59 ± 6	4.0 ± 1.0
	1 week	16.5 ± 1.6	51 ± 5	3.0 ± 1.0
	2 weeks	15.0 ± 1.5	45 ± 5	2.5 ± 1.0
	3 weeks	14.0 ± 1.1	43 ± 4	-----
	4 weeks	12.5 ± 1.0	37 ± 4	2.0 ± 1.0
	6 weeks	10.5 ± 0.9	31 ± 3	3.0 ± 1.0
	8 weeks	10.5 ± 0.9	31 ± 3	3.0 ± 1.0
	10 weeks	11.0 ± 1.0	33 ± 3	3.0 ± 1.0

\*Mean + or - 1 SD

*Note: This information is from Johnson TR, How Growing Up Can Alter Lab Values in Pediatric Laboratory Medicine, Diag Med (Special Issue) 1982, 5 13-18.*

## Urinalysis Screening

### **Urinary Albumin and Sugar Testing and Referral Standards**

*Note: Tests for urinary albumin and sugar must be done on every child routinely at 5 years old or at every screen, if clinically indicated or not done previously.*

Dipsticks are acceptable for testing.

A positive test must be suitably followed up or referred for further care. A 1+ albumin (or trace) with no symptoms need not be referred, as it is not an unusual finding.

### **Bacteriuria Testing and Referral Standards**

Screening is recommended if there are symptoms related to possible urinary tract infections.



## **Appendix A: Periodicity and Screening Schedule**

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Every child and family is unique; therefore, this periodicity and screening schedule has been designed as a preventive healthcare plan for children with the absence of any significant health problems and who are growing and developing in satisfactory fashion. This schedule can be adjusted to meet the healthcare needs of specific patients.

This periodicity schedule reflects recommendations of the American Academy of Pediatrics (AAP) and those of the Medicaid Clinical Advisory Committee. It is meant to be a guide for IHCP providers participating in the HealthWatch/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. This program emphasizes the importance of early and periodic screening for specific conditions and the need for continued diagnosis and treatment of conditions and symptoms identified by practicing professionals through the use of this schedule.

The periodicity schedule has also been published in Indiana Administrative Code (IAC) 405 IAC 5-15-8 ([http://www.state.in.us/legislative/iac/iac\\_title?iact=405&iaca=5&submit=+Go+](http://www.state.in.us/legislative/iac/iac_title?iact=405&iaca=5&submit=+Go+)).

Every child and family is unique, therefore this Periodicity and Screening Schedule has been designed as a preventive health care plan for children with the absence of any significant health problems who are growing and developing in satisfactory fashion. **This Schedule may need to be adjusted to meet the health care need of specific patients.**

This Periodicity Schedule reflects recommendations of the American Academy of Pediatrics along with those of the Hoosier Healthwise Clinical Advisory Committee and is meant to be a guide for Indiana Medicaid Providers participating in the EPSDT – HealthWatch Program. This program emphasizes

The importance of early and periodic screening for specific conditions, as outlined below, and the need for continued diagnosis and treatment of conditions and symptoms identified by practicing professionals through the use of this Schedule.

	INFANCY <sub>3</sub>								EARLY CHILDHOOD <sub>3</sub>					MIDDLE CHILDHOOD <sub>3</sub>				ADOLESCENCE <sub>3</sub>					
	NEWBORN <sub>1</sub>	2-4d <sub>2</sub>	By 1mo	2mo	4mo	6mo	9mo	12mo	15mo	18mo	24mo	3y	4y	5y	6y	8y	10y	12y	14y	16y	18y	20y	
AGE <sup>4</sup>																							
HISTORY:INITIAL/INTERVAL	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
MEASUREMENTS																							
Height and Weight	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Head Circumference	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Blood Pressure																							
SENSORY SCREENING																							
Vision <sup>5</sup>	S	S	S	S	S	S	S	S	S	S	O <sub>5</sub>	O	O	S	S	O	O	S	S	O	S	S	
Hearing <sup>6</sup>	S/R	S	S	S	S	S	S	←	←	←	←	←	O	O	S	S	O <sub>6</sub>	O <sub>6</sub>	S	S	O <sub>6</sub>	S	
DEVELOPMENTAL <sup>7</sup>																							
BEHAVIOR ASSESSMENT	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
PHYSICAL EXAMINATION <sup>8</sup>	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
PROCEDURES – GENERAL																							
Immunization <sup>9</sup>	←	←	←	•	•	•	←	←	←	←	←	←	←	←	←	←	←	←	←	←	←	←	←
Lead Screening <sup>10</sup>							•	•	•	•	R	R	R	R	R	R	R	R	R	R	R	R	R
Hematocrit or Hemoglobin				←	←	←	←	←	←	←	←	←	←	←	←	←	←	←	←	←	←	←	←
Urinalysis																		←	←	←	←	←	←
PROCEDURES – PATIENTS																							
AT RISK																							
Tuberculin Test <sup>13</sup>								R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R
Sickle Cell Test <sup>14</sup>																							
Drug/HIV Testing <sup>15</sup>	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R
STD Screening <sup>16</sup>																		R	R	R	R	R	R
Pelvic Exam																		R	R	R	←	←	←
ANTICIPATORY GUIDANCE																							
Injury Prevention	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Dental Referral								←	←	←	←	←	←	←	←	←	←	←	←	←	←	←	←
Dental Observation <sup>18</sup>	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Newborn Infant Screen <sup>19</sup>	←	←	←	←	←	←	←	←	←	←	←	←	←	←	←	←	←	←	←	←	←	←	←

<sup>1</sup>Breastfeeding encouraged and supported.

<sup>2</sup>For newborns discharged in less than 48 hours after delivery.

<sup>3</sup>Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.

<sup>4</sup>If a child comes under care for the first time at any point on this schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.

<sup>5</sup>If the patient is uncooperative, re-screen within six months. If objective vision methods indicate, refer to optometrist/ophthalmologist.

<sup>6</sup>Not to be duplicated if done in school system.

<sup>7</sup>By history and appropriate physical examination: if suspicious, by specific objective developmental testing.

<sup>8</sup>At each visit, a complete physical examination is essential, with infant totally unclothed, older child undressed and suitably draped.

<sup>9</sup>According to the schedule currently recommended by the American Academy of pediatrics. Every visit should be an opportunity to update and complete a child's immunizations.

<sup>10</sup>Blood lead screening, as recommended by the AAP at indicated intervals and for patients at risk.

<sup>11</sup>All menstruating adolescents should be screened.

<sup>12</sup>A dipstick urinalysis for leukocytes for male and female adolescents.

<sup>13</sup>Only children deemed to have increased risk of exposure to persons with tuberculosis should be considered for tuberculin (Mantoux) skin testing. The frequency of skin testing should be according to the degree of risk.

<sup>14</sup>Should be performed on time only, when critically indicated, or if not done in the newborn screen.

<sup>15</sup>Should be done on newborns and annually for those at risk, with patient/parent consent.

<sup>16</sup>All sexually active patients should be screened for sexually transmitted diseases (STDs).

<sup>17</sup>All sexually active females should have a pelvic examination. A pelvic exam and routine pap smear should be offered between the ages of 18 and 21 as part of an active preventive health plan.

<sup>18</sup>Dental referral may include fluoride treatments.

<sup>19</sup>Must be done 48 hours after birth.

Please consult the *HealthWatch Early and Periodic Screening, Diagnosis, and Treatment Program Provider Manual* for immunization schedules and risk factor definitions.

Key: • = to be performed R = to be performed on patients at risk S = subjective, by history O = objective, by standard testing method  
 ← → = range during which a service may be provided, with the dot or number indicating the preferred age.

Figure A.1 – HealthWatch/EPSDT Periodicity and Screening Schedule per the IAC Supplement for 2000

## **Appendix B: Summary of HealthWatch/EPSTD Codes (not all inclusive)**

Table B.1 – Diagnosis Codes

Diagnosis Code	Code Description
V20.2	Routine infant or child health check

Table B.2 – Visit Codes

Age	Initial Patient Exam	Established Patient Exam
Younger than 1 year	99381	99391
1 to 4 years	99382	99392
5 to 11 years	99383	99393
12 to 17 years	99384	99394
18 to 20 years	99385	99395

Table B.3 – Common Immunization/Screens

Code Type	Code Definition
80100	HIV/AIDS
81000	Urinalysis with microscopy
81002	Urinalysis without microscopy
85660	Sickle cell test
86580	TB Mantoux
90645	HIB, HBOC*
90647	HIB, PRP-OMP*
90648	HIB, PRP-T*
90669	Pneumococcal conjugate, polyvalent
90700	DtaP*
90701	DTP
90702	Tetanus-Diphtheria (DT)*
90707	MMR*
90713	Polio – IPV*
90716	Varicella (chicken pox)*
90718	Tetanus-Diphtheria (adult) Td*
90720	DTP – Hib
90721	DTaP/Hib*
90737	Haemophilus Influenza B
90744	Hepatitis B, newborn to 11 years*

Code Type	Code Definition
90745	Hepatitis B, 11 to 19 years*
90746	Hepatitis B, 20 years and older
90747	Hepatitis B, Dialysis or immunosuppressed, patient any age
90748	HEP B-Ped-Hib*
92551	Audiometry testing
90655, 90656, 90657, 90658, 90660	Influenza*
90734	Menactra*
90649	Human Papillomavirus (HPV) *

\*VFC - Available

Table B.4 – Codes for Providers without In-House Laboratories

Procedure Code	Code Description
36415	Venipuncture/finger stick
99000	Conveyance fee to send samples to lab
99001	Conveyance fee from other than a physician's office

Table B.5 – Additional Codes for Providers with In-House Laboratories

Procedure Code	Code Description
83655	Blood lead*
85013, 85014	Hematocrit
85018	Hemoglobin
85660	Sickle cell

\* Only when tested on an atomic absorption spectrophotometer (AAS)

Table B.6 – Most Common Diagnosis Codes on HealthWatch/EPSTD Claims

Diagnosis Code	Diagnosis Code Description
V20.2	Well child care
079.9	Viral syndrome
0088	Viral enteritis NOS
0340	Strep sore throat
460.0	Acute nasopharyngitis
461.9	Sinusitis
462.0	Acute pharyngitis
463	Acute tonsillitis

<b>Diagnosis Code</b>	<b>Diagnosis Code Description</b>
465.9	Acute respiratory infection
466.0	Bronchitis
477.0	Allergic rhinitis
558.9	Gastroenteritis
692.9	Eczema or dermatitis
780.6	Fever of unknown origin
789.0	Abdominal pain
3829	Otitis media NOS
4660	Acute bronchitis
6910	Diaper or napkin rash
6918	Other atopic dermatitis
7821	Nonspecific skin erupt NEC
7862	Cough
31400	Attn defic nonhyperactive
31400	Attn defic w/hyperactivity
37200	Acute conjunctivitis NOS
38100	AC non sup otitis med NOS
38200	AC supp om w/out drum rupt
49390	Asthma
53081	Esophageal reflux
56400	Unspecified constipation
78791	Diarrhea



# Appendix C: CMS-1500 Claim Form

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<b>HEALTH INSURANCE CLAIM FORM</b> <small>APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05</small>																																																																																																																																																																																															
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Figure C.1 – CMS-1500 Form



## Appendix D: Children's Programs in Indiana

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### Health-Related Programs

For information about the programs listed in this Appendix, call the Indiana Family Helpline at 1-800-433-0746.

### Indiana Health Coverage Programs

For a complete list of programs covered and contact information for the Indiana Health Coverage Programs (IHCP), refer to the *Indiana Health Coverage Programs Quick Reference* available on the IHCP Web site at [http://www.indianamedicaid.com/ihcp/Misc\\_PDF/Quick\\_Reference.pdf](http://www.indianamedicaid.com/ihcp/Misc_PDF/Quick_Reference.pdf), or in the IHCP Provider Monthly Newsletters. For more information, visit the Web site at [www.indianamedicaid.com](http://www.indianamedicaid.com).

#### ***Hoosier Healthwise (Medicaid and Children's Health Insurance Program)***

##### **Medicaid**

Any recipient of Temporary Assistance for Needy Families (TANF) is eligible for Medicaid (Title XIX). In addition, pregnant women, infants, and children 1 to 18 years of age with family incomes under 150 percent of the federal poverty level (FPL) are eligible for Medicaid. Claims are submitted to the appropriate IHCP delivery system.

##### **Children's Health Insurance Program**

The Children's Health Insurance Program (CHIP) is the State's program under *Title XXI* of the *Social Security Act* to provide healthcare coverage for children from birth through 18 years of age using a buy in option. Claims for services are submitted to the appropriate IHCP delivery system.

##### **Care Select**

The Indiana *Care Select* program is designed to improve the member's health status; enhance quality of life; improve client safety, client autonomy, and adherence to treatment plans; and control fiscal growth. Through this program, the State will focus on the following objectives:

- Development of treatment regimens for chronic illnesses will conform to evidence-based guidelines.
- Primary care providers will be able to incorporate knowledge of functional assessments, behavioral changes, self-care strategies, and methods of addressing emotional or social distress into overall patient care.
- Care will be less fragmented and more holistic (for example, care will address the physical and behavioral care needs as well as consider both medical and social needs), and communication will increase across settings and providers.
- Members will have greater involvement in their care management.

## **HealthWatch/EPSDT**

HealthWatch is the federally mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program for IHCP Medicaid members younger than 21 years old and CHIP members younger than 19 years old. All IHCP-covered preventive, diagnostic, and treatment services are provided, as well as other treatment services that are determined to be medically necessary by the EPSDT screening provider and prior authorized as required. Prior authorizations and claim submission must be within the delivery system that the member is enrolled at the time of service.

## **Medicaid Rehabilitation Option**

Medicaid Rehabilitation Option (MRO) services are clinical mental health services provided to individuals, families, or groups of people who live in the community and need care intermittently for an emotional disturbance or mental illness. IHCP reimbursement is available for mental health rehabilitation option services when those services are provided by a mental health center that is enrolled as an IHCP provider and complies with applicable federal, state, and local laws concerning operation of community mental health centers.

## **Waiver Program**

Waiver program applicants must contact the Area Agency on Aging (AAA) or bureau of developmental disabilities (BDDS) that serves their county of residence, and the AAA case manager completes the intake and application forms within 15 days. The applicant is then put on a waiting list. When the Medicaid Waiver Unit informs the case manager that a slot is open, the manager notifies the applicant within three days. The case manager schedules an evaluation and physical examination within seven days of the notification date.

Providers are enrolled with the IHCP and claims are processed through the IHCP.

## **Prenatal Care Coordination**

Prenatal care coordination is an active, ongoing process of assisting an individual with identification, access, and use of community resources and coordination of services to meet individual needs for pregnancy services. This includes locating service sources, making appointments for services, arranging transportation to services, and following up to verify appointments or reschedule appointments for women in the IHCP whose pregnancies are at risk for low birth weight or poor pregnancy outcome.

Pregnant women who are enrolled with a managed care organization (MCO) and are identified by the Notification of Pregnancy (NOP) to be high-risk patients because of medical or psychosocial conditions may also receive pregnancy care coordination and case management services through their MCO.

## **HIV Care Coordination**

Human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) care coordination is a specialized form of case management for members with HIV infection. Care coordination consists of goal-oriented activities that locate or create, facilitate access to, coordinate, and monitor the full range of HIV-related health and human services. The purpose is to encourage the cost-effective use of medical and community resources and to promote the well being of an individual while ensuring the individual's freedom of choice. To ensure freedom of choice, the individual signs a

*Freedom of Choice/Intent to Participate Form* acknowledging an understanding of the services provided and identifying the chosen care coordination provider. Care coordination services are those that assist Traditional Medicaid-eligible people from the targeted group to access needed medical, psychological, social, educational, and other services.

To be eligible for reimbursement for care coordination, a member must be a Traditional Medicaid member and have a documented HIV infection. There must be medical documentation or verification of medical diagnosis of HIV infection in the member's care coordination file. The diagnosis can be verified with the following types of documentation:

- Confidential, positive HIV test result
- A physician's statement
- Hospital discharge statement or other medical reports that verify the diagnosis
- Medical prescription for AZT, ddI, or ddC, or copy of approval for participation in the AIDS Drug Assistance Program (ADAP) or the Early Intervention Program (EIP)

### ***Family Planning***

Family planning services available under IHCP provide physical exams, family planning counseling, and contraceptive supplies on a self-referral basis. For more information, refer to the IHCP Provider Manual on the Web site at [www.indianamedicaid.com](http://www.indianamedicaid.com).

## **Indiana Family and Social Services Administration Health-Related Programs**

### ***Hoosier Assurance Plan***

This plan is administered by the Division of Mental Health and Addiction (DMHA). Children and youths are eligible for enrollment in the Hoosier Assistance Plan (HAP) if they have a psychiatric diagnosis, functional impairment (as identified through the use of a DMHA-approved assessment tool), and family income at or below 200 percent of the FPL. Throughout the year, providers submit names of eligible individuals for enrollment through the DMHA Community Services Data System (CSDS). DMHA pays providers a risk-adjusted case rate per individual enrolled, up to the maximum contract amount for each enrolled population. In turn, providers are responsible for making available to the enrolled individual a full range of psychiatric services.

For more information, visit the Web site at <http://www.in.gov/fssa/dmha/4409.htm>.

### ***Substance Abuse Services (Substance Abuse Services)***

Certified substance abuse treatment services can be provided to children with a Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) diagnosis when the family income is at or below 200 percent of the FPL. When funding is available, services can begin within one week after eligibility determination. Treatment includes planning, crisis intervention, case management, outpatient and intensive outpatient, acute stabilization including detoxification, residential, day treatment, medical evaluation, and family support services. If funds are not allocated or are depleted during the fiscal year, a wait list is available.

For more information, visit the Web site at <http://www.in.gov/fssa/dmha/4409.htm>.

## **Alcohol, Tobacco, and Other Drug Prevention Services**

Prevention providers are state agencies and community-based, not-for-profit agencies under contract with the Division of Mental Health and Addiction (DMHA).

Teen and middle level leadership training is available through the Juvenile Justice Task Force, Inc.

After-school substance abuse prevention programs are provided for youth 10 through 14 years of age from 3 p.m. to 6 p.m. in the winter months, and from 12 p.m. to 6 p.m. in the summer. *Focused* prevention programs, such as normative education about drug use, and *supportive* prevention programs, such as after-school tutoring, are among the categories of service made available by providers for selection by parents and children.

The Indiana Prevention Resource Center (IPRC) provides the Regional Alcohol and Drug Awareness Resource site for prevention providers. The PRC maintains a Web site at <http://www.drugs.indiana.edu>.

The state requires after-school program contractors to acquire specified levels of competence from prevention providers. An independent, not-for-profit organization, the Indiana Prevention Professionals, Inc., coordinates courses for individuals to acquire credentials as prevention professionals. Courses are offered at Ball State University, Indiana University, Indiana University-Purdue University Indianapolis, and Purdue University. Distance learning is available through Western Kentucky University and Ball State University.

### **First Steps**

Children up to 3 years of age with potential developmental delay may be eligible for First Steps. This program is not income-based but diagnosis-related. First Steps uses the Individualized Family Service Plan (IFSP) to authorize services. For more information, visit the Web site at <http://www.in.gov/fssa/ddrs/2633.htm>.

## **Indiana Division of Family Resources Health-Related Programs**

### **Healthy Families**

Healthy Families Indiana is a voluntary home visitation program designed to promote healthy families and healthy children through a variety of services, including child development, access to health care, and parent education.

For more information, visit the Web site at <http://www.in.gov/dcs/2459.htm>.

## **Indiana State Department of Health Programs**

For a complete list of Indiana State Department of Health (ISDH) programs, refer to the ISDH Web site at [www.in.gov/isdh](http://www.in.gov/isdh).

## **Maternal and Child Health**

Maternal and Child Health (MCH) is a program funded by a block grant. Local service providers consist of health departments, not-for-profit agencies, hospitals, and social services agencies. MCH programs include primary care medical services, well-baby services, well-child services, immunizations, treatment for minor illnesses, and referral for complicated or chronic illness. Clients can also receive social services and nutritional counseling as needed.

MCH programs are available to all women and children; however, the program targets women of childbearing age, families with incomes less than 250 percent of the FPL, and those who do not have access to healthcare. If family income is less than 100 percent of the FPL, services are free. Many MCH providers have agreements with Hoosier Healthwise PMPs to provide services to Hoosier Healthwise managed care members.

MCH manages the toll-free Indiana Family Helpline referral service from the offices of the ISDH. Hoosiers may call this toll-free number to find out where health and social services are available and request assistance in scheduling appointments or transportation services. MCH provides training for prenatal substance abuse prevention, education for care coordinators, and education for prevention of childhood lead poisoning.

For more information, contact the Indiana Family Helpline at 1-800-433-0746 or, visit the Web site at <http://www.in.gov/isdh/19571.htm>.

## **Children's Special Health Care Services**

Under ISDH's Maternal and Child Health program, the Children's Special Health Care Services (CSHCS) serves persons from birth to 21 years old. The current financial eligibility standard for the program is at or below 250 percent of the federal poverty level. CSHCS provides a basic package and a limited service package to help meet the needs of CSHCS clients. The basic package for medically and financially eligible children includes primary care, such as preventive care, immunizations, and sick child care. It also includes routine dental care and the provision of prescription medication. The limited service package consists of services that must be related to the child's eligible medical condition(s).

CSHCS has provider agreements with primary, specialty and dental providers throughout Indiana to provide direct services. The CSHCS Program uses the Medicaid rates for reimbursement for services. Benefits are coordinated among the CSHCS, Hoosier Healthwise, and First Steps programs for children that are eligible for two or more of these programs.

For more information, visit the Web site at <http://www.in.gov/isdh/19613.htm>.

## **Special Supplemental Program for Women, Infants, and Children**

The county Women, Infants, and Children (WIC) offices administer this program. The purpose of WIC is to improve participants' health and quality of life by providing nutrition education and counseling, medical and social referrals, and supplemental food to eligible women and children. To qualify for WIC, participants must meet the following three criteria:

- Be an Indiana resident
- Have an income at or below 185 percent of the FPL
- Be at medical or nutritional risk

Participants are limited to pregnant women, breastfeeding women up to one year after delivery, postpartum women up to six months after delivery, infants, and children younger than 5 years old.

For more information, visit the Web site at <http://www.in.gov/isdh/19691.htm>.

### **Immunization Program**

The immunization program is an ISDH program operated through 94 local health departments, 71 public health clinics, and about 1,000 primary care physicians. Eligibility is determined by the parent or guardian's completion of the *Vaccine Administration Consent Form* and, if applicable, the *Vaccines for Children (VFC) Eligibility Form*.

For more information, visit the Web site at <http://www.in.gov/isdh/17190.htm>.

### **Vaccines for Children Program**

The federal Vaccines for Children (VFC) Program supplies, at no charge, vaccines against various childhood diseases to VFC-enrolled providers. All Hoosier Healthwise and Medicaid enrollees ages 18 years and younger are eligible to receive the free VFC vaccines. Providers that are not currently a VFC provider, but are interested in becoming a VFC provider, can contact the Indiana State Department of Health through the Family Helpline. For more information, visit the Web site at <http://www.state.in.us/isdh/>.

For additional information regarding VFC, visit the national Web site at <http://www.cdc.gov/vaccines/programs/vfc/default.htm>.

### **Teen Pregnancy Prevention and Indiana RESPECT**

Indiana Reduces Early Sex and Pregnancy by Educating Children and Teens (RESPECT) is a program funded by Maternal and Child Health under the ISDH. Fund grantees provide sexual abstinence education and adolescent pregnancy prevention education. This education follows specific federal and state guidelines.

For more information, visit the Web site at <http://www.indianarespect.com/> or <http://www.in.gov/isdh/21045.htm>.

### **Family Planning**

Family planning through the Maternal and Child Health (Title V Indiana Family Health Council – IFHC) and Title X federal funding provides physical exams, family planning counseling, and contraceptive supplies. Ancillary services include nutritional assessment and counseling, psychosocial assessment, counseling and referral, and health education on a variety of topics, such as breast self-exam, sexually transmitted diseases, substance abuse prevention, smoking cessation, folic acid, and so forth.

The target population is low-income (less than 250 percent of the FPL) women of childbearing age, primarily ages 15-44 years. Family planning services are also available through the Medicaid program as a self-referral service.

For more information, visit the Web site at <http://www.in.gov/isdh/21043.htm>.

### **Indiana Perinatal Network**

The Indiana Perinatal Network (IPN) is a nonprofit organization with an advisory board that includes staff from the ISDH and the Family and Social Services Administration (FSSA), as well as the March of Dimes and Maternal and Child Health and Institute of Federal Health Care (IFHC) funding. IPN administers the *Baby First* media campaign and participates in professional development activities in the area of perinatal health. An IPN newsletter and online magazine provide information to promote healthier mothers and babies. IPN monitors the ISDH's outcome measures for low birth weight babies and infant mortality to evaluate the effectiveness of outreach efforts.

For more information, visit the Web site at <http://www.in.gov/isdh/21052.htm>.

### **Prenatal Substance Use Prevention Program**

The Prenatal Substance Use Prevention Program (PSUPP) is a three-tier prevention program administered by the Indiana State Department of Health and funded by the Indiana Division of Mental Health, the Indiana Tobacco Prevention and Cessation Program, and the Maternal and Child Health Services. The goal of this program is to prevent poor birth outcomes, by ensuring that babies born in Indiana are born to women who decrease or eliminate alcohol, tobacco and other drug use during pregnancy.

For more information, visit the Web site at <http://www.in.gov/isdh/22241.htm>. Brochures are available through ISDH and the Web site.

### **Sunny Start**

The Sunny Start Program, formerly Early Childhood Comprehensive Systems (ECCS), is funded by the Maternal and Child Health Bureau. The goal of the project is to support a coordinated system of resources and supports for young children from birth to 6 years and their families in Indiana. The program's five focus areas are access to health insurance and a primary medical provider, mental health and socio-emotional development, early care and education, parent education, and family support.

For more information, visit the Web site at <http://www.in.gov/isdh/21190.htm>.

## **Other Health-Related Programs for Targeted Populations**

### **Indiana Minority Health Coalition**

The Indiana Minority Health Coalition (IMHC) comprises local minority health coalitions in the following counties and areas: Allen, Delaware, Elkhart, Grant, Howard, Lake, LaPorte, Madison, Marion, St. Joseph, Tippecanoe, tri-county of southern Indiana, Vanderburgh, Vigo, and Wayne. The IMHC operates under the ISDH and was created to improve the health status of at-risk Indiana racial minorities. This statewide network of coalitions promotes healthy lifestyles through local disease prevention, health awareness, referral and information resources, and community outreach and program services. The IMHC also maintains a central registry of immunization records and makes this information available via a toll-free telephone line. The Minority Health Coalition collaborates with Hoosier Healthwise to enroll children in Indiana.

For more information, visit the Web site at <http://www.imhresource.org/>.

### **Northwest Indiana Healthy Start**

Northwest Indiana Healthy Start is a northwest Indiana Health Department Cooperative program funded by a federal grant. Services are provided in the following cities: East Chicago, Gary, Hammond, and Lake Station. The services include:

- Case management
- Community outreach and care coordination
- Health education
- Transportation
- Prenatal and postpartum medical referral and care
- Pregnancy testing

Services are provided to pregnant women, postpartum women, and infants up to 1 year of age. Several health education classes are offered including the following:

- Prenatal and postpartum care
- Infant development
- Smoking cessation
- Contraception
- Breastfeeding
- Parenting
- Lamaze childbirth techniques

Healthcare for infants up to 1 year is provided through an agreement with child healthcare providers, including several Maternal and Child Health clinics and hospital clinics.

For more information contact the following:

**Healthy Start Project Administration**  
7854 Interstate Plaza Dr.  
Hammond, IN 46324  
[www.nwihs.com](http://www.nwihs.com)  
Telephone: (219) 989-3939  
E-mail: [lhatch@nwihs.com](mailto:lhatch@nwihs.com)

### **Indianapolis Healthy Start**

Indianapolis Healthy Start is a program of the Marion County Health Department, funded by the Health Resources and Services Administration, to lower the numbers of babies who die each year in Marion County.

There are three main services that make up Indianapolis Healthy Start:

- *Case Management:* Similar to care coordination, Healthy Start case managers work one-on-one with pregnant women until the child is 2 years old. During this time, Healthy Start case managers help families access important medical and social resources. Case managers also help pregnant moms understand the importance of a proper diet, prenatal care, smoking cessation, breastfeeding, and others. Healthy Start case managers can screen mothers for postpartum depression and link them to services if needed.
- *Health Education:* Have you ever had questions about feeding your baby? What about questions about child development? Healthy Start has many education classes across the city to help answer

some of these questions. The classes are free and open to anyone interested in learning more: moms, dads, aunts, grandmothers, caregivers, and so forth.

- *Outreach:* The purposes of Healthy Start outreach services are two-fold. The first purpose is to raise community awareness about issues related to infant health. The Healthy Start outreach worker speaks to numerous groups on such topics as folic acid, family planning, breastfeeding, teen pregnancy, safe sleep, and many others. The second purpose is to help pregnant women receive prenatal care and access other needed health services.

To contact Indianapolis Healthy Start, call (317) 221-2317, or for more information visit the Web site at <http://www.mchd.com/mch.htm>.

### **Wishard Hispanic Health Project**

The Wishard Hispanic Health Project offers health services to low-income Hispanics. This program collaborates with Hoosier Healthwise for outreach and children's enrollment.

For more information, visit the Web site at <http://www.wishard.edu/hispanic.html>.

### **Hispanic Center**

The Hispanic Center offers information and referrals to healthcare, WIC, immunizations, and dental care for Hispanic women who are of reproductive age, expecting, or with school-aged children. Call the Hispanic Education Center at (317) 634-5022 for more information.

### **Black and Minority Health Fair**

The Black and Minority Health Fair is presented by ISDH. This health fair is the "largest health fair focusing on minority health issues" in the United States. The annual Black and Minority Health Fair's objective is to improve the health of minorities throughout Indiana and surrounding states by providing health screenings and education information. Each participant has the opportunity to receive medical screenings as well as health information and education at no charge.

For more information, visit the Web site at <http://www.in.gov/isdh/23411.htm>.

## **Other Types of Assistance Programs**

### **Food Stamps**

Food stamps are available through the county offices of the Division of Family Resources. Eligibility is determined through an interview with the applicant or the applicant's representative regarding relevant financial and nonfinancial information. Interviews can be face-to-face or by telephone. Financial eligibility is based on the evaluation of income and assets. The net income eligibility standard is equal to 100 percent of the FPL. Nonfinancial eligibility requirements include citizenship or legal alien status, state residency, the presence of a Social Security number, and cooperation with employment and training requirements.

For more information, visit the Web site at <http://www.in.gov/fssa/dfr/2691.htm>.

## **Free and Reduced School Breakfast and Lunch Programs**

The Division of School and Community Nutrition Programs contracts with school corporations and child care centers to participate in the Child Nutrition Programs. Contractor entities provide each household with an application for free or reduced-price meal benefits. Services to eligible participants include the National School Lunch Program, the School Breakfast Program, Special Milk Program, Food Distribution Program, and Supplemental Food Program (Child and Adult Care Food Program only).

## **Child Care Development Fund Voucher Program**

Child Care Development Fund (CCDF) Voucher Program is administered at the county level through voucher agents. TANF recipients are eligible by virtue of their TANF status; other applicants must establish a need for the service. Large waiting lists exist, primarily in urban areas. Waiting lists occur due to a lack of funding in a specific county.

For more information, visit the Web site at <http://www.in.gov/fssa/carefinder/>.

## **School-Age Child Care**

CCDF provides childcare to low-income families locally through voucher agents. TANF recipients are eligible by virtue of their TANF status; other applicants must establish a need for the service.

For more information, visit the Web site at <http://www.in.gov/fssa/carefinder/>.

## **Special Education Preschool**

The following public or private entities have direct or delegated authority to provide special education and related services:

- Public school corporations operating programs individually or cooperatively with other school corporations
- State developmental centers and hospitals operated or supported by the Division of Mental Health or Division on Developmental Disabilities of the FSSA
- State schools and programs operated by the ISDH
- Programs operated by the Department of Correction
- Private schools and facilities that serve students referred or placed by a public school corporation, the Division of Special Education (IDOE), or the Division of Family Resources (DFR)

Special education is specially designed instruction, provided at no cost to the parent, to meet the unique needs of a student, and may include the following:

- Classroom instruction
- Community-based instruction
- Instruction in hospitals, nursing homes, or other institutions
- Homebound or home-based instruction
- Instruction in physical education, vocational education, or speech-language therapy

Related services include, but are not limited to the following:

- Assistive technology devices and services
- Audiological services
- Counseling, early identification
- Medical services for evaluation
- Occupational therapy
- Parent counseling and training, physical therapy, psychological services
- Recreation
- School health services
- Social work services in schools
- Transportation
- Rehabilitation counseling

Eligible students must have one of the following disabilities and need special education and related services:

- Autism
- Communication disorder
- Dual sensory impairment
- Emotional handicap
- Hearing impairment
- Learning disability
- Mental handicap
- Multiple handicap
- Orthopedic impairment
- Other health impairment
- Traumatic brain injury
- Visual impairment

Early childhood special education services are limited to students 3 to 5 years old who meet the State's early childhood criteria and are suspected of having one of the disabilities listed. Special education is provided for all students between 3 and 22 years old.

For more information, visit the Web site at <http://www.in.gov/fssa/carefinder/>.

For information on Exceptional Learners and transition from First Steps to in school services, visit the IDOE Web site at <http://www.doe.state.in.us/exceptional/TaskForce.html>.

For information regarding vocational rehab assistance for transition from exceptional learners school programs, visit the Vocational Rehabilitation Web site at <http://www.in.gov/fssa/ddrs/2636.htm>

## **Head Start**

The Department of Health and Human Services (HHS) contracts directly with local grantees for Head Start programs. All grantees must be private, nonprofit entities with proven records of fiscal accountability that enforce the federally established Head Start performance standards and policies. All 92 Indiana counties have grantees for a 3-to-5-year-old program. Only new grantees may be funded for Early Head Start, the program for infants and toddlers, 0-to-3-years old. Head Start programs provide services as defined in the federal performance standards. These services normally involve the following:

- Developmentally appropriate early childhood education
- Health and nutrition services
- Social services
- Family literacy programs
- Parent involvement, education, and leadership opportunities
- Disability services
- Transportation for children

Most programs have a waiting list with numbers varying from county to county.

For more information, visit the Web site at <http://www.in.gov/fssa/dftr/2679.htm>.

## **Temporary Assistance to Needy Families**

County offices of the DFR administer the Temporary Assistance to Needy Families (TANF) program that provides temporary cash assistance to eligible families. Eligibility is determined through an interview with the applicant or applicant's representative regarding relevant financial and nonfinancial information. The average time for processing an application is approximately 20 calendar days. Cash assistance is provided to eligible families with dependent children in the home who are younger than 18 years old. Employment and training services are also provided to promote self-sufficiency of the child's parent or caretaker in the home.

For more information, visit the Web site at <http://www.in.gov/fssa/dftr/2684.htm>.

## **Public Information Resources**

### **Indiana Family Helpline**

The Indiana Family Helpline is a statewide information and referral service that assists in promoting and facilitating access to Maternal and Child Health (MCH), Women, Infants and Children (WIC), Children's Special Health Care Services (CSHCS), and other state programs. The Indiana Family Helpline number is 1-800-433-0746.

Helpline communication specialists are trained to provide callers with information and assistance on the following programs:

- IHCP, including information on eligibility determination, service delivery location, appointment scheduling, arranging transportation for Medicaid, Hoosier Healthwise, HealthWatch/EPSDT, *Care Select*, and Medicaid waiver services

- All ISDH programs, including MCH and CSHCS
- First Steps
- Step Ahead
- Day care centers
- Prenatal care providers
- Homes for pregnant teens
- Car seat loan
- Developmental screening
- Support groups for adolescents
- Community and Home Option to Institutional Care for the Elderly and Disabled program (CHOICE)
- Respite care
- Children in Need of Services (CHINS)
- Financial assistance

The following *special campaigns* have displayed the toll-free number in brochures, television advertisements, and so forth:

- Building Bright Beginnings
- 1-800-BABY (Healthy Start)
- CHIP and HealthWatch/EPSDT
- Ask for the Sake of our Kids
- Cancer
- Indiana perinatal prevention
- Folic acid
- Osteoporosis prevention
- Lead poisoning program
- WIC

Information about callers is sent to the coordinator of each of the programs.

For more information, visit the Web site at <http://www.in.gov/isdh/21047.htm>.

### **Indiana Black Expo**

Since 1998, Indiana Black Expo, Inc., (IBE) has worked in collaboration with many agencies to market and promote the Hoosier Healthwise for Children Program. IBE is a nonprofit community service organization that serves as a channel for communications and a catalyst for greater harmony within communities throughout Indiana and the nation. Today, IBE has grown from a single annual event to a year-round, multifaceted community service organization. IBE sponsors major programs and year-round events including the Youth Video Institute (YVI), Father-to-Father, Cool-n-Smart, We Can Feed The Hungry Program, Project Soar, and an annual scholarship program.

For more information, visit the Web site at <http://www.indianablackexpo.com/>.

## Other Resource Programs

### ***Bright Futures***

Bright Futures is a national health promotion initiative dedicated to the principle that every child deserves to be healthy and that optimal health involves a trusting relationship between the health professional, the child, the family, and the community as partners in health practice. The tools were developed through a partnership between Bright Futures at Georgetown University and the [National Technical Assistance Center for Children's Mental Health](#) with funding from the Child, Adolescent and Family Branch, [Center for Mental Health Services](#), [Substance Abuse and Mental Health Services Administration](#) and with [significant contributions](#) by many other dedicated professionals.

For more information, visit the Web site at <http://www.brightfutures.org/>.

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