GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
MEDICAL ASSISTANCE ADMINISTRATION
2100 MARTIN LUTHER KING, JR., AVENUE, S.E.
SUITE 302
WASHINGTON, D.C. 20020

FEB 3 2000

Medical Assistance Program
Action Transmittal: 00-06

TO: District of Columbia Managed Care Oganizations (MCOs

FROM: Herbert H. Weldon, Jr.
Deputy Director

SUBJECT: Head Start Health Screening Procedures for MCOs, Medicaid Primary Care Providers (PCP), Head Start Parents and Head Start Administrators

The DC Medical Assistance Administration (MAA) is committed to ensuring that **all** children have access to appropriate health screens under the *DC Healthy Tots and Teens/Early Periodic Screening, Diagnosis and Treatment (EPSDT)Program* (formerly known as the DC Medicaid Well-Child Program). In this regard, the MAA and United Planning Organization (UPO) Head Start convened meetings to address Medicaid child health screening concerns raised by Families USA Foundation (a health advocacy group), and Head Start. This group examined 1997-1998 "completed medical forms that doctors furnished to the Head Start program for three and four-year old Head Start children covered by Medicaid."

After an analysis of approximately 600 health records of Head Start children enrolled in MCOs, Families USA Foundation identified a majority of Head Start children who had missed, undocumented or incomplete EPSDT well-child health screens. Both the DC Healthy Tots and Teens/EPSDT Program and Head Start have the same federal health screening requirements.

In response to these findings, the attached Medicaid Screening Procedures for Children's Entry into Head Start Programs, were developed by staff from the MAA, MCOs and Head Start. The procedures are divided into three areas of responsibilities, with attachments.

We ask you to ensure that **all** children receive timely, complete and properly documented screens, and be aware that Head Start programs are federally mandated to follow requirements of the EPSDT child health screening schedule. **Please review and adhere to the sections of the procedures that reference MCOs and PCPs' responsibilities.** This collaboration helps to eliminate duplication of health services and maximizes resources.

If you have comments and/or questions about the procedures, call Sarah Davidson at (202) 727-0725x3016, fax to (202) 610-3209 and/or E-mail at SDavidson-doh@dcgov.org.

Thanks for your continued cooperation.

Attachments

DC HEALTHY TOTS AND TEENS/EPSDT(MEDICAID) HEALTH SCREENING PROCEDURES FOR CHILDREN'S ENTRY INTO HEAD START PROGRAMS

11/99

DEPARTMENT OF HEALTH
MEDICAL ASSISTANCE ADMINISTRATION
2100 Martin Luther King, Jr., Ave., S.E.
Washington, D.C., 20020

I. PARENT/CHILD RECEIVES ORIENTATION FROM HEAD START PROGRAM

Responsibility: Head Start Family Services Worker/Health Services Manager

(1) Ensures that parent completes required Head Start enrollment forms.

(2) Worker gives parent **Head Start Health Record Forms 3, 4, and 5* (attached) and instructs he/she about obtaining Managed Care Organization (MCO) services. This includes discussion of health services to disabled children.

(3) If known, Head Start will write child's MCO and PCP's name on the child's *Head Start Health Record Form I.*

(4) If family's MCO is not known, parent should call the DC Government Managed Care HELPLINE at (202) 783-2118.

(5) Parent knowing their child's MCO, but not the **Primary Care Provider (PCP)** should call their MCO's member services department. (Phone numbers attached.)

(6) Parent not having selected or not assigned to an MCO should be referred to the Medicaid Managed Care Enrollment Broker, (202) 216-9688.

(7) Head Start staff counsels parents to seek EPSDT health screening services for their child through his/her PCP and the MCO.

II SCHEDULE AN APPOINTMENT WITH CHILD'S PCP TO RECEIVE EPSDT SCREEN

Responsibility: Parents, Primary Care Providers (PCP)

(1) Parent calls PCP to schedule appointment(s) for a **complete EPSDT well-child screen.**

(2) Child receives all age appropriate required health screens, and parent obtains completed *Head Start Health Record Forms 3,4, and 5* and returns completed documents to the Head Start worker.

III. PARENTS NOT ABLE TO OBTAIN APPOINTMENT WITH CHILD'S PCP

Responsibility: Parent, MCO, MAA Managed Care Children's Unit

If parent is unable to get an appointment within 30 working days from the initial call to the PCP requesting the service, the parent should do the following:

(a) Call the MCO's member services department (phone numbers attached); or

(b) Call the Managed Care Children's Unit at (202) 727-0725x3016.

IV. PARENTS WITH CHILDREN IN HEAD START WITH INCOMPLETE SCREENS

Responsibility: PCP, Head Start, MCO, MAA

(1) After the child receives health screening from the **PCP**, Head Start Family Services Worker/Health Services Manager reviews *Head Start Health Record Forms 3, 4,* and 5 for completeness and accuracy and to identify health screens still needed. Also, rechecks the names of the MCO (health plan) and **PCP.**

(2) **When the health form is incomplete**, Head Start Family Services Worker/Health Services Manager gives parents a new copy of the *Head Start Health Record Form(s)* and the *Head Start Health Check List Form Letter* (indicates missing screens*)* to take back to the child's PCP to verify that screens occurred, but were not documented and/or completes screens. Parents will call the **PCP's** office to discuss deficiencies prior to making an appointment.

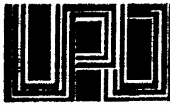
(3) The Head Start parent must return the completed health screening forms (*Head Start Health Record Form* and *Head Start Health Check List Form Letter)* to Head Start Family Services Worker/Health Services Manager within 25 working days of receipt of the documents.

(a) Head Start Family Service Worker/Health Service Manager will fax/mail a copy of the *Head Start Health Check List Form Letter* to the appropriate MCO EPSDT Coordinator (Phone numbers attached.) This letter will be used to **alert** the MCO that deficiencies occurred and to track and monitor the PCP's screening of Head Start children.

(b) If there are no results after the 25 working days referenced above, Head Start Family Service Worker faxes the *Head Start Health Check List Form Letter to* the MAA EPSDT Coordinator at (202) 610-3209 for resolution.

(c) The MAA EPSDT Coordinator will contact the appropriate MCO EPSDT Coordinator and will ask her/him to assist with getting the appropriate *Head Start Health Record Form(s)* from the PCP within 10 working days of contact.

* The Department of Health has convened a citywide child health committee to develop one universal health screening form for parents, thereby eliminating the multiplicity of forms parents now take to their children's doctor. We anticipate that this form and its requirements will be in place in FY 2000.



UNITED PLANNING ORGANIZATION
401 M Street, S.W., Waterside Mall - East Side - 2nd Floor
Washington, D.C. 20024

ISSELL D. SIMMONS
esident

BENJAMIN JENNINGS
Executive Director

Date:

Directions: It is requested that the services be provided and documented on the attached health record no later than ten (10) days after the receipt of this document.

Dear Primary Care Physician/EPSDT Coordinator:____________________________

The health record for____ has been reviewed
(Name of Child) (Medicaid No./HMO Membership)

and found to be deficient in documenting the following services as specified by the *"D C Healthy Tots and Teens/Early Periodic Screening Diagnosis and Treatment (EPSDT) Periodicity Schedule."*

____Height/Weight

____Blood Pressure

____Vision Screening

____Hearing Screening

____Speech/Language Screen

____ PPD (TB Test)

_____Urine Screening

_____Nutritional Assessment

_____Dental Referral

_____Initial/Interval History

____Head Circumference

____Developmental/Behavioral Assessment

____Physical Examination

____Metabolic/Hereditary Screening

____Sickle Cell Test

____Hematocrit/Hemoglobin

_____Lead Blood Test

_____Health Education

_____Immunizations
(Specify)

_____Other

Comments:____
____
____

Thank you for providing a Head Start to this child.

Sincerely,

Head Start Health Services Manager/
Family Services Worker
Telephone:

CHILD HEALTH RECORD: FORM 3, SCREENINGS, PHYSICAL EXAMINATION/ASSESSMENT

PART I. TO BE COMPLETED BY HEAD START STAFF OR HEALTH CARE PROVIDER BEFORE PHYSICAL EXAMINATION/ASSESSMENT

CHILD'S NAME: ____________ SEX: ______ BIRTHDATE: ______

HEAD START CENTER: ____________ PHONE: ______

ADDRESS: ____________

1. RELEVANT INFORMATION *(from Health History, Parent/Teacher Observations):*

2. SCREENING TESTS. *Starred items (*) are required by Head Start and recommended by the American Academy of Pediatrics for children 3-5 years. Enter dates if done previously. When recording results, enter at a minimum "N", "S", or "A" for NORMAL, SUSPECT, OR ATYPICAL/ABNORMAL, respectively.*

TEST	DATE	RESULTS	TEST	DATE	RESULTS
a. PRESENT AGE*		____ Yrs., ____ Mos.	g. VISION (Type of Test)* ____		
b. HEIGHT (no shoes, to nearest 1/8 in.)*			ACUITY, R/L ____		
			RESCREENING ____		
c. WEIGHT (light clothing to nearest 1/4 lb.:)*			STRABISMUS ____		
			COMMENTS		
d. BLOOD PRESSURE					
e. HEMATOCRIT or HEMOGLOBIN*			h. OTHER TESTS (if indicated)		
			(1) TB ____		
f. HEARING (Type of Test)* ____			(2) Sickle Cell ____		
RESULTS, R/L ____			(3) Lead ____		
RESCREENING ____			(4) Ova & Parasites ____		
COMMENTS			(5) Urinalysis ____		
			(6) Other ____		

PART II. COMPLETED BY HEALTH CARE PROVIDER DURING AND AFTER PHYSICAL EXAMINATION/ASSESSMENT

3. PHYSICAL EXAMINATION/ASSESSMENT. *Complete and return top three copies to Head Start.*

	NORMAL FOR AGE	ABNOR-MAL	NOT EVAL.	COMMENTS *(Use Additional sheet if necessary)*
a. GENERAL APPEARANCE				
b. POSTURE, GAIT				
c. SPEECH				
d. HEAD				
e. SKIN				
f. EYES: (1) External Aspects				
(2) Optic Fundiscopic				
(3) Cover Test				
g. EARS: (1) External & Canals				
(2) Tympanic Membranes				
h. NOSE, MOUTH, PHARYNX				
i. TEETH				
j. HEART				
k. LUNGS				
l. ABDOMEN (include hernia)				
m. GENITALIA				
n. BONES, JOINTS, MUSCLES				
o. NEUROLOGICAL/SOCIAL				
(1) Gross Motor ____				
(2) Fine Motor ____				
(3) Communication Skills ____				
(4) Cognitive ____				
(5) Self-Help Skills ____				
(6) Social Skills				
p. GLANDS (Lymphatic/Thyroid)				
q. MUSCULAR COORDINATION				
r. OTHER				

s. GENERAL STATEMENT ON CHILD'S PHYSICAL STATUS:

Signature: ____________ Date: ______

4. FINDINGS, TREATMENTS, AND RECOMMENDATIONS

	ABNORMAL FINDINGS/DIAGNOSIS	TREATMENT PLAN	RECOMMENDED FOLLOW-UP OR RESULTS *(Initial when complete)*	DATE
a.				
b.				
c.				
d.				

CHILD HEALTH RECORD

FORM 4. IMMUNIZATIONS

TO BE STARTED BY HEAD START STAFF AT PARENT INTERVIEW,
THEN USED BY PHYSICIAN OR CLINIC FOR COMPLETING RECORD FOR HEAD START.

CHILD'S NAME ______________________ **SEX** _____ **BIRTHDATE** __________

HEAD START CENTER ______________________________ **PHONE** __________

ADDRESS ____

PARENT OR GUARDIAN **ADDRESS**

____

1. IMMUNIZATIONS

VACCINE	DATE GIVEN DAY/MO/YR	DOCTOR OR CLINIC	DATE NEXT DOSE DUE
D T P			
Td			
DT			
POLIO -OPV			
MMR			
HIB - IF POSSIBLE			
SPECIFY VACCINE			
HBOC, PRP-OMP,			
OR PRP-D			
HB (AT BIRTH)			
HBIG (AT BIRTH)			
OTHER			

2. EXEMPTIONS

If a child cannot or should not receive a particular immunization, write one of the following reasons in the "Doctor or Clinic" column.

(a) HAS HAD DISEASE (attach physician's note). For Rubella only a serologic test is a valid exemption.
(b) ALLERGIC TO ________________ (specify allergen and attach physician's note).
(c) PARENT'S WILL NOT CONSENT (Attach parent consent form).

3. CERTIFICATION OF PREVIOUS IMMUNIZATIONS

I hereby attest that I have seen documentation of any immunizations the child received prior to enrollment in Head Start.

Signature ________________ Title ______________________ Date __________

INTERVIEWER: GO TO FORM 5

CHILD HEALTH RECORD: FORM 5, DENTAL HEALTH

PART I. TO BE COMPLETED BY HEAD START STAFF (CO... AT INTERVIEW)

CHILD'S NAME: ____________ **SEX:** ______ **BIRTHDATE:** ______

HEAD START CENTER: ____________ **PHONE:** ______

ADDRESS: ____________

1. IS THE CHILD NOW RECEIVING: *If "yes," include length of time receiving fluoride*
   - Topical Fluoride Application? No____ Unknown____ Yes____
   - Fluoridated water? No____ Unknown____ Yes____
   - Fluoride Supplement diet? No____ Unknown____ Yes____
   - (tablets____, liquid____)

2. DOES THE CHILD HAVE ANY TROUBLE WITH TEETH, GUMS, OR MOUTH THAN THE PARENT KNOWS ABOUT?

3. CHILD (___HAS, ___HAS NOT) PREVIOUSLY SEEN A DENTIST.
   Dentist's name____________ Date last visit________
4. CHILD (___IS, ___IS NOT) UNDER A PHYSICIAN'S CARE.
   Physician's name____________
5. CHILD (___IS, ___IS NOT) RECEIVING MEDICATION.
   Type____________
6. CHILD IS REPORTED TO HAVE *(Give details or attach Health History, Form 2A).*

	YES	NO		YES	NO
Allergies	___	___	Liver Dis.	___	___
Asthma	___	___	Rheumatic Fever	___	___
Bleeding	___	___	Sickle Cell Dis.	___	___
Diabetes	___	___	Other (List Below)	___	___
Epilepsy	___	___			
Heart/Vascular Dis.	___	___			

7. SOURCE OF REIMBURSEMENT OR SERVICES
   - ☐ EPSDT/Medicaid
   - ☐ Federal, State, or local Agency ____________
   - ☐ Head Start
   - ☐ In-kind Provider____________
   - ☐ Parents/Guardians
   - ☐ Other (3rd Party)____________
8. PRIORITY GROUP
   - ☐ A. Needs Attention Immediately
   - ☐ B. Needs Attention Soon
   - ☐ C. Needs Routine Care

PART II. TO BE COMPLETED BY DENTAL CARE PROVIDER

9. ORAL CONDITIONS BEFORE TREATMENT: *missing* (⊗), *decayed* (◎), *or filled* (●); *indicate restorations you perform in item 10.*

UPPER: D E F G, C LINGUAL H, B I, A J, 3 14
RIGHT LEFT
LOWER: 30 19, T K, S L, R LINGUAL M, Q P O N

10. EXAMINATION AND TREATMENT RECORD *(List recommended services in order).*

Tooth # or Letter	Surfaces	Description of Work	Treatment Approved	Date Service Performed MO.	DAY	YR.	A.D.A. Procedure Number	Actual Charges (Fee)

11. DENTAL NEEDS *(Check one or more and return 3 copies to Head Start after first visit).*
   - ☐ A. TREATMENT (restoration, pulp therapy, extraction)
   - ☐ B. CLEANING
   - ☐ C. FLUORIDE
   - ☐ D. OTHER
   - ☐ E. NO PROBLEMS

   Approximate number of visits____________. Approximate cost____________.

12. CHILD ORAL HEALTH SUMMARY *(Complete and return 2 copies to Head Start after final visit).*
   All planned treatment (___is, ___is not) complete. If not, explain here, as well as items checked.

   - ☐ a. Routine recall visits
   - ☐ b. Special home emphasis, oral hygiene
   - ☐ c. Dietary problem(s)
   - ☐ d. Developmental problem(s)
   - ☐ e. Harmful oral habits
   - ☐ f. Needs fluoride supplement

I certify that I have completed the service(s) listed in Part II, Item 10, and that itemized charges do not exceed my usual and customary fees.

Signature____________ Date______

INTERVIEWER: GO TO FORM 6

10/99

DISTRICT OF COLUMBIA
MEDICAID MANAGED CARE CONTRACTS

EPSDT COORDINATORS AND MEMBER SERVICES

Advantage Health Plan, Inc.
EPSDT Coordinator- Phone: (202) 686-8421 Fax: (202) 686-9797
Member Services Department: (202) 686-8555, press #1

Americaid Community Care
EPSDT Coordinator - Phone: (410) 981-4026 Fax: (410) 981-4080
Member Services Department: 1-800-454-3730

American Preferred Provider Health Plan
EPSDT Coordinator - Phone: (202) 463-2022 Fax: (202) 463-2956
Member Services Department: (202) 463-2022

Capital Community Health Plan
EPSDT Coordinator - Phone: (202) 218-6908 Fax: (202) 408-0881
Member Services Department: (202) 898-4850

Chartered Health Plan
EPSDT Coordinator - Phone: (202) 408-2031 Fax: (202) 408-5410
Member Services Department: (202) 408-4720, press pound (#)

George Washington Health Plan
EPSDT Coordinator - Phone: (202) 994-2420 Fax: (202) 994-5977
Member Services Department: (202) 994–6570

Health Right, Inc.
EPSDT Coordinator - Phone: (202) 518-2370 Fax: (202) 462-6128
Member Services Department: 1-(888)-339-3380

Health Services for Children w/Special Needs "The Net" (for Children on SSI)
EPSDT Coordinator - Phone (202) 467-2717 Fax: (202) 467-0978
Member Services Department: (202) 467-2717