Handbook for Providers of

Healthy Kids Services

Chapter HK-200
Policy and Procedures for
Health Care for Children

Illinois Department of Healthcare and Family Services

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Chapter HK-200

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Foreword

Please join us in making the future of today's youth and tomorrow's leaders healthy and bright. Your medical interventions will make a difference.

Become an Active Provider in our All Kids Program

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is the nation's largest preventive child health initiative. It is a comprehensive child health program that provides initial and periodic examinations and medically necessary follow up care. EPSDT is not a separate program but simply a way to refer to the comprehensive benefit package to which Medicaid clients are entitled. Illinois strives to ensure that children covered by the Illinois Department of Healthcare and Family Services (HFS) Medical Programs receive preventive health screening services, including immunizations, objective developmental screening, dental care, lead screening, vision screening and risk assessments, through Illinois' EPSDT program. It is HFS' commitment to families to establish access to quality primary and preventive health care services. A primary goal is to "put prevention into practice". Through partnership with you, the primary care provider, Illinois' children can be provided with "a medical home" for efficient, high quality health care, and receive needed referrals for health and health related services, including specialty care.

Medical Home

Every child deserves a medical home. The American Academy of Pediatrics (AAP) describes the medical home as "an approach to providing comprehensive primary care that facilitates partnership between patients, physicians, and families. The AAP believes that every child deserves a medical home, where care is accessible, continuous, comprehensive, patient and family centered, coordinated, compassionate, and culturally effective." The American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP) have defined the concept similarly and endorsed its widespread adoption.

The AAP advised that a medical home includes:

- Patient and family centered partnership
- Community based systems
- Attention to transitioning children and adolescents to adult care
- Recognition of the importance of quality health care and appropriate payment

A patient and family centered partnership requires providers to recognize constant individuals in a patient's life, as well as respect the patient's diversity. Understanding and incorporating these concepts fosters trust and collaboration between providers and their patients.

It is important to realize and understand that a medical home is a vital part of the community. It is a "patient and family centered coordinated network of community based services designed to promote the healthy development and well being of children and their families." This requires medical homes to provide and/or coordinate a variety of specialty, ancillary and related community services.

A goal of health care is to "optimize lifelong health and wellbeing." In order to ensure optimization of health, providers are responsible for providing high quality, developmentally appropriate, health care transitions. These transitions allow the individual to continually move without interruptions within the health care system from childhood to adulthood, between various providers and various sites of care.

Quality health care is important and essential to the medical home system. It is essential to assure the quality of the health care delivery system through shared responsibility and appropriate payment and reporting mechanisms, and through focused quality health measurement and benchmarking.

Bright Futures

Bright Futures is a set of principles, strategies, and tools that are theory based, evidence driven, and systems oriented that can be used to improve the health and well being of all children. The Bright Futures initiative was launched in 1990 under the leadership of the Maternal and Child Health Bureau (MCHB) of the Health Resources and Services Administration (HRSA). In 2002, the MCHB selected the AAP to lead the Bright Futures initiative. The mission of Bright Futures is to promote and improve the health, education, and well being of infants, children, adolescents, families, and communities.

Bright Futures uses a development based approach to address children's health needs in the context of family and community. The cornerstone of Bright Futures is a comprehensive set of health supervision guidelines developed by multidisciplinary child health experts – ranging from providers and researchers to parents and other child advocates – that provide a framework for well child care from birth to age 21. These guidelines are designed to present a single standard of care and a common language based on a model of health promotion and disease prevention. Released in 2008, the *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, Third Edition (Bright Futures, 3rd Ed.)*, is the most current version of the guidelines and is considered the gold standard for pediatric care.

Under the Patient Protection and Affordable Care Act of 2010, all non-grandfathered health plans are now required to cover all Bright Futures services for children, with no cost sharing, in accordance with the Bright Futures periodicity schedule. HFS has incorporated *Bright Futures, 3rd Ed.* guidelines into the standards of care described in this Handbook. References to *Bright Futures, 3rd Ed.* are inclusive of subsequent revisions, pending any statement to the contrary in future revisions to this Handbook. Existing State law and regulations supersede these and other guidelines as the required standard.

State of Illinois Medical Programs

In response to Medicaid Reform and the new era in care management, Illinois is expanding its delivery model to include different types of managed care entities. Care coordination will be provided to most Medicaid clients by these new managed care entities, including the expansion population of Medicaid enrollees eligible under the Affordable Care Act.

Regardless of the delivery model, the standards, guidelines and practices outlined in this Handbook apply universally to children and adolescents <1 through 20 years of age.

Pursuant to state law PA 96-1501(pdf), the Department is enrolling Illinois Medicaid and All Kids clients into care coordination in five mandatory managed care regions: Rockford, Central Illinois, Metro East, Quad Cities, Cook and Collar Counties. It is expected that 60 percent or more of clients statewide will have enrolled or be in the process of being enrolled in Health Plans offered by managed care entities (MCEs) by early 2015.

Clients have 60 days to select a Health Plan and Primary Care Provider (PCP); if no choice is made during this 60 day period, the client will be auto-enrolled in a Health Plan and PCP. Once enrolled in a Health Plan, clients then have 90 days from their effective date of enrollment to change their Health Plan, or they will be locked into their Health Plan choice for one year. The goal is to provide a PCP for every client; to maintain continuity of care with that PCP; to create comprehensive networks of care around our clients including primary care, specialists, hospitals and behavioral care; and to offer care coordination to help clients with complex needs to navigate the healthcare system. While these procedures are subject to change, we anticipate they will be in effect in similar form for the foreseeable future.

HFS is contracting with four primary types of managed care entities (MCEs) offering Health Plans for our different populations:

- Managed Care Organizations (MCO)
- Accountable Care Entities (ACE)
- Care Coordination Entities (CCE)
- Managed Care Community Networks (MCCN)

Most of the MCOs serving Medicaid clients are national insurance companies, organized under Illinois insurance law. They organize their provider Networks, assume full financial risk and are responsible for claims processing and payment. The other three models organized by providers have unique models of care delivery, many of which are unique to Illinois. Important to this change in Medicaid is payment reform -- the willingness of CCEs and ACEs to manage their large populations of Medicaid clients and accept (or move towards accepting) full-risk for the payment of claims for their clients. More information is available on the Care Coordination webpage.

Expanding managed care also means that Illinois will be transitioning from a fee-for-service system, with few restrictions on where or how to deliver or receive services – to a system where it will be expected that providers will work in a collaborative fashion to offer integrated healthcare services focused around the holistic needs of clients. This will require a change in operations for Medicaid clients, for Medicaid providers, and for state agencies.

The PCCM program, called Illinois Health Connect, will remain in regions of the state where there is not mandatory managed care and will underlie the ACE program for 18 months, as ACEs work to enhance the model. Illinois Health Connect is based on the AAP initiative to create medical homes to make sure that preventive healthcare is provided in the best setting. In Illinois Health Connect, clients have a medical home with a PCP, such as a doctor's office. The PCP also provides care coordination and case management. For more information, visit the Illinois Health Connect website or call Illinois Health Connect at the **Illinois Health Connect Helpline 1-877-912-1999**.

The healthcare delivery system and healthcare in general are dynamic and rapidly evolving systems. Updates on the state Medicaid programs are available on the Care Coordination website.

Quality Improvement

The quality of care delivered is assessed using health measures identified for each plan. At the managed care entity level, these measures align across plans serving similar populations so that comparative analyses can be conducted. Similarly, many measures reported by managed care entities are aligned with Child Core Set and Adult Core Set measures published by the Centers for Medicare and Medicaid Services (CMS). These child and adult core measures are available for states to use to show performance at the population level. States reporting these measures can compare their quality performance to other states. Annually, HFS voluntarily reports population based performance on as many of the child and adult core measures as feasible. HFS' annual reports to CMS are available on the HFS Reports website.

This Handbook for Providers of Healthy Kids Services, Chapter HK-200, specifically describes the components and frequency that well child screening services are to be performed, in accordance with the *Bright Futures, 3rd Ed.* or subsequent updated guidelines and the medical home model. It also describes the EPSDT benefits available to HFS' Medical Program participants who are under the age of 21, as mandated by the Social Security Act.

The Handbook for Providers of Medical Services, Chapter 100, provides General Policy and Procedures. Chapter 100 describes provisions of the Medical Programs administered by HFS that apply generally.

A separate Chapter 200 is published for each type of provider or category of service. Provider handbooks that may be relevant to providers performing well child medical screening services include, but may not be limited to:

Chapter 100	General Provider Handbook
A-200	Practitioner Handbook/Appendices
D-200	Encounter Clinic Services
S-200	School-Based/Linked Health Center Services Handbook/Appendices
L-200	Laboratories Handbook/Appendices
U-200	Local Education Agencies

All handbooks are available for download from HFS' website.

This Handbook lists resources to assist providers and families in understanding the medical services and benefits offered by HFS.

For eligibility information, providers may call the Provider Eligibility Inquiry Hotline at **1-800-842-1461**.

Families who have questions about HFS' Medical Programs may call Illinois Health Connect at: **1-877-912-1999** (TTY: 1-866-565-8577) or All Kids at: **1-866-4-OUR-KIDS** (1-866-468-7543) (TTY: 1-877-204-1012).

HK-200 Basic Provisions

HK-200.1 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

In Illinois, children enrolled in HFS' All Kids Program are entitled to preventive health screening services under the EPSDT benefit, without patient co-payments (refer to the Chapter 100, Topics 114 and 114.1).

Section 1905(r) of the Social Security Act (Act), 42 USC 1396d(r), sets forth the basic requirements of EPSDT. Under EPSDT, **health screening, vision, hearing and dental services** are to be provided at intervals, which meet reasonable standards of medical and dental practice. The Act requires that any Medicaid service allowable that is necessary to treat or ameliorate a defect, physical or mental illness, or a condition identified by a screen, is covered by HFS enrolled providers (refer to Chapter 100, Topic 103.1).

HFS requires all preventive health services be delivered consistent with guidelines published by the Committee on Practice and Ambulatory Medicine; American Academy of Pediatrics (AAP) or the American Academy of Family Physicians (AAFP), U.S. Preventive Services Task Force (USPSTF), National Heart, Lung, and Blood Institute (NHLBI), American Congress of Obstetricians and Gynecologists (ACOG) including the AAP's *Bright Futures, 3rd Ed.*; the Advisory Committee on Immunization Practices (ACIP); and procedures and protocols established by HFS.

The EPSDT program consists of two, mutually supportive, operational goals, as federally required:

- Assuring the availability and accessibility of required health care resources, through a "medical home" and
- Helping program participants and their parents' use them, as requested.

EPSDT services must be provided in full compliance with applicable federal and State laws and regulations.

The *Bright Futures, 3rd Ed.* guidelines, along with its periodicity schedule, pocket guide, and tool and resource kit, can be found at the AAP Bright Futures website. These guidelines are considered the gold standard for pediatric care. Medical guidelines, policy statements and recommendations from other professional organizations can be found on each group's website.

HK-200.2 EPSDT Definition

Early: Assessing a child's health early in life so that potential diseases and disabilities can be prevented or detected in their preliminary stages, when they are most effectively treated. (This means as early as possible in a child's life in the case of a family already receiving medical benefits or as

soon as a child's eligibility has been established.)

Periodic: Assessing a child's health at regular intervals in the child's life to assure continued healthy development. The Act requires periodicity schedules sufficient to assure that at least a minimum number of health examinations occur at critical points in a child's life, and that medically necessary inter-periodic screens be provided.

Screening: Preventive services utilizing special tests or standardized examinations in order to identify those children who require specialized intervention. Five categories of screenings covered under the program are medical, vision, hearing, dental, and developmental.

Diagnosis: A formal evaluation process resulting in a determination of the cause of an abnormal screening test, symptom or sign, and recommendation for treatment. Diagnostic evaluation is required if a screening examination indicates the need for a more complete assessment of a child's health status.

Treatment: The provision of medical services needed to control, correct or lessen health problems, including care coordination for chronic conditions.

HFS encourages participants' continuity of care with a PCP who coordinates needed services and provides continuing comprehensive care in a medical home setting. These include:

- Preventive care (periodic health screening), including health supervision and anticipatory guidance
- Diagnosis and treatment of acute and chronic illness - ambulatory and inpatient care
- Care over an extended period of time
- Identification of need for subspecialty consultation and referrals
- Interaction with other involved health, social, environmental and educational entities
- Creation and maintenance of a medical record for storage, safekeeping and retrieval of all pertinent medical information, preferably in federally Certified Electronic Health Record Technology (CEHRT) format.

HK-201 Provider Participation

HK-201.1 Participation Requirements

It is an HFS requirement that each provider enroll with HFS as a Medical Assistance Provider to be considered for participation, and agree to all requirements listed in Chapter 100, Topic 101.1. For information about provider enrollment or to learn how to access handbooks for the HFS' Medical Programs, providers may contact the Provider Participation Unit at **1-217-782-0538** or email their question(s) to HFS.PPU@illinois.gov.

HK-201.1.1 Enrollment in the Primary Care Case Management Program (PCCM) as a Primary Care Provider (PCP)

Physicians, clinics, and health centers enrolled in the HFS programs who wish to enroll in Illinois Health Connect as a Primary Care Provider should call the Illinois Health Connect Provider Services Helpdesk at **1-877-912-1999 (TTY: 1-866-565-8577)**. An application will be mailed or a Provider Service Representative will schedule a convenient time to meet with the provider, answer all of the provider's questions and help with the enrollment process.

Providers who do not enroll in Illinois Health Connect will no longer be able to provide primary care to their patients who are enrolled in Illinois Health Connect, unless they fall under the Direct Access exception noted below.

Direct Access: In Illinois Health Connect, services provided by Certified Local Health Departments are "direct access", meaning the Certified Local Health Department will not be required to have a referral from the client's PCP in order to provide and be reimbursed for well child health screening services.

In order to facilitate the medical home model, HFS encourages the Primary Care Provider (PCP) to coordinate care for their clients with direct access providers.

For individuals under age 21, direct access providers include Certified Local Health Departments, School Based/Linked Clinics, Local Education Agencies (LEAs), Early Intervention (EI) agencies and women's health care providers.

The provider types listed below may serve as PCPs:

- General Practitioners, Internists, Pediatricians, Family Physicians, OB/GYNs, and other specialists
- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs)
- Other clinics including certain specified hospitals
- Certified Local Health Departments
- School-Based/Linked Clinics
- In certain instances, nurse practitioners, midwives, physician's assistants and

advanced practice nurses
- Other qualified health professionals, as determined by HFS

Providers can enroll by mail, fax, or online.

Mail: **Illinois Health Connect**
1375 E. Woodfield Rd. Suite 600
Schaumburg, IL 60173
Fax: **1-847-995-0827**
Online: Illinois Health Connect PCP

HK-201.1.2 Maternal and Child Health (MCH) Primary Care Provider Agreement

Increased reimbursement rates for selected MCH services are available to all PCPs who have signed agreements to be part of the Illinois Health Connect (PCCM) program Providers outside of the Illinois Health Connect Program may be eligible for these enhanced rates as well but must meet the criteria of, and sign, HFS' MCH Primary Care Provider Agreement (HFS 3411), in addition to being enrolled as a Medical Assistance Provider. Providers must meet the following participation requirements to enroll as an MCH Primary Care Provider:

- Maintain admitting privileges at a hospital
- Provide periodic health screening and primary pediatric care as needed
- Provide obstetrical care and delivery services as appropriate to the provider's specialty
- Perform risk assessment for pregnant women and children
- Maintain 24-hour telephone coverage for consultation including ensuring that "sick" children and "at-risk" pregnant women are treated as needed, based or triaged as indicated
- Schedule diagnostic consultation and specialty visits as appropriate
- Provide adequate equal access to medical care for participants
- Communicate with the case management entity

HK-201.1.3 Other Provider Types That May Bill All Kids Services

In order to bill HFS and be reimbursed for All Kids preventive health services, providers are to be enrolled with HFS to be able to provide Healthy Kids Services. This includes, but may not be limited to: Physicians (Provider Type 10); Certified Local Health Departments (LHDs) (Provider Type 52); School-Based/Linked Health Centers (Provider Type 56); Local Education Agencies (LEAs) (Provider Type 47); Federally Qualified Health Centers (FQHCs) (Provider Type 40); Rural Health Centers (RHCs) (Provider Type 48); Encounter Rate Clinics (ERCs) (Provider Type 43), and other outpatient clinics.

HK-201.2 Participation Approval

When participation in HFS' Medical Programs is approved through the Provider Participation Unit, the provider will receive a computer generated notification, the Provider Information Sheet, listing all data being retained on HFS' computer files in regards to the provider's enrollment. The provider is required to review the Provider Information Sheet for accuracy immediately upon receipt. For an explanation of the entries on the form, refer to the Handbook for Physicians, Appendix A-7.

If all information on the Provider Information Sheet is correct, the provider retains the sheet for subsequent use in completing claims (billing statements) to ensure that all identifying information required is an exact match to that in HFS file. If any of the information is incorrect, refer to Topic HK-201.4.

An ownership change of greater than 50 percent, or a change in corporate structure terminates current participation. New ownership or corporate structure requires a new enrollment.

HK-201.3 Participation Denial

Written notification to a provider of denial of an application will include the reason for the denial. Within ten days after such notice, the provider may request a hearing. The request must be in writing and must contain a brief statement as to the basis upon which HFS' action is being challenged. If such a request is not received within ten days, or is received but later withdrawn, HFS' decision shall be a final and binding administrative determination. HFS rules concerning the basis for denial of participation is set out in 89 Ill. Adm. Code 140.14. HFS rules concerning the administrative hearing process are set out in 89 Ill. Adm. Code 104 Subpart C.

HK-201.4 Provider File Maintenance

The information carried in HFS files for all participating providers (including PCCM, MCO and ACE providers) must be kept current. The provider and HFS share responsibility for keeping the file updated.

Provider Responsibility

The information contained on the Provider Information Sheet is retained in HFS' files. Each time the provider receives a Provider Information Sheet, it must be reviewed carefully for accuracy. In as much as the Provider Information Sheet contains information to be used by the provider in the preparation of claims, any inaccuracies found must be corrected and HFS notified immediately.

Any time a provider effects a change to information on the Provider Information Sheet, such as a physical move, HFS is to be notified. When possible, notification should be made in advance of a change.

A copy of the Provider Information Sheet may be obtained from the PPU. Requests may be made at:

Mail: **Illinois Department of Healthcare and Family Services**
Provider Participation Unit
P.O. Box 19114
Springfield, Illinois 62794-9114
Email: HFS.PPU@illinois.gov

Procedure

If the information listed on the Provider Information Sheet is in need of correction, the provider is to enter the correct data in the space below the incorrect data, the effective date of the change if applicable, sign and date the Provider Information Sheet in the space provided, and forward the corrected Provider Information Sheet to the address listed above.

Failure of a provider to properly notify HFS of any corrections or changes, including the effective date of such changes, may cause an interruption in participation and payments.

HFS Responsibility

Whenever there is a change in a provider's enrollment status, an updated Provider Information Sheet will be generated indicating the change and the effective date. Confirmation of the requested change will be sent to the provider in the form of an updated Provider Information Sheet. Upon receipt of the corrected Provider Information Sheet, invoices may be submitted.

HK-202 Provider Reimbursement

Providers must determine the enrollment, and therefore the payer source, for their patients prior to services being rendered. This information is available through the HFS Medical Electronic Data Interchange System (MEDI) system or through the Department's Automated Voice Response System (AVRS) at **1-800-842-1461**.

Providers should check eligibility prior to providing services to determine if a patient is enrolled with a managed care entity. Provider reimbursement will be conducted consistent with the healthcare system enrollment of the patient.

HK-202.1 Charges

Providers are to submit charges to the department only after services have been rendered. Charges are to be the provider's usual and customary charges to the general public for the services provided. To be paid for services, all claims, including claims that are re-billed, must be received within 180 days of the date of service. Covered services may be billed to HFS either electronically or on the appropriate form (see Chapter 200 for the form and billing instructions for each specific provider type).

Diagnosis Codes

Refer to the most current International Classification of Diseases 9th Revision, Clinical Modification (ICD-9-CM), currently 6th Edition, until superseded by International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) for the description of the diagnosis code(s) per Federal CMS Rules. When billing, enter the specific ICD-9-CM or ICD-10-CM diagnosis code, when in effect, without any punctuation. When billing the Evaluation and Management Code, or Preventive Medicine Code, it is recommended that the appropriate "V" (ICD-9) or "Z" (ICD-10) diagnosis code be used for comprehensive medical screening.

Procedure Codes

Refer to the *Current Procedural Terminology* (CPT) reference book for instructions on selecting an Evaluation and Management code consistent with the level of service provided.

Comprehensive Health Screening

Comprehensive health screenings may occur when a child presents for an acute problem and providers are encouraged, whenever possible, to minimize "missed opportunities" to provide children with a comprehensive medical screening.

Preventive Medicine CPT Code

When using the Preventive Medicine Services CPT codes to bill for a well child visit, the

following components must be performed according to the CPT guidelines: evaluation and management of a patient including an age and gender appropriate history, physical, developmental and mental/psychological examination, counseling and anticipatory guidance/risk factor reduction interventions and ordering of appropriate immunizations(s) and laboratory/diagnostic procedures.

Component parts of the well child screening exam, such as objective developmental screening, risk assessment, immunizations, lead screening, objective hearing and objective vision screening may be billed separately, using the appropriate CPT code(s) or *Healthcare Common Procedure Coding System* (HCPCS) code(s). Federally Qualified Health Centers, Rural Health Centers and Encounter Rate Clinics must provide an office visit at the time of the health care visit in order to be reimbursed, and **must** detail all provided services on the encounter claim.

The following services should be detailed (billed) separately to HFS, using the appropriate CPT code, or HCPCS code, and are recommended to be performed at priority intervals (e.g., based on the recommended periodicity schedule), based on age, health history, and according to professional guidelines, or the child should be referred for such objective screenings, if unable to be performed in the PCP's office:

- Objective Risk Assessment - use the appropriate CPT code for administration and interpretation of a health assessment instrument (refer to Topic HK-203.9 and the Appendices)
- Perinatal Depression - use code H1000 for prenatal risk assessment and 99420, with the HD modifier (99420 HD) for postpartum depression screening, up to a year after the infant's birth; may be billed on the infant's recipient number, if infant is the patient (refer to Topic HK-203.9 and the Appendices)
- Objective Developmental Screening - performed no less than at priority intervals (e.g., based on the recommended periodicity schedule), with surveillance during all well child visits in order to identify children with developmental and social-emotional delays and make referrals to Early Intervention or other agencies as may be appropriate
  - For children under age three, providers should administer an objective developmental screening using a standardized instrument approved by HFS, according to the AAP guidelines, at 9 months, 18 months and 24/30 months of age
  - Objective developmental screening specific to Autism should be conducted for all children at the 18-month and 24-month visits
  - CPT codes differentiate developmental screening instruments as to whether the recognized developmental screening instrument meets the criteria of "developmental screening, with interpretation and report, per standardized instrument form" (refer to Topic HK- 203.4 and the Appendices)
- Objective Vision Screening - use the appropriate CPT code for the vision screening service when a separate objective vision screening is provided, at visits annually from age 3 through 6 years, and again at ages 8, 10, 12, 15 and 18 years (refer to Topic HK-203.7.1 and the Appendices)

- Objective Hearing Screening - use the appropriate CPT code for the objective hearing screening service when a separate objective hearing screening is provided, at the newborn visit, at visits annually from age 4 through 6 years, and again at 8 and 10 years. (refer to Topic HK-203.7.2 and the Appendices)
- Laboratory procedures - to receive reimbursement for laboratory services, all providers, regardless of type of business or professional licensure, must have a current Clinical Laboratory Improvement Amendments (CLIA) certificate on file with HFS
  - Payment will not be made for laboratory services performed by a provider if HFS does not have on file the required CLIA certification as described below, unless the laboratory procedure is CLIA waived
  - CLIA certification may be waived on blood lead analysis, depending on the laboratory process for the analysis
- Immunizations – use the appropriate CPT code for the specific immunization given
  - Vaccines should be ordered through the Illinois Department of Public Health (IDPH) Vaccine for Children Program (VFC), or in Chicago, the Chicago Department of Public Health Vaccine for Children Program (refer to Topic HK-207.2 and the Appendices)
- Fluoride Varnish Application – use code D1206 for application of fluoride varnish on children under 36 months.

Note: Providers of laboratory services must be in compliance with CLIA. For more information refer to the Laboratories Handbook and Appendices.

HFS' laboratory policy and additional information regarding compliance with CLIA can be found in that document.

Note: Providers are to bill HFS for each required component part of the screening that is billable, and has been performed during the visit by using the appropriate CPT code(s) or HCPCS code(s). Providers billing an encounter rate **must** detail all components of the screening provided during the visit.

HK-202.2 Electronic Claims Submittal

Any services that do not require attachments or accompanying documentation may be billed electronically. Further information concerning electronic claims submittal can be found in Chapter 100, Topic 112.3, and Chapter 300, Topic 302. Please note that the specifications for electronic claims billing are not the same as those for paper invoices. Please follow the instructions for the media being used. If a problem occurs with electronic billing, providers should contact HFS in the same manner as would be applicable to a paper claim. It may be necessary for providers to contact their software vendor if HFS determines that the service rejections are being caused by the submission of incorrect or invalid data.

Providers should take special note of the requirement that Form DPA 194-M-C, Billing

Certification Form must be signed and retained by the provider for a period of three years. Failure to do so may result in revocation of the provider's right to bill electronically, recovery of monies, or other adverse actions (refer to Chapter 100, Topic 130.5 for further details).

HK-202.3 Paper Claims Preparation and Submittal

Refer to Chapter 100, Topic 112, for general policy and procedures regarding claim submittal. For specific billing instructions, refer to A-200, Handbook for Practitioners Rendering Medical Services.

HK-202.4 Payment

Payment made by HFS for allowable services provided to eligible participants is based on the individual provider's usual and customary fees, within the limitations established by HFS. The payment made is the lesser of the provider's charge or the maximum amount established by HFS. HFS' maximum reimbursement rates are available on the HFS Medicaid Reimbursement webpage. The fee schedule also contains special billing information.

Payments made by HFS to providers for services to eligible participants are considered payment in full. If a provider accepts the patient as a Medical Programs participant, the provider may not charge eligible participants for co-payments, participation fees, deductibles, completing forms, or any other form of patient cost-sharing, except as specifically allowed in Chapter 100, Topics 113 and 114 and Appendix 12.

HK- 202.4.1 Fee-for-Service

Participants in HFS' Medical Programs can receive services from enrolled providers under a fee-for-service arrangement between HFS and participating providers. Fee-for-service refers to payment for services that are provided in any setting acceptable to HFS such as a hospital, outpatient, medical office etc.

Primary Care Case Management Program (Illinois Health Connect)

The Primary Care Case Management (PCCP) program, called Illinois Health Connect, will operate in regions of the state where there is not mandatory managed care and will underlie the ACE program for 18 months. Illinois Health Connect is based on the American Academy of Pediatricians' initiative to create medical homes to make sure that preventive healthcare is provided in the best setting. In Illinois Health Connect, clients have a "medical home" with a PCP, such as a doctor's office. The PCP also provides care coordination and case management.

Enrollees may choose their own doctor or clinic as their PCP if that doctor or clinic is enrolled with HFS as a provider and enrolled as a PCP with Illinois Health Connect. Enrollees who do not choose a PCP will be assigned to one.

Illinois Health Connect PCPs receive a monthly care management fee. The monthly care management fee is paid to Illinois Health Connect PCPs on a capitated basis for each person whose care they are responsible to manage. The fees are $2.00 per child (under age 21), $3.00 per adult, and $4.00 per senior or adult with disabilities. These rates are subject to change with notification. This care management fee will be paid monthly, even if the enrollee does not utilize a service that month. PCPs will continue to receive reimbursement from HFS for their services using current established rates. PCPs are to bill their usual and customary rate for the given service and will be reimbursed for covered services the lesser of the provider's billed rate, usual and customary rate or the State's maximum reimbursement rate.

Each physician enrolled as an Illinois Health Connect PCP may have up to a maximum of 1,800 enrollees. For each nurse practitioner or physician's assistant affiliated with the physician, the maximum increases by up to 900 enrollees. The maximum panel size for residency programs is 900 enrollees per resident. PCPs may limit the number of enrollees and may opt out of auto-assignment.

Participants enrolled in Illinois Health Connect will receive regular HFS medical cards. For more information, visit the Illinois Health Connect website.

Referrals for Primary and Specialty Care

Illinois Health Connect is in Phase 1 of its referral system, which is designed to improve care coordination through the medical home. Phase I enforces the PCP assignment on HFS claims for patients assigned to a PCP on that date of service. Only the assigned PCP and registered affiliates of the assigned PCP will be paid for claims without an IHC referral. Referrals can be submitted to IHC retroactively up to 60 days after the date of service and can be entered as far as a year in advance. Referrals can be submitted online using the IHC Provider Portal via the MEDI system or via fax or phone to the IHC Provider Services Help Desk.

In terms of specialty care, until the referral system is fully implemented, claims will continue to be processed without a referral. Although PCPs are encouraged to submit the referral, specialists can see IHC patients without an IHC referral during Phase I. Providers will be notified at least three (3) months prior to the full implementation of the Illinois Health Connect referral system. Direct access services such as hospital emergency department visits will not require a referral. For information on specialty care referrals, please visit the Illinois Health Connect website Frequently Asked Questions page.

Specialists who would like to be included in the Specialist Resource Database can contact Illinois Health Connect at **1-877-912-1999** to complete an application**.**

Incentive Payments

HFS will pay an annual incentive payment of $30 per patient to enrolled PCPs, Maternal and Child Health (MCH) physicians, advanced practice nurses and FQHCs who render all recommended well child visits during each year of a patient's life, from birth to age five. These include six well child visits from age 10 days to age one year; three well child visits from age one year to age two years; or one well child visit each year from age two years to age five years.

HK- 202.4.2 Managed Care

A MCO may be a Health Maintenance Organization (HMO) or Managed Care Community Network (MCCN). Under a MCO, health services are prepaid, based on a per member, per month (PMPM) capitation. The MCO is responsible for providing or arranging and reimbursing for all covered services as defined in their contract with HFS. Participants enrolled in MCOs will receive medical cards with the following message:

Managed Care Enrollee(s): Services may require payment authorization.

For more information about MCOs refer to Chapter 100, Topic 105 and General Appendix 11 for a list of the MCO contractors.

Incentive Payments

Incentive payments also apply to physicians participating with a MCO, for HFS MCO-enrolled children. HFS will pay an annual incentive payment of $30 per patient to enrolled PCPs, Maternal and Child Health (MCH) physicians, advanced practice nurses and FQHCs who render all recommended well child visits during each year of a patient's life, from birth to age five. These include six well child visits from age 10 days to age one year; three well child visits from age one year to age two years; or one well child visit each year from age two years to age five years. The incentive payment is made by HFS to the MCO, and the MCO passes the incentive payment to the respective provider or subcontractor. Each MCO may elect to offer additional incentive payments under a "Pay-for-Performance" (P4P) strategy.

HK-203 Covered Services

HK-203.1 Well-Child Examination

The five categories of preventive health care screening services for children under All Kids are **medical/mental health, vision, hearing, dental, and developmental**. Screening components are described in the sections to follow. Unless otherwise specified, the recommendations herein are taken from AAP policy statements, the *Bright Futures, 3rd Ed., 2008* published by the AAP; and treatment guidelines published by the Illinois Department of Public Health (IDPH) or the Illinois Department of Human Services (IDHS).

The *Bright Futures, 3rd Ed.* Recommendations for Preventive Pediatric Health Care can be found on the Recommendations for Preventive Pediatric Health Care. This periodicity schedule represents a consensus by the AAP and Bright Futures for the timing of pediatric preventive care services. Consult the appropriate chapter of this Handbook for Providers of Healthy Kids Services for specific guidelines. Refer to Topic HK-203.1.1 Health Screening for HFS' minimum requirements for physicals for children ages 6-20 years. HFS will pay for other screenings when medically necessary, regardless of a child's age or medical history.

HK-203.1.1 Health Screening

It is recommended that health screenings be provided to children on the periodicity schedule recommended by Bright Futures/the AAP. The following schedule provided by HFS as a minimum guideline is consistent with *Bright Futures, 3rd Ed.*

- Under age one:
  - Within 24 hours of birth in hospital
  - 3-5 days of life and within 48-72 hours after discharge
  - 1 month
  - 2 months
  - 4 months
  - 6 months
  - 9 months
- One to three:
  - 12 months
  - 15 months
  - 18 months
  - 24 months
  - 30 months
- Three to twenty-one:
  - Annually, per provider

Consistent with the above periodicity schedule, DCFS requires that children in their legal custody between the ages of two years and 21 years receive, at a minimum, annual health screenings.

According to Bright Futures, every well child visit should include all of the following components:

- Overview of the priorities for the visit
- Health supervision, including:
  - A comprehensive health history (including physical health, mental health [including social, emotional and behavioral issues, bullying, domestic violence or other potential abuse], development, and nutrition)
  - Observation of parent-child interaction
  - Surveillance of development
  - A comprehensive unclothed physical examination [Note: The comprehensive examination performed as part of the Preventive Medicine Evaluation and Management Service codes are further explained in the *Current Procedural Terminology* (CPT) reference book. In order to bill for these services, the guidelines set forth in the CPT reference book must be met and documented in the child's medical record. Also, it is recommended that the unclothed exam be preferably conducted in the presence of a parent or legal guardian)
  - Age appropriate screening tests, both universal and selective based on age and risk factors, and necessary referrals for:
    - objective developmental and social/emotional screening
    - vision and hearing
    - risk assessment (mental health, perinatal depression, tobacco use/exposure and substance use/abuse, trauma exposure – See Appendices)
    - oral health, including referral for preventive dental and dental treatment services
  - Appropriate immunizations, based on age and health history, and the correction of immunization deficiencies (according to the schedule established by the Advisory Committee on Immunization Practices [ACIP] for pediatric vaccines).
  - Assessment of age appropriate activity/exercise and exposure to second hand smoke
  - Other practice-based interventions, such as promotion of literacy using the Reach Out and Read model (refer to Appendices)
- Anticipatory guidance (Topic HK-203.10) and health education

HK- 203.1.2 Inter-periodic Screenings

Inter-periodic screenings may be provided as medically necessary, or when required or mandated for admission to day care; enrollment in an early childhood education program; participation in school; attendance at camp; participation in a sports program; placement in a licensed child welfare facility including foster home, group home or institution; adoption; prior to medical or dental procedures; enrollment in the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) (refer to Topic HK-207.5); in cases of trauma, accident, or suspected abuse or domestic violence (see Appendices); as required by the child's Individual Education Plan (IEP) or Individual Family Service Plan (IFSP); or at the request of the parent or guardian. Forms completion relative to these types of screenings or examinations is covered by the reimbursement arrangement between HFS and the provider. Charging enrollees a fee only for completion of forms without an examination or other services being provided is therefore prohibited.

Note: In order to receive reimbursement for an inter-periodic screening using the CPT code under Preventive Medicine Services, all component parts of the well child screening must be performed (e.g., comprehensive health and developmental history, comprehensive unclothed physical examination, appropriate immunizations, appropriate laboratory tests and anticipatory guidance). One inter-periodic screening visit is permitted per year. A provider may be reimbursed for an evaluation and management visit using the CPT code under Office or Other Outpatient Services, as appropriate, if all components comprising the well-child visit are not performed.

HK-203.1.3 Health History

The comprehensive health history should be sufficient to enable the providers to:

- Obtain information about previous health care and health problems;
- Obtain information about family medical history;
- Evaluate the risk for health problems;
- Obtain information about the child's academic performance, peer relationships and overall functioning within the community;
- Obtain information about the eligible participant's family and social environment, homelessness, hunger, and instances of violence, abuse, bullying, etc. to understand particular needs and provide appropriate care.

Information should be obtained from the eligible participant, when appropriate, and parents or guardians who are familiar with the child's health history. Attempts should be made and documented to obtain additional information and records from health care professionals or organizations that have provided health care services to the eligible participant.

A complete written history is required during the initial health screening. Interval histories will be maintained for the period between subsequent screening visits by the participating provider for the child.

Bright Futures recommends interval history is obtained according to the concerns of the family and the health care professional's preference or style of practice, or by using a *Bright Futures, 3rd Ed.* visit specific questionnaire (see Appendices). As medically and age appropriate, the following topics should be included in the health history:

- Current complaints and parental concerns
- Prenatal, birth, and neonatal history
- Medical history, including chronic medical problems/treatments, hospitalizations, surgeries, illnesses and accidents
- Immunization record and history of communicable diseases
- Developmental history, including hearing/communication/language development
- Mental health history
- Physical growth history
- Nutrition screening and dietary history, including breastfeeding history
- Fluoridation status and oral health history
- Family health history
- Social history, including family composition, cultural issues which may impact care, day care/school attendance, individual or family history of substance abuse
- Environmental exposures, including tobacco smoke and lead
- Medications taken and any adverse effects
- Complementary/alternative health remedies used
- Allergies, including to food or medication
- Sexual history, including the use or need for contraceptives, prior pregnancy, and history of sexually transmitted diseases or infections
- History of risk taking behaviors or substance use

HK-203.1.4 Nutritional Assessment

There is no one laboratory or physical measurement that will allow a positive statement of nutritional health. Instead, there are a number of assessments and measurements, which, when indicated, may collectively allow an estimate of such. Components of a nutritional assessment include the following:

- Dietary evaluation, including
  - breastfeeding history (i.e. duration and exclusivity of breastfeeding)
  - record of food intake
  - diet history including questions to identify unusual dietary practices or eating habits (e.g., prolonged use of bottle feedings, eating non-food items, etc.) or food frequency to identify the frequency of consumption of foods grouped together based on their principal nutrient contribution
  - evaluation of breastfeeding
- Anthropometric measurements, including
  - length or height
  - weight and head circumference
  - weight for length under age two using the World Health Organization (WHO)

  - infant growth curves
  - body mass index (BMI) percentile for age two and older measured and plotted on a standardized U.S. Centers for Disease Control and Prevention (CDC) growth chart
- Laboratory testing, including
  - screening test for anemia (hemoglobin or hematocrit – if anemic, evaluate for iron deficiency)
  - dyslipidemia screening for children at risk (e.g., family history of premature cardiovascular disease, other risk factors, or risk conditions) beginning at age two years, and universal laboratory screening at least once between the ages of 9 and 11 years and again between 17-21 years, as covered in topic HK-203.3.6 on Dyslipidemia Risk Assessment and Laboratory Screening
- Clinical evaluation, including
  - complete unclothed physical examination as covered in Topic HK-203.1.5
  - oral examination as covered in Topic HK-203.8
  - special attention should be paid to such general features as apathy or irritability

Follow up is indicated for the children exhibiting the following:

- Dietary intake inadequate/inappropriate for age or physical condition including inappropriate feeding practices
- Need for further evaluation of breastfeeding
- Height less than the 5th percentile on a standardized growth chart (the WHO charts for children under two years and the CDC growth chart for children ages two years and older)
- Height measurement that has declined in percentile on the growth curve
- Weight for age less than the 5th percentile on a standardized growth chart (less than 3rd percentile for infants), or a change (crossing over) of two or more percentile lines
- BMI less than 5th percentile or at or greater than 85th percentile for ages two years and older, or weight for length less than 3rd percentile or greater than 97th percentile on the WHO charts for under age two
- Diseases in which nutrition plays a key role such as early childhood caries, iron deficiency anemia, diabetes, allergies, metabolic disorders, and physical or mental disabilities, such as eating disorders, affecting feeding

Refer to Topic HK-203.3.2 for anemia risk assessment and iron status testing periodicity schedule. Children should be tested at other times if clinically indicated.

HK-203.1.5 Comprehensive Unclothed Physical Examination

The comprehensive preventive child health physical examination:

- Evaluates the form, structure and function of particular body regions and systems
- Determines if these regions and systems are normal for the child's age and background

- Discovers those diseases and health problems for which no standard screening test has been developed, including evidence of child abuse, neglect, trauma, or combination – see Appendices

The unclothed physical examination serves as a general health evaluation and provides important information for other components of the well child screening. It will include, but is not limited to, examination of:

- Measurements - vital signs, length (up to age 2 years, measured in supine position) or height (over age 2 years, measured in standing position), weight and head circumference up to age 3 years; measurements are to be plotted on a standardized growth chart, as appropriate**;** BMI percentile and classification should be determined for all children (using WHO growth curves for infants under age two and CDC growth charts for ages two years and older)
- Length or height, and weight should be measured at each visit; head circumference is measured at each screening visit until the child reaches 36 months of age; children age three and above are recommended to have an annual blood pressure screening using an appropriate cuff size; children under age three should be tested if a risk assessment indicates risk for hypertension (ex. History of prematurity, congenital heart disease, medications that may increase blood pressure, renal disease, etc)
- General appearance- body shape and proportions, gait and posture; skin evaluation (color, texture, rash, deformities, and birthmarks); hair and nails; speech pattern (vocalization and speech appropriate for age); orientation and mental alertness; parent and child interaction and behavior
- Head and neck- facial features and head shape; presence and size of fontanelle(s); presence of lymphadenopathy; nose and throat evaluation: includes inspection of nasal mucous membranes; mouth, teeth, gums evaluation: palate, uvula, pharynx, dental ridge, oral membranes and dental caries
- Eyes and ears - eyelids, extraocular motion; conjunctiva, cornea, iris, and red reflex; examination of conjugate eye movements and pupillary reaction to light; external and otoscopic examination of ear canals and drums
- Cardiovascular - palpation of the heart, auscultation for rate, rhythm, valvular sounds, murmurs; evaluation of peripheral vasculature and presence of edema
- Respiratory- inspection and palpation of the chest: shape, symmetry, respiratory rate, rhythm, and effort; thoracic condition; chest movements; percussion and auscultation
- Gastrointestinal - palpation of organs and masses, hernias, tenderness
- Reproductive systems and breasts – genitalia inspection (including speculum exam for females when indicated) and palpation of breasts; Tanner Stage; testicular examination in males
- Nervous system - neurological evaluation: including reflexes, gross/fine motor coordination
- Musculoskeletal –back inspection, muscle strength evaluation, evaluation of hips and gait, gross and fine motor coordination

- Lymphatic system - superficial lymph nodes and the spleen are accessible for assessment by inspection and palpation
- Integument - inspection of the skin, palpation when appropriate

Health care providers should consider the age of the eligible participant when conducting the physical examination. Some of the inspections mentioned above may not be appropriate at particular levels.

Health care providers are mandated to report suspicious injuries, abuse, neglect, or other similar conditions to:

Illinois Department of Children and Family Services
Child Abuse and Neglect Hotline
1-800-25-ABUSE (1-800-252-2873)
1-217-785-4020

Refer to the appendices for more information about trauma informed care.

HK-203.2 Appropriate Immunizations

The EPDST Program and All Kids Program require immunizations appropriate for a child's age and health history. **The Recommended Child and Adolescent Immunization Schedule** and the **Recommended Adult Immunization Schedule** (for 19-20 year olds) are annually updated, as approved by the Advisory Committee on Immunization Practices (ACIP) of the U.S. Department of Health & Human Services, CDC, the AAP and the AAFP.

Bright Futures uses the following sources to obtain the most up-to-date immunizations schedules:

- CDC National Immunization Program
- Childhood and Adolescent Immunization Schedule
  1-800-CDC-INFO (1-800-232-4636)
- AAP *Red Book*

Additionally, the immunization schedule is published in the Morbidity and Mortality Weekly Report (MMWR) annually and can be found on the CDC Immunization Schedules website and in the AAP Immunization website.

Immunization Resources

Providers seeking resources should refer to the AAP's Immunizations website for best practices and implementation resources from the AAP's Childhood Immunization Support Program (CISP). The CISP Immunization Training Guide is available for download and can be used to educate and properly train physicians, nurse practitioners, physician assistants, nurses, medical assistants, office managers, and other office staff.

Families and community members can be directed towards other immunization resources such as the CDC Teen Vaccine website, the Immunizations for Public Health (I4PH), and the AAP's parent website, which has a large section on vaccines.

Vaccines for Children (VFC) Program

The Omnibus Budget Reconciliation Act of 1993 (OBRA) created the **Vaccines for Children (VFC) Program** as Section 1928 of the Social Security Act in August 1993, to ensure that uninsured, Medicaid-enrolled, American Indian and Native Alaskan children (0-18 years of age) are able to receive all vaccines recommended by the ACIP and CDC. Health care providers serving VFC eligible children can enroll in the VFC program and will receive vaccines free of charge for their VFC eligible patients. Providers may not charge HFS for the cost of the childhood vaccine provided by the VFC Program. While HFS does not pay for the vaccine product itself, the provider may charge HFS for the administration of the vaccine to program participants. When submitting a claim for the administration of a VFC acquired vaccine, providers must bill using the CPT code for the specific vaccine product, rather than the vaccine administration service CPT code. However, the charge amount should be the provider's usual and customary (U & C) charge for the appropriate vaccine administration service CPT code, even if that charge exceeds the regional VFC maximum immunization administration fee.

Under VFC policy, providers may only charge one administration fee per vaccine (syringe), regardless of the number of components in the vaccine. Providers may not charge for additional components for multi-component vaccines.

For more information on the VFC Program and how to enroll, refer to Topic HK-207.2

Immunization Billing Instructions

Billing information is included in the Handbook for Providers Rendering Medical Services (Practitioners' Handbook) Chapter A-200 and Vaccine Billing Instructions are provided in Appendix A-8 of the Practitioners' Handbook.

HK-203.3 Laboratory Procedures

For more information about policy and procedures regarding laboratory services, refer to Chapter L-200, Handbook for Providers of Laboratory Services. The laboratory procedures that follow in this section, as appropriate for the individual's age and population group are recommended, as needed.

HK-203.3.1 Lead Related Evaluations and Blood Lead Testing

It is recognized that there is no safe level of lead. Updated (2012) guidelines from the CDC recommend enhanced follow up for children with a blood lead level (BLL) greater than or equal to 10 μg/dL. Additionally, young children (under age five) with blood lead levels of 5 to 9 μg/dL should also be considered for repeat blood lead level testing sooner

than is routinely recommended. All parents should receive education about primary prevention of lead exposure.

Federal mandates and HFS policy require that all children enrolled in HFS' Medical Programs be considered at risk for lead poisoning and receive a blood lead test at age 12 and 24 months. If a child is 3-6 years of age and has not been tested, a blood lead test is required. All children enrolled in HFS' Medical Programs are expected to receive a blood lead test regardless of where they live. Children at highest risk should be assessed on a regular basis. The city of Chicago requires a blood test to be performed at 6, 12, 18, 24 and 36 months or 9, 15, 24 and 36 months. Blood lead testing for diagnostic reasons (e.g., history of exposure, follow up of past test results) is always indicated. Recent immigrants, refugees, or international adoptees from 6 months to 16 years should be screened within 90 days of arrival in the U.S. Repeat BLL testing of all refugee children aged 6 months to 6 years, 3 to 6 months after arrival is necessary regardless of initial results.

HFS requires that lead testing be conducted in accordance with the state regulations and guidelines stipulated in the "Lead Poisoning Prevention Act," 410 ILCS 45/1 et seq. as amended.

Blood lead draw is the only laboratory draw fee that may be billed. HFS reimburses fee-for-service providers who do not receive an encounter rate for the blood lead draw (CPT 36415, with the U1 modifier, [36415U1] - venous blood lead draw, and CPT 36416, with the U1 modifier, [36416 U1] – capillary blood lead draw). The blood lead analysis using the ESA Biosciences LeadCare II Blood Lead Testing System does not require CLIA certification (CPT 83655, with the QW modifier [83655QW]). HFS reimburses fee-for-services providers who do not receive an encounter rate for the blood lead analysis performed in their office, with the appropriate CLIA certification (CPT 83655). Encounter rate clinics **must** report in detail the services performed during the office visit on the encounter claim.

Capillary specimens may be utilized for evaluative purposes with the understanding that diagnostic blood lead levels must be measured using venous samples. Using a venous sample initially is highly recommended. Children who have capillary blood levels greater than or equal to 10 μg/dL should have venous confirmation of these levels.

Diagnosis, Treatment and Follow Up

If a child is found to have a single venous blood lead level equal to or greater than 10 μg/dL, providers are to follow the CDC and IDPH guidelines covering eligible participant management and treatment. The IDPH Illinois Lead Program has identified physicians willing to act as medical consultants on any issues related to evaluation, testing, diagnosis, clinical management or treatment of lead poisoning, or to discuss any unusual cases that pose problems for clinicians. To confer with a medical consultant, contact the IDPH Illinois Lead Program.

The IDPH Illinois Lead Program will provide educational materials for providers to distribute to families and perform case management services for children with elevated blood lead levels. Additional information regarding lead poisoning, including copies of the guidelines, or educational materials, may be obtained by calling, emailing, or faxing the request to the:

Illinois Department of Public Health
Illinois Lead Program
Phone: 1-217-782-3517 or 1-866-909-3572
TTY: 1-800-547-0466
Email: Dph.lead@illinois.gov

Reporting

The Illinois Lead Poisoning Prevention Act requires reporting by laboratories of all blood lead test results to the IDPH Illinois Lead Program. Any blood lead test conducted within the practice laboratory by any method falls under the reporting requirement.

In the Illinois law, physicians are required to report to the IDPH Illinois Lead Program all blood lead results greater than or equal to10 µg/dL within 48 hours; blood lead results less than 10 µg/dL must be reported within 30 days after the end of the month in which the blood lead levels less than the permissible limits set forth in the rule are obtained. If the physician uses the IDPH (State) laboratory for blood analysis (which is highly encouraged by HFS), the physician reporting of elevated blood lead levels is waived, since the results of the blood lead levels are already known to the IDPH Illinois Lead Program. However, if the physician uses a private laboratory, the clinician should check with the laboratory they use to see if the laboratory automatically reports to IDPH. If not, the physician is responsible and should report every blood lead level according to the aforementioned reporting requirements. Physicians using in-office lead testing systems should contact the state to identify the most expedient method for reporting the lead test results from samples run in their in-office laboratory. Many laboratories in Illinois have electronic reporting to the state lead program of all the lead tests done at their laboratory.

Reporting forms are available on the Illinois Department of Public Health website and may be faxed to **1-217-557-1188**. The IDPH Illinois Lead Program may be contacted by calling or emailing:

Illinois Department of Public Health
Illinois Lead Program
Phone: 1-217-782-3517 or 1-866-909-3572
TTY: 1-800-547-0466
Email: DPH.Lead@illinois.gov

When reporting lead poisoning to IDPH, the child's Recipient Identification Number must be provided. The IDPH Illinois Lead Program will ensure that children with elevated blood lead levels are referred to a Certified Local Health Department for public health nurse

intervention. As a delegate agency of IDPH, the Certified Local Health Department provides care coordination by the public health nurse, which may include follow up testing, referrals to other services, and further investigation.

Specimen Handling and Provider Feedback

Blood specimens for lead analysis should be sent to:

Illinois Department of Public Health
Division of Laboratories
Mail: 825 North Rutledge
Springfield, Illinois 62702-4910
Phone: 1-217-782-6562
Fax: 1-217-524-7924

To obtain information on specimen pickup services provided by IDPH, contact the IDPH State Laboratory, at the above phone number. The IDPH State laboratory will send lead results to the provider through the mail. Results will be faxed when the provider has requested it and a fax number has been provided. Results in situations which constitute a medical emergency will be made available by telephone. Alert the laboratory prior to submitting the specimen of the medical emergency.

Environmental Assessment to Determine the Source of Lead Exposure

In accordance with IDPH standards, children with elevated blood lead levels will be referred by IDPH to the Certified Local Health Department for an environmental assessment of the home to determine the source of lead. An environmental assessment will be conducted if:

- A child younger than 36 months has a confirmed blood lead level (venous) at or above 10 μg/dL;
- A child 36 months or older has a confirmed blood lead level at or above 20 μg/dL;
- A child has three successive confirmed blood lead results of 15 μg/dL to 19 μg/dL with no time requirement between tests;
- A child has a single confirmed blood lead level at or above 10μg/dL and the child's physician requests an investigation to determine if the child should be removed from the regulated facility because of the lead hazard; or
- Mitigation notices are issued for two or more dwelling units in a building within a five year time period. The Department may inspect common areas in the building and shall inspect units where children 6 years of age or younger reside, at the request of a parent or guardian of the child, or where a pregnant woman resides, at the pregnant woman's request.

HFS reimburses IDPH for the environmental assessment of the child's home (or primary residence), to determine the source of lead for children participating in HFS' Medical Programs. Reimbursement for this investigation is limited to a health professional's time

and activities during the on-site investigation of a child's home. The testing of environmental substances, such as dust, water, soil, or paint is not covered by HFS, but sample analysis is performed by IDPH. The established procedure code for environmental assessment is T1029.

HK-203.3.2 Anemia Test

Iron deficiency is the most prevalent form of nutritional deficiency in this country. The risk of anemia is highest during infancy and adolescent because of the increased iron requirements from rapid growth (in full term infants, iron stores are adequate until age 4 to 6 months). The following information is from *Bright Futures, 3rd Edition*.

Hemoglobin or Hematocrit testing is recommended for persons:

- Age 9 months to 12 months
- Age 15 months to 18 months, as medically necessary
- At any age with a history of iron-deficiency anemia
- Whose history or risk assessment identifies medical needs or risk factors such as:
  - infants at 4 months with prematurity or low birth weight
  - infants at 4 months on low-iron formula, not receiving iron-fortified formula, or when cow milk is introduced early
  - children 18 months to 5 years at risk of anemia because of special health needs, low-iron diet, or environmental factors such as poverty
  - children 6-10 years who consume a strict vegetarian diet and do not receive an iron supplement
  - adolescent women 11-21 years with extensive menstrual blood loss or low iron intake

The most easily administered test for anemia is a microhematocrit determination from venous blood or a finger-stick.

HK-203.3.3 Sickle Cell Disease, Sickle Cell Trait and Hemoglobinaopathies

All children born in Illinois hospitals since January 1, 1989, are tested for Sickle Cell disease at birth. Children with abnormal results should be retested by the child's primary care physician or referred to a consultant. The following ethnic groups are more at risk for Sickle Cell disorders:

- African-American
- Hispanics from Mexico, Caribbean Islands and Other South American countries
- Natives of the Mediterranean Sea Coast countries and East Asia countries
- Middle Eastern

HK-203.3.4 Newborn Metabolic Screening

Newborn metabolic screening is required by state mandate to screen all Illinois newborns

for over 40 life threatening metabolic, endocrine and hemoglobin disorders soon after birth to prevent death and/or developmental disabilities. All newborn screening blood specimens are collected 24 hours after birth and submitted to the Illinois Department of Public Health (IDPH) centralized laboratory. Testing for biotinidase deficiency, congenital adrenal hyperplasia, congenital hypothyroidism, galactosemia, sickle cell disease, fatty acid oxidation and organic acid disorders, phenylketonuria and other amino acid disorders and cystic fibrosis is performed on every sample submitted. Testing for severe combined immunodeficiences was added in June 2014 and statewide screening for certain lysosomal storage disorders will occur during 2015. Abnormal test results are reported to the physician of record by the IDPH follow up staff who facilitate retesting and referral of the family to a medical specialist if needed. In addition, legislation passed in August 2013 mandates that all birth hospitals conduct pulse oximetry screening of newborns for the detection of critical congenital heart disease.

PCPs should verify documentation of newborn metabolic screening results, assure that appropriate rescreening is done when needed, and that referrals to medical specialists are made when required. If newborn screening has not been previously completed, for example, if the newborn delivered at home or if the newborn was discharged without testing, the PCP should conduct screening as required by the IDPH Newborn Screening and Genetics Program.

The PCP can contact the IDPH newborn screening follow up program to obtain results by calling 1-217-785-8101. If there are any abnormal results, the PCP should ensure that appropriate rescreening has been performed or referrals are made to appropriately credentialed subspecialists. IDPH Newborn Screening and Genetics Program staff is available for assistance with parent and provider education, completing subspecialist referrals and long term follow up through 15 years of age for children with diagnosed disorders.

HK-203.3.5 Tuberculosis Screening

Tuberculosis screening is recommended to be done at the provider's discretion based on medical indication. *Bright Futures, 3rd Ed.* guidelines state that simple risk assessment questions can identify children with risk factors for Latent TB Infection (LTBI). On recognition of risk factors, children should be tested with a Tuberculin Skin Test (TST).

Risk assessment for tuberculosis should be performed at first contact with a child and every 6 months thereafter for the first 2 years of life (e.g., 1-, 6-, 12-, 18- and 24-month visits). If at any time, risk of tuberculosis disease is determined, a TST should be performed, although this test is unreliable in infants younger than 3 months of age. After 2 years of age, risk assessment for tuberculosis should be performed annually, if possible.

Validated Questions for Determining Risk of LTBI in Children in the United States:

- Has a family member or contact had tuberculosis?
- Has a family member had a positive tuberculin skin test?

- Was your child born in a high risk country (countries other than the United States, Canada, Australia, New Zealand, or Western European countries)?
- Has your child traveled (had contact with resident populations) to a high risk country for more than one week?

Children for whom immediate tuberculin skin testing is indicated:

- Children who have contact with persons who have confirmed or suspected infectious tuberculosis (contact investigation)
- Children with radiographic or clinical findings suggesting tuberculosis
- Children immigrating from endemic countries (e.g., Asia, Middle East, Latin America)
- Children with travel histories to endemic countries/or significant contact with indigenous persons from such countries

Children who should have annual tuberculin skin testing:

- Children infected with HIV
- Incarcerated adolescents

Risk for Progression to Disease

Children with other medical risk factors including diabetes mellitus, chronic renal failure, malnutrition, and congenital or acquired immunodeficiencies deserve special consideration. Without recent exposure, these children are not at increased risk of acquiring tuberculosis infection. Underlying immunodeficiencies associated with these conditions theoretically would enhance the possibility for progression to severe disease. Initial histories of potential exposure to tuberculosis should be included for all these patients. If these histories or local epidemiologic factors suggest a possibility of exposure, immediate and periodic TST should be considered. An initial TST should be performed before initiation of immunosuppressive therapy, including prolonged steroid administration, use of tumor necrosis factor- alpha antagonist, or immunosuppressive therapy in any child requiring these treatments.

HK-203.3.6 Dyslipidemia Risk Assessment and Laboratory Screening

Atherosclerosis begins in youth. Prevention of risk factors development and management of identified risk factors are key to prevention of future cardiovascular disease. A risk assessment including family history of cardiovascular disease should be done starting at age 2 and updated at each well child visit until age 21. Laboratory screening should be initiated for children at risk starting at age 2.

Children at risk include:

- children with a positive family history (myocardial infarction, angina, coronary artery bypass graft/stent/angioplasty, sudden cardiac death in parent, grandparent,

- aunt, or uncle at <55 y for males, <65 y for females)
- children who have high-level risk factors (hypertension that requires drug therapy [BP ≥ 99th percentile + 5 mm Hq], current cigarette smoker, BMI at the ≥97th percentile, presence of high-risk conditions)
- children who have moderate-level risk factors (hypertension that does not require drug therapy, BMI at the ≥95th percentile, <97th percentile, HDL cholesterol <40 mg/dL, a child born premature, presence of moderate-risk conditions)
- children with the presence of high risk conditions (T1DM and T2DM, chronic kidney disease/end-stage renal disease/post-renal transplant, post-orthotopic heart transplant, Kawasaki disease with current aneurysms)
- children with the presence of moderate risk conditions (Kawasaki disease with regressed coronary aneurysms, chronic inflammatory disease [systemic lupus, erythematosus, juvenile idiopathic arthritis], HIV infection, nephrotic syndrome)

Universal laboratory screening is recommended at least once between the ages of 9 and 11 years and between the ages of 17 to 21.

For the most current recommendations and guidelines for cardiovascular risk reduction in children and adolescents, visit the National Heart, Lung, and Blood Institute (NHLBI) website.

HK-203.3.7 Urinalysis

The AAP does not recommend urinalysis as part of continuing well child care at any age. The screening of urine in well children for asymptomatic urinary tract infections may be considered by the provider if medically indicated.

HK-203.3.8 Reproductive Health and Sexually Transmitted Diseases

Consistent with requirements of the Affordable Care Act, all HFS enrolled providers shall ensure that the full spectrum of family planning options and reproductive health services are appropriately provided with no cost sharing. Family planning and reproductive health services are defined as those services offered, arranged or furnished for the purpose of preventing an unintended pregnancy, and to improve health and birth outcomes. Family planning and reproductive health services shall be provided by, or administered under the supervision/collaboration of a physician (MD or DO), advanced practice nurse or physician assistant, and must follow the most current nationally recognized evidence-based standards of care and guidelines for sexual and reproductive health, such as those established by the Centers for Disease Control and Prevention (CDC) (pdf) or the American Congress of Obstetricians and Gynecologists. Information about contraception from most effective to least effectiveness, medical eligibility criteria, use of contraceptives during the postpartum period, long-acting reversible contraceptive resources, etc is available on HFS' Illinois Family Planning Provider webpage.

Medicaid's free choice of provider's statute (pdf) allows clients to see any Medicaid provider of their choice when seeking family planning and reproductive healthcare

services. Thus, clients can access contraceptive services and supplies without managed care network restrictions. Additionally, provider policies/protocols shall not present barriers that delay or prevent access, such as prior authorizations or step-therapy failure requirements. Clients should receive education and counseling on all FDA-approved birth control methods (pdf) from most effective to least effective, and have the option to choose the preferred birth control method that is most appropriate for them – CDC Guidance (pdf).

It is important to address youth behaviors related to sexual health, including discussion about reproductive coercion, safe practices to avoid sexually transmitted diseases (STD) and pregnancy, and provide education regarding all forms of FDA approved contraception. Comprehensive, medically accurate, age appropriate sexual health education is an integral part of health education. This should be addressed in a manner that assures confidentiality and where there is trust so the adolescent feels comfortable to speak candidly about the sensitive matter of reproductive health.

Evaluations of external genitalia of all patients should be performed at yearly visits to confirm normal anatomy, assess pubertal development, and look for evidence of abnormal lesions, infection, or trauma. Pelvic examinations are recommended by the AAP for adolescent girls who have persistent vaginal discharge, dysuria or urinary tract symptoms, dysmenorrhea unresponsive to non-steroidal anti-inflammatory drugs, amenorrhea, abnormal vaginal bleeding, lower abdominal pain, suspected rape, child abuse and/or pregnancy. A pelvic exam is not required for the purposes of prescribing contraception. Abnormal findings during a pelvic exam such as masses, chronic pelvic pain, suspected pregnancy, menstrual disorders unresponsive to medical management, unknown genital lesions, and other genital anomalies should be referred to a gynecologist or other gynecological provider when indicated.

Sexually active young adults are at high risk of unintended pregnancy and STDs. Education and counseling should include abstinence, delaying sexual activity, and barrier protection; however, clients requesting birth control should be offered the most effective form with discussion about emergency contraception. See HFS' family planning services and reproductive health services Informational Notice [pdf] for more information. See CDC's webpage (pdf) for contraceptive effectiveness. Contrary to commonly held belief, intrauterine devices and the implant are the most effective forms of long acting reversible contraception and generally are safe and efficacious for use in nulliparous adolescents.

Recommendations for cervical cancer screening or Papanicolaou (pap) testing reached consensus status in March 2012 with ACOG, the USPSTF and the American Cancer Society (ACS), with all groups agreeing that screening should not begin until the age of 21 regardless of sexual history or pregnancy. The consensus report concluded screening under the age of 21 produces more harm than benefits. Visit the ACOG Committee on Adolescent Health Care website or USPSTF Screening for Cervical Cancer website for more information about these guidelines.

It is recommended by the CDC that all sexually active youth be screened for gonorrhea and chlamydia annually. For high risk youths (e.g., recent incarceration, males having sex with males, IV drug use) and those who screen positive for chlamydia or gonorrhea, hepatitis B, HIV and syphilis tests also should be performed each year, and testing should be considered as often as every three to six months or with onset of new symptoms. For routine screening, Nucleic Acid Amplification Tests (NAAT) are the recommended method for testing of urogenital chlamydia and gonorrhea. First catch urines (male and female) and vaginal swabs are appropriate due to the sensitive nature of NAATs. A pelvic exam with a speculum is not required for asymptomatic STD screening of the female client.

Beginning January 1, 2010, health care professionals in Illinois (licensed physicians, physician assistants and advanced practice nurses) have the option of providing antibiotic therapy, otherwise known as expedited partner therapy (EPT), for the sex partners of individuals infected with chlamydia and gonorrhea, even if they have not been able to perform an exam on the infected patient's partner(s) (Public Act 96-613). Informational brochures in English and Spanish are available by visiting IDPH's "Expedited Partner Therapy for Chlamydia and Gonorrhea in Illinois" website

Reproductive and sexual coercion is where one asserts power or abuse to control the relationship; from tampering with birth control to pressuring one to become pregnant. Providers should discuss and document intimate partner violence screening, establish safety plans, and provide harm reduction strategies such as discreet forms of contraception (e.g., implant, injection, or intrauterine device).

HK-203.3.9 Other Laboratory Tests

Laboratory tests are performed as determined appropriate for individual age, sex, health history, clinical symptoms, at risk behavior, exposure to disease and sexual practices, and anticipatory guidance provided about risk-taking behavior.

HK-203.4 Developmental Milestones

Developmental and behavioral surveillance and screening are recommended across the Bright Futures visits, with specific screening at certain visits. The Appendices provide a sample of the developmental milestones for surveillance purposes.

If the child does not appear to be progressing through basic developmental milestones as expected, it is recommended that monitoring become more vigilant, with further screening, evaluation or assessment, and referrals, as appropriate (refer to Topic HK-207.6) and the Appendices.

HK-203.5 Developmental Surveillance

Developmental surveillance is a structured evaluation of a child's competencies (including

knowledge, skills, and aptitude) gathered through skilled observations of knowledgeable professionals during provision of health care services, e.g., well child visits. Subjective developmental surveillance is performed at each well child visit as part of the well child examination, and is not a separate billable service.

Subjective developmental surveillance alone has been shown to miss a significant number of mildly developmentally delayed and at risk children who would benefit from further evaluation and services. Therefore, Bright Futures strongly recommends that quality objective screening tools, rather than informal methods, be used at well child visits at no less than the priority intervals identified in *Bright Futures, 3rd Ed*. The prioritized times for developmental screening are at the 9- and 18-month visits, and at the 24- and/or 30-month visits (refer to Topic HK 203.5.2).

If there are significant parental concerns or the screening results are concerning, referrals to Early Intervention or other agencies should be made at this time. Refer to the Appendices for information on referral sources and care coordination tools and protocols including the Standardized Illinois Early Intervention Referral form and fax back form.

Developmental surveillance is the range of activities surrounding the examination of children, adolescents and young adults to determine whether they fall within the typical range of achievement for their age group and cultural background. It should help identify those children with significant differences in mental and physical development. Information from parents and others who know the child as well as personal observation also are used to assess behaviors.

Developmental surveillance should be culturally sensitive and age appropriate. At every visit, solicit concerns from the parents (e.g., "Do you have any concerns about your child's development or behavior?") as recommended by *Bright Futures, 3rd Ed.*

Detailed age specific surveillance recommendations can be found in the *Bright Futures, 3rd Ed.* "Promoting Child Development" document (pdf). The following elements are recommended to be included in the developmental surveillance of children of all ages:

- Gross motor development, focusing on strength, balance, coordination and locomotion
- Fine motor development, focusing on eye/hand coordination
- Communication skills or language development, focusing on expression, comprehension and speech articulation (Any time there is parent/guardian or school concern about language development and/or hearing loss, the child should be referred for a standard audiometric evaluation by an audiologist)
- Self-help and self-care skills
- Social-emotional development, focusing on the ability to engage in social interaction with other children/adolescents, parents and other adults
- Cognitive skills, focusing on problem solving or reasoning
- Parenting and family functioning

The following areas should be used for surveillance of infants. Detailed age specific recommendations can be found in the *Bright Futures 3rd Ed.* "Infancy" document (pdf) .

- Use of hearing and vision to interact with the environment
- Increasing awareness of, and attachment to important adults
- Maternal depression or other family stressors

The following areas should be used for surveillance of preschool aged children. Detailed age specific recommendations can be found in the *Bright Futures, 3rd Ed.* "Early Childhood" document (pdf).

- Quality of emerging play skills, including make believe play
- Inclusion of others in play
- Maternal depression or other family stressors

The following areas should be used for surveillance of school aged children. Detailed age specific recommendations can be found in the *Bright Futures, 3rd Ed.* "Middle Childhood" document (pdf).

- Attention problems
- Potential presence of learning disability
- Problems with school performance
- Family stressors

The following areas should be used for surveillance of adolescents. Detailed age specific recommendations can be found in the *Bright Futures, 3rd Ed.* "Adolescence" document (pdf).

- Potential presence of learning disabilities or problems with school
- Peer relations
- Psychological/psychiatric problems
- Vocational skills
- Family stressors
- Pubertal changes and development

HK-203.5.1 Developmental Screening and Assessment

An objective developmental screening using a recognized instrument is a structured evaluation of a child's development — physical, language, intellectual, social and emotional – and is performed by the PCP or other trained provider. Screening may be tailored to a child's suspected problem or delay. Children should be referred for a comprehensive evaluation and services if indicated by the results of a well child visit, or by the results of an objective developmental screening tool.

HK-203.5.2 Objective Developmental Screening and Evaluation

Providers are encouraged to follow at minimum the recommendations in AAP's Policy Statement "Identifying Infants and Young Children with Developmental Disabilities in the Medical Home: An Algorithm for Developmental Surveillance and Screening", July 2006, Volume 118, Issue 1, pages 402-420 (reaffirmed December 2009).

It is recommended that developmental surveillance be incorporated at every well child preventive care visit (refer to Topic HK-203.5). Any concerns raised during surveillance should be promptly addressed with standardized objective developmental screening tests in order to identify children with developmental and social-emotional delays and make referrals to Early Intervention or other agencies as indicated through screening results or due to a parent/clinician concerns.

In addition, the AAP recommends that objective screening tests should be administered regularly at the 9- and 18-month visits, and at the 24- and/or 30-month visits and more frequently when there is parental or physician concern. Autism Spectrum Disorder screenings should be administered at the 18- and 24-month visits as well (refer to Topic HK-203.6) Objective developmental screening should include all domains, including social and emotional development. Current detection rates of developmental disorders by surveillance alone are lower than their actual prevalence when assessed with appropriate standardized screening instruments.

Standardized developmental screening tools can detect risks for developmental delays and disabilities and can help to effectively monitor and record a child's development. Screening tools also serve as a reminder to providers to observe development and clearly communicate their interest in development as well as the physical health of the child. Developmental screening often can be performed by an office nurse or other trained non-physician personnel under the direction of the PCP. However, the billing code (96110) and reimbursement level is the same regardless of the individual administering the screen. Only an appropriately trained health professional, however, may interpret the results.

A list of objective developmental screening tools approved by HFS can be found in the Appendices. An approved objective developmental screening tool may be used to evaluate levels of:

- Social and emotional development
- Fine motor adaptive development
- Language development
- Gross motor development
- Cognitive development

Objective developmental testing must meet the definition provided by CPT and must be provided according to the guidelines provided for the instrument, including use of the instrument form, as applicable. If a parent or caregiver checklist is the screening instrument, the provider must interpret and document the findings in the medical record in

order to bill for the objective developmental screening. Providers using electronic health records (EHR) must ensure that screening or evaluation tools used are noted in the electronic record. Notations shall include the name of the developmental tool administered and the screening or evaluation results, and the subsequent anticipatory guidance provided and referrals made. Providers may use the screening or evaluation tool as a teaching tool and may give the tool itself to the parents for reference. In these instances, when there is a paper file, providers must keep the scoring sheet in the hard copy record, as evidence of the screening. Appropriate documentation must also be kept in the hard copy record, e.g., the scoring sheet, and analysis of the child's developmental needs and referral, if any, as a result of the screening; or follow up plans. If providers are using an electronic medical record, documentation as indicated above will be needed, however, a separate paper file does not need to be maintained. Documentation should cover all components of the tool. For purposes of this Handbook, developmental screening tools (96110) and testing tools (96111) will be referred to collectively as assessment tools.

Reimbursement

In order to be reimbursed for using an objective developmental assessment tool, providers must bill under the proper CPT code (see Topic HK-202.1 and the Appendices for billing procedures), maintain the tool and document results in the child's medical file for auditing purposes. Anticipatory guidance and referrals made as a result of the assessment shall be documented. For auditing purposes, providers using an EHR must ensure that assessment tools used are noted in the electronic record. Notations shall include the name of the developmental tool administered and the results, and the subsequent anticipatory guidance provided and referrals made. There must be sufficient documentation that the tool used and follow up occurred to warrant HFS payment for the assessment. Providers with the capacity to scan the assessment tool may do so and keep the scanned tool in the EHR as documentation. However, scanning the assessment tool is not required. Providers who scan the tool(s) used also must maintain notations in the EHR regarding the resulting anticipatory guidance provided and referrals made. Providers billing an encounter rate, such as FQHCs, RHCs and ERCs will not receive a separate reimbursement but must detail the objective developmental assessment performed on the encounter claim.

Additional Developmental Tests

Providers may request additions to the list of objective developmental tools recognized by HFS for payment. The Provider must document that an instrument meets the following criteria:

- Is listed in the Mental Measurement Yearbook Series
- Is nationally distributed
- Is age appropriate
- Is formally validated

- Is individually administered

Requests must be submitted using Form HFS 724 "Screening, Assessment and Evaluation Tool Approval Request Form". Providers are strongly encouraged to access the form on-line and to complete the form electronically. The form may be accessed on HFS' Medical Forms webpage. The form and other requested information must be submitted following the instructions provided on the form. For reference, the form is included in the Appendices.

Developmental assessment tools may be updated to reflect new advances. Updates to previously approved tools listed in this manual and appendices are approved for reimbursement by HFS. However, HFS reserves the right to periodically review updates to previously approved tools to assure they continue to meet the reimbursement approval criteria. If the updated iteration does not meet the criteria, HFS can deny approval for reimbursement for the updated tool. HFS will post the rescission of approval on our website at least 180 days prior to initiation of denials. It is the responsibility of the provider to consult the list of approved tools on the website from time to time, especially if there is doubt the tool continues to be approved for reimbursement.

HK-203.6 Autism Spectrum Disorder (ASD) Screening

Bright Futures, 3rd Ed. states that an autism spectrum disorder-specific screening should be conducted for all children at the 18- and 24-month visits or at any encounter when a parent raises a concern about possible ASD symptoms.

See the Appendices for a list of HFS approved objective developmental assessment tools, including those specific to autism spectrum disorder.

Public Act 93-0395 created the Autism Program and the establishment of three Regional Centers. The Autism Program (TAP) is a network of resources for Autism Spectrum Disorders in Illinois. TAP provides the strategy and framework for Illinois to address the complex issues involved in diagnosis, treatment and research for the thousands of children in Illinois with ASD. TAP has developed an infrastructure to train, support, and coordinate the linkage of an informed provider network to help Illinois families. A list of resources is available in the Appendices.

HK-203.6.1 Developmental Resources

Illinois Department of Human Services, Division of Developmental Disabilities
The Illinois Department of Human Services, Division of Developmental Disabilities (IDHS/DD) is the state agency for operating the waiver programs for children with developmental disabilities. IDHS/DD's *Home and Community-Based Services Waivers for Children* may provide services and supports to keep children with developmental disabilities, including autism, in home or community settings. Effective July 1, 2007, two home and community based services waivers for children with developmental disabilities, including autism, were approved. The waiver programs provide services and supports to

keep children in home or community settings. Information on these services can be found on the Developmental Disabilities How We Can Help webpage. The toll-free telephone number is:

1-888-DDPLANS (1-888-337-5267) or **1-866-376-8446 (TTY)**

HK-203.7 Vision and Hearing Screening

Bright Futures, 3rd Ed. recommends that assessing for risk of vision and hearing impairment, based on family history and parent observations be a part of every well child visit. Assessing risk is not separately reimbursable or reported by a CPT code.

Objective vision screening and objective hearing screening using valid, age appropriate instrument(s) are to be provided in the primary care medical home according to the Bright Futures periodicity schedule (available on the Bright Futures Clinical Practice website) and are separately reimbursable services. In cases where the provider does not perform an objective vision screening or an objective hearing screening, a referral for the screening should be made in accordance with the periodicity schedule and child's health history, and that referral should be recorded in the child's medical record. A copy of the screening results should be requested by the provider for inclusion in the medical record and appropriate follow up and care coordination should occur. For best practices around care coordination, refer to the Appendices.

To bill a separate objective screening CPT code, the vision or hearing screening criteria must be met. HFS allows reimbursement for vision or hearing screening if an age appropriate, valid screening instrument is utilized and results are documented in the child's medical record. The encounter rate clinic (e.g., FHQC, RHC or ERC) does not receive separate reimbursement for the vision or hearing screening, but **must** detail the services provided during the visit on their encounter claim. Refer to the Appendices for the CPT codes appropriate for billing and reporting hearing and vision screening using an age appropriate, valid screening instrument.

HK-203.7.1 Vision Screening

Public Act 95-0671 requires any child entering kindergarten to receive an eye examination by an optometrist or ophthalmologist. However, one encounter with the eye specialist during childhood is not adequate and should not replace current guidelines. Assessing risk for ocular problems and vision impairment should begin with the newborn exam and continue at each well child visit. *Bright Futures, 3rd Ed.,* recommends that all children have formal vision screening as part of their health supervision visit annually from 3 through 6 years of age, and again at ages 8, 10, 12, 15 and 18 years. Vision screening should be conducted at other health supervision visits as necessary based on risk assessment or any concern on the part of the family or child.

Vision Screening Goals and Guidelines

The goals of vision screening are to:

- Refer all children who do not pass screening to an optometrist or ophthalmologist appropriately trained to treat pediatric patients. Screening is appropriate for developing children. Children with signs and symptoms of visual, developmental, or learning difficulties should be examined by the eye specialist as part of their differential diagnosis work up. Referrals may be made for initial evaluation, follow up or for eyeglasses. For information relating to eyeglasses, refer to Topic HK-207.3.
- Provide anticipatory guidance to the parent or guardian relating to the child's vision and eye needs
- Refer to an optometrist or ophthalmologist those children whose vision is not sufficient to function in the normal setting (such as in school) for possible special services, e.g., special education

Vision Screening in the Primary Care Medical Home

Vision screening should be conducted in the medical home by a PCP (or the PCP's staff, under the direct supervision of the PCP) enrolled in the HFS Medical Assistance Program.

Subjective surveillance and vision risk assessment should occur in the primary care setting and be recorded in the medical record for all infants, toddlers, and children as a component part of the EPSDT screening. Surveillance and risk assessment is not a separate billable service.

An objective (quantitative) vision screening is billable if it meets HFS criteria. Encounter rate reimbursed providers (e.g., FQHCs, RHCs and ERCs) **must** detail the services provided on the encounter rate form. Objective vision screening should be added to subjective vision risk assessment and both should be performed at every well child visit from age 3 through 6 years of age, and again at ages 8, 10, 12, 15 and 18 years in accordance with the Bright Futures periodicity schedule (available on the Bright Futures Clinical Practice website).

HFS strongly recommends vision screening be conducted in accordance with guidelines established by the IDPH, as found in Illinois Administrative Code, Title 77, Chapter I, Part 685, and summarized in part below, whenever possible.

Vision Screening in Other Settings

When conducted in school or local health department settings, vision screening should be administered by nurses or technicians certified by the IDPH. Non-physician personnel working in a certified local health department and administering vision screening tests to preschool and school age children must be certified by the IDPH. Certification is awarded upon successful completion of specialized training in the use of vision screening instruments and in working with children.

Objective screening should follow procedures established by the IDPH. Each child, regardless of age or grade, is to be carefully observed to identify any problems. Non-physicians who observe eye or vision problems in children who pass quantitative screening should immediately refer the child to their PCP so that appropriate preventive care can be rendered and referrals can be made.

Community based objective screening is valuable for children who miss well child visits and should follow the schedule described below. Ideally, the results of community screening should be communicated to the PCP and care coordination should occur. For best practices around care coordination, refer to the Appendices. Vision screening should occur more often than the scheduled vision screening if indicated by appearance, behavior, complaints or health history.

DCFS requires that children in their legal custody have a vision screening annually beginning at age 3 years until the child reaches age 21 or is no longer in DCFS custody.

The IDPH Child Vision and Hearing Test Act and Vision Screening Rules and Regulations state that quantitative vision screening services be administered:

- Annually to all pre-school aged children, beginning at age three years, in any public or private educational program or licensed child care facility
- To school aged children who are in kindergarten, second and eighth grades
- Annually for all children who are in special education classes
- Upon teacher referral and upon admission of transfer students

It is recommended that children in grades 4, 6, 10 and 12 also receive vision screening services. The IDPH Child Vision and Hearing Test Act relates to vision screening conducted in local health departments and in schools and preschools.

Children Birth to 3 Years

Eye evaluation should occur at the newborn and all subsequent well child exams and be conducted by the primary care physician, nurse practitioner or physician assistant using the following procedures:

- Ocular history
- Age appropriate vision assessment
- External inspection of the eyes and lids
- Ocular motility assessment
- Pupil examination
- Red reflex examination
- Age appropriate test of alignment (light reflex test, cover test, or quantitative test of depth perception)
- Photo Screening is an acceptable quantitative method to screen children who are

not yet ready for visual acuity testing (AAP Policy Statement, Use of Photo Screening for Children's Vision Screening, *Pediatrics,* Vol.109, No.3, March 2002, pp.524-525)

Non-quantitative vision assessment is appropriate for children younger than age 3, or in any non-verbal child, and is accomplished by evaluating the child's ability to fix and follow objects. A standardized assessment strategy is to determine whether each eye can fixate on an object, maintain fixation and then follow the object into various gaze positions. Failure to perform these maneuvers indicates significant visual impairment.

A binocular as well as monocular assessment should be performed. If poor fix and following are noted binocularly after 3 months of age, a significant bilateral eye or brain abnormality is suspected, and referral for more formal vision assessment is advisable. It is important to ensure that the child is awake and alert, because disinterest or poor concentration can mimic a poor visual response. In addition, providers should inquire regarding the child's progress in achieving certain vision related developmental milestones. Such milestones include:

Vision Developmental Milestones

Age	Milestones
0-3 months	• Turns eyes and head to look at light sources • Briefly holds gaze on bright light or objects • Stares at surroundings • Blinks at camera flash • Moves eyes and head together • Tracks vertically and horizontally • Begins eye contact at 6-8 weeks • Focuses 8-12 inches away • Eyes wander, occasionally cross • Prefers black/white, or high contrast patterns • Prefers human face to all other patterns
4-7 months	• Follows adults or moving objects with eyes across midline • Begins moving eyes with less head movement • Watches own hands before face • Looks at hands, food, bottle when sitting • Watches face when spoken to • Briefly fixes still objects • Reaches for small objects
8-12 months	• Orients to objects in home • Notice small objects, like cereal • Interested in pictures • Enjoys hide and seek (recognizes partially hidden objects) • Inspects toys held in hand • Responds to smiles and voices • Sweeps eyes across room

1-1½ Years	• Uses "pincer grasp" to hold objects between forefinger and thumb • Looks for toys that fall out of sight • Builds tower with 3 blocks • Enjoys picture books and points to pictures • Uses both hands • Holds objects close to eyes to inspect
2-3 Years	• Builds tower with 6 blocks • Imitates vertical line • Recognizes people in photographs • Begins to inspect objects without touching objects • Smiles and face brightens when looking at favorite people or objects • Likes to watch movements of objects, such as wheels on toy vehicle • Watches and imitates other children • "Reads" pictures in books • Begins to control hand movement while coloring or drawing

Preschool Aged Children (3-5 Years)

The USPSTF and *Bright Futures, 3rd Ed.* recommend annual screening to detect amblyopia, strabismus, and defects in visual acuity in children ages 3 to 5 years. Amblyopia must be treated or vision will be permanently impaired. However, early testing and treatment can restore full vision. Treatment for amblyopia is best when started before a child is age 5. After age 5, vision in the eye that does not see clearly may never fully develop and fewer children will respond to treatment.

Bright Futures, 3rd Ed. recommends that PCPs and their staff perform formal vision screening for distance, visual acuity, ocular alignment, and stereovision at each health supervision visit from age 3 to 5 years using valid, age appropriate tools. PCPs and their staff may:

- Use the Snellen Notation 20/40-symbol size for three and four year old children at a distance position of 20 feet
- Use the Snellen Notation 20/30-symbol size for five year old children at a distance position of 20 feet
- Use the HOTV or Lea charts for three to five year old children at a distance of 10 feet.

Children in preschool settings (age 3 and older) are to be evaluated for visual acuity using the Illinois Child Vision and Hearing Test Act approved symbols at a distance only.

Vision screening tests for preschool aged children are presented binocularly to train the child and then tested for each eye. Per *Bright Futures, 3rd Ed.* guidelines, referrals should be made for children aged 3 through 5 who do not pass the 20/40 symbol sizes or who have a 2-line or more difference between each eye, even if in passing range. These guidelines apply to all providers.

In order to receive separate reimbursement, objective vision screening must be

performed in accordance with guidelines established by the IDPH, as found in Illinois Administrative Code, Title 77, Chapter I, Part 685. Guidelines established by the IDPH, as found in Illinois Administrative Code, Title 77, Chapter 1, Part 685 follow.

Approved Vision Screening Instruments for use with Preschool-aged Children in the School or through the Certified Local Health Departments:

The approved vision screening instruments for use in schools and through the certified **local health departments** include:

- The Good-Lite Insta-Line with HOTV crowded faceplate test instrument and the Michigan Preschool Slides (MPS) for use with a stereoscopic instrument are approved for preschool testing beginning at age 3 years.
- The preschool testing must be done at a simulated distance point of 20 feet.

With both the MPS slides and the Insta-Line with HOTV faceplate:

- The 20/30-symbol size is used for five-year-old children
- The 20/40-symbol size is used for three and four year old children

School Aged Children (6-18 Years)

Vision screening must evaluate visual acuity, hyperopia, and muscle balance (phoria). Visual acuity measures how a child sees with each eye independently. Hyperopia tests determine whether or not a child has an excessive amount of farsightedness, which may cause visual difficulty at the near point or reading distance. Muscle balance measures the use of the two eyes together.

Bright Futures recommends that PCPs and their staff conduct screening at 6, 8, 10, 12, 15, and 18 years of age. PCPs and their staff may:

- Use the Snellen Notation 20/30-symbol size at 10 feet.

Referrals should be made if vision is less than 20/30 or if there is a 2-line or more difference between each eye, even if in passing range.

Color vision screening, using the Ishihara Test recommended by *Bright Futures, 3rd Ed.,* is an optional test that should be given once during a child's school career. It is recommended that color screening be done at the second grade level.

Note: State law requires any child entering kindergarten to receive an eye examination by a licensed optometrist or ophthalmologist. Refer to Public Act 95-0671.

In order to receive separate reimbursement, objective vision screening must be performed in accordance with guidelines established by the IDPH, as found in Illinois Administrative Code, Title 77, Chapter I, Part 685. Guidelines established by the IDPH, as found in Illinois Administrative Code, Title 77, Chapter 1, Part 685 follow.

Approved Vision Screening Instruments for use with Preschool Aged Children in the School or through the Certified Local Health Departments

The approved vision screening instruments for use in schools and through the **certified local health departments** include:

- The Good-Lite Insta-Line with HOTV crowded faceplate test instrument and the Michigan Preschool Slides (MPS) for use with a stereoscopic instrument are approved for pre-school testing beginning at age 3 years.
- The preschool testing must be done at a simulated distance point of 20 feet.

With both the MPS slides and the Insta-Line with HOTV faceplate:

- The 20/30-symbol size is used for five-year-old children
- The 20/40-symbol size is used for three and four year old children

In order to receive separate reimbursement, objective vision screening must be performed in accordance with guidelines established by the IDPH, as found in Illinois Administrative Code, Title 77, Chapter I, Part 685. Guidelines established by the IDPH, as found in Illinois Administrative Code, Title 77, Chapter 1, Part 685 follow.

Approved Vision Screening Instruments for use with Children Kindergarten to Grade 7 in the School or through the Certified Local Health Departments

- Children in kindergarten are screened at the distance position using the 20/30 Snellen symbol size and the approved preschool test battery
- The Massachusetts Battery is approved for screening of school aged children grades 1-6. This group of slides must be used with a stereoscopic type vision-screening instrument
- The Titmus OV-7, Titmus II, and Stereo-Optic are examples of this type of equipment
- The optional color test requires the Pediatric Color Deficiency (PCDF-1) slide. Visual acuity is screened at far point using the 20/30-symbol size based on Snellen Notation. Hyperopia is screened at the far distance position using Snellen 20/20 size symbols. The muscle balance test is performed at both near and far distance positions

Local health departments must conduct an objective vision screening in accordance with guidelines established by the IDPH, as found in Illinois Administrative Code, Title 77, Chapter 1, Part 685. Guidelines established by the IDPH, as found in Illinois Administrative Code, Title 77, Chapter 1, Part 685 follow.

Approved Vision Screening Instruments for use beginning at Grade 7 in the School or through the Certified Local Health Department:

The substitution of the BRL slide (both right and left) is acceptable beginning at grade 7. It

is an alternative test, which evaluates monocular acuity and binocular fusion. This test replaces the Massachusetts Battery and allows for an age appropriate substitute means of making the required evaluations. Visual acuity and fusion are screened using the 20/30 size symbols as based on Snellen Notation. The approved instrumentation remains the same as for the Massachusetts Battery. The required group of slides is changed.

Children with Special Needs

The above detailed approved tests and preschool vision screening procedures are applicable to testing children with special needs, including children with developmental disabilities, learning disabilities and hearing impairment, as well as children who use English as a second language.

Many children with special needs should have an optometrist or ophthalmologist on their Individualized Family Service Plan team or their Individualized Education Program team.

If the child cannot participate in objective vision screening and the child is not under the care of an eye professional, the child may be screened by photorefraction alone. If photorefraction is unavailable, refer the child to an optometrist or ophthalmologist appropriately trained to test and treat pediatric patients.

Children Wearing Glasses or Contact Lenses

The screening battery for children wearing glasses or contact lenses should consist of observation, inspection of the lenses and frames, and determination of the child's last vision test or visit. Instrument screening of children while wearing glasses or contact lenses is not appropriate.

For information relating to eyeglasses, refer to Topic HK-207.3.

HK-203.7.2 Hearing Screening

The Hearing Screening for Newborns Act requires all newborns receive an objective hearing screening, using an electro-physiological testing methodology, otoacoustic emission (OAE) or auditory brainstem (ABR), for identifying congenital hearing loss. Surveillance or risk assessment is recommended as part of each well child visit. If a child did not pass his/her newborn hearing screening, the child should be tested by or referred for an objective electro-physiological hearing screening.

Reports of follow up screening from a newborn hearing screening referral must be reported to IDPH and may be faxed to:

Fax: 1-217-557-5324

More information on hearing screening may be obtained from:

Illinois Department of Public Health, Vision & Hearing Program
535 West Jefferson, 3rd Floor
Springfield, IL 62761
Phone: 1-217-524-2396 782-4733
Fax: 1-217-524-4201 557-5324

The IDPH Child Vision and Hearing Test Act and Hearing Screening Rules and Regulations state that hearing screening services be provided annually to all preschool children age three years (or older) in any public or private educational program or licensed child care facility; annually for all school age children who are in grades kindergarten through 3; annually for all children who are in special education classes; upon teacher referral and upon admission of transfer students; and recommended for school age children who are in grades 4, 6, 8,10 and 12.

Hearing Screening in the Primary Care Medical Home

According to Bright Futures, regular surveillance of auditory skills, parental concern, and middle ear status should be a part of every well child visit within the medical home consistent with the Bright Futures periodicity schedule (available on the Bright Futures Clinical Practice website). All infants should have an objective standardized screening of global development with a validated assessment tool at 9, 18, and 24 to 30 months of age, or at any time if the health care professional or family has concerns. Infants who do not pass the speech language portion of a medical home global screening, or for whom there is a concern regarding hearing or language, should be referred for speech-language evaluation and audiology assessment.

Objective hearing screening, using standard testing methodology, is recommended annually for all children between the ages of 4 through 6, and at 8 and 10 years of age.

PCPs, or their staff working under the direct supervision of the PCP, do not need to be certified by IDPH. PCPs should follow the hearing screening recommendations above set out by *Bright Futures, 3rd Ed*.

For children 4 years and older, conventional screening audiometry can be used. Each ear should be tested at 500, 1000, 2000 and 4000Hz. Air conduction hearing threshold levels of >20 dB at any of these frequencies indicate possible impairment.

Audiometric evidence of hearing loss should be substantiated by repeat screening. A child whose repeat test shows hearing thresholds >20 dB at any of these frequencies, especially if there is no pathologic abnormality of the middle ear on physical examination, should be referred for formal hearing testing. Children with unilateral or mild hearing loss also should be further evaluated. Studies show such children to be similarly at risk for adverse communication skills as well as difficulties with social, emotional, and educational development.

Hearing Screening in Other Settings

Hearing screenings should be in compliance with guidelines established by the IDPH, as found in the Illinois Administrative Code, Title 77, Chapter I, Part 675, for children age three and older, and in compliance with 89 Illinois Administrative Code, Chapter IV, Part 504 for newborns and children under 3 years of age, and summarized in part below.

All newborns shall be screened for congenital hearing loss prior to hospital discharge.

The timing and number of hearing re-evaluations for children with risk factors should be customized and individualized depending on the relative likelihood of a subsequent delayed-onset hearing loss. Infants who pass the neonatal screening but have a risk factor should have at least one diagnostic audiology assessment by 24-30 months of age. Early and more frequent assessment may be indicated for children with CMV infection, syndromes associated with progressive hearing loss, neurodegenerative disorders, trauma, or culture-positive postnatal infections associated with sensori-neural hearing loss; for children who have received ECMO or chemotherapy; and when there is a caregiver concern or a family history of hearing loss.

Every infant with confirmed hearing loss should be evaluated by an otolaryngologist with knowledge of pediatric hearing loss and have at least one examination to assess visual acuity by an ophthalmologist experienced in evaluating infants. A genetics consultation should be offered to families of children with congenital hearing or vision deficits.

Infants with risk factors highly associated with acquired or late onset hearing loss should have more frequent hearing assessments. Every child with a known risk factor who has not had a hearing evaluation beyond the newborn period and before the age of 30 months should have a standard audiometric evaluation by an audiologist knowledgeable in evaluating children.

All infants and children under age 3 years identified with a hearing loss must be referred for Early Intervention services within 48 hours of diagnosis. Infants identified with hearing loss should begin Early Intervention services no later than age 6 months for optimal benefit.

DCFS requires that all children in their legal custody receive a hearing screening beginning at age 3 years and annually thereafter until the child reaches age 21, or is no longer in DCFS custody.

Hearing Screening by Schools and Certified Local Health Departments

Non-physician personnel working in local health departments or schools administering hearing screening tests to children age three and above must be certified by IDPH or hold an Illinois Audiology License as issued by the Illinois Department of Financial and Professional Regulations.

Screening should include the following:

History

This should include questions about the individual's ear and hearing history and speech development including questions regarding whether or not the child passed newborn hearing screening and, if not, if follow up testing has been done. If the outpatient follow up testing has not been done or has not been passed, the child should be tested or referred to an audiologist for screening by electrophysiological measures. Results of such screening must be reported to IDPH.

Sample Questions

- *Ear history* - Has your child ever had trouble with his ears? What kind of trouble? (e.g., draining ears, ear infections). How often has this been noticed? When was the last time this occurred? How has this been treated?
- *Hearing history* – Did your child have a newborn hearing screening test? Did your child pass the test? (If the response is no, or I don't know, refer the child for electrophysiological testing through an audiologist.) Do you feel your child hears adequately? If not, what problems have you noticed, how long have you noticed a problem, are there times when you notice this more than other times?
- *Audiometric screening* - Audiometric (hearing) screening shall follow procedures set forth in the training course for audiometric screeners provided by IDPH. The screening procedure establishes the presence or absence of hearing sensitivity at defined levels and specific, pure-tone, discrete frequencies. Audiometric Screening, as opposed to electro-physiological measures, is not appropriate for children under 3 years of age.

Instrumentation

Pure-tone audiometers utilized for identification audiometry must comply with minimum specifications established by the American National Standards Institute as published in the American National Standard Specifications for Audiometers (ANSI 3.6 1996).

Pure-tone audiometers utilized for identification audiometry must undergo an electro-acoustic coupler calibration check at least every 12 months.

Method and Criteria for Referral

A referral for medical and/or audiology evaluation is recommended after the child has failed a rescreening AND after the child has met referral criteria based on a threshold test. It is not recommended that a child be referred solely on the basis of a failed screening or rescreening test. Rescreening procedures are identical to the initial screening and should be conducted following a 10-14 day delay.

Procedures for screening, rescreening and threshold testing are presented in the hearing screening training classes offered by IDPH.

HK-203.8 Oral Health Screening/Fluoride Varnish

Beginning at the six-month visit, physicians should counsel caregivers on oral health, perform a dental screening for visual signs of decay and assess the child's oral health, and provide anticipatory guidance. Physicians should refer children to a dental home for routine and periodic preventive dental care within six months of the eruption of the first tooth or by age 1, as per recommendations by the American Academy of Pediatrics (AAP), the American Dental Association (ADA), and the American Academy of Pediatric Dentists (AAPD). Primary care providers should continue to assess a child's oral health on a regular basis until a dental home has been established. The AAP's *Bright Futures, 3rd Ed.* recommends oral health assessments begin at 6 months and continue at well child visits at 9-, 12-, 18-, 24-, 30-, and 36-months and 6 years.

The visual assessment of the child's teeth should consist of the following steps:

- The clinician should assess the child's teeth using the knee-to-knee position. Place two chairs facing each other with the provider sitting in one chair and the caregiver holding the child facing them in another. The caregiver should lower the child into the lap of the provider and hold the child's arms. Alternatively, the clinician may assess the child on the exam table by standing behind the child.
- Lifting the upper lip of the child, the clinician should assess all tooth surfaces, especially near the gum line, looking for white, chalky lesions (pre-cavitated smooth surface caries), brown spots (cavitated smooth surface caries) or plaque.
- The clinician should assess the child's gums for bleeding or inflammation or evidence of infection. Any findings should be noted in the patient's chart and appropriate referrals to a dentist should be provided.

Anticipatory guidance for families should begin at 6 months or the eruption of the first tooth. Guidance should include the following:

- Do not put juice, diluted juice, milk, formula or sweetened beverages in the bottle.
- Do not give child a bottle in bed or while child is sleeping.
- Tell caregiver to model good oral hygiene behaviors by brushing and flossing twice daily and visiting the dentist.
- Avoid frequent snacking or drinking of sweetened beverages between meals.
- Explain the development of early childhood caries (ECC): transmission of bacteria from caregiver to child and frequent exposure to complex carbohydrates can lead to ECC
- Avoid the sharing of utensils, cups, or toothbrushes among family members.
- Clean pacifiers with water and do not clean with own mouth before giving to the child.
- Do not dip pacifiers in sweetened liquids, sugar, or syrups and do not add any such liquids or sugar to the child's bottle.
- Drink fluoridated tap water.
- As soon as teeth erupt, brush the child's teeth twice daily with fluoridated toothpaste. For children under two, a very small rice-size smear of fluoridated

- toothpaste should be used. For children over two, a pea-size amount of toothpaste should be used.
- Brush teeth for the child until age 6 or until the child can tie his/her own shoes.
- Take the child to the dentist by age one or within 6 months of the eruption of the first tooth and continue visits as instructed by the dentist.

Fluoride varnish for children under 36 months of age may be applied by physicians trained through Bright Smiles from Birth or other training program approved by HFS. Fluoride varnish application should begin after the eruption of four teeth and be repeated every four months thereafter until regular dental care is established. Use of fluoride varnish in young children is recommended by the AAP, the AAPD, and the ADA in the prevention of early childhood caries. Fluoride varnish strengthens tooth enamel, making it less prone to decay, and, along with changes in diet, may reverse white spot lesions (pre-cavitated smooth surface caries) by re-mineralizing the tooth structure.

Physicians trained on fluoride varnish application may be reimbursed for this procedure up to three times every 12 months on children less than 36 months of age. Providers must be trained in an HFS-approved training program to be eligible for reimbursement. The procedure code for application of varnish is D1206. Information about HFS' reimbursement rates is available on the HFS Medicaid Reimbursement webpage. The Bright Smiles From Birth training program can be found on the American Academy of Pediatrics Illinois Chapter website. Physicians trained in the program must perform the oral health assessment themselves. The fluoride varnish application may be delegated to ancillary medical staff that have been either trained in an HFS-approved training program themselves or trained by another provider who has been trained through the program.

An oral health screening is part of the physical examination but does not replace referral to a dentist. HFS encourages parents or guardians to obtain a dental home for their child (or children) which will provide a periodic oral evaluation and a routine prophylaxis once every six months and fluoride treatment (for children ages 36 months and older) once per year in the dental office setting. Dental benefits for children include services for treatment of early childhood caries, relief of pain and infections, restoration of teeth, dental sealants, prophylaxis, and maintenance of dental health including instruction in self-care oral hygiene procedures. Dental care for children is **not** limited to emergency services. For oral health resources or assistance finding a dentist for referral, see Appendices.

HK-203.9 Behavioral Health

As stated on the Health Resources and Services Administration website, "[behavioral health and physical health are inter-related and providing behavioral health care in a primary medical care setting can reduce stigma and discrimination, be cost effective and lead to improved patient outcomes." Behavioral health surveillance is an essential part of a preventive health care visit. This section focuses on promoting behavioral health in the primary care setting while a separate section in the Handbook focuses specifically on developmental screening, which is another component of behavioral health.

HK-203.9.1 Risk Assessment for Children and Adolescents

During a well-child health examination, youth who show signs or symptoms of mental or emotional problems, or indicate signs of substance abuse, should be screened using the Mental Health Screening Instrument or Substance Abuse Screening Instrument. The Experience Questionnaire (EQ) is another tool that may be used to identify the need for referral to substance abuse treatment and may be obtained from:

Division of Mental Health and Addiction Recovery Services
Phone: 1-866-213-0548

Parent(s) who indicate the need for mental health or substance abuse treatment services for themselves or their family members may contact Division of Mental Health and Addiction Recovery Services at the number below. Coverage for services extends to eligible participants in HFS' Medical Programs.

Division of Mental Health and Addiction Recovery Services
Phone: 1-866-213-0548

Youth are less likely than adults to be referred to treatment by a parent, family member or through self-referral. It is important to be able to identify youth alcohol, tobacco and other drug problems and refer the youth for further assessment and/or treatment when needed. Youth in at-risk environments should be screened, using a tool designed for adolescents, to uncover indicators of alcohol, tobacco and other drugs and related problems. Youth with possible alcohol, tobacco and other drug problems as identified through the screening should be referred for a more comprehensive assessment for substance abuse or dependence.

Mental Health Screening

In an effort to improve children's mental health, Illinois has developed an enhanced Screening, Assessment and Support Services (SASS) Program for children, including adolescents, experiencing a mental health crisis. The SASS Program features a single point of entry called the CARES Line, for all children using this system that will ensure that children receive crisis services in the most appropriate setting. A child experiencing a crisis and in need of SASS services, should be referred to the:

CARES Line: 1-800-345-9049

Refer to the Appendices for HFS' Mental Health Screening Instrument.

Substance Abuse Screening

Screening refers to a brief procedure used to determine the probability of the presence of a problem, substantiate that there is a reason for concern, or identify the need for further evaluation. It should focus on the adolescent's substance use severity (primarily

consumption patterns) and a core group of associated factors such as legal problems, mental health status, educational functioning and living situation. It must have peer-reviewed published data on the reliability and validity of the measure. The following are the substance abuse screening tools approved by HFS for adolescents:

- CRAFFT Screening Tool
- MAYSI-2
- GAIN-Q
- GAIN-SS (Recency)
- GAIN-SS (Past Year)

HFS' Substance Abuse Screening Instrument is found in the Appendices.

Comprehensive Assessment of Substance Abuse

A comprehensive assessment should be performed when an adolescent screens positive for a substance use disorder. The assessor will need to be a well trained professional with experience in adolescent substance use issues. The assessor should be familiar with the local slang terms for particular drugs. If the PCP does not believe they possess the unique skills required to assess and refer this population, a referral should be made once a screening assessment has been preformed. The referral process is currently under review and will be finalized in the near future. Official notification from the Department on the referral process will be provided once finalized.

Primary Care Practitioner Behavioral Health Support

The Illinois DocAssist Program is a primary care psychiatric consultation line facilitated by the University of Illinois – Chicago, School of Psychiatry. Administered by HFS in collaboration with the Division of Mental Health and Addiction Recovery Services and the Illinois Children's Mental Health Partnership (ICMHP), the Illinois DocAssist program is designed to deliver direct physician-to-physician support for diagnosis and treatment of behavioral health conditions and for prescription of psychotropic medication. Supported by Board Certified Psychiatrists with specialization in Child and Adolescent Services, the Illinois DocAssist program provides physicians with clinical consultation within one business day of their call.

Illinois DocAssist: 1-866-986-2778

HK-203.9.2 PERINATAL DEPRESSION

Perinatal depression may occur at any time during the pregnancy, immediately after delivery, or even up to one year after delivery. The consequences of untreated perinatal depression can be devastating and have long-term adverse effects for the woman, her child and other family members. Yet, perinatal depression remains both under recognized and under treated. Early detection of symptoms and prompt initiation of treatment can greatly reduce adverse consequences. Medications and psychosocial interventions can

effectively treat depression both during pregnancy and the postpartum period. Formal screening is significantly more effective than informal clinical screening for detecting perinatal depression.

Public Act 95-0469, Perinatal Mental Health Disorders Prevention and Treatment Act was passed to increase awareness and to promote early detection and treatment of perinatal depression. The Act requires the following:

- Licensed health care professionals providing prenatal care provide education to women, and if possible and with permission, to their families about perinatal mental health disorders.
- All hospitals providing labor and delivery services provide new mothers, prior to discharge following child birth, and if possible, provide to fathers and other family members, complete information about perinatal mental health disorders.
- Licensed health care professionals providing prenatal care, postnatal care, and care to the infant invite the women to complete a questionnaire to assess whether they suffer from perinatal mental health disorders.

Perinatal Depression Screening

Often, perinatal depression may not be apparent without specific screening. Information about perinatal depression risk factors is available on HFS' Risk Factors Associated with Perinatal Depression webpage. Information about identifying women who may be at risk of prenatal or postpartum (perinatal) depression is available on HFS' Maternal and Child Health Promotion webpage.

To promote early identification and treatment of perinatal depression, providers are encouraged to screen women for perinatal depression and make appropriate referrals. Screening should be provided to women during prenatal and postpartum visits and with the mother when she is present during well-baby visits provided prior to the infant's first birthday.

Screening for perinatal depression using an approved instrument is a reimbursable service to HFS-enrolled providers for screening HFS-enrolled women. The instruments approved for HFS reimbursement are listed in the Appendices. Please be aware that reimbursement will only occur for screenings using one of the listed and approved tools.

Perinatal Depression Referral Resources

In accordance with Public Act 95-0469, IDHS supports screening, assessment and treatment of women with Perinatal Mental Health Disorders. All IDHS funded case management programs are required to conduct screenings for Perinatal Mental Health Disorders at or after 25 weeks of pregnancy, and at least once during a child's first year of life. A referral mechanism is in place for women who have been identified needing further care. Referral resources for perinatal depression are listed in the Appendices.

Reimbursement for Perinatal Depression Screening

In recognition of the importance of screening, identifying and treating women suffering from perinatal depression, HFS provides reimbursement for perinatal depression screening. Reimbursement is available for both prenatal and postpartum depression screening for up to one year after delivery. Providers billing an encounter rate (FQHCs, RHCs, ERCs) will not receive separate reimbursement but must detail each service performed during the encounter.

The following codes should be used for perinatal depression screening:

- Prenatal screening: H1000
- Postpartum screening: 99420 with HD modifier – this code should be used when billing for any postpartum screening, whether it occurs during a well-child or episodic visit for an infant (under age one) or during any visit for the postpartum woman up to one year after delivery.

If the postpartum depression screening (for the woman) occurs during a well-child visit or episodic visit for an infant (under age one) covered by HFS' Medical Programs, the screening may be billed as a "risk assessment" using procedure code 99420 with modifier HD (pregnant/parenting women's program) under the **infant's** Recipient Identification Number (RIN). Record this screening as a "risk assessment" in the infant's record and indicate "referral and "anticipatory guidance" as appropriate. Maintain the results and the copy of the screening instrument in a separate file, not in the infant's file. If the PCP does not maintain a separate file for the mother, return the screening instrument to the mother or destroy it.

If the woman is postpartum and covered by HFS' Medical Programs, the perinatal depression screening should be billed using procedure code 99420 with modifier HD (pregnant/parenting women's program) under the **woman's** Recipient Identification Number (RIN). Maintain the results and copy of the screening instrument in the mother's file.

Information about reimbursement rates is available on HFS' Medicaid Reimbursement webpage.

The perinatal depression screening instruments approved for HFS reimbursement are listed in the Appendices. Please be aware that reimbursement will only occur for screenings conducted using one of the listed and approved tools.

The provider must obtain approval from HFS prior to using a perinatal depression screening instrument other than those approved by HFS in order to obtain reimbursement for the screening. Providers must request additions to the list of approved developmental screening and evaluation tools, health risk assessment tools, and perinatal depression screening tools to be recognized by the Department for payment using Form HFS 724 "Screening, Assessment and Evaluation Tool Approval Request Form". Providers are strongly encouraged to access the form on-line at HFS' Medical Forms Numeric Listing webpage and to complete the form electronically. For reference, the form is included in the Appendices. The form and other requested information must be submitted following the instructions provided on the form.

HK-203.10 Anticipatory Guidance

A Bright Futures well child visit is an age specific health supervision visit that is family-

driven and is designed to allow practitioners to improve their desired standard of care. This family centered emphasis is demonstrated through several features:

- Solicitation of parental and child concerns
- Surveillance and screening
- Assessment of strengths
- Discussion of certain visit priorities for improved child and adolescent health and family function over time. Sample questions and anticipatory guidance for each priority are provided as starting points for discussion. These questions and anticipatory guidance points can be modified or enhanced by each health care professional using *Bright Futures, 3rd Ed.*

Anticipatory guidance is a required component of every well child visit and not a separate billable service. Health education provided to both families and children is designed to assist them to understand what to expect in terms of the child's development and to provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention. Observation of parent or guardian interaction with the child assists providers in identification of strengths, issues and potential risk factors, which need to be taken into consideration for anticipatory guidance.

HFS' recommended minimum topics to be covered by the provider's anticipatory guidance at each well child visit are listed in Appendix 1. *Bright Futures, 3rd Ed.* parent handouts for each visit also can be accessed from this Appendix or found on the American Academy of Pediatrics Bright Futures website. The *Bright Futures, 3rd Ed.* handouts are available for download for review and reference purposes only. Providers wishing to make multiple copies should purchase a Tool and Resource Kit from the AAP Bookstore.

Bright Futures identifies ten themes of key importance to families and health care professionals from birth through adolescence that should be a part of anticipatory guidance. The ten health promotion themes are:

- Promoting Family Support
- Promoting Child Development
- Promoting Mental Health
- Promoting Healthy Weight
- Promoting Healthy Nutrition
- Promoting Physical Activity
- Promoting Oral Health
- Promoting Healthy Sexual Development and Sexuality
- Promoting Safety and Injury Prevention
- Promoting Community Relationships and Resources

Two above issues identified as Significant Challenges to Child and Adolescent Health for *Bright Futures, 3rd Ed.* are Promoting Healthy Weight and Promoting Mental Health. Promoting Healthy Weight is expanded upon below. Promoting Mental Health is described in HK203.9.

HK-203.10.1 Promoting Healthy Weight

Providers are encouraged to follow recommended clinical guidelines for evaluation and management of overweight and obesity. In 2007, the American Medical Association (AMA) published the *Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report*. In 2010, the USPSTF released its recommendation on Screening for Obesity in Children and Adolescents that can be found on its website.

Primary Care Physicians and other providers are encouraged to routinely assess and document children's weight status and weight trajectory, and counsel parents about how to help their children achieve and maintain a healthy weight. The CDC's Research to Practice series, available through their Nutrition Resources for Health Professionals website, provides information for practitioners regarding the use of therapeutic lifestyle changes, and guidance for encouraging modifications around nutrition and physical activity.

Body Mass Index Assessment Documentation in Claims

Annually, HFS reports performance on a core set of child health measures to the Centers for Medicare and Medicaid Services (CMS). One of these measures reports the prevalence of weight assessment of children and adolescents documented through claims. In accordance with expert committee recommendations as referred to above, providers are encouraged to assess and document BMI percentile at least one time per year for pediatric patients ages 2 through 20. BMI assessment may be done during any visit, whether sick child or preventive.

Claims for an episode or encounter where BMI is assessed must include the appropriate CPT or UB-04 revenue code, **and** ICD-9-CM (or ICD-10) codes V85.51 – V85.54. If ICD codes V85.53 or V85.54 are used, then also include ICD code 278.00 – 278.02, as appropriate. Providers should append a BMI-related diagnosis code for every episode or encounter of care during which BMI was assessed, documented, and addressed, if indicated.

Documentation must include a note in the patient's record indicating:

1. The date on which the BMI percentile was assessed
2. One of the following measurements:
   - BMI percentile, or
   - BMI percentile plotted on age-growth chart
3. If indicated, pertinent recommendation or a plan of management consistent with the codes used.

Weight Management Visits: BMI >85th Percentile

1. Providers may bill for weight management visits for children with BMI >85th percentile; BMI percentile, as described above, must be measured and documented during that visit.
2. Visits addressing problem focused care delivered by a physician or an advance practice nurse or physician's assistant billing under a physician, may be billed for care delivered and documented using evidence based clinical guidelines as described above.
3. For those in the >85th percentile, payable weight management visits may include a maximum of 3 visits spread over a course of six months; follow up visits after the initial visit must include, in the patient's record, a note addressing the patient's/parent's readiness to change and outcomes of intervention to date.
4. An appropriate CPT code or UB-04 revenue code, an appropriate five-digit ICD-9 or ICD 10 upon implementation, diagnosis code 278.00 through 278.02 and one of V85.53 or V85.54 codes must be included on the claim form for each visit.
5. Diagnosis codes for obesity related co-morbid conditions, if present and addressed at that visit, need to be listed on the claim form for each visit.
6. Each visit should include, in patient record, documentation of educational handouts given, care plan and outcomes based on specific treatment and behavior changes (e.g., nutrition, physical activity, etc.) recommended and made, compliance with past recommendations, results of screening laboratory tests, reports of referrals and consultations if any, and time spent by provider with patient and family during that visit.
7. No further visits related to weight management will be payable after a maximum of 3 visits over a six month period, unless improvement in BMI percentile is evident based on the V85.5x codes submitted for that claim or documentation of favorable outcome is appended to the claim.

Additional Notes on Payment Policies Related to Weight Management

1. Weight management visits cannot be billed on the same day as a Preventive Medicine visit.
2. Weight management counseling services can be billed as part of a problem focused evaluation and management visit using CPT codes 99204-99205, if provided to a new patient, or 99214-99215 if provided during a follow up visit to an established patient. CPT guidance on this topic allows for this provision when counseling and/or care coordination dominates (more than 50%) face-to-face encounter time with the patient and/or family. The extent of counseling and/or coordination of care (time as well as content of care, coordination and counseling) must be documented in the medical record.

Bright Futures, 3rd Ed. suggests that parents need information on how to encourage their children and adolescents to practice healthy eating behaviors, beginning in childhood. Additional information and tools are available on the American Academy of Pediatrics Bright Futures website.

Bright Futures, 3rd Ed. and clinical recommendations from the AAP that provide a set of recommendations for health care professionals to assist families are:

- Encourage and support exclusive breastfeeding for about six months
- Encourage and support continued breastfeeding as complementary foods are introduced, for 1 year or longer as mutually desired by mother and infant
- Gradually weaning formula fed infants from the bottle at about 9 to 10 months of age
- Encourage to begin self-feeding appropriate foods around 9 months of age
- Encourage adequate sleep based on the child's age and other medical considerations
- Discourage media use for children younger than age 2
- Recommend safe play and physical activity
- Limit total media time for children age 2 and older to no more than 1 to 2 hours per day
- Switch children from breast milk or formula to 2%, 1%, or fat-free milk at age 1 dependent on the child's growth, appetite, intake of other nutrient dense foods, intake of other sources of fat, and risk for cardiovascular disease.
- Gradually reduce children's fat intake to no more than 30 percent of their daily calories by age 5
- Encourage including fruit and vegetable choices with meals, offering whole grain bread, cereal and/or pasta
- Limit the consumption of high sugar foods and sugar sweetened beverages, limiting juices to 100% juice and to no more than 4-6 ounces per day for younger children ages 1 to 6 and to no more than 8 to 12 ounces for children ages 7 to 18 years old
- Recommend no juice from birth up to one year
- Being aware of portion sizes, especially of high fat and high sugar foods
- Encourage offering appropriate amounts of healthy foods and allowing the child to determine which and how much of the foods offered he/she will consume
- Limit the consumption of convenience and fast foods
- Encourage family meals
- Encourage family members to drink water
- Offer and encourage children and adolescents healthy food choices based on the Dietary Guidelines for Americans and the U.S. Department of Agriculture's Choose My Plate website.
- Encourage pre-teens and teens to develop and maintain healthy eating habits and routines to support appropriate growth and development
- Discuss body image
- Recommend moderate amounts of physical activity on most, if not all, days of the week
- Encourage active play
- Preschool and elementary age children should be encouraged to participate in active play for at least one hour per day
- Adolescents should be encouraged to have 60 minutes or more of physical activity daily, mostly of moderate to vigorous intensity and including muscle and bone

- strengthening activities
- Children and adolescents can achieve this level of activity through intense
- activities (e.g., hiking for 30 minutes) or through shorter, more intense activities (e.g., jogging or playing basketball for 15 to 20 minutes)
- Parents, recreation program staff, and health professionals need to promote physical activity in children and adolescents and help them increase their physical activity levels and decrease sedentary activities

HK-203.10.2 Smoking and Tobacco Use Cessation

Assisting tobacco users to quit is essential to reducing harmful health consequences. Tobacco use cessation information provided to children and adolescents or parent(s) and guardian(s) who use tobacco is recommended as part of anticipatory guidance. Anticipatory guidance is considered to be included in the office visit fee; it is not separately reimbursed.

Section 4107 of the Affordable Care Act (P.L. 111-148), amended Title XIX (Medicaid) of the Social Security Act to provide for Medicaid coverage of comprehensive tobacco cessation services for pregnant and up to 60-day post-partum women age 21 and over, including both counseling and pharmacotherapy, without cost sharing.

HFS administrative rules formalize coverage of tobacco cessation counseling services and pharmacotherapy for pregnant and up to 60-day postpartum women. While children through age 20 have been eligible to receive tobacco cessation services under the EPSDT benefit, these counseling procedures and pharmacotherapy also apply to this population.

Effective with dates of service on and after January 1, 2014, tobacco cessation counseling services for those through age 20, pregnant and up to 60-day post-partum women age 21 and over may be a separately billable service (see Appendices for billing codes).

Duration of Counseling

For pregnant and up to 60-day post-partum women age 21 and over, HFS will reimburse up to a maximum of three quit attempts per calendar year, with up to four individual face-to-face counseling sessions per quit attempt. The 12 maximum counseling sessions include any combination of the two procedure codes listed in the Appendices. Please note, children through age 20 are not restricted to the maximum twelve counseling sessions.

These counseling sessions must be provided by, or under the supervision of, a physician, or by any other health care professional who is legally authorized to furnish such services under State law, and who is authorized to provide Medicaid covered services other than tobacco cessation services.

In addition, the patient's medical record must be properly documented with provider signature, and include the total time spent and what was discussed during the counseling session, including cessation techniques, resources available and follow-up.

Pharmacotherapy

The department covers FDA-approved nicotine replacement therapy in multiple forms, as well as two prescription medications indicated as an aid to tobacco use cessation. Providers may refer to the Department's Drug Prior Authorization webpage to determine specific drug coverage and prior approval requirements. Nicotine replacement duration of therapy is normally limited to three months in a year; however, duration limitations may be overridden by the Department through the prior approval process on an individual patient basis. To request prior approval for a specific drug, please link to the Drug Prior Approval Information webpage.
Please note, per U.S. Public Health Service published guidelines, pharmacotherapy for tobacco cessation is not recommended for pregnant women due to lack of evidence regarding its safety and effectiveness in pregnant women; however, its use may be evaluated on an individual basis by the woman and her physician.

HFS does not cover tobacco use cessation techniques such as hypnosis, acupuncture, herbal remedies, ear clips, or any other technique that does not conform to a medical model. Use of e cigarettes is also not recognized or covered by HFS for purposes of smoking cessation or harm reduction due to lack of such evidence.

Illinois Tobacco Quitline

HFS encourages all providers to take advantage of the resources available to address tobacco use cessation including information provided by the Illinois Department of Public Health available through the Illinois Tobacco Quitline website. The Illinois Tobacco Quitline is a free service funded by the Illinois Department of Public Health and managed by the American Lung Association of Illinois. Quitline staff includes registered nurses, registered respiratory therapists and counselors who have years of experience and are trained in all aspects of tobacco cessation. The Quitline also has a full time Spanish speaking interpreter. For callers who speak other languages, an interpretation service with access to more than 200 other languages is used. Hours of operation are from 7:00 a.m. to 11:00 p.m., daily. The Quitline services are available through the toll-free number:

1-866-QUIT YES (1-866-784-8937)

For more information regarding tobacco use cessation programs in your area, contact the local health department. For more information about the harmful effects of tobacco use and resources to prevent tobacco use initiation refer to the CDC Smoking and Tobacco Use website. For information and resources on Smoking and Tobacco Use Cessation, refer to the Appendices.

HK-203.11 Other Services

Coverage is provided for other necessary health care, diagnostic services, treatment and other measures described in Section 1905(a) of the Social Security Act (Act), to correct or ameliorate defects; physical and mental illnesses; and conditions discovered by the screening services, including treatment for pre-existing conditions. The medical services that are covered under EPSDT are identified in Chapter 100, Topic 103.1.

Prior approval may be required for some of the covered items or services. Services or items requiring prior approval are identified in Chapter 200 of the handbook that pertains to that type of service.

HK-203.11.1 Quality Monitoring

HFS is committed to monitoring the quality of its programs and the care provided to its beneficiaries. Quality monitoring ensures program goals are met and provides tools to providers to improve care. Quality monitoring uses pediatric quality indicators including Healthcare Effectiveness Data and Information Set (HEDIS®) measures and state defined measures, the Children's Health Insurance Program Reauthorization Act (CHIPRA) core measure set, and other state-specific indicators to assess HFS and provider performance.

The pediatric quality indicators include, but are not limited to:

- Percentage of children with various numbers of well child visits in the first 15 months of life
- Percentage of children who receive appropriate lead screening
- Percentage of children with objective developmental screening
- Percentage of two year olds with appropriate immunizations
- Percentage of children who are 3, 4, 5 or 6 years of age who received one or more well child visits
- Percentage of children with objective vision screening
- Percentage of adolescents with at least one well child visit during the year
- Percentage of children with appropriate medication management for asthma
- Percentage of children ages 3-17 with BMI percentile documented at an outpatient visit reflected in the claim submittal

The specific measures tracked and how feedback is reported to providers vary depending on the program.

- As a component of the PCCM program, Illinois Health Connect tracks pediatric quality indicators such as those above and provides feedback to providers regarding their performance on these individual indicators via panel rosters, provider profiles and bonus payments. Information and additional resources can be found on the Illinois Health Connect Quality Tools website.

- Information on quality indicators and the external quality review of the MCO programs can be found through the HFS Care Coordination webpage. Providers should contact the specific Health Maintenance Organization (HMO), Managed Care Organization (MCO), Accountable Care Entity (ACE), or Managed Care Community Network (MCCN) with which they are enrolled for information on quality tools and reporting.

- Reports on quality performance and federally required reporting also are available on the HFS Report Center webpage.

HK-204 Non-Covered Services

Services for which medical necessity is not clearly established are not covered in HFS' Medical Programs. Refer to Chapter 100, Topic 104, for a list of services and supplies for which payment will not be made.

Services that are available at no cost to the general public will not be supported by HFS for HFS enrolled clients; for example:

- Local health department vaccination clinics
- Communicable disease clinics

Exceptions include the following, which are covered by HFS:

- The Maternal and Child Health (MCH), Title V Block Grant, pays the provider (in whole or in part) for that service. The MCH Title V Block Grant supports certain services for children from families who meet the financial qualifications. Certified Local Health Departments and other public health agencies generally receive those grant dollars. IDPH administers the MCH Title V Block Grant.
- The service is provided pursuant to an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) as set forth under the Individuals with Disabilities Act (IDEA), under the School Based Health Services Program website.
- The service is "bundled" as part of another service when billed to other payers and the service is requested by HFS to be "unbundled" and individually billed, or in the case of an encounter rate clinic (e.g., FQHC, RHC or ERC) specifically detailed on the encounter claim (e.g., risk assessment or objective developmental screening).

For general policy and procedures relative to billing requirements, refer to the appropriate Chapter 200 for the specific provider or service type.

HK-205 Record Requirements

Refer to Chapter 100, Topic 110 for record requirements applicable to all providers. Providers must maintain an office record for each patient, hardcopy or electronic. In group practices, partnerships, and other shared practices, one record is to be kept with chronological entries by the individual practitioner rendering services.

The record maintained by each provider is to include the essential details of the patient's condition and of each service provided. Any services provided to a patient by the provider outside the office are to be documented in the medical record maintained in the provider's office. All entries must include the date, be legible and in English. If an audit is conducted, records that are unsuitable because of illegibility or because they are written in a language other than English, may result in no payment made or payments previously made being recouped.

Medical records for EPSDT services must include the following, where applicable:

- Problem list
- Medication list
- Personal health, social history and family history
- Relevant history of current illness or injury, if any, and physical findings
- Diagnostic and therapeutic orders, including medications lists
- Clinical observations, including results of treatment
- Reports of procedures, tests and results, including findings and clinical impression from screenings or assessments
- Diagnostic impressions
- Immunization records
- Allergy history
- Periodic examination record
- Growth chart
- Objective developmental screening tools or risk assessment screening tools, as applicable
- Health education/anticipatory guidance
- Nutritional assessment, including documentation and interpretation of BMI for children starting at 2 years of age
- Hospital admission and discharge, if any
- Family planning services, if any
- Referral information and specialty consultation reports, if any

All services provided must be documented in the permanent medical record. The medical record must support the managed care encounter data or fee-for-service claim. Encounter rate clinics (e.g., FQHCs, RHCs and ERCs) must detail all services rendered at the visit on the encounter claim and detail those services in the medical record.

For children with chronic diseases, the provider must develop and use treatment plans that are tailored to the individual child and conform to accepted clinical guidelines and

best practices. The plan includes appropriate ongoing treatment reflecting the prevailing community standards of medical care designed to minimize further deterioration or complications of the child's health. Treatment plans should be on file with the permanent record for each child with a chronic disease.

HFS and its professional advisors regard the preparation and maintenance of adequate medical records as essential for the delivery of quality medical care. In addition, providers should be aware that medical records are a key document for post payment audits and quality of care reviews.

In the absence of proper and complete medical records, no medical payments will be made and payments previously made may be recouped.

Certified Local Health Departments and public health clinics using *Cornerstone* as the medical record

Providers must maintain a complete, accurate and dated medical record of all services (including the component parts of an EPSDT examination) provided. The record can be on paper or electronic. The record is subject to a quality of care review by HFS or its agent. The use of the IDHS *Cornerstone* documentation system qualifies as an acceptable method for EPSDT documentation by the Certified Local Health Department (or other public health provider) when the appropriate data fields are completed and the information clearly supports the claim. The following *Cornerstone* screens, as appropriate, may be used for the physical examination, health history and screenings, as long as supported by an objective screening, as appropriate, as detailed in this Handbook:

708 1–10	Family History
708 11–26	Vision and Hearing Assessment
708 31–52	Physical Examination
708 53–58	Mental Health/Substance Abuse Assessment
708 59–69	Laboratory Test
708 70–80	Lead Assessment
708 81–92	Nutritional Assessment
708 93–97	Oral Health Assessment
708 A–R	Age Appropriate Anticipatory Guidance
CM04	Case Notes
PA09	Infant Child Health Visit may also be used for documentation
PA12, PA23	Immunization Entry Screens
PA13	Immunization History
PA14	Future Immunizations

If *Cornerstone* is being used for documentation for EPSDT, there must be:

- A case note indicating an EPSDT exam was completed, the findings of the exam, any referrals made, and the name of the person who conducted the examination
- A completed growth chart that is stored in the child's chart

- Documentation of abnormal findings that are reported to the child's medical provider or the local health department medical director for follow up
- A copy of the screening instrument, and results of the screening as appropriate
- Documentation of appropriate referrals and specialty consultation reports

The following *Cornerstone* assessments are part of the EPSDT examination, and are used to indicate if further objective screening tests are needed. If the Certified Local Health Department bills HFS for an objective vision and hearing screening, a developmental assessment, or an oral health screening, additional documentation (which is not in *Cornerstone*) is needed to record these services, the findings and validate billing.

708 11-26 – Vision and Hearing Assessments are NOT adequate documentation to bill HFS. Separate objective vision and hearing testing must be conducted and appropriately documented that they were performed in accordance with the guidelines of this Handbook.

708 27-30 – Objective Developmental Assessment is a place to document findings and is NOT an approved developmental screening tool for separate billing to HFS. To bill for a developmental assessment, an approved developmental screening tool also must be completed and documented in the child's record. If such an objective Developmental Screening Tool is utilized, with findings analyzed and documented in the child's medical record, it is a separate billable service.

708 93-97 – Oral Health Assessment is NOT a dental service and cannot be billed as such.

HK 205.1 Child Health Profiles

HFS makes available to enrolled providers a fax copy of any Child Health Profile requested via the Provider Eligibility Inquiry Hotline at: **1-800-842-1461**. The information requested will be faxed back to the requestor.

To obtain a Child Health Profile, the provider will need the following information:

- 9-, 10-, or 12-digit Medicaid Provider Number
- 9-digit Recipient Identification Number (RIN) or the participant's name and date of birth or the participant's name and Social Security Number

A child's claims history information also can be obtained through the MEDI system.

All providers can access MEDI via the Illinois Health Connect website or myHFS.

Child Health Profile information includes paid claims or managed care encounter information related to preventive child health services (e.g., well child visits, immunizations, lead screenings). The information provided includes the:

- Date of service
- Description of service(s)
- Provider's name

The requesting provider may then obtain a copy of the medical record from the previous treating provider(s) with proper consent.

Child Health Profile information is transmitted to the managed care organizations under contract with HFS when a child becomes a beneficiary of the plan.

To access the MEDI training materials, please refer to the MEDI/IEC Training website or contact HFS' toll-free number at: **1-877-805-5312**. Select the "Getting Started" topic for more information on how to use MEDI.

HK-205.2 Illinois Health Connect Provider Profiles

To help support the PCP's quality assurance efforts, Illinois Health Connect will provide Provider Profiles to PCPs on a semi-annual basis. This report will provide information to each PCP on their achievement of patient care goals compared to statewide average achievement on the same goals. These quality indicators will be compiled using administrative data based on industry standards for each quality indicator, e.g. HEDIS®.

Some examples of measures for the profiles that are or may be relevant to individuals under age 21 include:

- Well child visits in the first 15 months of life
- Childhood immunization rates for two year olds
- Objective developmental screening
- Well child visits at ages three, four, five and six
- Well child visits for adolescents
- Percent of first trimester prenatal entry into care
- Percent of women who have delivered that have received a postpartum visit
- Adult preventive screening — Cervical Cancer Screening
- Diabetes measures
- Percent of children ages 3-17 with BMI percentile documented at an outpatient visit

Measures reported on the profiles are subject to change.

Illinois Health Connect will offer support and guidance to PCPs in reducing inappropriate utilization or under utilization with respect to preventive health care services.

For more information about the Illinois Health Connect Provider Profiles, please call your Illinois Health Connect Provider Service Representative at: **1-877-912-1999.**

HK-206 Certified Local Health Departments

HK-206.1 Standing Protocols

HFS recognizes that certain child preventive screening services may be performed by Certified Local Health Department qualified medical staff. Such services may include, but are not limited to, comprehensive health examination; objective developmental assessment; objective risk assessment; objective hearing screening; objective vision screening; laboratory services (in compliance with CLIA certification); lead assessment/screening; childhood immunizations and anticipatory guidance/health education (although anticipatory guidance is not a separate billable service, nor are subjective screenings).

Within the allowed scope of practice, HFS recognizes that registered nurses (RNs) at Certified Local Health Departments who have successfully completed the IDHS Pediatric Assessment Course, including clinical practicum (or a similar course approved by IDHS and the Certified Local Health Department's Medical Director), may perform well child physical examinations in the clinic as defined by the Certified Local Health Department's policy, in compliance with HFS' screening requirements and as detailed by the Medical Director's Standing Orders and under the Supervision and the responsibility of the Medical Director.

Standing Orders for RNs performing well child examinations at the Certified Local Health Department must be in place and must clearly identify their scope of service(s), the names and titles of all individuals performing the service(s), and the authorizing physician responsible for the medical care provided. All services provided must be appropriately documented in the child's medical record. All abnormal findings will be reported to the child's primary care provider, per the agency's written policy, and appropriate follow up shall occur. The authorizing Physician/Medical Director must sign and date the Standing Orders. The Standing Orders will include orders for specific laboratory tests, screenings, assessments and immunizations, and appropriate referral and follow up care.

HK-207 Other Related Agencies and Referral Sources

Bright Futures, 3rd Ed. recognizes that beyond the traditional primary care that is essential for all children, families also may benefit from a broad range of community based services such as family support (housing, employment, and social services), educational services, mental health services, substance abuse treatment, language assistance, respite care, recreation opportunities, and services for children and youth with special health care needs. Below are related agencies, referral sources, and other resources in Illinois not previously described that may help promote family and child health and well being.

HK-207.1 Transportation Assistance

Transportation is a covered service for an eligible All Kids beneficiary (whose family income is under 200 percent of the federal poverty level) and if necessary, for an attendant, to or from a source of medically necessary care when a cost free mode of transportation is not available or is not appropriate. Medically necessary care is defined as any medically necessary service covered under the Medical Assistance Program.

HFS has a contractor to handle the prior approval of non-emergency transportation services covered under the Non-Emergency Transportation Services Prior Approval Program (NETSPAP). The contractor does not provide transportation services under NETSPAP. Prior approval from the HFS contractor is required for all non-emergency medical transportation. Prior approval is not needed for emergency medical transportation.

The participant, medical provider, or transportation provider may call to receive prior approval for single trips. Requests for standing orders must be made in writing to the HFS contractor and can be made by anyone for all services. For more information about prior approval, visit the NETSPAP.com website.

In order to be considered for reimbursement by HFS, non-emergency transportation services must be:

- Provided to or from a covered source of medically necessary care
- Provided by an enrolled transportation provider
- Prior approved by HFS' contractor
- To the nearest medical provider that meets the participant's needs
- Provided in the least expensive mode that meets the participant's medical needs on the date of transport.

See the Appendices for more information about Transportation Assistance.

If the child is enrolled in a MCO under contract with HFS, that MCO is required to approve, arrange and reimburse for the transportation to and from the source of medical care, if needed by its member. Prior approval from the MCO is not needed for emergency medical transportation. Contact the MCO for more information on how to arrange

transportation to and from a source of medical care.

HK-207.2 Vaccines for Children Program

The Omnibus Budget Reconciliation Act (OBRA) of 1993, created the Vaccines for Children (VFC) Program, as Section 1928 of the Social Security Act, to ensure that children from low income families receive immunization services. The Illinois VFC Programs – operated by the Chicago Department of Public Health and the Illinois Department of Public Health:

- Provide state purchased vaccine, for HFS enrolled children, through the age of 18 years, at no charge to public and private providers
- Provide federally purchased vaccines, for children whose insurance does not cover routinely recommended vaccines, in FQHCs, RHCs and certified local health departments (LHDs)
- Cover vaccines recommended by the Advisory Committee on Immunization Practices (ACIP)
- Save enrolled provider's up front expenses for vaccine purchases
- Reduce the practice of referring children from the private sector to the public sector for vaccination, keeping children in their "medical home" for comprehensive health care. However, underinsured children will need to be referred to FQHCs, RHCs or LHDs to access VFC vaccines.

This program is a federally funded, state operated program. The population covered under the VFC Program includes children who meet at least one of the following criteria:

- Receiving Medical Assistance or All Kids
- Without health insurance
- Native American or Alaskan Native
- Children whose health insurance does not cover immunizations are consider underinsured and must be referred to FQHCs, RHCs or LHDs to access VFC vaccines

Participation in the VFC Program requires that the provider complete a Provider Enrollment Form and a Provider Profile Form. Participation in the VFC Program for *Chicago* providers occurs through the Chicago VFC Program. Participation in the Illinois VFC Program for providers outside the city of Chicago is administered by the Illinois Department of Public Health (IDPH). For more information about enrollment see the Appendices.

The HFS Medical Electronic Data Interchange System (MEDI) provides comprehensive data on childhood immunizations from various sources. These include childhood immunizations paid by HFS, or reported through encounter data by the child's MCO; recorded on the IDHS *Cornerstone* system, which tracks immunizations and other services provided by the public health system; recorded on Global, the immunization tracking system in Cook County; or recorded on IDPH's *I-CARE (*Illinois Comprehensive

Automated Immunization Registry Exchange) registry system or other IDPH tracking systems. For more information visit the FAQs – Medical Electronic Data Interchange (MEDI) System website.

HFS strongly encourages PCPs to participate in I-CARE, the Illinois' immunization registry maintained by IDPH. Contact IDPH for more information (refer to the Appendices).

HK-207.3 Eye Care – Glasses

Children less than 21 years of age do not have limits on glasses. Eyeglasses may be replaced as needed without prior approval if there is a change in the prescription meeting HFS' requirements or if they are broken beyond repair, lost, or stolen.

The department regards the maintenance of adequate records essential for the delivery of quality medical care. Providers must maintain an office record for each patient. The record maintained by the provider is to include the essential details of the patient's condition and of each service or material provided. The signature of the provider is required for the record of the service/visit to be complete. If there is no signature, then the record is incomplete.

Providers obtain lenses and frames from the Illinois Department of Corrections/Illinois Correctional Industries (IDOC/ICI) laboratory at Dixon Correctional Facility. Providers use the Optical Prescription Order (OPO), Form HFS 2803, to order lenses, frames, or both. The OPO is attached to the Provider Invoice Form HFS 1443 and submitted to HFS in the usual manner for claim submittals. The Provider Invoice should show charges only for a dispensing fee, not lenses and frames. IDOC/ICI will mail the eyeglasses directly to the ordering provider. HFS provides reimbursement to IDOC/ICI for the lenses and frames.

Charges for examinations and office visits should be submitted on the HFS 2360, Health Care Claim Form, in accordance with the Chapter A- 200, Handbook for Practitioners Rendering Medical Services, or electronically utilizing the 837 Professional.

For additional information regarding prescription requirements, record requirements and other information consult the Chapter 200, Optometrist Services Handbook on HFS' website.

HK-207.4 Family Case Management

All women known to HFS as being pregnant and infants who are enrolled in HFS' Medical Programs are referred to IDHS for family case management services. HFS transmits the names of participants to *Cornerstone*, IDHS' tracking system designed to track maternal and child health services provided by or through its provider networks. Additionally, family case management services may be provided to older children based on need and availability of funding, in accordance with current IDHS policies governing same.

IDHS has contracts with the following types of organizations to provide family case management services:

- Local Health Departments
- Federally Qualified Health Centers
- Local community based agencies

Case management services also are provided to:

- High-risk infants up to age two who are identified through the Illinois Department of Public Health's Adverse Pregnancy Outcome Reporting System (APORS)
- All wards of the Illinois Department of Children and Family Services (DCFS) for the first 45 days after DCFS receives temporary custody
- Ongoing for DCFS wards from birth to age five, pregnant wards, and children of older wards identified as high risk

Case managers are responsible for:

- Providing face to face services and ongoing assistance to families to remove barriers to receiving ongoing preventive health care services
- Providing education about the importance of child health including appropriate immunizations and screenings

Providers are encouraged to work closely with Family Case Management staff to assist clients in receiving needed services. For more information about the Family Case Management Program, contact:

Illinois Department of Human Services
Helpline: 1-800-323-4739
TTY: 1-800-447-6404

HK-207.5 Special Supplemental Nutrition Program for Women, Infants and Children (WIC)

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC), administered by IDHS, seeks to stress the relationship between proper nutrition, physical activity and health of women, infants and children; promote exclusive breastfeeding; and assist individuals at nutritional risk in achieving positive changes in dietary and physical activity habits to prevent nutrition related problems through optimal use of the supplemental foods and breastfeeding. For breastfeeding information and resources refer to the Appendices.

The WIC target populations are low-income, nutritionally at risk:

- Pregnant women (through pregnancy and up to six weeks after birth or after pregnancy ends)

- Breastfeeding women (up to infant's first birthday);
- Non-breastfeeding postpartum women (up to six months after the birth of an infant or after pregnancy ends)
- Infants (up to their first birthday)
- Children up to their fifth birthday

WIC coordinates services with other community maternal, prenatal and child health care services. It is a prevention program designed to influence lifetime nutrition and health behaviors. Nearly one out of every three infants born in Illinois receives WIC services.

Providers are encouraged to refer categorically eligible patients for a WIC nutrition assessment and potential certification to the program. For the location of the nearest WIC clinic, use the IDHS Office Locator or refer to the Appendices for more information.

Certified Local Health Departments may not bill an office visit to HFS if the purpose of the visit is WIC certification. The WIC program provides benefits for WIC related nutritional services, including the certification visit for WIC. However, any component part of the well child screening that is performed during the WIC certification visit (e.g., immunization(s), lead screening) may be billed to HFS.

HK-207.6 Early Intervention (EI) Services

IDHS serves as the lead agency to implement the Early Intervention Services System. Early Intervention (EI) is for children under 36 months of age who have disabilities, delays or are at a substantial risk of delays. EI services are defined by the Illinois Early Intervention Services System Act and Rule 500.

Children eligible for EI services:

- Experience a 30% or greater level of delay in at least one of these areas:
  - Cognitive development
  - Physical development, including vision and hearing
  - Language, speech, and communication development
  - Social-emotional development or
  - Adaptive self-help skills;
- Or are diagnosed with a physical or mental condition which typically results in developmental delays, such as Spina Bifida, Down Syndrome;
- Or are determined at risk of substantial developmental delay because the child is experiencing either
  - A parent who has been medically diagnosed as having a severe mental disorder as set forth under axis I and axis II of the Diagnostic and Statistical Manual (DSM) IV or a developmental disability;

  or
  - three or more of the following risk factors as defined by IDHS' EI program:
    - Current alcohol or substance abuse by the primary caregiver;
    - Primary caregiver who is currently less than 15 years of age;

- Current homelessness of the child. Homelessness is defined as children who lack a fixed, regular and adequate nighttime residence, in conformity with the McKinney Vento Homeless Assistance Act (see Appendices for resources to assist the homeless);
- Chronic illness of the primary caregiver;
- Alcohol or substance abuse by the mother during pregnancy with the child;
- Primary caregiver with a level of education equal to or less than the 10th grade, unless that level is appropriate to the primary caregiver's age; or
- An indicated case of abuse or neglect regarding the child and the child has not been removed from the abuse or neglect circumstances.

Families access the Illinois Early Intervention Services System through the Child and Family Connections (CFC) office, which serves their local area. Sites are operational throughout the state. These regional offices provide:

- Service coordination
- Assist with eligibility determination and coordinate the development of the initial and annual Individualized Family Service Plans (IFSP), which list EI services needed by the child and family, including transportation for those services identified in the child's IFSP

Under Part C of the Individuals with Disabilities Education Act, health care providers are required to make a referral to Early Intervention within two working days after a child has been identified with a disability or possible developmental delay. Refer to the Appendices for more information about best practices in making referrals and coordinating care.

To obtain resource information for the nearest CFC office, use the IDHS Office Locator, refer to the Appendices, or contact:

Illinois Department of Human Services
Helpline: 1-800-843-6154 or 1-800-323-4769
TTY: 1-800-447-6404

HK-207.7 Special Education Services

The Illinois State Board of Education serves as the lead agency to implement Special Education services. Special Education services are provided for children ages three through twenty-one with an educationally related disability, or developmental delay for children three through nine, (Part B of the Individuals with Disabilities Education Act.) Local school districts evaluate children to determine eligibility and if eligible, create an Individual Education Program (IEP) to identify special education and related services. Key services provided are individually determined based on the child's needs but may include:

- Assistive technology (durable medical equipment and supplies)
- Audiology, aural rehabilitation, and other related services

- School nurse or school health services
- Occupational therapy
- Physical therapy
- Psychological and other counseling services
- Speech/language therapy
- Transportation
- Vision services
- Parent counseling and training

Information about intervention services for children who are age three and over can be accessed through contacting the child's local school district office, or the Illinois State Board of Education Special Education Services website.

HK-207.8 Rehabilitation Services

Throughout the State, services are available to families of youth with disabilities through the IDHS Division of Rehabilitation Service website. For general information, contact:

Illinois Department of Human Services Help Line
Phone: 1-800-843-6154

HK-207.9 UIC – Division of Specialized Care for Children (DSCC)

UIC-Specialized Care for Children's mission is to partner with Illinois families and communities to help children with special healthcare needs connect to services and resources.

The UIC Core Program offers care coordination and cost supported diagnosis and treatment for children with chronic health impairments determined eligible for program support. The program supports non-investigational treatment recommended by physician specialists, such as therapy, medications, specialized equipment and supplies. Application forms are available on the How We Help/How to Apply page of the website or by calling 1-800-322-3722. To make a referral for a child, go to the website and select For Providers/Refer a Family.

The UIC Home Care Program offers care coordination for medically fragile/technology dependent children residing in the community setting. UIC-Division of Specialized Care for Children operates this program on behalf of HFS. Application forms are available on the How We Help/How to Apply page of the website or call 1-800-322-3722. To make a referral for a child, go to the website and select For Providers/Refer a Family.

The Supplemental Security Income - Disabled Children's Program is administered by UIC-Division of Specialized Care for Children to provide rehabilitative services to children under 16 years of age who are eligible for the Supplemental Security Income (SSI) program. The Division provides information about and referral to community resources, including referrals to Early Intervention or preschool programs when appropriate, and

Core Program services as described above. Information is available on the UIC Specialized Care for Children website.

Application forms are available on the UIC Specialized Care for Children How to Apply website. Refer to the Appendices for children with special health care needs referral and resource information.

HK-207.10 Electronic Health Record Medicaid Incentive Payment Program (eMIPP)

CMS has implemented, through provisions of the American Recovery and Reinvestment Act of 2009 (ARRA), incentive payments to eligible professionals (EP) and eligible hospitals (EH), including critical access hospitals (CAHs), participating in Medicare and Medicaid programs that are meaningful users of certified EHR technology. The incentive payments are not a reimbursement, but are intended to encourage EPs and EHs to adopt, implement, or upgrade certified EHR technology and use it in a meaningful manner.

The Illinois EHR Medicaid Incentive Program (eMIPP) will provide incentive payments to eligible professionals, eligible hospitals and critical access hospitals (CAHs) as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology.

The CMS Medicare and Medicaid EHR PIP program is voluntarily offered by individual states and territories, and can begin in 2011 once the state has a CMS approved infrastructure in place to manage the program. The program will continue until 2021. The last year a Medicaid provider may begin participation in the program is 2016.

Information about how to sign up for eMIPP is available at the Electronic Health Record Medicaid Incentive Payment Program (eMIPP) webpage.