

## **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](http://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](http://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 <sup>1,2</sup>	X <sup>3</sup>	X			X	
CBC		X		X <sup>4</sup>	X	
HIV serology (E/WB) <sup>5</sup>						X
Serum chemistries <sup>6</sup>						
Zidovudine <sup>7,8</sup>	>>>>>	>>>>>>	>>>>			
Bactrim <sup>9</sup>			>>>>	>>>>>>>	>>>>>>>	

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/m<sup>2</sup>/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**

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

<b>HUH C.A.R.E.S.</b> 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
<b>Health Care Sites – Young Adults (18+ years old)</b>			
<b>Site/Provider</b>	<b>Medical Services</b>	<b>Support Services</b>	<b>Hours</b>
<b>Alexandria Health Department</b> STD/HIV Clinic 517 N. St. Asaph St. <b>Alexandria, VA 22314</b> (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
<b>HUH C.A.R.E.S.</b> 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
<b>Max Robinson Center</b> 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)			
<b>Site/Provider</b>	<b>Medical Services</b>	<b>Support Services</b>	<b>Hours</b>
Taylor Medical Center Whitman-Walker Clinic 1701 14 <sup>th</sup> 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
<b>Taylor Medical Center</b> Whitman-Walker Clinic 1701 14 <sup>th</sup> 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."