

D.C. DEPARTMENT OF HEALTH

Health



Check

MEDICAL ASSISTANCE ADMINISTRATION

MANUAL

(Formerly Early and Periodic Screening Diagnosis and Treatment)

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PREFACE

This manual contains information on Early and Periodic Screening, Diagnosis and Treatment (HEALTHCHECK) coverage, limitations, and billing and reimbursement procedures for participating District of Columbia HealthCheck Medicaid well-child primary care providers (PCPs) and their health care staff. It is presented in a three-ring notebook so that providers can keep the manual current with child health information provided by the Department of Health, Medical Assistance Administration (MAA). Each section of the manual stands alone and may be changed in whole or in part at any time. All providers will receive a copy of this manual and copies of all updates, transmittals and other information in a timely manner.

Some of the provisions in the manual are mandatory and are stated as such. The revised manual includes a new numbering system to make it easier for providers to insert new information as it is issued. Most information will be in the form of transmittals. An update may be a change, addition, or a correction of policy; it may be either a dated pen-and-ink revision or a correction page or section. The Appendix will contain additional child health transmittals. It is very important that providers read all updated materials and file them in the manual. To determine if all updates to the handbook have been received, providers should use the *Update Log on page x*.

Providers should use the Revision Index in the HealthCheck Medical Provider Billing Manual (Appendix I) for all updates pertaining to billing and reimbursement issues.

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The following are a list of organizations and agencies that participated in the development of this manual:

Department of Human Services Income Maintenance Administration
Office of Early Childhood Development
Early Intervention Office
District of Columbia Public Schools
Public Benefit Corporation
Children's National Medical Center
Center for Mental Health
Department of Health Divisions of Immunization, Office of Maternal and Family Health, Office of Sexually Transmitted Disease, Bureau of Tuberculosis Control
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As always, the content of this manual is based on the information available at time of publication and will be reviewed periodically.

Section 1

BACKGROUND AND GENERAL INFORMATION

Section 1.1

What Is the HealthCheck Program?

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program was created by Congress in 1967 as part of the Medicaid program. In the District of Columbia, EPSDT is known as the HealthCheck Program. Federal legislation requires states to make available to all Medicaid-eligible children under age 21 comprehensive, periodic health assessment, dental, vision and hearing services, and “medically necessary” follow-up diagnostic and treatment service (see definition below).¹¹¹¹¹ The program’s emphasis is on preventive and primary care, with the overall goal of preventing childhood illnesses or disabilities and identifying children’s and young adult’s problems early on, before they become severe and disabling. Early identification and treatment improves children’s outcomes and enables families to access important resources that will improve family functioning and outcomes.

The District of Columbia’s Healthy Tots and Teens/HealthCheck Program began in 1974. Formerly known as the DC Well-Child Program, it is now called the DC HealthCheck Program. Its aim is to assure the availability and accessibility of appropriate quality health care for all District of Columbia Medicaid-eligible children from birth up to age 21. Although families have the option of using HealthCheck services, the DC Department of Health (DOH)’s Medical Assistance Administration encourages parents to make sure their children remain current with their HealthCheck health screenings so providers can detect and treat any critical health conditions before they become disabling.

The District of Columbia HealthCheck service requirements are incorporated into the contracts of all managed care organization (MCO) providers. Each child is to have a medical home (see Section 1.4.1), whether enrolled in an MCO or with a fee-for service provider. This will provide ongoing health supervision and, when appropriate, intervention to correct or ameliorate physical and mental problems and ongoing treatment of any chronic conditions discovered. All medically necessary services must be provided for children and adolescents receiving HealthCheck, regardless of whether the services are included in the Medicaid State Plan.

In 1994 the District of Columbia initiated the DC Medicaid Managed Care Program (DCMMC), which requires families with dependent children who receive payments through the Temporary Assistance for Needy Families (TANF) Program (formerly the Aid to Families with Dependent Children (AFDC) Program) to enroll in a managed care program.

¹¹¹¹¹ Definition of ‘medically necessary’: A covered service or item can be defined as medically necessary if it will do, or is reasonably expected to do, one or more of the following: (a) arrive at a correct medical diagnosis; (b) prevent the onset of an illness, condition or injury or disability in the individual or in covered relatives, as appropriate; (c) reduce, correct, or ameliorate the physical, mental, developmental, or behavioral effects of an illness, condition, injury or disability; (d) assist the individual to achieve or maintain sufficient functional capacity to perform age appropriate or developmentally appropriate daily activities.

Section 1.2 Categories of Eligible Children

Children and adolescents under age 21 who are eligible for Medicaid are automatically eligible for HealthCheck services. HealthCheck Program services are provided to the following categories of children:

- **TANF Children:** Temporary Assistance for Needy Families (TANF) children are those who qualify based on criteria for assistance to low-income families;

Newborns: A child born to a woman eligible for and receiving medical assistance plan under which the mother is enrolled. They are members as long as the mother is a plan member or the baby is officially enrolled in the plan by the MAA. (For a detailed explanation, refer to DC Medicaid Managed Care Transmittal No. 95-09)

- **Foster Children:** Foster children are those who are placed in protective services because they cannot remain at home. These children may have experienced neglect or abuse in the home and are generally placed with a substitute family.
- **DC Healthy Families Program:** Children in the DC Healthy Families Program (DCHFP) (Appendix II) qualify for Medicaid services because they qualify for the Temporary Assistance For Needy Families (TANF), TANF related programs, of the Child Health Insurance Program.
- **Child and Adolescent Supplemental Security Income (SSI) and SSI-Related Plan (CASSIP):** Children with Special Health Care Needs are children who, because of a disability, are eligible to receive Supplemental Security Income (SSI). They receive services beyond mandated provisions. These children are not included in the TANF DC Medicaid Managed Care Program and represent less than 5 percent of Medicaid children in the District of Columbia. HealthCheck screens and services are provided to all children enrolled in this program under age 22.

Section 1.3 Screening Providers

All DC Medicaid Managed Care primary care providers (PCPs) are responsible for providing HealthCheck screening services to patients up to age 21. PCPs in the DC HealthCheck Program are defined as Pediatricians, Family Practitioners, General Practitioners, Internists, Nurse practitioners, and Gynecologists. States cannot limit HealthCheck providers to only those who can provide all HealthCheck diagnostic and treatment services. When the MAA certifies new groups of providers to deliver certain HealthCheck screening, diagnostic and treatment services, the agency will issue updates to this manual in the form of transmittals.

Section 1.4 How Do Children and Adolescents Receive Services

If the family member is enrolled in a prepaid, capitated plan, referred to in this manual as a

Managed Care Organization (MCO), they are required to choose a provider or one will be chosen for them. If the member is in a special category of eligibility, they also are required to choose a participating fee-for-service provider.

The goal of managed care is to provide people with better health care at lower cost. This requires enrollees to choose a PCP who will provide some of their medical care and will also coordinate the delivery of care from other providers when necessary. In this role, the PCP should refer and track medical, mental health or developmental problems that require treatment.

Many enrollees may continue to see the PCP they have been seeing under another health program. For those who have not had a provider whom they have seen regularly, the PCP provides a “medical home” (see Section 1.4.1 below) for the child and consistent health care under the HealthCheck Program. For a young child, the PCP may be a pediatrician. For the older child or adolescent, the specialist may be a pediatrician, an Internist, a Family Practitioner, or a General Practitioner.

Section 1.4.1 Primary Care/ Medical Home

Families who establish a long-term relationship with a primary care provider through a medical home tend to receive continuous, coordinated, comprehensive care and to use services more appropriately. A medical home includes:

- Provision of preventive care, including all HealthCheck screening elements;
- Assurance of ambulatory and in-patient care on a 24-hour basis;
- Continuity of care from infancy through adolescence;
- Appropriate referrals to sub-specialty services;
- Interaction with school and community agencies; and
- A central record and database containing all pertinent health information
(Bright Futures 2000).

Section 1.5 Mental Health Services

CASSIP MCOs are responsible for providing and arranging for behavioral health services (this includes both mental health and substance abuse services), either directly or through contractual arrangements or through referral protocols.

The DCHFP MCOs are responsible for referring beneficiaries for behavioral health and mental health services. The services themselves will be provided through a fee for service, integrated, community-based mental health treatment network. The mental health services include in-patient and outpatient services. The Addiction, Prevention and Recovery Administration will select providers for treatment of alcohol and drug abuse such as outpatient, methadone, and detoxification services. In-patient detoxification services are the responsibility of the DCHFP MCO's. DC MAA will reimburse outpatient substance abuse services on a fee for service basis.

The CASSIP MCO is responsible for comprehensive mental health services and substance abuse services, including ambulatory, inpatient, and residential treatment services.

Section 1.6 Recipient Support Services

Section 1.6.1 Case Management (Care Coordination)

Medically Necessary Case Management is a HealthCheck service that MCOs provide to children under age 21 who require assistance with identification, implementation, and coordination of a variety of medically necessary services but do not qualify for the District of Columbia's Supplemental Security Income (SSI) children's program/HSCSN, Inc. (Appendix III) The service involves: (a) identification of a need for coordination of care between two or more medically necessary services; (b) arranging for the recipient to receive the service; (c) coordinating the services (including assisting the client with scheduling all medically necessary services); and (d) monitoring the delivery of services. In the case of HSCSN, Inc. Care/Case Management services are provided to all members as part of their contractual responsibilities.

Section 1.6.2 Transportation and Scheduling Assistance

Under the federal EPSDT statute, the HealthCheck Program is required to provide scheduling and transportation assistance to members as part of their contracts with the DC program. MCOs are required to provide scheduling and transportation services to their Medicaid enrollees. Members not enrolled in an MCO, receive transportation assistance through their provider or who are pregnant or have children less than 2 years of age may call 1-800-MOM-BABY. Transportation includes bus tokens, Metro fare cards, taxi transportation vouchers, van services, and non-emergency ambulance services. Medicaid providers, with the approval of MAA, can purchase and give tokens onsite to their clients. MAA provides Medicaid providers with taxicab vouchers, which can be issued to member when necessary. Medicaid providers, based on Medicaid's medical necessity criteria, can only request van service and non-emergency ambulance services.

For information on:

- tokens and Metro cards, call (202) 698-1706
- taxicab vouchers, call (202) 698-1706
- van and non-emergency transportation, call (202) 698-2026

To obtain a copy of the DC Medicaid Provider Transportation Manual, call (202) 783-5610.

Section 1.6.3 Eligibility Support: Help line

The DC Managed Care Help line is available to Medicaid Managed Care members who are seeking to select an HMO as their health plan. This process requires the client to answer limited health assessment questions to choose a PCP within the health plan. To access this system, clients must call (202) 639-4030. (Spanish & English)

Section 1.6.4 Enrollment Broker

The District of Columbia's enrollment broker is a contracted vendor hired by MAA to objectively enroll MMC-eligible members into an MCO. The enrollment broker operates the Help line and facilitates outreach to hard-to-reach MMC members. The telephone number for the current enrollment broker is (202) 639-4030.

Section 1.6.5 Program to Reimburse for Out-of-Pocket Expenses

DC Medicaid clients who paid for drug prescriptions, doctor visits or hospitalizations that should have been paid by Medicaid are entitled to reimbursement. To be considered for reimbursement, clients must submit a request no later than six months after the expense was incurred, or by April 1, 2001, for claims dating back to March 2, 1999, and:

1. Complete an attached Medicaid Reimbursement Form Transmittal (01-02) by providing their name, address, telephone number, Social Security number, date of birth, date(s) of service provided, providers of the service, name of person receiving services (i.e., child), the medical services for which they paid, and the amount paid.
2. Attach a receipt(s) from the provider(s) showing payment for the medical service(s), if available. (If not available, most providers will give the patient a copy.)
3. If provider receipts are not available, clients may provide a sworn statement that the information provided is true and accurate with an explanation of why no receipt is included. (*Note*: "...any falsification or concealment of a material fact may be prosecuted under Federal and State laws.")

Questions pertaining to claims for out-of-pocket expenses can be answered by calling the DC Medical Assistance Administration, Program Operations, at (202) 698-2000.

Section 2 OUTREACH AND COORDINATION

Section 2.1. Program Coordination and Outreach

Federal legislation requires state HealthCheck programs to coordinate with child health-related programs to maximize access to services, prevent duplication, and ensure health care for children. These programs include childcare and Head Start agencies; Maternal and Child Health (MCH) programs; the Women, Infant and Children's Program (WIC); state and local education agencies; and social service agencies. These collaborative efforts may include interagency agreements, cross-referrals, or child health coordinating committees, such as the HealthCheck Task Force. This coordination can play an important role in assisting with outreach activities.

The DC HealthCheck Program coordinates with the Healthy Start Project to ensure that member receive counseling, transportation, scheduling and other necessary support services as a part of comprehensive health care. MAA requires providers of care to refer Medicaid families found to

be at nutritional risk to the WIC Program and the Commodity Supplemental Food Program (CSFP) (For a list of CSFP sites and referral form, see Appendix V).

WIC provides nutritional services for families in the following risk categories: Pregnant, and breastfeeding women, new mothers, infants and children up to age 5. Commodity Supplement Food Program provides services: pregnant and breastfeeding women, and new mothers who have a baby less than six months old, children up to age 6, women who have delivered a baby in the past year, and senior citizens. The program provides members with written nutritional information and vouchers redeemable for specific nutritious foods at certain stores at no cost to the participant. For assistance in making referrals or requesting copies of referral forms, call (202) 645-5663. (For a list of WIC sites and a copy of the referral forms, see Appendix IV.)

The State Children's Health Insurance Program (SCHIP) called D.C. Healthy Families expands Medicaid eligibility to families and children with incomes up to 200% of the federal poverty level. IMA's determines eligibility for D.C. Healthy Families and refers eligible individuals and families to the appropriate enrollment broker. For further information about enrolling in D.C. Healthy Families, contact (202) 526-6266 D.C. Healthy Families has an active outreach and enrollment program. There are D.C. Healthy Families Applications available throughout the community in drug and grocery stores throughout provider's offices and in locations in the community frequented by potential beneficiaries. Providers may obtain enrollment application by calling: (202) 526-6266.

Section 2.2 The Role of the Medical Assistance Administration (MAA)

MAA identifies eligible children and families to:

- _ Encourage their participation in Medicaid and the HealthCheck Program,
- _ Inform them of the availability and benefits of preventive services,
- _ Provide assistance with scheduling appointments and transportation,
- _ Help families use health resources effectively and efficiently, and
- _ Monitor and evaluate the quality of services provided to beneficiaries

Section 2.3 The Role of the Income Maintenance Administration (IMA)

Information about the DC HealthCheck Program screening service is provided during the initial Medicaid eligibility interview conducted by the Commission on Social Service/Income Maintenance Administration (IMA) and through the subsequent recertification process. During the initial eligibility interview, IMA personnel advise Medicaid applicants of:

- _ The benefits of regular preventive health care for their children, and themselves
- _ The range of preventive health care services available, especially D.C. HealthCheck program,
- _ Procedures for obtaining services,
- _ The fact that services are free, and
- _ The availability of necessary transportation and scheduling.

Each applicant or recipient is given a gold and blue “Get Healthy, Stay Healthy” HealthCheck flyer (Appendix VI) describing the DC HealthCheck Program in easy-to-understand language. The flyer is available in English and Spanish.

Section 2.4 The Role of Managed Care Organizations (MCOs)

Members who select or who are assigned to an MCO receive HealthCheck information from the MCO. Within 60 days after a recipient becomes a member, MCOs are required to reiterate the five items in section 2.3. In addition, MCOs should provide scheduling assistance upon request. If transportation services are requested, MCOs must provide necessary transportation.

MCOs shall conduct outreach activities to assist HealthCheck-eligible enrollees keep well-child appointments. Required outreach activities include making every reasonable effort to remind enrollees about upcoming appointments, including telephone calls or mailed reminders prior to the date of each visit. For a first missed appointment, the MCO should call the enrollee and/or mail a reminder. If there is still no response, a personal home visit, where feasible, must occur to urge the parent or guardian to bring the child for his or her HealthCheck appointment. When appropriate, such contacts should also be directed directly to teenagers.

MCOs are also expected to coordinate their enrollees’ health care with the following child health related groups: DC Public Schools (DCPS), Department of Special Education; Department of Human Services (DHS), DC Early Intervention Program (refer to section 4.8.1 in this manual); DHS, Administration for Child and Family Services; Head Start; Department of Mental Health; Maternal and Family Health Services and others as appropriate.

Section 3 HEALTH SUPERVISION PROCEDURES

Section 3.1 General Descriptions of Health Supervision Procedures; HealthCheck Screening

It is expected that well-child care preventive health supervision will include all the recommended components listed below. It is also recognized, however, that the PCP may exercise medical judgment to modify the content of the examination in consideration of the needs of the individual child and more recent changes in the current recommended standards of medical practice. A health supervision HealthCheck Screen visit must include:

- A comprehensive health and developmental history or update of medical and mental health status;
- A comprehensive, unclothed physical examination;
- Immunizations;
- Appropriate laboratory test; and
- Anticipatory guidance (health education);
- Vision Screening and when medically necessary, diagnostic and treatment services;
- Hearing screening and when medically necessary, diagnostic and treatment services;

Direct referral to a dentist for children beginning at the age of 3 years, and a dental inspection and anticipatory guidance on dental health by the PCP at 12 months and on continuing through childhood and adolescence.

Section 3.2 Periodicity Schedule: Initial and Periodic Screens and Time Frame

When parents request a preventive health screening, the examination must be completed within 30 days of the request. Initial screens must be offered by providers within 60 days of taking over care of the child or youth and must be completed within six months, unless refused by the parent or youth. (If the recipient is under age 2, screening must occur more frequently and in accordance with the DC HealthCheck Program Periodicity Schedule (see Appendix VII).) If age-appropriate HealthCheck screens have not been completed within six months of the child's enrollment, the provider must conduct additional provider outreach to families and must document outcomes.

The periodic well-child screen is a complete evaluation in accordance with standards included here and provided at intervals recommended in the DC HealthCheck Periodicity Schedule. This schedule, which follows the American Academy of Pediatrics' (AAP) recommendations, was developed in consultation with recognized medical and dental groups having expertise in child and adolescent health, including AAP. The recommendations are for the care of children who have no manifestation of any important health problems and are judged not to be at undue risk. If a child misses a regular periodic screening, the child must be screened as soon as possible (off the regular periodicity schedule) in order to bring him/her up to date. All children must be screened for special health needs and disabilities within 90 days of enrollment. The contents of the exam should not preclude providers from performing additional tests when determined by the provider to be needs and disabilities within 90 days of enrollment. The contents of the exam should not preclude providers from performing additional tests when determined by the provider to be medically necessary, i.e., medical conditions and/or referrals by Head Start, DC Public Schools, Early Intervention, or special education programs.

Section 3.3 Definition of Interperiodic and Partial Screens

Medical, vision, hearing or other screens that are provided outside of and in addition to regular screens are called interperiodic screens. Interperiodic screens occur more frequently than scheduled screens due to medical necessity (e.g., when a child has tested positive for a condition and the PCP determines that there is a medical need to rescreen for that condition).

Partial screens are incomplete screens that occur when the provider is able to perform only part of the screen required by the recipient during the office visit. Although the member may request both types of screens, his or her family and/or child-related groups may also request a screen. DOH/MAA discourages partial screens because the goal of the program is to provide all needed screening services during a single encounter.

The provider should record both the interperiodic and partial screen in the child's medical record, with documentation of the reasons for these screens.

It is important to note that children and adolescents with chronic health problems, such as HIV, Asthma, Sickle cell, etc., may need to be seen more often than the recommendations in the periodicity schedule. The content, frequency and scope of services should be based on evidence-based practice guidelines and protocols and the clinical judgment of the PCP and/or the specialist caring for the child or adolescent.

Section 3.4 Follow-up Diagnosis and Treatment Requirements

One of the main purposes of the DC HealthCheck Program is to ensure that health problems are identified, diagnosed and treated early before they become more serious and the treatment more costly. Federal HealthCheck legislation requires coverage of any services “that are necessary to treat or ameliorate a defect, physical and mental illness or condition identified by a screen.” Such services are allowed under the federal law regardless of whether or not they are included in the State Plan. PCPs are required to document if any well-child screen resulted in the need for treatment and/or referral. All HealthCheck treatment should be reported to the MCO or MAA via claims for fee-for-service members.

Diagnosis

When a PCP detects a physical or behavioral health problem in a health, vision and hearing screening assessment, the provider shall either provide the service indicated or make an appropriate referral for diagnosis and/or treatment without delay. Any necessary referrals should be made at the time of preventive health supervision, if possible. PCPs, as well as MCOs, must make all reasonable efforts to follow up on referrals for treatment, including referrals made outside the DC Medicaid Managed Care Program, such as mental health referrals. Fee-for service providers shall give the parents or guardian freedom of choice of providers when making a referral. MCOs may limit referrals for covered services to their provider network and should give the parents or guardian freedom of choice of providers when making a referral for non-covered services. All treatment, including referral treatment, should begin within 60 days of the screening.

Treatment

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

- Physician services
- Outpatient hospital services
- Inpatient hospital services
- Home health services
- Eyeglasses
- Family planning services
- Hospice care
- Nurse Midwife Services
- Physical, occupational and speech therapies
- Private duty nursing services
- Prosthesis and other durable medical equipment
- Skilled-nursing facility services

- Extended services for pregnant women
- Rehabilitative services

Referrals for diagnosis and initial treatment should not be limited solely to services covered by Medicaid or Medicaid enrolled providers. **ALL MEDICALLY NECESSARY SERVICES MUST BE PROVIDED WHETHER THEY ARE COVERED BY THE DISTRICT OF COLUMBIA’S MEDICAID STATE PLAN OR NOT. REFERRALS MUST BE MADE TO THE APPROPRIATE PROVIDER FOR DIAGNOSIS AND TREATMENT FOR EACH HEALTH FINDING.**

Section 3.5 Documentation and Record Keeping

Section 3.5.1 Importance of Documentation and Record Keeping

The importance of documentation and accurate record keeping for all members in the DC HealthCheck Program cannot be overemphasized. **Incomplete documentation results in lack of evidence that a complete screen occurred. All screens must be documented in the child’s medical record.**

It is imperative that all eligible children receive all screens as indicated on the HealthCheck periodicity schedule. **THESE SCREENS ARE NOT CONSIDERED TO HAVE TAKEN PLACE IF THEY ARE NOT DOCUMENTED IN THE CHILD’S MEDICAL RECORD.**

Section 3.5.2 How to Document a HealthCheck Screen

The record must have the child’s individual identification as a unique record. Documentation must include the date seen and all elements of the HealthCheck visit including those identified on the DC periodicity schedule. It is critical that you document all of the key screening services listed in section 3.1.

Section 4 Contents of HealthCheck Supervision

Section 4.1 Comprehensive Health History

At the initial preventive health supervision visit, a PCP is required to obtain a comprehensive health and developmental history from the parents or other responsible adults who are familiar with the child’s history. On subsequent visits, the health and developmental history must be updated, summarizing events affecting the child’s health and well being since the preventive health supervision visit.

The purpose of the health and developmental history is to gather information about those diseases and health problems for which there is no single standard screening test and to compile historical and current information about the child and the child’s family. Providers must assess and document all required HealthCheck screening components.

Contents of Health History

The following elements should be included in a comprehensive health and developmental history:

For a new patient, a complete family history, social history, past medical history and review of body systems must be obtained and recorded.

When obtaining the Past Medical History of children 5 years of age and younger, the history must include documentation of immunizations, mother's pregnancy, delivery, birth weight, and the neonatal period.

When obtaining the Past Medical History of adolescents, a review of the body systems should include a psychosocial assessment, a history of substance abuse, personal violence, sexual activity, and use of contraceptives, and for females, a menstrual history. It should also include, to the maximum extent feasible, documentation of past immunizations.

For a known patient, the history may be confined to the interval since the last health evaluation.

Allied health personnel may obtain the histories initially. The examining PCP must always review and supplement the history at the time of his/her evaluation of the child/adolescent.

Section 4.2 Comprehensive Physical Examination

The examination consists of a systematic examination of all parts of the body. At each preventive health supervision visit, a complete physical exam is essential, with infants totally unclothed and older children suitably draped in a light gown. Assessments and supporting documentation of the following are required:

- general appearance
- body measurements
- head and neck (including fontanelles for infants and facial features)
- skin and hair assessment (evidence of scars, burns, bruises)
- eyes and ability to see
- ears and ability to hear
- nose and throat
- oral cavity -- this includes an inspection/examination of:
 - palate, cheeks, tongue, and floor of the mouth
 - dental ridges, including erupting teeth
 - gums for evidence of infection, inflammation or bleeding, and malformation of erupting teeth or decay
- need for daily fluoride intake
- need for dental referral for obvious cavities, regardless of age
- vocalization and speech
- blood pressure (for children 3 years and older)
- pulses

- _ gastrointestinal system (organs, masses)
- _ urogenital system
- _ musculoskeletal system (including muscle tone and scoliosis)
- _ nervous system (including gross and fine motor coordination)

The general appearance of the child should be checked to determine overall health status. The process can pick up obvious physical defects, including orthopedic disorders, hernia, skin disease, and congenital abnormalities. Physical inspection includes an examination of all organs and systems, such as pulmonary, cardiac, and gastrointestinal. The physical exam must also address any functional structural abnormalities that would interfere with the child's ability to communicate.

Section 4.2.1 Adolescent Exam

All sexually active females must be offered a routine gynecologic examination, including test for gonorrhea, chlamydia, syphilis (RPR), and hepatitis B, as well as a Pap smear. Adolescent females should also receive a breast exam. Adolescent males must receive a testicular exam. Sexually active males and females must receive at least a microscopic urinalysis testing for the presence of white blood cells; if white blood cells are present, testing for gonorrhea, chlamydia, hepatitis B, and an RPR must take place.

Section 4.3 Assessment of Physical Growth

Body measurements of infants and children help identify significant conditions, including growth retardation, malnutrition, obesity, and developmental abnormalities. Head circumference measurement can identify abnormal brain development, including hydrocephalus in infants. In order children and adolescents, body measurements may flag eating disorders and obesity.

Height and weight should be measured at each visit for all ages. Head circumference should be measured at birth, 2-4 days, and at months 1, 2, 4, 6, 9, 12, 15, 18, and 24.

Height should be obtained by measuring recumbent length of children less than 2 years of age and those aged 2 to 3 who cannot stand unassisted. A measuring board with a stationary headboard and a sliding vertical foot piece should be used if available. Standing height should be obtained for children beginning at 2 to 3 years of age and above. Measurements may be made accurately by using a graduated ruler or tape attached to a wall with a flat surface placed horizontally on top of the child's head. The child's feet should be bare or in socks only. The child should stand with head, shoulder blades, buttocks, and heels touching the wall. The knees should be straight and feet flat on the floor, and the child should be asked to look straight ahead. The flat surface should be lowered until it touches the crown of the head, compressing the hair.

A balance-beam table model or electronic scale should be used to weigh infants and small children. Spring-type scales are not sufficiently accurate for this use. The scale should be checked to make sure it is zeroed before each use. The infant or child should be weighed wearing only a dry diaper or light underpants. Older children and youth who can stand without

support can be weighed on a floor model beam scale. Scales should be checked regularly for accuracy.

Head circumference should be measured by extending a non-stretchable measuring tape (metal, fiberglass, and disposable paper tapes are better than cloth) around the most prominent part of the occiput to the middle of the forehead. The tape should be tightened to compress the hair.

Measurements should be plotted on age- and gender-specific National Center for Health Statistics (NCHS) growth charts for comparison with NCHS reference standards (Appendix IX). Although there is disagreement about the validity of using a single set of reference standards for all sub-populations of American children, most authorities support the use of the NCHS standards. Recording serial measurements over time provides an accurate record of growth, with large or sustained deviations signaling a potential problem. Measurements should be interpreted within the context of the individual child's family and growth history. For children whose measurements fall within the 10th through 25th percentile range or the 75th through 90th percentile range, past growth patterns and genetic and environmental factors should be assessed to help determine whether more in-depth follow-up is necessary. Measurements below the 5th or above the 95th percentile should be rechecked. If these measurements are confirmed, detailed medical evaluations may be needed.

Section 4.4 Nutrition Assessment

All PCPs are required to assess the child's nutritional status and eating habits and to identify any nutritional risk factors by means of the health and developmental history and/or comprehensive physical examination. Nutritional screening is required from birth to age 21.

Section 4.4.1 Nutritional Screening Protocol

Nutritional screening should adhere to the following protocol:

Ask questions about dietary practices to identify unusual eating habits (such as pica or extended use of bottle feedings) or diets that are deficient or excessive in major nutrients and calories.

Perform a complete physical examination, including body measurements and an oral cavity assessment, paying special attention to such general features as pallor, apathy and irritability.

Perform laboratory tests to screen for iron deficiency.

Check serum cholesterol or lipoprotein level for children 2 years and older who have a family history of premature cardiovascular disease or a parent with a total cholesterol of 240 mg/dL or greater (see Section 4.11.6, Cholesterol Screening).

If information suggests dietary inadequacy, or obesity or other nutritional problems, further assessment is warranted, including:

investigating family, socioeconomic or any other community factors;

determining quality and quantity of the child's diet (e.g., dietary intake, food acceptance, meal patterns, methods of food preparation and preservation, and utilization of food assistance programs);

performing further physical and laboratory examinations; and

performing preventive, treatment and follow-up services, including dietary counseling and nutrition education.

Refer to WIC Program when appropriate (see Appendix IV)

Section 4.4.2 Identification of Children for Possible Referrals

Accurate measurements of height and weight are among the most important indices of nutritional status. Inadequate intake of nutrients is reflected in slow growth rates, inadequate mineralization of bones, and low body reserves of micronutrients. Inadequate caloric intake is less of a problem for children than excessive intake. Some children are substantially overweight, physically inactive, and have dietary intakes of cholesterol, unsaturated and saturated fats. These factors may lead to obesity and poor eating habits in adulthood, resulting in heart disease, Type II diabetes, high blood pressure, certain types of cancers, and other chronic diseases. Children in the following groups should receive special attention with the possibility of a referral:

Children who demonstrate continued or excessive weight loss or no weight gain over a period of time;

Children who are considerably overweight in proportion to their height or measure greater than 90th percentile weight for height;

Children with other variations from expected growth parameters (such as weight for age and height for age) below the 5th percentile. Adjustment for prematurity in infancy and parent-specific adjustment for height may be considered.

Children with congenital conditions or chronic illness affecting ability to meet nutrient needs, e.g., cleft palate, congenital heart defects, cystic fibrosis, inborn errors of metabolism, and physical or mental handicaps affecting feeding.

Children with elevated blood lead levels (see Section 4.11.3.2 Blood Lead Assessment), iron deficiency anemia, food allergies, or evidence of drug/nutrient interaction.

Section 4.5 Vision Screening

Section 4.5.1 Subjective Versus Objective Screening

Vision screens provide early detection of and prompt referral for potentially blinding diseases and visual impairments, such as congenital abnormalities and malformation, eye disease, including retinoblastoma, refractive errors, strabismus, amblyopia, and color blindness. A subjective vision assessment is required at each preventive health supervision visit. A PCP may use a Snellen-E for the objective portion of the test. Vision screens have two components: subjective screens and objective screens. A subjective screen is part of the comprehensive history and physical exam assessment. Prior to both the subjective and objective screen, gathering patient historical information in the following areas is important in screening for present or potential visual disorders:

- Family history of vision or eye problems;
- History of maternal, intrapartum or neonatal conditions that may place the child at high risk for visual disorders;
- Parental concerns about a child's visual functioning (It is important to listen to families' concern about their child's eye or vision problems; parental observations are often correct.); and
- School performance, worsening grades and other school difficulties may be a sign of vision problems.

Section 4.5.2 Methods of Screening

For children less than 3 years of age, testing should include the following:

Red Reflex – The red reflex may be performed with an ophthalmoscope or other light source. In a darkened room, the light source should be held at arm's length from the infant and the infant's attention drawn to look directly at the light. Both retinal reflexes should be red to red-orange and of equal intensity.

Corneal Light Reflex – The corneal light reflect test, for detection of strabismus, is also performed with an ophthalmoscope or other light source. Corneal light reflections should fall symmetrically on corresponding points of the patient's eyes. Improper alignment will appear as asymmetric reflections.

Differential Occlusion – The test for differential occlusion is performed by gently covering the infant's eyes, one at a time. Aversion to the occlusion is normal. This test generally gives false-positive results and is less accurate than the corneal light reflex test for detecting strabismus.

Fixation – In examining for fixation, a light, small object or toy is held in front of the infant. In a normal exam, the infant's eyes will be aligned in the same direction, without deviation.

Cover/Uncover – The cover/uncover test is performed by having the child focus on a stationary target. While placing a hand or cover in front of an eye, the examiner observes the other eye.

Such movement of the observed eye is abnormal and demonstrates the presence of strabismus. As the covered eye is uncovered, the examiner observes it for movement. If movement is abnormal, heterophoria might be present.

For children 3 years of age and older, testing should include the following:

Vision Acuity -- Testing for visual acuity is to be performed and repeated at each examination and must include a distant visual acuity test, which can be performed using the Snellen Letters, Snellen Numbers, Tumbling E, HOTV, Allen Figures, or the LH (Leah Hyvarinen) Test. The test with the highest difficulty that the child is capable of performing should be used. The Tumbling E or the HOTV test should be used for ages 3 through 5 years, and the Snellen letters or numbers should be used for ages 6 years and older. A passing score should be given for a line on which the child gives more than 50 percent correct responses.

If a child wears eyeglasses, an assessment regarding the need for referral for optometric re-evaluation should be made based on screening the child with eyeglasses and the length of time since the last optometric evaluation.

- Color Perception -- A color perception screening using polychromatic plates must be performed at least once after the child reaches 6 years of age.

For school-aged children, the results of a school health screening conducted by the school nurse may be used, in addition to the history and complete physical exam. The school nurse at the child's school may be contacted to obtain this information.

Section 4.6 Speech and Language Screening

The ability of a child to communicate in his or her environment is essential from the time he/she begins life. Early identification of possible communication deficits is often in the hands of the pediatrician even before true words are typically acquired. Speech and language skills should be assessed at every well-baby/well-child visit through the age of 5 years. Because speech and language is developmental in nature, with the greatest acquisition occurring between birth and age 3, both subjective and objective methods of screening should be used.

Objective findings should be obtained using a standardized screening measure, such as the Denver Developmental Screening Test 11 (W.K. Frankenburg et al.) or the Language Development Survey (L. Rescorla).

Subjective screening should be in the form of direct questioning. There are four general areas of communication development that should be explored during each visit. The following are questions that will address a child's communication abilities in these areas:

Comprehension

1. Is your child having any difficulty understanding what you say?
2. Is your child responding to his/her name when called?
3. Is your child able to answer simple questions?
4. Is your child able to follow simple directions around the home?
5. Is your child showing an interest in what you or others are saying?

Expressive Language

1. How does your child make his/her wants known?
2. Is your child communicating using true words?
3. If yes, is your child combining words into sentences?
4. If no, is your child communicating using combinations (i.e., jargoning), gestures, or other expressive body language?
5. Is your child able to express his/her thoughts clearly and easily?
6. Is your child experiencing any frustration communicating with others?

Speech Development

1. Is your child pronouncing words clearly?
2. Is your child having trouble pronouncing certain sounds, such as s, z, k, g, t, d, l, etc.?
3. Do you understand what your child is saying?
4. Do others understand what your child is saying?
5. Is your child having any difficulties moving his/her mouth to make sounds?

Social Language

1. Does your child look at you and others during a conversation?
2. Does your child request assistance or information from you or others?
3. Does your child appropriately respond to questions, comments or directions presented to him/her?
4. Does your child naturally imitate phrases heard in conversation or do so in way that is excessive?
5. Does your child enjoy/avoid communicative interactions with others?

Note should also be made of the child's hearing screening results and whether there is any question about hearing ability. Persistent episodes of otitis media may be an indication that hearing loss, although transient, may have affected speech acquisition. All children should have a subjective speech/language screening annually from birth to 5 years of age. Although recommended ages for objective screening are included in the DC HealthCheck Periodicity Schedule under developmental assessment, objective screens should occur as needed. Referrals for a more comprehensive screening or diagnostic evaluation should be made to a speech and hearing clinic.

Section 4.7 Hearing Screening

The early detection of hearing impairment in children is essential in order to initiate the medical and educational interventions critical for developing optimal communication and social skills. A hearing assessment is required at each preventive health supervision visit. When performing physical examinations, look for structural defects in the ear, head, and neck. Look for abnormalities of the ear (inflammation, cerumen impaction, tumors, or foreign bodies) and the eardrum (perforation, retraction, or evidence of effusion).

Section 4.7.1 Subjective Versus Objective Screening

Hearing screening, like vision screening, has two components: subjective screening and objective screening. Subjective screening for hearing is part of the comprehensive history and physical exam. Subjective hearing screening must include the health history, including information about the child’s response to voices and other auditory stimuli, delayed speech development, chronic or current otitis media, or other health problems that place the child at risk for hearing loss or other hearing impairments

Section 4.7.2 “At-Risk” Children Less than 3 years of Age

Gathering patient historical information is important in screening for present or potential hearing disorders. Infants who exhibit one or more of the following risk criteria should be screened as soon as possible, but no later than 3 months after the child has been identified as “at-risk”:

- Parent/caregiver concern regarding hearing, speech, language and/or developmental delay;
- History of bacterial meningitis;
- History of neonatal events associated with hearing loss (e.g., cytomegalovirus, prolonged mechanical ventilation, and inheritable disorders);
- History of head trauma, especially with fracture of the temporal bone;
- Recognizable syndromes associated with hearing loss;
- History of ototoxic medications, such as aminoglycosides used for more than five days (Some medications contribute to hearing disorders.);
- Presence of neurodegenerative disorders;
- History of childhood infectious diseases associated with hearing loss (e.g., mumps or measles).

Infant Testing Procedures

- In infants, assessment of hearing by observational techniques is very imprecise. For infants and children older than 6 months, behavioral testing using a conditioned response or auditory brainstem response (ABR) testing are appropriate approaches.
- Infants who fail the screen should be referred for a comprehensive audiological evaluation as soon as possible.

– Children should have pure-tone screening performed at the following ages: newborn, 6 months, and 5, 6, 8, 10, 12, 15, and 18 years.

Section 4.7.3 Methods of Screening Children 3 Years and Older

Objective screening should start at age 5. The purpose is early detection of a prompt referral for congenital abnormalities, central auditory problems, sensorineural hearing loss, and conductive hearing impairments. Temporary hearing loss is common among school-age children, usually as a complication of otitis media with middle ear effusion. A PCP can perform an objective test using the pure-tone audiometer, Welsh Allyn Audioscope, or other approved instruments.

Testing Procedures

When hearing impairment or progressive hearing loss is suspected, the PCP should promptly refer the child to an approved speech and hearing center. If a successful evaluation cannot be made due to behavioral difficulties or other factors, a prompt referral for assessment and treatment should be made to a facility that provides audiological services.

The pure-tone audiometry test should be performed in a quiet environment using earphones since ambient noise can significantly affect test performances, particularly at the lower frequencies (i.e., 500 and 1000 Hz). Handheld audiometers are of unproven effectiveness in screening children. Each ear should be tested separately. Air-conduction hearing threshold levels of greater than 20-db at any of these frequencies indicate possible impairment. The audiometer must have double earphones and meet American National Standards Institute (ANSI) standards. The audiometer or audioscope should be calibrated yearly. The operator should listen to it each day of use to detect gross abnormalities.

Section 4.8 Developmental Screening

For children from birth through age 5, a developmental history of the infant or child must be obtained and augmented at each well-child scheduled visit and documented in the child's medical record. A child between the ages of 3 through 5 years may be eligible for further assessment if he/she experiences difficulties that interfere with normal development in these areas:

- Fine and gross motor skills
- Behavioral/social skills
- Self-help skills
- Speech/language
- Problem-solving skills, and
- Cognition/readiness skills.

After the age of 5 years, developmental screening should continue to include information related to cognitive, language, and psychosocial development. The following tests are strongly recommended for children up to 3 years of age and may be used up to the age of 5 years:

- Denver Developmental Screening Test (DDST II)
- Revised Developmental Screening Inventory
- Gesell Development Examination

For children ages 3 through 5 years of age, the Early Screening Inventory (Meisels) is available. This instrument is also available in Spanish.

Particular care should be taken to note “red flags” signaling behavioral health problems at each visit. To obtain more information on developmental screening instruments, see Bright Futures Web site: www.brightfutures.org

Use of a psychometric instrument does not preclude the need for multiple sources of data and/or clinical information as well. Any developmental screening tests carried out by the Early Intervention Program, Head Start, Early Education or childcare staff, DC Public Schools, or other community-based providers should be incorporated into the HealthCheck screening process. Any child who has a negative result on the developmental screening assessment should be referred for in-depth diagnostic testing in the area of concern and for treatment, if indicated.

Children at known risk for developmental delay, including HIV-infected children whose development is expected to deteriorate, should be referred for evaluation without hesitation whenever screening indicators are noted.

Since very few developmental tests are actually known to be free of cultural bias, care should be taken in administering tests to members of culturally diverse groups. The norming procedures of tests are typically described in the manuals that accompany the tests. In addition, it is helpful if the person administering the test is knowledgeable about the culture and language of the child and his/her family. Further, the federal Individuals with Disabilities Education Act (IDEA) requires that “tests and other evaluation materials and procedures be administered in the native language of the parents or other mode of communication, unless it is clearly not feasible to do so.”

Section 4.8.1 DC Early Intervention Program

Children who are aged birth to 3 years and are identified as having a developmental delay or disability should be referred to the District of Columbia’s Early Intervention Program (EIP)(Appendix XI). This program provides service coordination, Individual Family Service Plan (ISFP) development and early intervention services to infants and toddlers who meet the following eligibility requirements:

- The child has a diagnosed condition with a high probability of affecting his/her growth and development.
- The child is 50 percent or more delayed in one or more of the following areas of development: cognitive, adaptive, social/emotional, physical (including vision and hearing), and speech/language.

Infants and toddlers who do not meet these requirements but are at risk of developmental delay are monitored by EIP; thus it is important to make a referral even if you do not believe that a child will meet the requirements for entry into the program. Further, a child who otherwise would be eligible under Medicaid for an early intervention service in a child's IFSP continues to be eligible for the provision of that service under Medicaid. To obtain more information on the DC Early Intervention Program, call (202) 727-5847.

If a child does not meet these requirements, but requires treatment to ameliorate developmental delays or other problems due to medical necessity, it is the responsibility of the PCP to ensure that a referral for that treatment is made.

Section 4.8.2 DC Child Find Program

Children who are aged 3 and older with developmental delays should be referred to the Child Find Program in the DC Public Schools. This program provides special education and related services. Under federal law, children and youth eligible for services under Medicaid that are on a child's Individual Education Plan (IEP) continue to be eligible for that service under Medicaid. Agreements between the school system, Medicaid and its providers ensure coordination of that benefit. It is important to note that many children and youth require treatment over the summer months and during vacations when school is not in session.

For children ages 6 to 12 years of age, an assessment of developmental status and psycho-social adjustment should include a discussion of peer and family relationships and an evaluation of physical development.

Section 4.8.3 Developmental Behavior for Adolescents

For adolescents 10 years of age and older, an assessment of developmental status and psycho-social adjustment should include a discussion of peer and family relationships, school/job performance, use of drugs, alcohol or tobacco, sexual development and activity, and an evaluation of physical development, including Tanner staging.

Section 4.9 Protocol for Behavioral Health Screening

Behavioral health consists of those areas classified as the "classic mental health" issues and substance abuse. Since the PCP is usually the health care professional who first sees the child or adolescent with behavioral health problems, it is extremely important that the PCP screen and provide appropriate referrals for children and adolescents needing behavioral health services.

Section 4.9.1 Initial Assessment

The initial assessment of all children and adolescents should include the following elements:

- Complete health history and physical examination by the PCP
- Psychosocial assessment including:

- Family history
- Childhood experience
- School history, when applicable
- Substance abuse history, both child and family
- Frequency of moving
- Developmental history
- Triage of all new or existing patients for risk in the following areas:
 - History of increased emergency room use
 - History of increased hospitalizations
 - History of school attendance, truancy, or absences
 - History of attention deficit hyperactivity disorder (ADHD)
 - History of substance abuse by member of family
 - History of violent behavior, including fire setting, cruelty to animals, or cruelty to other children
 - History of problems with the law, including theft or selling drugs
 - History of homicidal or suicidal ideation
- Review of all information by the PCP and/or by an interdisciplinary team
- Identification of children/youth at risk, based upon above assessments
- Referral to appropriate behavioral health provider, based upon the risk assessment

Section 4.9.2 Indications for Emergency Referral to a Psychiatrist

If the initial assessment reveals potential problems, the PCP must refer the child or adolescent to an appropriate provider. The problems listed below would indicate a need for an immediate referral to a psychiatrist or to a psychiatric emergency center, depending upon the child's or the adolescent's level of acuity:

- Truancy
- Running away
- Fire setting
- Theft
- Substance abuse
- Homicidal ideation
- Suicidal ideation
- Other violent or abusive behavior
- Major psychoses (e.g., schizophrenia, bipolar disorder)
- Hallucinations
- Organic problems including thought processes, functioning

Anyone who requires medication management should be referred to a psychiatrist. All individuals who have had one or more acute psychiatric hospitalizations need at a minimum immediate follow-up with a psychiatrist. All individuals undergoing more than six months of therapy need at least one visit per year to a psychiatrist for oversight and review of the case.

Section 4.9.3 Indications for an Initial Evaluation by a Psychiatrist on a Nonemergency Basis

The PCP should refer a child or adolescent to a psychiatrist if the provider discovers any of the symptoms listed below. These symptoms, however, are not generally thought to be as critical as those listed in Section 4.9.2.

- Pseudopsychosis
- Paranoia
- Less than total separation from reality, i.e., pre-psychoses
- Psychoses
- Disassociative disorders

Section 4.9.4 Indications for Referral to a Psychologist

The PCP should refer the child or adolescent to a psychologist for the following indications:

- Psychological testing, including IQ and Projective tests, for:
 - Substance abuse
 - Chronic behavioral problems
 - Truancy
 - Arrests
 - History of group home residency
 - Learning disabilities
 - Behavior modification

Psychological testing is generally valid for two years. Onset of puberty, by itself, is not an indication for re-testing.

Section 4.9.5 Indications for Referral to a Psychiatric Social Worker

A psychiatric social worker may be the appropriate provider if the child/adolescent:

- Is not psychotic
- Does not need medication
- Has no confounding medical conditions
- Needs behavior modification
- Needs anger management
- Has a history of depression less than six months
- Is experiencing reactive depression, such as from death of a family member or friend,
 - lasting less than six months
- Is facing major family stresses, such as divorce or family conflicts

Section 4.9.6 Indications for Acute Psychiatric Hospitalization

Only a psychiatrist should determine the necessity for acute psychiatric hospitalization. The child/adolescent's PCP, however, should work closely with the psychiatrist to provide medical information, family history, school history, and all other items discussed in this section. The PCP should also stay involved following discharge from an acute care facility since the PCP remains the provider to whom the child or adolescent may first turn to in an emergency.

Section 4.9.7 Indications for Residential Treatment

In general, residential treatment is indicated when all other modalities, including outpatient therapy or acute hospitalization, have failed. Again, the PCP has a major role to play, including making appropriate referrals and providing medical and family histories, medical diagnoses, and other pertinent information. The PCP will remain an active member of the child/adolescent's health care team following discharge from a residential treatment program.

Section 4.10 Immunizations

All PCPs must ensure that patients receive age-appropriate immunizations and use each encounter as an immunization opportunity. At each preventive health supervision visit, the child's immunization status must be reviewed and brought up to date.

Every year the Centers for Disease Control and Prevention's (CDC) Committee on Immunization Practices (ACIP) reviews the recommended childhood immunization schedule. This is to ensure that the schedule remains current with changes in manufacturers' vaccine formulations, any revised recommendations for the use of licensed vaccines, and recommendations for newly licensed vaccines. These changes are endorsed and supported by the AAP's Committee on Infectious Diseases and the American Academy of Family Physicians (AAFP) (Appendix XI).

The following immunizations are recommended by ACIP, AAP and the AAFP working group: diphtheria, tetanus, pertussis, polio, haemophilus influenzae type b, measles, mumps, rubella, hepatitis B, varicella, and pneumococcal vaccines. For information and availability of all vaccines, including the recommended schedule and regulations governing school immunization requirements, contact the DC Immunization Program at (202) 576-7130, ext. 24 or 25.

All vaccines should be administered according to the recommended immunization schedule and at the appropriate preventive health visit. For specific vaccine information, practitioners should consult the manufacturer's official package inserts, the report of the Committee on Infectious Diseases (Red Book, 2000), or the ACIP statements on specific vaccines. Additional vaccine information may be obtained from CDC's National Immunization Program Web site (www.cdc.gov/nip/publications/vis) or the AAP web site (www.aap.org).

Section 4.10.1 Vaccines for Children Program

The National Vaccines for Children Program (VFC) supplies the majority of vaccines to immunize Medicaid-eligible children from birth through 18 years of age at no cost to physicians

who enroll in the VFC program. Other children eligible to receive VFC-provided vaccines include children who do not have health insurance and children who are Native Americans or Alaskan natives. In addition, children who have health insurance that does not pay for vaccines are eligible to receive VFC vaccines at Federally Qualified Health Centers (FQHCs). All PCPs participating in Medicaid (including those providers in an MCO) are eligible to enroll and participate in the VFC program. Details of this program and enrollment information are available from the DC Immunization Program at (202) 576-7130, ext. 27. The Immunization Program can also provide information on FQHCs in the District of Columbia.

Section 4.10.2 National Childhood Vaccine Injury Act

The National Childhood Vaccine Injury Act of 1986 obligates physicians to provide a copy of the most current Vaccine Information Statement (VIS) to the child's parent/legal guardian or to adolescents who are 18 years of age or younger and are covered under the VFC program. VISs are available and required for all vaccines that are routinely recommended for infants and children covered by the National Childhood Vaccine Injury Act. VISs are also available for influenza, pneumococcal, and hepatitis A vaccines; use of the VIS forms for these vaccines are recommended but not required by federal law. Whether in public clinics or private physician offices, providers are required not only to maintain documentation of when and what vaccines were administered, but also to document in the patient's medical record the date that the VIS was given, along with the statement's publication date.

Section 4.10.3 Immunization Documentation

If an immunization history is based on a verbal report of a parent, guardian, or other responsible adult, the PCP must confirm immunization histories through the child's previous health care provider, school or day care center and must properly document the information (vaccine dates and source) in the medical record. If the child's immunizations are not up to date according to age and health history, the PCP should document why immunizations were not given at the time of the initial office visit. To locate missing or lost immunization records, the DC Central Immunization Registry, a computerized information system that contains data on children's immunization histories, represents an important tool in locating vaccine dates for children living in the District of Columbia. The telephone number is (202) 576-7130, ext. 7 on-call person will locate information.

If verbal reports of vaccine dates cannot be verified, the immunizations must be repeated. For measles, mumps, and rubella, serological evidence of immunity to all three antigens is an acceptable alternative.

Section 4.10.4 Adolescent Immunizations

ACIP and AAP recommend that adolescent immunization visits be part of the childhood immunization schedule. This visit should occur between ages 11 and 12 years. This routine preventive care visit offers an ideal opportunity to ensure that measles, mumps and rubella (MMR) dose 2, hepatitis B (if there is no documentation that the series of three vaccines has not been completed), and varicella (chickenpox) vaccines, along with a tetanus and diphtheria (Td)

booster dose are up to date and to administer those vaccines that are missing. This visit also offers the opportunity to review the patient's medical history and to administer other vaccines that may be recommended for certain adolescents.

Section 4.10.5 Adverse Events

Adverse events following vaccinations must be reported to the federal Vaccine Adverse Event Reporting System (VAERS) and the DC Immunization Program. VAERS is a joint CDC-Food and Drug Administration program providing a single nationwide mechanism for reporting and tracking all vaccine adverse events following immunization. For VAERS information and reporting, call 1-800-822-7967. In the District of Columbia, call the DC Immunization Program at (202) 576-7130, ext. 13.

Section 4.10.6 School Exemptions

The compulsory school immunization law (D.C. Law 3-20) provides for two exemptions for students from the required immunizations: religious and medical. A religious exemption may be granted to a student who in good faith believes that immunizations would violate his/her religious belief. A medical exemption may be granted by a physician who determines that immunizations would be medically inadvisable because of health reasons or a time-limited condition.

All exemptions must be in writing and submitted for approval to: Chief, Bureau of Epidemiology and Disease Control, 825 North Capitol St., NE, Washington, DC 20002. The telephone number is (202) 442-9366; the fax number is (202) 442-4834.

Section 4.10.7 Vaccine Contraindications and Precautions

Before administering any vaccine, PCPs should consider the following:

- Refer to package inserts and statements from ACIP and AAP for additional details.
- Follow the manufacturer's recommendations regarding dosage, route of administration, and storage of vaccines.
- The decision to administer or delay DTaP vaccine because of a current or recent febrile illness depends largely on the severity of the symptoms and their etiology.
- Mild acute illnesses with or without low-grade fever and current use of antibiotics or other medicine (except immunosuppressive medicine or radiation therapy) are **not** contraindications for any vaccine. If, however, the patient has a moderate or severe illness with or without a fever and appears to be very sick, immunization should be delayed.
- Anaphylactic reaction to a vaccine contraindicates further doses of that vaccine.
Anaphylactic reaction to a vaccine constituent contraindicates the use of vaccines

containing that substance.

- All live virus vaccines should not be given to females known to be pregnant or considering becoming pregnant within a three-month time period.
- MMR vaccine is contraindicated for those who have experienced an anaphylactic reaction to egg ingestion or to neomycin. IPV is contraindicated for children who have experienced an anaphylactic reaction to neomycin or streptomycin. Anaphylactic reaction to common baker's yeast contraindicates the use of hepatitis B vaccine.

This information is based on the recommendations of ACIP and AAP. Sometimes these recommendations vary from those contained in the manufacturer's package inserts. For more detailed information, PCPs should consult the published recommendations of ACIP, AAP, and the package inserts. This information may be obtained by calling the DC Immunization Program at (202) 576-7130, ext. 24.

Section 4.11 Laboratory and Diagnostic Testing Services

Certain age-appropriate routine laboratory tests must be performed on children in the DC HealthCheck Program. If any laboratory tests are medically contraindicated at the time of the preventive health supervision visit, they must be provided as soon as they are no longer medically contraindicated. The required age-appropriate tests are described in the following sections.

Section 4.11.1 Metabolic/Hemoglobinopathy Screening and Follow-up Services

DC law requires all hospitals and maternity centers in the District of Columbia to make available blood tests to screen newborns for certain metabolic disorders so that referral and treatment may be provided, to inform the parent(s) of the availability and purpose of the tests, and to test the newborn unless parental consent is withheld or an identical test has been performed. The current panel of disorders to be screened for includes: sickle cell disease, G-6-PD deficiency, congenital hypothyroidism, galactosemia, phenylketonuria, maple syrup urine disease, and homocystinuria. The purpose of the legislation is to prevent life-threatening complications and serious chronic consequences, including mental retardation and developmental disabilities.

For the full-term, well newborn, the blood specimen should be obtained as close as possible to the time of discharge from the hospital, at 24 to 48 hours of age. If the initial specimen is obtained earlier than 24 hours after birth, a second specimen should be obtained by 1 week of age to decrease the probability that testing on the first day of life will miss some disorders screened for. Unacceptable samples (insufficient quantity of blood, improper sample storage, etc.) will also require repeat testing.

The Department of Health, Maternal and Family Health Administration (MFHA) is responsible for administering the Newborn Screening Program and assuring that providers adhere to established protocols and procedures in order to ensure that District of Columbia residents

receive quality screening services. MFHA staff notifies the physician/facility of abnormal laboratory findings (inclusive and presumptive positive test results), provide appropriate educational materials and referral information, monitor the results of repeat tests, and track those patients who require treatment. It is the physician's responsibility to obtain the repeat test and provide appropriate referrals to pediatric specialists with expertise in endocrinology, hematology and genetic. The well-child PCP is also responsible for documenting and maintaining a record of the infant's follow-up services related to the newborn screening.

Pediatrix Screening, Inc., of Bridgeville, PA, is under contract with the DC Government to analyze blood samples from all babies born in the District of Columbia and provide test results. Recently the laboratory developed two systems to allow physicians automated access to laboratory test results. There is no cost to the user. The new systems offered are: (1) Interactive Voice Response via a toll free telephone number and (2) Laboratory Information System, Internet Data Analysis Component. The user must obtain written parental consent before accessing both systems, in accordance with the DC Newborn Screening Law. The systems do not permit access unless the user verifies that he/she has obtained written parental consent.

To register as a user, contact Pediatrix Screening by mail, phone, fax or e-mail -- mailing address: Pediatrix Screening, Attention: Registration, 90 Emerson Lane Suite 1403, Bridgeville, PA 15220; phone: (412) 220-2300; fax: (412) 220-0784; or e-mail address: Registration@pediatrixscreenng.com. Include the following physician information: name, mailing address, telephone number, fax number, e-mail address, medical license number, specialty, and signature. Also select IVR, Internet or Both systems; the user will be assigned specific identifying information to access the systems.

For more information on the DC Newborn Metabolic Screening Program, contact DOH-MFHA, 33 N Street, N.E., Washington DC 20002; phone (202) 727-7540.

Section 4.11.2 Sickle Cell Screening

District of Columbia law requires screening infants for sickle cell disease at birth unless parental consent is withheld. All infants and children who are at risk for sickle cell disease must receive sickle cell screening (refer to Section 4.11.1). All other children who are at risk for sickle cell disease (if there is any doubt about previous testing) should be screened for hemoglobinopathy disorders as part of the HealthCheck screen. A statement of the test results must appear in the child's medical record.

If the clinician makes the judgment that the child is not at risk (by ethnicity or previous screening), a statement of the assessment should appear in the child's medical record.

Section 4.11.3 Lead Screening

District of Columbia law states that all children under age 6 attending DC Public Schools (DCPS) or in a licensed day care center, Head Start or similar childhood program, prekindergarten or kindergarten must furnish the school with a Certificate of Testing for Lead Poisoning (Appendix XII). The physician certifying that the blood lead test was performed must

complete the form. The child's parent or guardian is required to return the completed form to the school or facility. The physician should maintain the test results in the medical record.

Childhood lead poisoning is the most common environmental disease of children below age 6 in the United States. Lead poisoning has serious implications for children's present and future health status. Lead poisoning during early childhood puts a child at risk in later childhood of learning disabilities, attention deficits, hyperactivity, and behavioral disorders, with known serious adverse effects on future growth and development. It is also recognized that lead poisoning is both treatable and preventable. CDC requires lead testing to be a two-part process consisting of a verbal assessment and screening blood lead tests.

Section 4.11.3.1 Verbal Lead Risk Assessment

Starting at the health supervision visit at 6 months of age and at each screening visit thereafter to age 6, the parents or guardians should be counseled on how to create an environment safe from lead exposure for the child. Advice should be given on eliminating peeling or chipping paint, decreasing the lead content of water, preventing contact via hobbies or contaminated work clothing, remaining alert for pica behavior, and assuring good hygiene. The PCP must start asking parents the following CDC lead risk assessment questions when children are 6 months of age (when most start crawling) and continue until they are 6 years old:

1. Has your child been diagnosed with lead poisoning (elevated lead level)?
2. Are there any children with a current or past history of lead poisoning living in or regularly visiting your home?
3. Does your child live in or regularly visit a home with chipping or peeling paint?
4. Does your child eat dirt or cigarettes or fireplace ashes or chew on old metal or painted toys?
5. Have you seen your child chewing on paint chips or painted surfaces (doors, railing, Windowsills, etc.)?
6. Does your child live in or regularly visit a home with recent, ongoing, or planned renovations or remodeling?
7. Do you or any other adults within your home have a hobby that involves lead, i.e., furniture refinishing, home renovations, constructions work, or automobile repairs?
8. Do you regularly store food or liquid in pottery, ceramic dishes, or previously opened metal cans?
9. Does or did your child regularly live in or visit a home near an active lead smelting plant, battery recycling plant, or industry likely to release lead?

Determining Risk

Risk is determined from the responses of the child's parent or guardian to the questions listed above. If the answers to all questions are negative, the child is considered low risk for high doses of lead exposure. If the parent or guardian appears to be uncertain as to how to answer the questions or states that he or she does not know the answers, you must assume the child is high risk. Subsequent verbal risk assessment can change a child's risk category. If, as the result of a verbal risk assessment, a previously low-risk child is reevaluated as high risk, that child shall be given a screening blood test more frequently. Frequency will be determined on the basis of assessment data.

Section 4.11.3.2 Blood Lead Assessment

The Department of Health, in conjunction with the Department of Human Services (DHHS), requires all PCPs to screen all Medicaid-eligible children for elevated blood lead levels as part of their well-child visits at 9 or 12 and 24 months of age. Children who have not been previously screened should be tested between 36 and 72 months of age. The District of Columbia Lead Poisoning Prevention Division (DCLPPD) requires a venipuncture technique to collect all blood specimens for blood lead screening.

If a child is determined by the verbal risk assessment to be at:

Low Risk -- a screening blood lead test is required once between 9 and 12 months for all children residing in DC and is required again at or around 24 months of age.

High Risk -- a blood lead test is required when a child is identified as being high risk, beginning at 6 months of age. If the initial blood test produced results of greater than 10 micrograms/per deciliter (ug/ dl), a screening blood test is required at every visit prescribed in the DC HealthCheck Periodicity Schedule.

It is recommended that blood specimens be tested at a laboratory that participates in a blood lead proficiency-testing program with CDC. In the District of Columbia, the participating proficiency testing labs are: DHS' Bureau of Laboratories, (202) 727-0557, and the Clinical Laboratory at Children's Hospital National Medical Center, (202) 884-5355.

Blood specimens may be sent to the DHS Bureau of Laboratories for lead testing. There is no cost for this service. Laboratory results are sent back to the PCP and forwarded to DCLPPD. For more information, contact DCLPPD at (202) 535-1396.

Section 4.11.4 Hematocrit/Hemoglobin (Anemia)

The most common cause of anemia in children and adolescents is iron deficiency. The American Academy of Pediatrics recommends that a test for anemia occur at 9 months and once between 11 and 20 years. High-risk infants under 9 months should also be tested. When a child's history indicates a high risk, the test should be performed more frequently. Referring to the nutritional

assessment, which is part of the HealthCheck screening, may also provide information on the level of risk for anemia.

Hemoglobin (Hgb) and Hematocrit (Hct) testing to screen for anemia can be accomplished by either two basic methods: venipuncture with analysis by automated cell counter or capillary puncture with microhematocrit analysis by centrifuge. If the microhematocrit method is used, the following principles of collection should be followed:

- In infants, the best sites for collections are the medial and lateral aspect of the plantar surface of the heel. In older children, the best sites are the medial and the lateral aspects of the pulp of the finger. The puncture should be made perpendicular to the skin and across the dermal ridges.
- To increase blood flow, a warm (100° to 108° F) moist towel may be applied to the site.
- Massage of the collection site should be avoided if possible, as this may dilute the sample with tissue fluids.
- Before puncture, the site should be cleaned with an antiseptic and allowed to dry.
- Sterile, disposable lancets with tips less than 2.5 mm long should be used with infants 6 months of age or younger. Lancets with longer tips (up to 5 mm) may be used for older children.
- The first drop of blood, which contains tissue fluid, should be wiped away with dry sterile gauze.

Section 4.11.5 Urinalysis

A urinalysis must be performed at 5 years of age but may be performed as early as 3 years of age for schools. Urinalysis is required again once between 11 years and 20 years, with preference at 16 years of age. Sexually active males and females should have urine screening (with dipstick leukocyte esterase test) for leukocytes to determine the presence of gonorrhea and/or chlamydia. Those found to be positive should be evaluated for urethritis.

Section 4.11.6 Cholesterol Screening

The American Academy of Pediatrics states that compared to their counterparts in other countries, US children and adolescents have higher blood cholesterol levels and higher intakes of saturated fatty acids and cholesterol and that US adults have higher rates of coronary artery disease. AAP recommends an individualized approach including selective screening to detect children and adolescents with hypercholesterolemia.

Section 4.11.6.1 Identification of High-Risk Children

AAP recommends screening children whose parents:

- Or grandparents underwent coronary angiography and were found to have coronary artery disease under the age of 55 years;
- Or grandparents had a documented myocardial infarction, angina pectoris, peripheral vascular disease, cerebral vascular disease, or sudden cardiac death;
- Have an elevated blood cholesterol of greater than 240 mg/dl; and
- Have a history that is unobtainable, particularly those with other risk factors, such as obesity, smoking, and poor dietary habits.

Section 4.11.6.2 High-Risk Children in Washington, DC

MAA adopted a modified version of AAP's schedule with screening recommendations, based on an article published in the September 1996 issue of Pediatrics. The article recommended that high-risk children and youth be screened to detect hypercholesterolemia. In the journal article, D'Angelo, Rifal and others discussed the inadequacy of AAP guidelines for screening urban African American populations. Studying 260 children in Boston and Washington, DC, the authors found that 12 percent of the children with elevated cholesterol would have been missed using AAP guidelines alone. They also found that many children were unable to provide adequate family histories and fell into the risk categories of obesity or smoking, for example, as mentioned in the AAP recommendations. The authors recommended screening for total cholesterol and high-density cholesterol at the initial screening and universal screening for adolescents and young adults of African American origin.

Section 4.11.6.3 Recommended Screening Intervals

The initial test should be a measurement of total cholesterol. If the child/adolescent's level is higher than 200 mg/dl, a fasting lipoprotein analysis should be performed to measure HDL and LDL cholesterol. It is therefore recommended that PCPs screen high-risk patients at 24 months and at 5, 6, 8, and 10 years. Subjective screening should occur at 3 years of age. At age 4 children should be screened for total cholesterol and high-density cholesterol. All children ages 11 through 20 at risk should receive objective screening.

The following table contains classifications of “Total” and “LDL-Cholesterol Levels” from the AAP recommendations:

Category	Total Cholesterol (mg/dL)	LDL-Cholesterol (mg/dL)
Acceptable	<170	<110
Borderline	170-199	110-129
High	>200	>130

Section 4.11.7 AAP’s Recommendations for Management

The AAP recommendations for management include:

- **Acceptable LDL cholesterol levels** -- provide education on eating patterns and on other risk factors; repeat analysis in 5 years;
- **Borderline LDL cholesterol levels** -- advise about risk factors for cardiovascular disease and initiate the American Heart Association (AHA) low-fat diet and other risk factor interventions; test again in one year;
- **High LDL Cholesterol levels** -- examine for secondary causes (thyroid, liver and renal disorders) and familial disorders and screen all family members; initiate AHA low- fat diet.

Section 4.11.8 Tuberculin Test

The DOH Bureau of Epidemiology and Disease Control, Division of Tuberculosis Control, recommends that all children have the TB skin tests using the Mantoux Method (PPD). The first test should occur at age 12 months, and if the child is at high risk, should be repeated between 15 and 24 months. Children should be tested at least once during their preschool years (ages 3-5), and annually beginning at age 8. Children with positive tests are to have treatment and additional evaluations by physicians promptly and yearly.

Children are considered high risk if they:

- Are in contact with adults with infectious tuberculosis;
- Are from, or have parents who are from, regions of the world with prevalence of tuberculosis;
- Have abnormalities on chest roentgenogram suggestive of tuberculosis;
- Have clinical evidence of tuberculosis;
- Are HIV-seropositive;
- Have immunosuppressive conditions;

- Have other medical risk factors, such as Hodgkins’s disease, lymphoma, diabetes mellitus, chronic renal failure, or malnutrition;
- Are or were incarcerated adolescents; or
- Are frequently exposed to the following adults: HIV-infected individuals, homeless persons, users of intravenous and other street drugs, poor and medically indigent city dwellers, residents of nursing homes, and migrant farm workers.

Section 4.11.9 Sexually Transmitted Diseases and Pregnancy Screening

Sexually active females (high-risk) should be screened annually starting at age 11 for chlamydia, gonorrhea, and hepatitis B. Additionally, any young female acknowledging symptoms of either chlamydia or gonorrhea or an instance of sexual assault should be screened for both diseases. Similarly, males acknowledging high-risk behaviors or symptoms consistent with gonorrhea or chlamydia should be screened for both diseases. Both sexes should be counseled regarding the prevention of unplanned pregnancy, HIV infection, and other sexually transmitted diseases. Females should be routinely offered pregnancy testing; if pregnant, they should receive counseling from the PCP or from an organization such as Planned Parenthood. Males and females should also be routinely offered HIV and if not adequately immunized, hepatitis B testing, as appropriate. DC law (District of Columbia Municipal Regulations, Chapter 2, Section 205, “Communicable and Reportable Diseases”) requires laboratory testing for gonorrhea at the first pregnancy visit and during the last trimester. If the PCP is not properly equipped to perform these services, referral to an appropriate provider should be made.

Section 4.11.10 Serology Testing

Syphilis screening is required for pregnant women during the first prenatal visit and in the last trimester of pregnancy. Annual syphilis serological testing is recommended for all high-risk adolescents. Immediate screening should occur for all adolescents acknowledging a sexual assault, presenting symptoms consistent with syphilis, gonorrhea or chlamydia, or admitting to a recent history of symptoms. HIV testing should be offered to adolescents whenever syphilis testing occurs.

Because the causative agent of syphilis cannot be cultured, screening relies on serology. A nontreponemal test -- usually the Venereal Disease Research Laboratory (VDRL) or the Rapid Plasma Reagin (RPR) test -- is recommended for initial screening. At times, uninfected individuals may have a positive VDRL or RPR; in such cases, the florescent treponemal antibody absorption (FTA-ABS) test should be used to confirm or rule out the diagnosis.

Section 4.11.11 Papanicolaou Smear

The Papanicolaou smear (Pap smear) should be offered to all females between the ages of 18 and 21 as part of preventive maintenance. All sexually active adolescent females should receive a yearly PAP smear regardless of age.

Section 4.12 Health Education and Anticipatory Guidance

Section 4.12.1 Background: Bright Futures Approach

The primary care provider has a central role in promoting the optimal physical and emotional development of children and adolescents. The PCP can enhance this role by carefully observing interactions between parent and child, actively listening to concerns, and seeking ways to guide and support the family. Health supervision offers the health care professional the opportunity to monitor physical health, growth, and development and parent/caregiver-child relationships. It also provides the opportunity to increase competence, confidence, and the active participation of children, adolescents and their families in their health care.

In 1994 the National Center for Education in Maternal and Child Health (NCEMCH) published *Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents, Second Edition, Revised*. The guidelines were issued as part of the *Bright Futures* project, sponsored by the Health Resources and Services Administration's Maternal and Child Health Bureau and the Health Care Financing Administration's Medicaid Bureau. Among the many child and adolescent health-related organizations participating in the development of the guidelines were the American Academy of Child and Adolescent Psychiatry, the American Academy of Pediatrics, the Association of Maternal and Child Health Programs, the Child Welfare League of America, and the Society of Pediatric Nurses. (*The Bright Futures* guidelines are available on the Bright Futures at Georgetown University's Web site (www.brightfutures.org)).

At the beginning of the 20th century, infectious diseases caused most of the morbidity and mortality in children. Health care, therefore, consisted mainly of physical examinations to detect contagious diseases. Although immunizations and improvements in sanitation have greatly reduced the mortality rate among children since then, children and youth today face new dangers as a result of societal changes. Injuries, both intentional and unintentional, are the leading cause of death. An estimated 12 to 15 percent of children and adolescents have behavioral health problems. Among 15-year olds, one in seven smokes, one in three has consumed alcohol excessively; one in five smokes marijuana on a daily basis, and one in four girls and one in three boys is sexually active (Bright Futures 2002).

Today's health professionals must address the issues of these new morbidities. Health supervision must include physical, behavioral, cognitive and social development. It must be done within the context of the family, socioeconomic and cultural variables, and the community at large. The approach must be developmental and longitudinal. It must include partnerships with the family, the child/adolescent and the community and must be integrated with other health care disciplines, including behavioral health (*Bright Futures*). The managed care organizations have a responsibility to work with the primary care physician, the family and the child, coordinating these needed services to the greatest extent possible. The *Bright Futures* approach as discussed in this manual, addresses these ideas.

Health education and anticipatory guidance, based on *Bright Futures* concepts, is a required component of each preventive health visit and must be documented at each visit. It should focus

on both parent and child and should be integrated throughout the encounter. Health education and anticipatory guidance are to be presented in a manner that will:

assist the family in understanding what to expect in terms of the child's development; provide information about the benefits of healthful lifestyles and practices; and promote the prevention of diseases, injuries, and accidents.

Age-specific anticipatory guidance is included in each of the age-specific encounter forms. As part of anticipatory guidance, the provider is required to advise the parent or guardian when to schedule the next visit according to the Periodicity Schedule (Appendix VII).

Section 4.12.2 General Discussion Topics

Following are general topics that providers should discuss with parents and their children as part of health education and anticipation guidance:

Healthful habits	Social Development
Nutrition	Prevention of illness and injury
Family Relationship	Self-responsibility
Oral Health	School/vocational achievement
Parental health	Spirituality
Community interaction	Sexuality

Since not all these topics can be adequately discussed during time-limited visits, providers should consider providing supplementary educational handout for parents and older children.

Section 4.12.3 Age-specific Discussion Topics

Infant through Preschools Child

The following topics should be discussed with parents of infants and preschool children:

Developmental task	Parenting
Injury/prevention	Dental care
Nutrition	Family planning (mothers)
Sleep	School readiness
Child care	Behavior/discipline
Toilet training	
Self-comforting behaviors	

The following topics should be addressed to parents of school-aged children, with increasing involvement of the child in the discussion and decision-making:

Developmental tasks	• School progress
Parenting	Health habits/self care
Behavior/discipline	Social interactions
Sex education	Injury prevention
Nutrition	Dental care
Counseling regarding	

Adolescent

The following topics should be addressed to parents and their adolescents, focusing on the adolescent's increasing responsibility in decision-making:

Developmental tasks

Parenting

Contraception

STDs including AIDs

Smoking

Alcohol/drugs

Nutrition

Dental care

School progress

Social responsible

Safe driving

Counseling regarding sexual activity

Health habits/self-care

Injury prevention

Suicide prevention

Violence

Accidents

Social interactions

Respect for self/other

Section 4.12.4 Dental Education and Referral

Appropriate dental health education should be provided at each visit. Beginning at age 3 and yearly thereafter, all children are to be informed about the need to see a dentist for good oral health. The MCO is responsible for making a direct referral to a dentist.

Section 4.12.5 Periodicity of Health Supervision

Recommendations for how often children require supervision by health professionals are based on the tenets of child and family development. Prevalent issues and opportunities are targeted to enhance strengths at key developmental stages with adherence to specific frequency and timing of health supervision.

“The periodicity schedule suggests the amount of care needed by infants, children and adolescents judged not to be at undue risk. However, health supervision should always be tailored to meet individual needs” (Bright Futures 1994). In addition, longitudinal and developmental health supervision allows health promotion and prevention to be introduced and reinforced at multiple stages of the child/adolescent’s development.

Certain populations -- such as children and adolescents with chronic illness or disability, in foster care, living in chaotic households, or assessed as being at high risk medically, developmentally, or socially – will require more health supervision or interventions. Moreover, during critical periods of family transition or discontinuity -- such as divorce, remarriage, death, a parent’s mental or physical illness, or school entrance -- special care or supplementary health supervision may be needed. Accordingly, each family’s needs should be the determining factor for the expanded schedule of care. See the DC Healthy Tots and Teens Periodicity Schedule in Appendix VII.

Section 4.12.6 Tips for Working with Parents

The following suggestions for developing effective working relationships with parents are offered:

- The family is the primary support system for the child and the preferred point of intervention.
- Communication with parents is best when it is simple, honest and nonjudgmental.
- What you say (and how you act) is important. How adequate a parent feels may depend strongly on your judgment of their child.
- Because every child is unique, providers should communicate that they recognize and value a child’s individuality.
- There is no “average” child. Providers should avoid labels and stereotypes.

- Providers must take into account that individuals make different choices based on cultural factors; these choices must be considered if service is to be helpful.
- Showing respect for the child’s current status and helping the family cope with any problems may be just as important as determining the cause of the problem.
- Physicians can help parents understand that certain problem behavior (e.g., night fears in toddlers) may be developmentally appropriate and normal.
- Parents may regard their physician as an expert beyond his/her area of expertise. Providers should not hesitate to refer parents to behavioral health and support services as appropriate.

Section 4.12.7 Tips for Working with Adolescents

From a traditional medical perspective, adolescents for the most part are healthy. But they face many risks. Adolescence is a time of significant change that can lead to emotional disorders and health-risk behaviors, some of which may cause serious morbidity and mortality. Depression, suicidal ideation, unsafe sexual behaviors leading to sexually transmitted infections and pregnancy, alcohol and drug use, use of tobacco products, and unintentional injuries are just a few of the significant health problems confronting adolescents today.

On the other hand, adolescence is one of the most dynamic periods of human development. Adolescence is accompanied by dramatic physical, cognitive, social and emotional changes as the young person grows into adulthood. Providers need to be sensitive to these changes and to develop a partnership with the adolescent, understanding that over time he or she will become increasingly independent. The role of the provider is to respect these changes, nurture self-assurance, provide knowledge about how to meet challenges, and encourage healthful choices (Bright Futures 2000).

Contraceptive Options Counseling

Before an adolescent can consent to any form of contraception, the PCP must fully explain the benefits and risks of each method. The following methods may be discussed:

- **Abstinence** should be encouraged as the most effective way to prevent pregnancies, AIDS, and other STDs.
- **Condoms** should be recommended for all sexually active males and females. Provide information on different types of condoms (latex, lubricated vs. non-lubricated), and instruct both males and females on their proper use, including how to put them on. Participating pharmacies can dispense 12 latex condoms at a time without a prescription to those with a Medicaid card.

- **Contraceptive foam, suppositories, and sponges** are available as nonprescription items in pharmacies and some food chains. Contraceptive effectiveness is increased when spermicidal preparations are used with condoms.
- **Depo-Provera**, a progestin-only injection providing contraceptive efficacy for three months, is becoming the method of choice for adolescents.
- **Diaphragms** can be effective as contraceptives if the adolescent is conscientious.
- **Intrauterine devices (IUDs)** are not a primary choice for adolescents, but young women who have had a child may choose this method.
- **Norplant**, a five-year contraceptive system consisting of six matchstick-size capsules implanted in the upper arm, may be an option for some female adolescents.

HIV Prevention/Education

The information presented on HIV prevention should be based on the level of maturity and sexual development of the adolescent. Appropriate emphasis should be placed on abstinence from sex and drugs.

- HIV Risk Reduction Messages for Sexually Active Adolescents
- Abstain from sex.
- Maintain a mutually monogamous relationship with an uninfected partner.
- Consistently use protective barriers during sex.
- Use latex condoms with water-based lubricant (oil-based lubricants weaken condoms).
- Use lubricants/spermicides containing nonoxynol-9.
- HIV Risk Reduction Messages for Drug-using Adolescents
- Enter a drug treatment program.
- Avoid sharing any drug-injecting paraphernalia.
- Disinfect needles and syringes using household bleach (twice).
- Draw bleach into syringe and expel (twice).
- Beware of injection “works” sold as clean on the streets.
- Use protective barriers (latex condoms) during sex.

For additional information and HIV/AIDS prevention materials for your office, call the Agency for HIV/AIDS at (202) 727-2500.

Section 4.13 Mental Health and Anticipatory Guidance

Health professionals, especially primary care clinicians, are uniquely able to promote mental health among the children and adolescents to whom they provide services. Traditionally, mental health in the clinical setting has focused on behavioral health disorders and its treatment. The primary care provider, however, has the opportunity to promote good mental health and assist in the prevention and/or amelioration of emotional difficulties by developing a partnership with the family, the child or adolescent, and the community.

The primary care provider can encourage healthy attitudes and behaviors with regard to a child/adolescent's self-esteem, family relationships, school performance, friendships, and activities of daily living. The PCP must also have an understanding of childhood development and be able to convey that understanding to the family. What may be normal behavior at 2 years of age could be considered unhealthy at age 10.

Bright Futures discusses these issues extensively in the sections entitled "Anticipatory Guidance for the Family/Anticipatory Guidance for the Adolescent." They include discussions on how to promote social competence, constructive family relationships, school achievement, responsibility, and community interactions. For further information, see the Bright Futures Web site at www.brightfutures.org.

Section 4.14 Injury Prevention and Anticipatory Guidance

Accidental injuries are the leading cause of death for children in this country. The DC HealthCheck Program views injury prevention as part of health education and anticipatory guidance. According to the National SAFE KIDS Campaign, in 1996 nearly 6,300 children ages 14 and under died as a result of unintentional injuries. Additionally, each year, almost 120,000 children become permanently disabled from injuries, while 14 million are injured seriously enough to require medical attention. Childhood injuries account for 223,000 hospitalizations, close to 8.7 million emergency room visits, and over 12 million visits to physicians' offices. The estimated annual lifetime cost of these unintentional injuries is nearly \$175 billion. Appropriate health education and counseling on injury prevention can alert parents and children to many risk behaviors and unsafe environments and advise them on how to modify behaviors and the environment to prevent injury.

PCPs should initially direct the guidance toward the parents, who serve not only as role models, but also as the persons most in control of the child's environment. Counseling should be increasingly directed toward the child and the adolescent as they mature and become more responsible for their own behavior.

Section 4.14.1 Age-Appropriate Safety Issues

Infants and Preschoolers

PCPs caring for infants and preschool children should advise parents about:

- **Traffic safety** -- Discuss the appropriate use of currently approved child safety restraints (required in all states). Use of a car seat should begin with the first ride home from the hospital. Hospitals generally have car seat loaner programs.
- **Burn prevention** -- Home smoke detectors should be installed and maintained. Hot water heaters should be set between 120° and 130° F to prevent scalding.
- **Electrical shock prevention** -- Electrical outlets should be covered with plastic guards.
- **Poison prevention** -- Medicine and dangerous household products should be kept in childproof containers and out of the reach of children. Parents should have available a 1-ounce bottle of syrup of ipecac to be administered after consultation with the physician or poison control center.
- **Drowning prevention** -- Advise parents to empty and properly store buckets immediately after use and to never leave an infant or child in the bathtub without constant adult supervision. Backyard swimming pools should be completely fenced, and children should never swim unsupervised.
- **Choking/suffocation prevention** -- Advise parents to remove from reach small objects that can lead to choking or suffocation, including toys, plastic bags, and foods such as whole grapes, popcorn, hot dogs, or peanuts.
- **Sudden infant death syndrome (SIDS)** -- Infants should be placed on their backs instead of their stomachs to decrease the risk of SIDS.
- **Emergency preparedness** -- Parents should be trained in basic life-saving skills, including infant and child cardiopulmonary resuscitation (CPR), and should know how to contact local emergency services.

School-Age Children

As children move into elementary school, advise parents to become more focused on the child's behavior. The child should participate in the counseling process, while parents are advised of the importance of modeling safe behaviors. Safety issues for this age group include:

- **Traffic safety** -- Continue to emphasize the use of seat belts. Review safe pedestrian practices. Emphasize the importance of wearing approved bicycle

helmets on every bike ride and using protective equipment for in-line skating and skateboarding.

- **Water safety** -- Children age 5 and older should be taught to swim and should learn rules for water play. They should never be allowed to swim alone. When involved in a boating activity, they should always wear Coast Guard-approved personal flotation devices.
- **Sports safety** -- Adults who supervise children in organized sports should emphasize the importance of appropriate protective equipment and physical conditioning for the sport.
- **Firearm safety** -- Encourage parents to keep firearms out of the home. If they choose to have them, they must keep unloaded guns and ammunition in separate locked cabinets.

Adolescents

Counseling on injury prevention to adolescents should be part of a broader discussion of healthful lifestyles choices, particular the use of alcohol and other drugs. Specific areas of injury prevention guidance to adolescents should include:

- **Traffic safety** -- Encourage seat belt use and discuss the role of alcohol in teenage motor vehicle accidents.
- **Water safety** -- Discuss the dangers of alcohol use in water-related activities, particularly diving, and new rules for use of personal flotation device in boating
- **Sports safety** – Teens participating in organized sports programs need to be reminded of the importance of safety equipment and appropriate physical conditioning for the particular sport.
- **Firearm safety** -- In-home firearms are particularly dangerous during adolescence because of the potential for impulsive, unplanned use resulting in suicide, homicide, or other serious injuries. If parents choose to keep firearms at home, guns and ammunition must be stored in separate locked cabinets.

Section 4.15 Dental Inspection

An oral assessment is part of the physical examination conducted by the PCP. However, this examination does not substitute for an examination through direct referral to a dentist. The DC Health Check Program recommends referral for the first dental appointment at 3 years of age. A child should have a direct referral to a dentist if the parent or guardian has not made a dental appointment for the child by age 3. If the child's assessment indicates the need, an earlier referral should be made. Physicians must document verbal reports from parents, such as when teething started, and referrals in the medical record.

All MCOs are required to offer dental services to their enrollees who are under age 21. Dental health education begins with the PCP during the infant's first preventive health supervision visit and continues throughout childhood and adolescence. (See Appendix XIX)

Dental Services

At a minimum, dental services must include relief of pain and infection, restoration of teeth, and maintenance of dental health. Dental services includes emergency and preventive services and therapeutic services for dental disease which, if left untreated, may become problems or may cause irreversible damage to the teeth or supporting structures. These services may not be limited to emergency room services. The periodicity schedule for other HealthCheck services does not govern the schedule for dental services. Dental services are provided to HealthCheck recipients according to the MCOs contract with MAA. Dental caries is the most frequently found health problem in children and PCP's are required to refer children with caries to a dental provider.

For further clarification of the dental requirements under the HealthCheck program the following HCFA (now CMS) State Medicaid Manual provisions should be followed.

The "Dental Inspection" requirement of the District of Columbia periodicity schedule may be satisfied as follows, (Section 5123.2G):

Dental Screening Services - although an oral screening may be part of a physical examination, it does not substitute for examination through direct referral to a dentist. A direct dental referral is required for every child in accordance with the District of Columbia's periodicity schedule and at other intervals as medically necessary.

The referral must be for an encounter with a dentist, or a professional dental hygienist under the supervision of a dentist, for diagnosis and treatment. However, where any screening, even as early as the neonatal examination indicated that dental services are needed at an earlier age, provide the needed dental services.

The requirement of a direct referral to a dentist can be met in settings other than a dentist's office. The necessary element is that the child be examined by a dentist or other dental professional under the supervision of a dentist. Dental paraprofessionals under direct supervision may perform routine services when in compliance with State practice acts. The PCP is ultimately responsible for assuring that the direct referral is made and that the assuring that the child gets to the dentist's office in a timely manner.

Emergency Services - are those necessary to control bleeding, relieve pain, eliminate acute infection; operative procedures which are required to prevent pulpal death and the imminent loss of teeth; treatment of injuries to the teeth or supporting structures (e.g., bone or soft tissues contiguous to the teeth); and palliative therapy for pericoronitis associated with impacted teeth. Routine restorative procedures and root canal therapy are not emergency services.

Preventive Services - provided either individually or in groups, include:

_ Instructions in self-care oral hygiene procedures;

Oral prophylaxis (cleaning of teeth, both necessary as a precursor to the application of dental caries preventatives where indicated, or independent of the application of caries preventives for patients 10 years of age or older; and

Professional application of dental sealants when appropriate to prevent pit and fissure caries.

Orthodontic Services – Limited orthodontic services may be available, if upon evaluation by an educationally qualified dental specialist utilizing a standardized and objective assessment tool, indicates that such services are **medically** necessary. Cosmetic dentistry is not covered under Medicaid.

Therapeutic Services include:

Pulp therapy for permanent and primary teeth;

Restoration of carious (decayed) permanent and primary teeth with silver amalgam, silicate cement, plastic materials and stainless steel crowns;

Scaling and curettage;

Maintenance of space for posterior primary teeth lost permanently

Provision of removable prosthesis when masticatory function is impaired, or when existing prosthesis is unserviceable.

Service required when the condition interferes with employment training or social development.

Section 5 Related Health Issues

Section 5.1 Durable Medical Equipment (DME) Guidelines

The DOH/MAA Durable Medical Equipment Program guidelines provide for medically justified supplies and equipment for eligible children and adolescents in the home environment. This service includes a range of supplies and equipment from gauze pads to wheelchairs (see Appendix XIII). Physicians must justify the medical necessity for each request. The request must be written on Form 719A (Prior Authorization Approval Form). The forms are prenumbered to prevent fraud and abuse. To request a form, have your Medicaid provider number available and call (202) 783-6510.

Section 5.1.2 DME and Member Not in an MCO

Fee-for-service providers requesting DME for DC HealthCheck Program patients must request Form 719A and submit the completed form, with a narrative plan of treatment, to: DOH/MAA, Medicaid DME Program, 2100 MLK Ave., SE, Room 304, Washington, DC 20020.

The narrative letter must contain the following:

- the patient’s name, age, and Medicaid number;
- an explanation of the patient’s diagnosis or condition; and
- the use of equipment/supplies and the monitoring process.

Other issues the plan of treatment must address:

- the diagnosis related to the reason for the DME request;
- the patient’s functional limitations and their relationship to the requested DME;
- how the DME service will treat the patient’s medical condition:
 - to identify the quantity needed and the reason the amount is needed,
 - to identify the frequency of use,
 - to identify the estimated length of use of the equipment, and
 - to identify any conjunctive treatment related to the use of DME/supplies;
- how the equipment will be used in the recipient’s environment; and
- the patients or caregiver’s ability, willingness and motivation to use the DME.

The patient’s current resident (home, institution, school, etc.) must be written in black on Form 719A.

Section 5.2 Identifying of and Reporting Suspected Child Abuse and Neglect

Section 5.2.1 Professional Responsibility

The District of Columbia’s child abuse law, the Prevention of Child Abuse and Neglect Act of 1977 (D.C. Law 2-22), is designed to protect you as you help the District of Columbia protect its children. Under the law, it is your responsibility to report any child known to you in your professional capacity whom you suspect has been or is in danger of being physically or mentally abused or neglected.

Section 5.2.2 Who Must Make a Report

All persons involved in the care and treatment of patients **must report suspected child abuse and neglect**. This list includes physicians, registered nurses, licensed practical nurses, dentists, medical examiners, chiropractors, psychologists, mental health professionals, social service workers, day care workers, law enforcement officers, etc.

Section 5.2.3 Penalty for Not Reporting

“Any persons required to make a report ... who willfully fails to make such a report shall be fined not more than one hundred dollars (\$100) or imprisoned for not more than thirty (30) days or both” (if prosecuted and found guilty).

Section 5.2.4 Recognizing Abuse

If you see or hear about one or more of the following situations, you must report it:

- Non-accidental injuries that are inadequately explained by parent or caretaker;
- Bruises or wounds in various stages of healing; consider the repetitiveness or the seriousness of the injury;
- Injuries that appear to have been caused by blows, beating, physical violence, or the use of a weapon;
- Other signs of harsh punishment, sexual abuse, or exploitation;
- A child’s reluctance to discuss his/her injuries or apparent fear of a parent or caretaker.

Section 5.2.5 Recognizing Neglect

Major neglect includes the following:

- Physical evidence of insufficient food or water; poor skin tone;
- Inadequate clothing or clothing not appropriate for the weather;
- Poor personal care of the child, such as being unwashed;
- Inadequate shelter or filthy, cold, overcrowded or hazardous living conditions;
- Inadequate supervision or lack of supervision.

Section 5.2.6 How to Make a Report

A report can be made by calling the DHS Child Protective Services Division’s 24-hour hotline at (202) 671-SAFE (7233). If requested, you must follow your oral report with a written report.

Section 5.2.7 Information to Be Included in a Report

A written report must include the name, age, sex and address of the following individuals:

- The child who is the subject of the report;
- Brothers and sisters of the child; and
- The parents of the child or others responsible for his/her care.

Additionally, the report must contain the following information:

- The nature and extent of the abuse or neglect as you know it and any previous abuse or neglect;
- Any other information that may be helpful in establishing the cause and the

- identity of the person responsible; and
- The name, occupation, address and phone number of the person making the report and a statement of any action taken concerning the child.

Report all known information. Do not hesitate to report even if answers to some items are unknown to you.

You may obtain additional health education information and posters on child abuse by calling Child USA National Child Abuse Hotline at 1-800-4-A-CHILD. This organization can also provide crisis counseling and referral services.

Section 5.3 Guidelines for HIV-Seropositive Infants, Children and Adolescents

Section 5.3.1 DOH/MAA Requirements for HIV-Infected and Pregnant Women

DOH/MAA requires hospitals, diagnostic and treatment centers, MCOs and birthing centers to provide HIV counseling and to recommend voluntary HIV testing to all women in prenatal care. Identification of maternal HIV status prior to or during pregnancy provides the opportunity to assess the most appropriate therapy for the woman as well as to initiate treatment for the reduction of perinatal HIV transmission.

A breakthrough in the prevention of perinatal HIV transmission occurred in 1994 when

the National Institutes of Health (NIH) AIDS Clinical Trial Group (ACTG) 076 demonstrated that the risk of maternal-infant transmission can be reduced by as much as two-thirds through the administration of zidovudine (ZDV), also known as AZT, to the HIV-positive pregnant woman during her pregnancy, during delivery, and to her infant immediately after birth.

HIV treatment has become increasingly complex as the medication options have expanded. Treatment of the HIV-infected pregnant woman necessitates careful coordination of maternal therapy while considering the mother's health status, including any pre-pregnant medication regimen, and the timing of her HIV diagnosis.

Section 5.3.2 Guidelines for the Screening and Treatment of HIV-Exposed Infants

The identification of HIV-exposed infants and the documentation of HIV infection are critical priorities in the care of infants born to HIV-positive women. All such infants will initially test ELISA positive due to maternal antibodies; most, however, are not infected. In the last several years testing technology has allowed clinicians to reliably diagnose or exclude HIV infection in an exposed infant by 4 months of age. The earlier the diagnosis of HIV infection, the better the prognosis; the provision of early appropriate care improves the child's chances of a better quality of life. In addition, the ability to exclude an HIV diagnosis provides important peace of mind for the families.

Infants born to HIV-seropositive mothers should be tested according to the Public Health Service Treatment Guidelines (Appendix XVII).

Section 5.3.3 Guidelines for the Treatment of HIV-Infected Children

A diagnosis of HIV infection in a child should be reported to a family in person, with support staff available. The identification and primary care of HIV-infected children should be provided in medical facilities that have the capacity to provide comprehensive, family-centered primary health care onsite and can refer to sub-specialty services as needed. In order to facilitate care for both mother and child, providers should make every attempt to coordinate care, such as scheduling several medical appointments on the same day and coordinating treatment plans. Support services, including nutrition, mental health, case management, childcare, and health education, can also enhance a family's ability to manage this as well as most chronic health conditions.

Children may be HIV infected without becoming symptomatic for years. For these individuals, comprehensive, routine and frequent monitoring is essential. Consultation with or referral to a facility offering comprehensive HIV care should take place at the time of initial diagnosis. Since guidelines and the available protocols change frequently, the PCP has a responsibility to work closely with the specialist to understand the medical regimen and support the family's ability to adhere to the treatment plan. It is critical that an HIV specialist be involved in the development and ongoing assessment of the appropriateness of the treatment plan. It is important to know that early anti-retroviral therapy with several drugs is recommended at this time for all infected children less than 1 year of age and for a majority of older children.

The assessment and medical management of HIV-infected infants, children, and adolescents should include:

- An explanation of HIV transmission and the importance of universal precautions;
- A general review of the medical care of HIV-infected children and preventive strategies (e.g., good nutrition, medication administration, surveillance for infections, pneumocystis carinii pneumonia (PCP) prophylaxis, immunizations, and guidelines on when to call the doctor);
- A review of HIV confidentiality and disclosure issues (e.g., identification of persons in the family who are aware of the diagnosis, the status of disclosure of the diagnosis to the child, school notification concerns, and signing of appropriate releases);
- A review of the child's health status and CDC classification, including the AIDS diagnosis (the CDC classification system for children was revised in 1994); and
- A review of available treatments, the pros and cons of clinical trials, and the

child's current treatment plan. **It is essential for families and children/adolescents to be partners in the discussion of treatment options and the development of a plan.**

Medical management issues are complex. Refer to the HIV/AIDS Treatment Information Service's Web site at www.hivatis.org for the most recent and regularly updated guidelines on anti-retroviral therapy in children, adolescents, and adults.

PROTOCOL FOR INFANTS BORN TO HIV-SEROPOSITIVE MOTHERS

**SPECIAL IMMUNOLOGY SERVICE
CHILDREN'S NATIONAL MEDICAL CENTER**

OCTOBER 6, 2000

LAB STUDIES	BIRTH	1 MONTH	6 WEEKS	2 MONTHS	4 MONTHS	18 MONTHS
HIV DNA PCR ^{1,2}	X ³	X			X	
CBC		X		X ⁴	X	
HIV serology (E/WB) ⁵						X
Serum chemistries ⁶						
Zidovudine ^{7,8}	>>>>>	>>>>>>	>>>>			
Bactrim ⁹			>>>>	>>>>>>>	>>>>>>>	

Notes:

- 1) *HIV DNA PCR is the test currently preferred at CNMC. HIV culture may be preferred at some institutions. HIV RNA quantitative (viral load), particularly the ultrasensitive assay detecting >50 copies of HIV RNA/ml, may prove to be a good alternative, but there is not enough data yet.*
- 2) *If HIV DNA PCR (or culture or HIV RNA assay) is positive at any time, the infant is presumed infected and the above protocol no longer applies. The child needs to be referred ASAP to a specialist for confirmatory tests and for early initiation of antiretroviral therapy, continued monitoring of T cells and HIV viral load. Such a child will also need Pneumocystis carinii pneumonia (PCP) prophylaxis until at least 1 year of age.*
- 3) *NEGATIVE HIV DNA PCR at birth has no value in ruling out HIV infection. Positive PCR is significant and provides an early clue that the child is infected and needs different management (see above).*
- 4) Monitoring for Bactrim-induced neutropenia.
- 5) *HIV serology should be positive at birth and early in life in all infants born to HIV-seropositive mothers. The uninfected infant should lose maternal antibodies to HIV and serorevert by 18 months of age. The loss of maternal antibodies is the final proof that the child is NOT infected since an occasional infected child can have one or more negative PCR tests in the first year of life (rare – about 1 percent).*
- 6) *More intensive monitoring of CBC and serum chemistries is indicated for infants exposed to multiple drugs in utero.*
- 7) *All infants born to HIV-seropositive women should be on zidovudine (AZT, ZDV) from birth until 6 weeks of age. This represents post exposure prophylaxis and is a part of the treatment aimed at prevention of vertical transmission of HIV. The dose of ZDV in neonates is 2 mg/kg/dose q6hr; for dosing in premature infants refer to the expert or the PHS recommendations. As more mothers are treated with more than one drug in pregnancy, it may become necessary to use more than one drug for post exposure prophylaxis of the newborn: consult experts.*
- 8) *All infants exposed to antiretroviral drugs in utero or neonatal period should be followed into adulthood because of the theoretical concerns about the potential for carcinogenicity of the nucleoside analogue antiretroviral drugs. The follow-up should include yearly physicals, and for older adolescent females, gynecologic evaluation with Pap smears.*
- 9) PCP prophylaxis is started at 6 weeks of age (at 4 weeks of age for the infants who were not on ZDV postnatally)

in all HIV-seropositive infants. The drug of choice is TMP-SMX (Bactrim), 75 mg of TMP compound/m²/dose given BID on Monday, Tuesday and Wednesday of each week. PCP prophylaxis may be discontinued if PCR tests at 1 and 4 months of age are negative and T cells are normal. See # 2 above for PCP prophylaxis in the infected infant.

HIV TREATMENT SITES
Washington, DC, and Metropolitan Area

Health Care Sites – Children (0-13 years old)			
Site/Provider	Medical Services	Support Services	Hours
Special Immunology Service Children’s National Medical Center 111 Michigan Ave., NW Washington, DC 20010 (202) 884-3495	HIV specialty care (confidential counseling and testing – by appointment or walk-in)	case management social work transportation support groups child care mental health/substance abuse nutrition	8:30-5:00 M-F
HUH C.A.R.E.S Howard University Hospital 2041 Georgia Ave., NW Washington, DC 20060 (202) 865-4564	primary medical care HIV specialty care dental care (confidential counseling and testing – by appointment)	case management social work support groups mental health/ substance abuse child care transportation	9:00-5:00 M-F
Georgetown University Hospital Pediatric Infectious Disease Department 3800 Reservoir Rd., NW 2 PHC Washington, DC 20007 (202) 687-8262	HIV specialty care (confidential counseling and testing)	case management nutrition mental health	8:30-5:00 M-F
Burgess Clinic (& Adolescent Health Center) Children’s National Medical Center 111 Michigan Ave., NW Washington, DC 20010 (202) 884-5389	primary medical care HIV specialty care (confidential counseling and testing – by appointment or walk-in)	case management social work transportation support groups child care mental health/ substance abuse nutrition	8:30-5:00 M-F

HUH C.A.R.E.S. Howard University Hospital 2041 Georgia Ave., NW Washington, DC 20060 (202) 865-4842	primary medical care HIV specialty care dental care (confidential counseling and testing – by appointment)	case management social work support groups mental health/substance abuse	9:00-5:00 M-F
Health Care Sites – Young Adults (18+ years old)			
Site/Provider	Medical Services	Support Services	Hours
Alexandria Health Department STD/HIV Clinic 517 N. St. Asaph St. Alexandria, VA 22314 (703) 838-4388	HIV specialty care (anonymous or confidential counseling and testing – no appointment necessary)	case management social work mental health/ substance abuse	Wed.: 2:00-3:30 pm Thur.: 5:00-6:30 pm Fri.: 9:00-10:30 am
Burgess Clinic (& Adolescent Health Center) Children’s National Medical Center 111 Michigan Ave., NW Washington, DC 20010 (202) 884-5389	Primary medical care HIV specialty care (confidential counseling and testing – appointment or walk-in)	case management social work mental health/ substance abuse nutrition transportation support groups	8:30-5:00 M-F
HUH C.A.R.E.S. Howard University Hospital 2041 Georgia Ave., NW Washington, DC 20060 (202) 865-485-4842	primary medical care HIV specialty care dental care (confidential counseling and testing – by appointment)	case management social work support groups mental health/ substance abuse, nutrition	9:00-5:00 M-F
Max Robinson Center Whitman-Walker Clinic 2301 Martin Luther King, Jr., Ave., SE Washington, DC 20020 (202) 562-1160	HIV specialty care (anonymous counseling and testing)	case management, mental health/ substance abuse housing nutrition food bank	9:00-5:00 M-F

Prince Georges' County Health Dept. Penn Silver Health Center 508 Silver Hill Rd. Forestville, MD 20747 (301) 817-3180	primary medical care HIV specialty care dental care (anonymous or confidential counseling and testing)	case management social work support groups mental health/ substance abuse nutrition	9:00-4:30 M-F
Health Care Sites – Young Adults (18+ years old)			
Site/Provider	Medical Services	Support Services	Hours
Taylor Medical Center Whitman-Walker Clinic 1701 14 th St., NW Washington, DC 20009 (202) 797-3500 (new patients) (202) 332-EXAM	HIV specialty care (anonymous counseling and testing)	case management mental health/ substance abuse legal housing nutrition food bank support groups	9:00-5:00 M-F
Washington Hospital Center HIV Services/Infectious Diseases 110 Irving St., NW Washington, DC 20010 (202) 877-0333 (new patients)	HIV specialty care (confidential counseling and testing)	social work nursing mental health/ substance abuse	8:00-5:00 M-F
Taylor Medical Center Whitman-Walker Clinic 1701 14 th St., NW Washington, DC 20009 (202) 797-3500 (new patients) (202) 332-EXAM	HIV specialty care (anonymous counseling and testing)	case management mental health/ substance abuse legal housing nutrition food bank support groups	9:00-5:00 M-F
Washington Hospital Center HIV Services/Infectious Diseases 110 Irving St., NW Washington, DC 20010 (202) 877-0333 (new patients)	HIV specialty care (confidential counseling and testing)	social work nursing mental health/ substance abuse	8:00-5:00 M-F

Section 6 Health Check Reporting

Section 6.1 What the MCOs Report to MAA

MCOs are required to provide MAA monthly, quarterly and annual enrollment reports using client encounter data. They are also required to provide feedback on operational issues, including system problems and overall enrollment problems.

Section 6.2 What MAA Reports to the Federal Government

MAA is required to report to centers for Medicaid and Medicare Services, by April 1 of each year, health screening information using Form HCFA 416 for children participating in the managed care and fee-for-service programs for the year ending September 30 of the previous year (Appendix XV). This data allows the federal government to analyze and compare the delivery of EPSDT services in the states.

Section 6.3 The Role of the Primary Care Physician in the Reporting Process

The PCP is contractually required to report certain data to the MCO to enable it to make required reports to MAA. The District of Columbia's fiscal agent is responsible for reporting fee-for-service provider EPSDT procedure code data on or before March 1 of each year for inclusion in the annual HCFA 416 Report. The role of the PCP in documenting and reporting EPSDT services is crucial.

Section 7 PROGRAM SPECIFIC BILLING PROCEDURES

DOH/MAA sets the reimbursement coverage and limitation policies for the District of Columbia's Medicaid program. Policies that govern Medicaid allow for the payment of a variety of medical services. The EPSDT Medicaid Provider Billing Manual describes how to complete and file claims for reimbursement for Medicaid (Appendix I). Medicaid contracts with a private company to pay claims; this company is referred to as the "Medicaid fiscal agent."

The purpose of the billing manual is to furnish the Medicaid provider with the policies and procedures needed to receive reimbursement for covered services provided to eligible DC Medicaid member. The manual contains descriptions and instructions on how and when to complete forms, letters, or other documents.

Section 7.1 Types of Reimbursement

— Fee-for-service – Fee-for-service is a method of payment where the provider is paid a fee for each procedure performed and billed.

Cost-based reimbursement – Cost-based reimbursement, which is sometimes referred to as a per diem rate or an encounter rate, is based on the provider's actual cost for rendering services to a Medicaid member.

- Capitation reimbursement -- A health maintenance organization (HMO) is paid a fixed amount each month for each recipient (per capita) who is enrolled in its organization.

Section 7.2 Member and Billing Issues

Exceptions to Payment Provisions

Medicaid will not reimburse for services for Medicaid member if non-Medicaid member are provided the same service free of charge. The only exceptions are services provided by agencies that receive federal funds from:

- Title V Maternal and Child Health of the Social Security Act (i.e., public health clinics); or
- Part B or C of the Individuals with Disabilities Education Act (i.e., early intervention or special education health-related services).

Patient's inability to pay

A provider cannot deny service to HealthCheck member between ages 18 and 21 based solely on the recipient's inability to pay a Medicaid co-payment amount. If the recipient is unable to pay at the time services are rendered, the provider may bill the recipient for the unpaid charge. Cost sharing is allowed for prescription drugs (\$1) and eye glasses (\$2). There is no cost sharing for DC HealthCheck recipient under age 18 (DC Medicaid Program Transmittals No. 95-29 and 95-25).

Charging member for administrative services

Participating Medicaid providers are prohibited from charging for the completion of children's health forms. A charge is defined as "cost sharing."