MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: Local Health Department 02-01
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Subject: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Policy

Effective: September 1, 2002

Programs Affected: Medicaid, Children's Special Health Care Services Special Health Plans

This bulletin consolidates all provider information relative to the early and periodic screening, diagnosis, and treatment (EPSDT) program.

The schedule of visits and the components of these visits now more closely reflect recommendations from the American Academy of Pediatrics (AAP), Centers for Disease Control and Prevention (CDC), and the Centers for Medicare and Medicaid Services (CMS), which was formerly known as the Health Care Financing Administration (HCFA).

Please read the entire document carefully; some information is new and some is older standard operating procedure. All components and the new schedule shall be implemented by September 1, 2002.

Manual Update

The pages attached to this bulletin are not in manual format but, as a temporary measure, you may file them in the Medical Assistance Program Manual until the entire Chapter is rewritten.

Local health departments may file the attached pages in their manuals.

Practitioners may discard pages 130-137 of the current Chapter III and insert the pages attached to this bulletin.

Medicaid health plans (MHPs), formerly known as qualified health plans (QHPs), and Children's Special Health Care Services special health plans (SHPs) may discard pages 7-13 of Chapter IV and insert the pages attached to this bulletin.

NOTE: Any providers who still have the very old "EPSDT Chapter" that was used when the "comprehensive EPSDT program" was in effect should discontinue using it as the basis for EPSDT visits.

Practitioner bulletins 00-02, 98-09, 98-02, 96-03, and 94-05 are obsolete and may be discarded.

Health maintenance organization/clinic plan (QHP) bulletins 00-01, 98-10, and 98-03 are obsolete and may be discarded.

MSA bulletins 00-02, 98-11, and 98-03 are obsolete and may be discarded.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30479, Lansing, Michigan 48909-7979 or e-mail ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll free 1-800-292-2550.

Approval

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EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) PROGRAM

Federal regulations require state Medicaid programs to offer early and periodic screening, diagnosis, and treatment (EPSDT) to eligible Medicaid beneficiaries under 21 years of age; however, beneficiary participation is voluntary. The intent is to find and treat problems early so they do not become more serious and costly. Accordingly, EPSDT visits and any needed follow-up services are covered.

The main parts of the EPSDT program that providers are responsible for are:

- well child visits, including immunizations
- referrals for:
  - other preventive health care
  - medically necessary follow-up services to treat detected conditions
- transportation and reporting

WELL CHILD VISITS

The Michigan Department of Community Health (MDCH) supports the concept of a medical home for each Medicaid beneficiary. A medical home is a primary care provider who assumes responsibility for assuring the overall care of an individual, and for the maintenance of an individual's medical record. When a physician or other primary care provider accepts a child in a primary care relationship, the provider takes responsibility for arranging or providing well child/EPSDT visits and updating the child's medical record at each visit.

Well child visits are the health checkups, newborn, well baby, and well child exams represented by Current Procedural Terminology (CPT) Preventive Medicine Services Procedure Codes 99431, 99432, 99381-99385, and 99391-99395 and Evaluation and Management Procedure Codes 99201-99205 and 99211-99215 if they are used in conjunction with International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes V20.0 – V20.2, V70.0, and/or V70.9

The periodicity schedule (Exhibit 1 at the end of this package) indicates all components and age-specific indicators for performing the various components.

OUTREACH

The MDCH provides outreach to beneficiaries through various means, including informational publications and other beneficiary contacts.

When the first Medical Assistance ID Card is issued, it is mailed with the MDCH Pub 492 (containing English, Spanish, and Arabic text). Pub 492 is entitled "A Hug Shows You Care" and it explains the benefits of a well child visit, indicates the recommended periodicity schedule, describes procedures included in the free health checkup, and presents information about transportation.

Soon after the Medical Assistance ID Card is issued, the case is included in a monthly outreach list and the grantee receives a letter that stresses the importance of well child visits and provides transportation information.

Fee for Service

For beneficiaries under two years of age, the letter is sent every six months. The grantee is encouraged to schedule the visits recommended during those six months with the child's provider.

For beneficiaries two years of age and older, if a claim for a well child visit has not processed through our system by the time the child is half way to his/her next "due" date according to the periodicity schedule, the grantee receives the letter again.

The letters generate a list of fee-for-service beneficiaries that goes to the local health department. Local health departments are paid to assist in informing beneficiaries of the EPSDT program, scheduling appointments, and explaining transportation options.

Medicaid Health Plan (MHP)/Children's Special Health Care Services special health plan (SHP)
Each MHP/SHP is able to download an electronic monthly outreach list of enrollees due or overdue. The health plan must either notify the grantee directly or may have the local health department assist in notification, scheduling appointments, and explaining transportation options.

Once each year, "A Hug shows You Care" is mailed to the grantee of each Medicaid case.

Examples of the current MDCH Pub 492 and outreach letter appear in Exhibit 2 attached to this bulletin.

TRANSPORTATION

Transportation is available (free of charge to the beneficiary) for travel to and from well child visits, if requested by the family.

- For those enrolled in an MHP or SHP, the family needs to make arrangements directly through that plan or with the assistance of the local health department.
- Beneficiaries not enrolled in an MHP or SHP need to contact their local Family Independence Agency directly or with the assistance of the local health department to make transportation arrangements for the EPSDT visit. It may take some time to make these arrangements, so the Family Independence Agency needs to be contacted as soon as the date and time of the appointment are known.

WELL CHILD VISIT REPORTING

REPORTING WELL CHILD VISITS

All information relative to the well child visit is gathered and used to update the child's EPSDT history file.

- Fee-for-service providers bill well child visits via the ASC X12N 837 (currently version 3051 or the Michigan Medicaid interim version 4010) for electronic submission; or the HCFA 1500 (12-90) for paper claim submission. **NOTE:** Providers may no longer bill using magnetic tape.
- MHP and SHP information relative to well child visits is gathered through encounter data.

If the beneficiary has other insurance, the provider is encouraged to bill the other insurance for the well child visit. If there is no response within 30 days, the provider may then bill the MDCH. If the provider knows that the insurance does not cover preventive health care, the well child visit may be billed to the MDCH immediately.

FEDERAL REPORTING

Each state is required to file an annual EPSDT report with Centers for Medicare and Medicaid Services (CMS), formerly known as the Health Care Financing Administration (HCFA), by April 1 of each year. To reflect the correct data for Michigan, it is imperative that fee-for-service providers bill well child visits accurately and primary care providers include well child visit information in the encounter data they submit to MHPs and SHPs.

Exhibit 10 (HCFA-416 form) shows the current items that must be reported to CMS.

PERIODICITY SCHEDULE/COMPONENTS

The chart titled "EPSDT COMPONENTS BY AGE OF BENEFICIARY" (Exhibit 1) indicates the periodicity schedule and components for well child visits. This chart closely resembles the American Academy of Pediatrics' (AAP) schedule: Recommendations for Preventive Pediatric Health Care (RE9939), Pediatrics, Volume 105, Number 3, March 2000, p. 645. However, the MDCH does not follow the AAP schedule exactly because the MDCH also observes guidance provided by the CMS, Centers for Disease Control and Prevention (CDC), and input from Michigan experts.

NOTE: Information relative to the AAP may be obtained by a search at http://www.aap.org.

Head Start agencies are directed by federal regulation to meet state EPSDT standards for health screening. The Department urges you to cooperate with these agencies. Results of well child visits may be shared if requested, since Head Start agencies are bound by confidentiality standards.

Providers will complete all testing components at the specific ages indicated on the periodicity schedule. Well child visits may be performed more frequently than the periodicity schedule indicates if required by court order, foster care standards, or if considered medically necessary. The child's medical record shall reflect documentation of the circumstances.

For providers wishing to learn techniques for administering objective hearing and/or vision screenings, the MDCH has arranged with the Michigan Public Health Institute (MPHI) to provide training sessions. For information on locations, schedules, and registration, providers may call MPHI at (517) 324-7398.

The item arrangement of the Well Child Visits section corresponds with the order of the components shown on the "EPSDT COMPONENTS BY AGE OF BENEFICIARY" chart (Exhibit 1). **NOTE:** If our policy differs from the AAP's recommendations, *the difference appears in italic print.*

HISTORY

Immunization Review

A review shall be performed at each visit, with immunizations administered according to current recommendations and standards of practice recognized by the AAP and the US Public Health Service Advisory Committee Immunization Practices (ACIP). Providers are reminded that all immunizations should be reported to the Michigan Childhood Immunization Register (MCIR).

Initial/Interval History

An initial history shall be obtained for each new patient at the first well child visit, with an update (interval history) at each subsequent well child visit.

Sample history forms from other states are located at www.michigan.gov/mdch; click on Providers (left side of the screen), Information for Medicaid Providers (left side of the screen), and Medicaid Provider Forms and Other Resources (center of the screen).

MEASUREMENTS

Blood Pressure
Providers shall obtain a blood pressure reading at each well child visit beginning at three years of age.

Head Circumference
This measurement is required at each well child visit through 24 months of age.

Height and Weight
Height and weight shall be measured each time the provider conducts a well child visit, with good practice requiring graphing of the measurements. **NOTE:** A suitable graphing document may be found at http://www.cdc.gov/growthcharts.

SENSORY SCREENING

Hearing
Newborn

The AAP now recommends that ALL newborns be screened using evoked otoacoustic emissions (EOAE) and/or auditory brainstem response (ABR) methods. Therefore, the MDCH is now requiring hearing screening of all Medicaid-covered newborns per AAP statement "Newborn and Infant Hearing Loss: Detection and Intervention" (RE9846), Pediatrics, Volume 103, Number 2, February 1999, pp. 527-530.

This screening must be accomplished in one of the following ways:

- If the hospital delivered 15 or more Medicaid-covered babies between October 1, 1997 and September 30, 1998, the hospital MUST provide newborn hearing screenings for Medicaid-covered newborns using the policies and procedures recommended by the AAP. If the newborn fails the first screening, another shall be conducted prior to the newborn's discharge. **NOTE:** Reimbursement for the EOAE and ABR newborn hearing screenings is included within the applicable diagnosis related group (DRG) payment for the newborn's inpatient stay. The hospital shall not "upcode" its claim to force an upgraded DRG assignment, resulting in an increased payment. The MDCH will monitor hospital coding practices. If hospitals are found to be upcoding for these newborn hearing screenings, payments will be subject to recovery by the MDCH.

- If the hospital delivered fewer than 15 Medicaid-covered babies between October 1, 1997 and September 30, 1998, the following options are available:

  The hospital may obtain the appropriate equipment and train staff to perform newborn hearing screenings using the policies and procedures recommended by the AAP. If the newborn fails the first screening, another shall be conducted prior to the newborn's discharge. **NOTE:** Reimbursement for the EOAE and ABR newborn hearing screenings is included within the applicable diagnosis related group (DRG) payment for the newborn's inpatient stay. The hospital shall not "upcode" its claim to force an upgraded DRG assignment, resulting in an increased payment. The MDCH will monitor hospital coding practices. If hospitals are found to be upcoding for these newborn hearing screenings, payments will be subject to recovery by the MDCH.

  Beneficiaries Under Fee-for Service
  If the hospital delivered fewer than 15 Medicaid-covered babies and is not equipped for EOAE and/or ABR, the child's physician, nurse-midwife, or nurse practitioner shall be made aware of this fact so the newborn can be referred to a Medicaid-enrolled hearing and speech center for screening prior to one month of age.

Beneficiaries Enrolled in an MHP or SHP

If the hospital delivered fewer than 15 Medicaid-covered babies and is not equipped for EOAE and/or ABR, the child's primary care provider (physician, nurse-midwife, or nurse practitioner) shall be made aware of this fact so the child can receive an appropriate referral for screening prior to one month of age.

Preschool

Subjective hearing screening (i.e., by history) shall be performed at each well child visit.

Objective screening may be performed by the primary care provider or referred to the local health department. A Head Start agency (with approval from the child's primary care provider) may refer preschool-aged children to the local health department for objective hearing screening. The results must be reported to the child's primary care provider. The results must also be shared with the Head Start agency if that agency was the referral source.

To bill the MDCH directly for these objective screenings, the local health department must submit a quarterly report no later than its cost report covering the same quarters. A sample format of the report appears as Exhibit 3 of this package and may be copied for your use, or you may develop your own report IF all of the same information is included. Payment will be made (based on cost) via gross adjustment. ***NOTE:*** *The MSA-1751 form (Exhibit 8) must contain the hearing information in addition to submission of the quarterly reports. The MSA-1751 must accompany the cost report for these services to be considered for cost settlement.*

The MDCH will monitor the number of MHP and SHP referrals reported by local health departments, and may initiate charge-backs to the health plans for their members.

School Age

Subjective hearing screening (i.e., by history) shall be performed at each well child visit. Children with symptoms or risk factors should be referred to a hearing and speech center, an otologist, or CSHCS-sponsored otology clinic at a local health department for further objective testing or diagnosis.

All Ages

For children of any age, a subjective hearing screening (i.e., by history) shall be performed at each well child visit. Referral to a hearing and speech center, an otologist, or CSHCS-sponsored otology clinic at a local health department should be made if there are symptoms (e.g., parent or caregiver has suspicions about poor hearing in the child), risk factors (e.g., exposure to ototoxic medications, family history of hearing deficits), or other medical justification.

Vision

Providers shall perform a subjective vision screening (i.e., by history) at each well child visit. For asymptomatic children three years of age and older, objective screening shall occur as indicated on the periodicity schedule. For children of any age, referral to an optometrist or ophthalmologist shall be made if there are symptoms or other medical justification.

Preschool

Since most children cannot cooperate prior to three years of age, the standard screening is subjective. Objective screening should begin at age three, using techniques described in the AAP statement "Eye Examination and Vision Screening in Infants, Children, and Young Adults" (RE9625*).*

Referrals for objective vision screening by the local health department may be made directly by the primary care provider or a Head Start agency (with approval from the child's primary care provider). The results must be reported to the child's primary care provider. The results must also be shared with the Head Start agency if that agency was the referral source.

To bill the MDCH directly for these objective screenings, the local health department must submit a quarterly report no later than its cost report covering the same quarters. A sample format of the report appears as Exhibit 4 and may be copied for your use, or you may develop your own report IF all of the same information is included. Payment will be made (based on cost) via gross adjustment. ***NOTE:*** *The MSA-1751 form (Exhibit 8) must contain the vision information in addition to submission of the quarterly reports. The MSA-1751 must accompany the cost report for these services to be considered for cost settlement.*

The MDCH will monitor the number of MHP and SHP referrals reported by local health departments, and may initiate charge-backs to the health plans for their members.

School Age

Subjective vision screening shall be performed at each visit; objective screening shall be performed as indicated on the periodicity schedule.

DEVELOPMENTAL/BEHAVIORAL ASSESSMENT

Screening for development and behavior may be accomplished by observation, history, and appropriate physical examination, with parenting skills fostered at every well child visit. Or, the provider may administer a:

- standardized developmental instrument such as the Developmental Screening Test II or Bayley Scales of Infant Development. Providers may use Procedure Codes 96110 or 96111, as appropriate.
- mental health screening. Suggestions for screening instruments may be obtained from your local community mental health services provider (CMHSP) or from the Department's Division of Mental Health Services to Children and Families at (517) 335-9101, or e-mail wotringj@michigan.gov.
- substance abuse screening. Suggestions for screening instruments may be obtained from the Department's Division of Substance Abuse Quality and Planning at (517) 335-8623, or e-mail travissc@michigan.gov.

If suspected problems are observed, specific objective testing shall be administered either directly by the primary care provider or referred as appropriate. **NOTE:** The MHP and SHP contracts include a limited mental health benefit coverage for beneficiaries with mild/moderate mental health conditions and CMHSPs are responsible for the provision of covered specialty mental health services necessary for the treatment of Medicaid beneficiaries with more significant, persistent, complex, and/or serious psychiatric conditions. Bulletin MSA 00-10 contains details and specific guidance regarding coordination of these benefits and referrals.

INSPECTIONS

Dental

The dental health of beneficiaries depends a great deal on the attitude and concern expressed by the child's primary care provider. Therefore, the MDCH requires providers to stress the importance of preventive and restorative dental care and adhere to the following.

The oral cavity must be inspected at each well child visit regardless of whether teeth have erupted.

Beginning at three years of age (younger if the individual child exhibits needs) it is extremely important that the child see a dentist every six months for prophylaxis and other preventive care. If the child does not have his/her next preventive dental appointment scheduled, the provider shall make a referral. When restorative dental care is needed, the child shall be referred for treatment.

Physical Examination

A complete physical examination shall be performed at each well child visit. Infants are to be totally unclothed; all other children must be undressed and suitably draped.

PROCEDURES -- GENERAL

Anticipatory Guidance

Anticipatory guidance explains any and all changes that will most likely occur before the next recommended well child visit, and offers strategies for dealing with the anticipated changes. This applies to all aspects of the child's life (e.g., physical, developmental, nutritional, psychosocial). Providers may refer to the AAP "Guidelines for Health Supervision III" (1994).

Hematocrit or Hemoglobin

The child's hematocrit or hemoglobin shall be tested according to the periodicity schedule. Providers may refer to the AAP Pediatric Nutrition Handbook (1998) and "Recommendations to Prevent and Control Iron Deficiency in the United States" MMWR, April 3, 1998; 47(RR-3): 1-36.

Hereditary/Metabolic Screening

As required by law, hospitals must test newborns for biotinadase, congenital adrenal hyperplasia, galactosemia, hemoglobinopathies, hypothyroidism, maple syrup urine disease, phenylketonuria (PKU), and sickle cell. ***NOTE:*** *If the child was born in a Michigan hospital on or after October 1, 1987, the sickle cell test should have been performed on the newborn. For other children with all or some black heritage, the test is required prior to the child's 21st birthday unless electrophoresis for sickle cell was done when the child was at least six months of age and the results are known to the parent. If sickle cell testing is appropriate (as explained on the periodicity schedule), a capillary blood sample may be mailed to the Sickle Cell Detection and Information Center, 18516 James Couzens, Detroit, MI 48235. Tubes, forms, and envelopes may be obtained from the same address. Questions may be telephoned to (313) 864-4406.*

Injury Prevention

Injury prevention shall be discussed at each well child visit. From birth to 12 years of age, providers should refer to the AAP's injury prevention program in "A Guide to Safety Counseling in Office Practice" (1994).

Interpretive Conference

The interpretive conference is to explain the results of the well child visit. Depending upon the age and/or family status of the beneficiary, the conference may be directly with the beneficiary, the beneficiary and parent/guardian, or only with the parent/guardian.

If a beneficiary has a potential or apparent abnormality, the provider is responsible for providing or referring follow-up diagnostic service and treatment.

Nutritional Assessments

Nutritional assessments shall be based on height, weight, and their relatedness; the most recent hematocrit/hemoglobin value; physical examination; and health history. Age appropriate nutrition counseling should be provided at each visit per the AAP Pediatric Handbook of Nutrition (1998).

Sleep Position Counseling

Positioning of infants through six months of age for sleep shall be discussed at each visit. Healthy infants should be placed on their backs; side positioning is a reasonable alternative but has a slightly higher risk of Sudden Infant Death Syndrome (SIDS). Providers may refer to the AAP statement Changing Concepts of Sudden Infant Death Syndrome: Implications for Infant Sleeping Environment and Sleep Position (RE9946), Pediatrics, Volume 105, Number 3, pp. 650-656, March 2000. Printed material for parents is available from the SIDS Alliance by calling 1-800-331-7437.

Urine Testing

A urinalysis (at a minimum, via dipstick) shall be performed for all beneficiaries at five years of age and for sexually active male and female adolescents. A microscopic urinalysis is not necessary for screening an asymptomatic beneficiary.

Violence Prevention

Prevention of violence shall be discussed at each visit. Providers may refer to the AAP statement "The Role of the Pediatrician in Youth Violence Prevention in Clinical Practice and at the Community Level" (RE9832), Pediatrics, Volume 103, Number 1, January 1999, pp. 173-181.

PROCEDURES – CHILDREN AT HIGH RISK

Cholesterol

High risk children should be tested according to the AAP statement "Cholesterol in Childhood" (RE9805), Pediatrics, Volume 101, January 1998, pp. 141-147. Beginning at two years of age, children with the following risk factors shall be screened if:

- parents or grandparents, at <55 years of age, underwent diagnostic coronary arteriography and were found to have coronary atherosclerosis. This includes those who have undergone balloon angioplasty or coronary artery bypass surgery. Perform a fasting lipoprotein analysis.

- parents or grandparents, at <55 years of age, had a documented myocardial infarction, angina pectoris, peripheral vascular disease, cerebrovascular disease, or sudden cardiac death. Perform a fasting lipoprotein analysis.
- a birth parent has an elevated blood cholesterol level (i.e., 240 mg/dL or higher). Perform a random serum cholesterol.

If a family history cannot be ascertained and other risk factors exist, testing is at the provider's discretion.

Diabetes (Type 2)
High risk children shall be tested according to the AAP statement "Type 2 Diabetes in Children and Adolescents, Consensus Statement of the American Diabetes Association," endorsed by the AAP in *Pediatrics, Volume 105, March 2000, pp. 671-680.*

Beginning at age ten (or at the onset of puberty, if it occurs at a younger age), a risk assessment shall be performed at each well child visit. Children at risk should be tested using the fasting plasma glucose, two-hour oral glucose tolerance, or two-hour plasma glucose tests.

A child is considered high risk if he/she is overweight (i.e., body mass index >85th percentile for age and sex, weight for height >85th percentile, or weight >120% of ideal for height) **AND** has any two of the following factors:
- has a family history of type 2 diabetes in first- and second-degree relatives
- belongs to a certain race/ethnic group (American Indian, African-American, Hispanic, Asian/Pacific Islander)
- has signs of insulin resistance or conditions associated with insulin resistance (acanthosis nigricans, hypertension, dyslipidemia, polycystic ovarian syndrome).

Pelvic Exams, Pap Smears, *Breast Exams, Counseling, and Risk Factor Interventions*
Beginning at puberty, all females should receive clinical breast exams and be taught self-breast examination.

All sexually active females shall have a pelvic, Pap smear, *and breast exam* as indicated on the periodicity schedule. Pelvic exams and Pap smears shall be offered to all females 18 years of age and older. *Whenever a pelvic exam is provided, a breast exam, counseling, and risk factor interventions shall be provided.*

Sexually Transmitted Diseases (STDs)
All sexually active patients shall be screened for STDs according to the periodicity schedule.

Tuberculosis (TB) Testing
The CMS now recommends that children be tested for TB according to the guidelines of the AAP, which is based on risk. A risk assessment shall be completed at each visit. **NOTE:** For assistance in determining high risk and testing, providers may refer to the current edition of the AAP Red Book: Report of the Committee on Infectious Diseases, or contact the Michigan Department of Community Health's Communicable Disease and Immunization Division at (517) 335-8165.

Based on current standards of good practice, Mantoux testing (Procedure Code 86580) is the preferred testing method.

Blood Lead
All Medicaid-covered children are considered at high risk for blood lead poisoning. The CMS has mandated that these children be tested at 12 and 24 months of age*. In addition, CMS mandates that if a Medicaid-covered child is between the ages of 36 and 72 months of age and has not previously been tested for blood lead, he/she MUST be tested.* ***NOTE:*** *If the parent or guardian is unsure if the child was previously tested, he/she must be tested.*

For children who have been tested, the following questions are intended to assist physicians and nurse practitioners in determining if further testing is necessary in addition to that completed at the mandated ages.

Does the child live in (or often visit) a house built before 1950 with peeling or chipping paint? This could include day care, preschool, or home of a relative.

Does the child live in (or often visit) a house built before 1978 that has been remodeled within the last year?

Does the child have a brother or sister (or playmate) with lead poisoning?

Does the child live with an adult whose job or hobby involves lead? **NOTE:** The chart following these questions presents examples.

Does the child's family use any home remedies that may contain lead? **NOTE:** The chart following these questions presents examples.

Possible Means of Exposure:

OCCUPATIONAL
auto repair
radiator repair
battery manufacturing or repair
bridge reconstruction worker
construction worker
plumber, pipe fitter
police officer
migrant farm worker
printing
glass manufacturing
chemical manufacturing
plastics manufacturing
rubber products manufacturing
steel welding and cutting
industrial machine operator

OTHER
Asian cosmetics
folk remedies and/or food additives
(e.g., Greta, Azarcon, pay-loo-ah, ghasard,
Hai ge fen, Bali Goli, Kandu, Kohl, X-yoo-Fa,
Mai ge fen, poying tan, lozeena)

HOBBIES
car or boat repair
casting lead figures (e.g., toy soldiers)
painting
furniture refinishing
jewelry and pottery making
stained glass making
lead soldering (e.g., electronics)
making lead shot, fishing sinkers, bullets
target shooting at firing ranges
brass/copper/aluminum processing

ENVIRONMENTAL
ceramicware/pottery
lead crystal
lead-soldered cans (imported)
lead paint
lead-painted homes
renovating/remodeling older homes
burning lead-painted wood
use of water from lead pipes
living near lead-related industries
soil/dust near industries and roadways

Publications and other materials concerning blood lead may be obtained from the agency indicated below. The State of Michigan laboratory telephone number is also included for your convenience.

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
CHILDHOOD LEAD POISONING PREVENTION PROGRAM
PO BOX 30195
LANSING MI 48909
(517) 335-8885

State of Michigan Laboratory: (517) 335-8244

If you have questions about blood lead testing or treatment, there are pediatricians in your area who have expertise in the treatment of blood lead and are available to discuss blood lead issues with you. Please call the Childhood Lead Poisoning Prevention Program at (517) 335-8885 to obtain the names and telephone numbers of these pediatricians.

For blood lead analysis, the blood sample may be obtained via the capillary method (i.e., heel prick or finger stick) or venipuncture. The sample may be sent to the Michigan Department of Community Health, Blood Lead Laboratory, PO Box 30035, Lansing, MI 48909 or to any laboratory qualified to do blood lead testing. If the State laboratory is used, blood lead supplies may be obtained by calling (517) 335-9867 or (517) 335-8244.

Michigan has established a statewide blood lead registry. This requires that certain information accompany each blood lead specimen (or request, if the specimen is drawn elsewhere) to the laboratory.

- Before you begin sending blood lead samples to the State of Michigan Laboratory, you must obtain a "Submitter Clinic Code" by telephoning the number shown at the end of this paragraph. If you send blood lead samples to the State of Michigan Laboratory, you must use form DCH-0696, Blood Lead Sampling Request. A facsimile of the DCH-0696 appears as Exhibit 5. Providers may obtain a supply of these forms by calling the Michigan Department of Community Health, Bureau of Laboratories at (517) 335-8244.

- If you send blood lead samples to a private laboratory or if the private laboratory draws and tests the sample, you may copy the DCH-0395 (Michigan Department of Community Health Blood Lead Analysis Report) for use or you may develop your own form IF all of the information from the DCH-0395 is included. A facsimile of the DCH-0395 appears as Exhibit 6. When testing is completed, the laboratory completes the information contained in Part III of the form and submits it to the registry.

Primary care providers shall draw blood in their offices for all children needing blood lead testing. There may be instances when a blood draw is not accomplished. If this occurs and the child resides in a jurisdiction where the local health department agrees to obtain a blood sample for blood lead testing, the primary care provider may refer a child to the local health department for the service.

The State of Michigan Laboratory will report all results to the child's ordering provider if information about the ordering provider is included. When ordering provider information is not available, results will be sent to the appropriate local health department.

To bill the MDCH directly for these blood draws, the local health department must submit a quarterly report no later than its cost report covering the same quarters. A sample format of the report appears as Exhibit 7 and may be copied for your use, or you may develop your own report IF all of the same information is included. Payment will be made (based on cost) via gross adjustment. **NOTE:** The MSA-1751 form (Exhibit 8) must contain the blood draw information in addition to submission of the quarterly reports. The MSA-1751 must accompany the cost report for these services to be considered for cost settlement.

The MDCH will monitor the number of MHP and SHP referrals reported by local health departments, and may initiate charge-backs to the health plans for their members.

If the results of a capillary blood lead sample indicate an elevated value, a confirmatory venous sample must be obtained. (Capillary and venous blood lead value/action charts follow.) **NOTE:** For fee-for-service providers, if a venipuncture is the only service provided to a given child on a given day, the Remarks section of the claim must reflect why blood handling is being billed rather than having the testing laboratory obtain the blood sample.

BLOOD LEAD (Pb) INTERPRETATION
Capillary (Microblood) Samples

Pb Result (micrograms per deciliter of blood)	**Action**
≤ 9	No action needed.
10 – 14	Obtain **venous sample within one month**. Emphasize the importance of the venous confirmation.
15 -19	Obtain **venous sample within two weeks**. Emphasize the importance of the venous confirmation.
20 - 44	Obtain **venous sample within one week**. Emphasize the importance of the venous confirmation.
45 – 69	Obtain **venous sample within 48 hours**. Emphasize the importance of the venous confirmation.
≥ 70	Obtain **venous sample IMMEDIATELY**. Emphasize the importance of the venous confirmation.
N.R. (no results-insufficient or clotted blood)	Repeat capillary sample one time **OR** obtain venous sample.

KEY: ≤ = less than or equal to
≥ = greater than or equal to

NOTE: For values above 9, the provider shall always provide general health education to the parents regarding nutrition, house-cleaning techniques, and lead poisoning prevention. (This is considered part of the interpretive conference and is not separately reimbursable.)

BLOOD LEAD (Pb) INTERPRETATION
Venous (Macroblood) Samples

Pb Result (micrograms per deciliter of blood)	**Action**
≤ 9	No action needed.
10 – 19	Refer **within one month** for medical evaluation and retesting. The provider shall contact the local health department to determine if resources are available to provide follow-up services for this Pb range.
20 – 44	Refer **within five working days** for a complete medical evaluation. Refer to the local health department **within ten working days** for blood lead poisoning follow-up services.
45 – 69	Refer **within 48 hours** for medical intervention. Refer to the local health department **within five working days** for blood lead poisoning follow-up services.
≥ 70	Refer **IMMEDIATELY** for a complete medical evaluation. Refer to the local health department **within 24-48 hours** for blood lead poisoning follow-up services.
N.R. (no results-insufficient or clotted blood)	Repeat venous sample.

KEY: ≤ = less than or equal to
≥ = greater than or equal to

NOTE: For values above 9, the provider shall always

- emphasize the importance of following through with any retesting, evaluation, or intervention.
- provide general health education to the parents regarding nutrition, house-cleaning techniques, and lead poisoning prevention. This is considered part of the interpretive conference and is not separately reimbursable.

REFERRALS

If a problem is found or suspected during a well child visit, the (suspected) problem shall be diagnosed and treated as appropriate. This may mean referral to another provider or a "self referral" for further diagnosis and treatment. Referrals shall be made based on standards of good practice and the MDCH's established periodicity schedule or presenting need, if outside the normal schedule.

When a fee-for-service provider performs medically necessary treatment involving diagnostic or therapeutic procedures beyond examination of the child (e.g., wart removal) for a condition found during a well child visit, he or she may bill the separately identifiable procedure(s) in addition to the well child visit. Other medical visits/examinations will **NOT** be reimbursed on the same date of service as the well child visit when performed by the same provider. If the provider cannot perform the needed treatment, a referral shall be made to an appropriate provider. If you are not familiar with providers in the area, the local health department can assist you with referrals.

MHP and SHP providers must follow the referral procedures for the specific plan in which the beneficiary is enrolled.

PSYCHIATRIC (e.g., suspected behavioral disorder)

A full range of psychiatric services is available for Medicaid-covered fee-for-service beneficiaries under 21 years of age from a community mental health services provider (CMHSP).

The MHP and SHP contracts include a limited mental health benefit coverage for beneficiaries with mild/moderate mental health conditions and CMHSPs are responsible for the provision of covered specialty mental health services necessary for the treatment of Medicaid beneficiaries with more significant, persistent, complex, and/or serious psychiatric conditions. Bulletin MSA 00-10 contains details and specific guidance regarding coordination of these benefits and referrals.

WOMEN, INFANTS AND CHILDREN (WIC)

The Women, Infants and Children (WIC) program located at local health departments, Indian tribal clinics, and federally-funded clinics is a special supplemental feeding program that provides food coupons and nutritional education to eligible children under five years of age and pregnant women. The provider is expected to make referrals to a WIC site for eligibility determination.

OTHER PROGRAMS

Other programs exist that could benefit Medicaid beneficiaries, such as Head Start, intermediate school district services, genetics counseling, nutrition programs, and public health nursing. The provider is encouraged to become familiar with available programs and make full use of them whenever referrals are appropriate.

BLOOD LEAD POISONING FOLLOW-UP SERVICES

Many local health departments provide blood lead poisoning follow-up services, which consist of environmental investigations and nursing assessment/investigation visits. The provider shall contact the local health department to determine if services are available in the area and the blood lead levels at which referrals are accepted.

Local health departments may bill the MDCH directly for blood lead poisoning follow-up services provided to any Medicaid-covered child, regardless if the child is enrolled with an MHP, SHP, or is in the fee-for-service program. Authorization for these services is not required by the MHP/SHP; however, local health departments must notify the plan of the service(s) provided and provide the plan with a summary of each.

Documentation of the child's blood lead poisoning level that initiated service must be maintained, as well as documentation of all environmental investigations and nursing assessment/investigation visits.

All blood lead follow-up services must be billed using the child's Medicaid ID Number.

Environmental Investigations

To be eligible for reimbursement of environmental investigations, the health officer from the local health department must complete a copy of the BLOOD LEAD POISONING FOLLOW-UP SERVICES ASSURANCE OF PROVISION form (DCH-1530), which appears as Exhibit 9. The form must be mailed to:

PROVIDER ENROLLMENT
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
PO BOX 30238
LANSING MI 48909

If more than one child in the home has blood lead poisoning, the local health department must select one child's Medicaid ID Number and bill a single initial and a single follow-up environmental visit if provided.

Initial Environmental Investigation (Procedure Code Z6200)

A risk assessor certified by the State of Michigan's Lead Hazard Remediation Program must conduct the investigation of the child's home. If necessary, an investigation may be covered at a second site if the child spends time regularly at that site and it is a possible source of lead exposure. The MDCH will reimburse a maximum of two such investigations per episode of blood lead poisoning.*

The investigation must follow the "Protocol for Environmental Investigations for Children with Elevated Blood Lead Levels" and risk assessment activities per the Lead Abatement Act of 1998. The investigation must include the testing of appropriate potential sources of paint, house dust, soil, water, and other household risk factors such as pottery and home remedies. Education must be provided regarding known and potential sources of lead poisoning, reduction of future exposures, and suggestions for specialized cleaning techniques.

The risk assessor must prepare a risk assessment report per rule R325.9916 promulgated pursuant to the Lead Abatement Act that will include lead hazard control recommendations and the potential relocation of the child depending upon the severity of the lead hazards found.

Discussion with the family shall include agencies that may be able to provide assistance with lead hazard control recommendations provided in the risk assessment report.

* An episode includes a venous blood sample indicating the child is at risk according to recommendations of the Centers for Disease Control and Prevention, and also includes resulting treatment and follow-up services.

Follow-up Environmental Investigation (Procedure Code Z6210)
The MDCH will cover one follow-up environmental investigation per episode of poisoning* to determine if lead hazard control interventions were performed satisfactorily and verified by a visual inspection and dust wipe clearance sampling. However, if a second site was investigated as the possible source of lead exposure and had lead hazard control interventions performed, the MDCH will reimburse for a follow-up environmental investigation performed at that site.

Environmental Investigation Resource Documents
Providers may obtain the "Protocol for Environmental Investigations for Children with Elevated Blood Lead Levels", a list of certified risk assessors, applications for training and certification, and education materials from:

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
LEAD HAZARD REMEDIATION PROGRAM
PO BOX 30195
LANSING MI 48909
(517) 335-9390

Nursing Assessment/Investigation Visits
The MDCH will reimburse up to two nursing assessment/investigation visits per episode of blood lead poisoning.* If more than one child in the home has blood lead poisoning, the nursing assessment/investigation visits may be billed for each child.

The blood lead nursing visits must be provided in the child's home. The visits may be conducted by and reimbursed to a fee-for-service home health agency (Provider Type 15) or a local health department or other Provider Type 77 or physician (Provider Type 10 or 11) using Procedure Code Z6220. **NOTE:** Maternal Support Services and Infant Support Services providers may not bill this procedure code.

Blood lead nursing visits provided directly by an MHP or SHP may not be billed separately to the MDCH.

The first nursing assessment/investigation visit focuses on:
- assessment of growth and developmental status of the child, including any symptomatology that may be present in the child
- behavioral assessment of the child, including any aggressiveness and/or hyperactivity
- nutritional assessment of the child
- assessment of typical family practices that may produce lead risk (e.g., hobbies, occupation, cultural practices)
- limited physical identification of lead hazards within the dwelling
- identification and planning for testing for any other family member at risk for sequelae of lead hazard exposure
- education and information regarding lead hazards and ways to minimize those risks in the future
- development of a family plan of care to increase the safety of the child from lead hazards

The second blood lead nursing visit focuses on:
- reinforcement of the educational information presented to the family during the first visit
- validation of the family's ability to carry out activities to minimize risks of continued lead exposure
- modifications of the plan to minimize lead risks, as needed

* An episode includes a venous blood sample indicating the child is at risk according to recommendations of the Centers for Disease Control and Prevention, and also includes resulting treatment and follow-up services.

Blood Lead Resource Documents

Providers are encouraged to review "Guidelines for Environmental and Nursing Investigations for Children with Elevated Venous Blood Lead Levels" and apply these standards of good practice. This publication, plus other materials concerning blood lead poisoning, may be obtained from:

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
CHILDHOOD LEAD POISONING PREVENTION PROGRAM
PO BOX 30195
LANSING MI 48909
(517) 335-8885

EPSDT COMPONENTS BY AGE OF BENEFICIARY

Exhibit 1 - Front

	INFANCY [5]									EARLY CHILDHOOD [5]					MIDDLE CHILDHOOD [5]				ADOLESCENCE [5]									
AGE [1]	PRENATAL [2]	NEWBORN [3]	2-4 [4] Days	1 Mo	2 Mo	4 Mo	6 Mo	9 Mo	12 Mo	15 Mo	18 Mo	24 Mo	3 Yr	4 Yr	5 Yr	6 Yr	8 Yr	10 Yr	11 Yr	12 Yr	13 Yr	14 Yr	15 Yr	16 Yr	17 Yr	18 Yr	19 Yr	20+ Yr
HISTORY																												
Immunization Review [6]		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Initial/Interval	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
MEASUREMENTS																												
Blood Pressure													•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Head Circumference		•	•	•	•	•	•	•	•	•	•	•																
Height and Weight		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
SENSORY SCREENING																												
Hearing		O [7]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Vision [8]		•	•	•	•	•	•	•	•	•	•	•	O [9]	O	O	O	O	O	•	O	•	•	O	•	•	O	•	•
DEVELOPMENTAL/BEHAVIORAL ASSESSMENT [10]		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
INSPECTIONS																												
Dental Inspection [11]		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Physical Examination [12]		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
PROCEDURES -- GENERAL																												
Anticipatory Guidance [13]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Hematocrit or Hemoglobin [14]								◄•►	►	H	►	►	►	►	►				F	F	F	F	F	F	F	F	F	F
Hereditary/Metabolic Screening																												
biotinadase [15]		•																										
congenital adrenal hyperplasia [15]		•																										
galactosemia [15]		•																										
hemoglobinopathies [15]		•																										
hypothyroidism [15]		•																										
maple syrup urine disease [15]		•																										
phenylketonuria (PKU) [15]		•																										
sickle cell [16]		•					◄•	►	►	►	►	►	►	►	►	►	►	►	►	►	►	►	►	►	►	►	►	►
Injury Prevention [17]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Interpretive Conference	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Nutritional Assessment [18]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Sleep Position Counseling [19]	•	•	•	•	•	•	•																					
Urine Test [20]															•				◄	►	►	►	•	►	►	►	►	►
Violence Prevention [21]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
PROCEDURES – CHILDREN AT HIGH RISK																												
Cholesterol [22]												H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H
Diabetes (Type 2) [23]																		H		H		H		H		H		H
Pelvic Exam [24]																			H	H	H	H	H	H	H	•	•	•
STD Screening [25]																			H	H	H	H	H	H	H	H	H	H
Tuberculin (TB) Test [26]									H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H
Blood Lead [27]									•			•	M	►	►													

• = to be performed H = test high risk children M = mandatory if not previously tested O = objective screen (i.e., standardized method)

◄•► = the range during which a service should be provided, with the dot indicating the preferred age F = test menstruating adolescent

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include pertinent medical history, injury prevention, and anticipatory guidance. The benefits of breastfeeding should be discussed as well as the planned method of feeding per AAP statement "The Prenatal Visit" (RE0053), Pediatrics, Volume 107, Number 6, June 2001, pp. 1456-1458.
3. Every infant should have a newborn evaluation after birth. Breastfeeding should be encouraged and instruction and support offered. Every breastfeeding infant should have an evaluation 48-72 hours after discharge from the hospital to include weight, formal breastfeeding evaluation, encouragement, and instruction as recommended in the AAP statement "Breastfeeding and the Use of Human Milk" (RE9729), Pediatrics, Volume 100, Number 6, December 1997, pp. 1035-1039.
4. For newborns discharged within 48 hours of delivery, per AAP statement "Hospital Stay for Healthy Term Newborns" (RE9539), Pediatrics, Volume 96, Number 4, October 1995, pp. 788-790.
5. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.
6. An immunization review shall be performed at each appointment, with immunizations being administered at appropriate ages, or as needed. See schedules published annually in the January edition of Pediatrics.
7. **ALL** Medicaid-covered newborns must be screened using evoked otoacoustic emissions (EOAE) and/or auditory brainstem response (ABR) methods per AAP statement "Newborn and Infant Hearing Loss: Detection and Intervention" (RE9846), Pediatrics, Volume 103, Number 2, February 1999, pp. 527-530.
8. A subjective vision screening (i.e., by history) shall be performed at each appointment. For asymptomatic children three years of age and older, objective screening shall occur as indicated. For children of any age, a referral to an optometrist or ophthalmologist shall be made if there are symptoms or other medical justification.
9. If the patient is uncooperative, rescreen within six months.
10. By history and appropriate physical examination and/or via a screening instrument. If suspicious, by specific objective developmental, mental health, or substance abuse testing. Parenting skills should be fostered at every visit.
11. A dental inspection should be performed at each screening. Provide reinforcement of routine preventive dental care, stressing the recommended schedule of the American Academy of Pediatric Dentistry. If the next preventive dental visit is not scheduled, if the beneficiary does not have a dentist, or if restorative dental care is needed, a referral shall be made.
12. A complete physical examination shall be performed at each appointment. Infants should be totally unclothed, older children undressed and suitably draped.
13. Age-appropriate discussion and counseling should be an integral part of each visit per the AAP "Guidelines for Health Supervision III" (1994).
14. See AAP *Pediatric Handbook of Nutrition* (1998) for a discussion of universal and selective screening options. Consider earlier screening for high risk infants (premature infants, low birth weight infants). Also see "Recommendations to Prevent and Control Iron Deficiency in the United States" *MMWR*, 1998; 47 (RR-3):1-29.
15. By law, these newborn tests should be initiated before the child is discharged from the hospital.
16. If the child was born in a Michigan hospital on or after October 1, 1987, the test should have been performed on the newborn. For other children with all or some black heritage, the test is required prior to the child's 21st birthday unless electrophoresis for sickle cell was done when the child was at least six months of age and the results are known to the parent.
17. From birth to 12 years of age, refer to the AAP injury prevention program as described in *A Guide to Safety Counseling in Office Practice* (1994).
18. Age-appropriate nutrition counseling should be an integral part of each visit per the AAP *Pediatric Handbook of Nutrition* (1998).
19. Parents and caregivers shall be advised to place healthy infants on their backs when putting them to sleep. Side positioning is a reasonable alternative but carries a slightly higher risk of Sudden Infant Death Syndrome (SIDS). Consult the AAP statement "Changing Concepts of Sudden Infant Death Syndrome: Implications for Infant Sleeping Environment and Sleep Position" (RE9946), Pediatrics, Volume 105, Number 3, March 2000, pp. 650-656.
20. A urinalysis (at a minimum, via dipstick) for all children at five years of age and for sexually active male and female adolescents.
21. Violence prevention and management per AAP statement "The Role of the Pediatrician in Youth Violence Prevention in Clinical Practice and at the Community Level" (RE9832), Pediatrics, Volume 103, Number 1, January 1999, pp. 173-181.
22. Test high risk children per AAP statement "Cholesterol in Childhood" (RE9805), Pediatrics, Volume 101, January 1998, pp. 141-147. If a family history cannot be ascertained and other risk factors are present, testing is at the discretion of the provider.
23. Test high risk children every two years beginning at ten years of age (or at onset of puberty if it occurs at a younger age). Refer to the AAP statement "Type 2 Diabetes in Children and Adolescents, Consensus Statement of the American Diabetes Association" in Pediatrics, Volume 105, March 2000, pp. 671-680.
24. All sexually active females (high risk) shall have a pelvic exam and Pap smear. A pelvic exam, breast exam, and Pap smear should be offered to all females beginning at 18 years of age.
25. All sexually active patients (high risk) shall be screened for sexually transmitted diseases (STDs).
26. Test high risk children according to the current edition of the AAP Red Book: Report of the Committee on Infectious Diseases. Based on standards of good practice, Mantoux testing is the preferred method.
27. Medicaid children are considered high risk and shall be tested accordingly. Information relative to testing, treatment, and referrals may be obtained by calling the Childhood Lead Poisoning Prevention Program at (517) 335-8885.

If any problems are detected or suspected, a referral should be made.

If a test is contraindicated at the time of appointment, it need not be performed; if the provider wishes to perform certain tests more frequently (e.g., take blood pressure at each visit, test an older child for blood lead), they may be provided; or if the child requires more frequent health checkups, they may be provided. If additional tests are required, they may be performed or referred, as appropriate.

Exhibit 2

STATE OF MICHIGAN

JOHN ENGLER
GOVERNOR

DEPARTMENT OF COMMUNITY HEALTH
LANSING

JAMES K. HAVEMAN, JR
DIRECTOR

Dear Beneficiary:

Our records show that you or your child(ren) may be due for, or may have missed, a very important health checkup or well child visit. These visits are for those under 21 years of age, and include services such as:

head-to-toe exam	lab tests (e.g., blood lead, diabetes)
needed immunizations (shots)	vision and hearing checks
blood pressure check	mental and physical developmental checks
nutrition review	referral to a dentist or other medical provider

These regular checkups may find health problems that you do not know about. Problems can often be treated at an early stage before they become more serious.

Please call your doctor to find out if anyone in your family is due for a well child visit or health checkup, and schedule it if needed.

- If you have trouble setting up this visit, your local health department can help you.
- If you need a ride to the well child visit, one is available through your local Family Independence Agency. Contact them as soon as you know the date and time of your appointment. They need advance notice to arrange for your transportation needs.
- If you have questions about this letter, please call **1-800-642-3195**.

You and your family are important to us. We want to help you stay in good health. To do this, we need your help. ***Please call your doctor today to find out if any of you are due for a well child visit or health checkup.***

Cordially,

James K. Haveman, Jr.

EPSDT-01-2002

Exhibit 2

A Hug Shows You Care

Free Health Checkups
Exámenes médicos gratuitos
فحوصات طبية مجانية

If you or your children haven't had a checkup recently, look at the schedule in this pamphlet and see when you need to visit your doctor for a checkup. Call your health plan or doctor to make a checkup appointment. If you need help getting an appointment with your doctor or dentist, call your local health department. They can make an appointment for you.

Regular checkups help your doctor know about changes in your or your children's health. Talk with your doctor about when and how often each member of your family under age 21 should get a health checkup.

A checkup can find problems you may not know about such as lead poisoning or hearing or vision problems. Early treatment may prevent you and your children from getting really sick later.

Checkups include:

- head-to-toe exam
- health history
- height, weight and head measurements
- check for normal growth and development
- blood pressure check
- needed immunizations (shots)
- health education and information
- nutrition history
- hearing and vision checks
- dental check
- blood lead testing and other lab tests, as needed
- referral to a dentist or other medical provider, as needed

To become and stay as healthy as possible, use this guide to schedule regular checkups:

Birth to 12 months:

- Newborn
- 2-4 days
- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months

15 months to 4 years:

- 15 months
- 18 months
- 24 months
- 3 years
- 4 years

5 to 10 years:

- 5 years
- 6 years
- 8 years
- 10 years

11 years and over:
Each year through the early 20s

Medicaid must assure necessary transportation. You can get help in getting a ride if:

- You do not have a way to get to and from a doctor or dentist visit or
- You do not have a way to get medical or dental items or services Medicaid covers.

In some cases, the rides you need must be approved in advance. If you belong to a Medicaid health plan, contact your plan. If you do not belong to a health plan, contact the Family Independence Agency (FIA).

Si usted o sus hijos son menores de 21 años de edad y tienen Medicaid, puede que ya sea tiempo para un examen médico.

Si usted o sus hijos no se han hecho un examen últimamente, consulte el plan indicado en este folleto y enterese de cuándo necesita ver a su doctor, para un examen médico. Llame a los representantes de su plan de salud o a su doctor para hacer una cita para su examen. Si necesita ayuda para obtener su cita con el doctor o con el dentista, llame al departamento de salud de su localidad. Ellos le pueden hacer la cita.

Los exámenes regulares permiten que su doctor se mantenga enterado de los cambios ocurridos en su salud o en la de sus hijos. Hable con su doctor sobre cuándo – y con qué frecuencia – cada miembro de su familia menor de 21 años debe tener un examen médico.

El examen médico puede descubrir problemas de cuya existencia que usted no esté enterado, tal como envenenamiento por plomo o problemas de la vista o de los oídos. El tratamiento temprano puede prevenir que usted o sus hijos se agraven más tarde.

Los exámenes médicos abarcan:

- Examen de cabeza a pies
- Historial de salud
- Estatura, el peso y la medida de la cabeza
- Verificación de crecimiento y desarrollo normales
- Revisión de la presión sanguínea

HEARING SCREENS – QUARTERLY REPORT

Time Period: _____ through _____

Health Department Name _____
Contact Person's Name _____ Telephone #_____
Medicaid Provider I.D. # _____

SCREENING TEST, PURE TONE, AIR ONLY					PURE TONE AUDIOMETRY (THRESHOLD), AIR ONLY			
Child's Medicaid I.D. #	D.O.B.	Date of Service	Referral Source*		Child's Medicaid I.D. #	D.O.B.	Date of Service	Referral Source*

_____ Total Number of Screening Tests, Pure Tone, Air Only

_____ Total Number of Pure Tone Audiometry (Threshold), Air Only

_____ Total Cost of Screening Tests Pure Tone, Air Only

_____ Total Cost of Pure Tone Audiometry (Threshold), Air Only

_____ Total Number of Hearing Screens

_____ Total Cost of Hearing Screens

Submit this form to: Department of Community Health, Attention: EPSDT, P.O. Box 30479, Lansing, MI 48909-7979

*Enter the name of the MHP, SHP, Fee-For-Service provider, or Head Start Agency.

Exhibit 3

Exhibit 4

VISION SCREENS – QUARTERLY REPORT

Time Period _____ through _____

Health Department Name _____

Contact Person's Name _____ Telephone #_____

Medicaid Provider I.D.# _____

Child's Medicaid I.D.#	D.O.B.	Date of Service	Referral Source*

_____ Total Number of Vision Screens

_____ Total Cost of Vision Screens

Submit this form to: **Department of Community Health**
Attention: EPSDT
P.O. Box 30479, Lansing, MI 48909-7979

*Enter the name of MHP, SHP, Fee-For-Service provider, or Head Start Agency

Exhibit 5 - Front

BLOOD LEAD SAMPLING REQUEST

Michigan Department of Community Health

Blood Lead Laboratory, PO Box 30035, Lansing, MI 48909

Submitter Clinic Code

Date Rec'd at MDCH

Instructions:

- Keep canary copy for your file.
- Type, or print using black ball point pen.
- Send white copy with specimens.
- Detailed instructions on reverse.

SUBMITTER INFORMATION

Physician or Agency

Medicaid Provider Type Number | Medicaid Provider ID#

Mailing Address | City | State | Zip

Area Code and Phone Number | Screening Date | County

CLIENT INFORMATION - COMPLETION REQUIRED TO MAINTAIN NECESSARY PROGRAM RECORDS

TUBE ID#

Last Name | First Name | M.I. | Birthdate | MDCH Specimen Number (MDCH Use ONLY)

Mailing Address | City | State | Zip | County | Area Code and Phone Number

Employer | Occupation | Social Security Number

Payment: ☐ Payment Enclosed ☐ Medicaid # ☐ Bill to Provider ☐ Exempt (must be pre-authorized) ☐ Headstart ☐ Grants or other funded programs

Sex: ☐ Male ☐ Female

Patient's Racial Group: ☐ White ☐ Asian/Pacific ☐ Black ☐ Other ☐ Native American ☐ Multiracial

Ethnic Notation (if appropriate): ☐ Hispanic ☐ Middle-Eastern

Level of Care: ☐ Qualified Health Plan ☐ Special Health Plan

EPSDT?: ☐ Yes ☐ No

Sample Type: ☐ CAPILLARY ☐ VENOUS

Is this the **first** sample ever submitted on this child to the MDCH lab? ☐ No ☐ Yes ☐ NA

Parent/Guardian Name | Parent/Guardian Social Security Number

MAIL ADDITIONAL COPY TO: (Local Health Dept. or Physician/HMO Name) | Mailing Address | City

State | ZIP Code | County | Area Code and Phone Number | Clinic Code

TUBE ID#

Last Name | First Name | M.I. | Birthdate | MDCH Specimen Number (MDCH Use ONLY)

Mailing Address | City | State | Zip | County | Area Code and Phone Number

Employer | Occupation | Social Security Number

Payment: ☐ Payment Enclosed ☐ Medicaid # ☐ Bill to Provider ☐ Exempt (must be pre-authorized) ☐ Headstart ☐ Grants or other funded programs

Sex: ☐ Male ☐ Female

Patient's Racial Group: ☐ White ☐ Asian/Pacific ☐ Black ☐ Other ☐ Native American ☐ Multiracial

Ethnic Notation (if appropriate): ☐ Hispanic ☐ Middle-Eastern

Level of Care: ☐ Qualified Health Plan ☐ Special Health Plan

EPSDT?: ☐ Yes ☐ No

Sample Type: ☐ CAPILLARY ☐ VENOUS

Is this the **first** sample ever submitted on this child to the MDCH lab? ☐ No ☐ Yes ☐ NA

Parent/Guardian Name | Parent/Guardian Social Security Number

MAIL ADDITIONAL COPY TO: (Local Health Dept. or Physician/HMO Name) | Mailing Address | City

State | ZIP Code | County | Area Code and Phone Number | Clinic Code

TUBE ID#

Last Name | First Name | M.I. | Birthdate | MDCH Specimen Number (MDCH Use ONLY)

Mailing Address | City | State | Zip | County | Area Code and Phone Number

Employer | Occupation | Social Security Number

Payment: ☐ Payment Enclosed ☐ Medicaid # ☐ Bill to Provider ☐ Exempt (must be pre-authorized) ☐ Headstart ☐ Grants or other funded programs

Sex: ☐ Male ☐ Female

Patient's Racial Group: ☐ White ☐ Asian/Pacific ☐ Black ☐ Other ☐ Native American ☐ Multiracial

Ethnic Notation (if appropriate): ☐ Hispanic ☐ Middle-Eastern

Level of Care: ☐ Qualified Health Plan ☐ Special Health Plan

EPSDT?: ☐ Yes ☐ No

Sample Type: ☐ CAPILLARY ☐ VENOUS

Is this the **first** sample ever submitted on this child to the MDCH lab? ☐ No ☐ Yes ☐ NA

Parent/Guardian Name | Parent/Guardian Social Security Number

MAIL ADDITIONAL COPY TO: (Local Health Dept. or Physician/HMO Name) | Mailing Address | City

State | ZIP Code | County | Area Code and Phone Number | Clinic Code

Exhibit 5 - Back

INSTRUCTIONS FOR COMPLETING BLOOD LEAD SAMPLING REQUEST

When preparing the request form to be mailed to the laboratory, it is very important that the Submitter and Client information sections are completely and properly filled out.

- Do not write in the shaded areas of the form.
- All information must be typed or printed legibly with ink.
- The request form is set up to include only three client names. To reduce any confusion, do not put more than three (3) names on a request.
- Where possible, include data for children from the same family on the same form.
- Be sure to keep the canary copy of the request form for your clinic records.

SUBMITTER INFORMATION

Clinic Code - If you do not have a clinic code, contact the MDCH Lead Laboratory at (517) 335-8244 prior to sample submission.

Submitter - The submitter is the service provider who collected the sample. The submitter's complete name, Medicaid provider type, Medicaid ID number, and complete address (including zip code) where the results are to be sent must be included. If using an address stamp, be sure that all copies of the request form are stamped.

Phone Number - It is critical that the complete phone number (including area code) is filled out so that the laboratory can contact the provider in case of problems. Including your fax number below the phone number will be helpful in an emergency.

Screening Date - Enter the date the sample is drawn. Information is necessary to meet Federal regulations.

County - Necessary for completing provider directory information.

CLIENT INFORMATION

Client - The client information includes:

- the last name, first name, middle initial (M.I.), and birthdate
- complete mailing address, county, area code and phone number
- employer and occupation (fill in if appropriate), and social security number
- sex, racial group, ethnic notation, and visit type, check appropriate box
- level of care (LOC), check appropriate box
- EPSDT - Is this test being performed as part of an EPSDT Well Child visit?

Payment - Mark appropriate method of payment box. For payment enclosed box, make checks payable to the State of Michigan. Insurance companies can not be billed. Provider (submitter) may be billed on a monthly basis. For a Medicaid insured child mark only the Medicaid box and enter his/her 8 digit ID number (do not enter the case number).

Sample Type - The sample type should be given as either a capillary sample or a venous sample.

Note: Please place information for venous and capillary samples on separate Blood Lead Sampling Request forms. This allows the laboratory to process confirmatory venous samples as first priority.

First Sample Ever Submitted - Check appropriate response. "NA" means information is not available.

Parent/Guardian - It is important that the parent or guardian's name and social security number also be recorded in order to be able to contact the responsible adult caring for the child.

Mail Additional Copy To - If different than the submitter, enter information about the physician or agency requesting test results: name; complete address; area code and phone number; and clinic code.

TUBE ID# - A double identifier is required to be attached to each capillary or venous tube. In addition to the clients first and last name, assign a random/identifying number to each specimen and record here and on tube.

Exhibit 6

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
BLOOD LEAD ANALYSIS REPORT
DATA/INFORMATION REQUIRED BY ADMINISTRATIVE RULE # R 325.9082 and R 325.9083

I. PATIENT INFORMATION

Last Name _____ First Name _____ Initial _____

Address _____ City _____ State _____ ZIP Code _____ County _____

( ) -
Area Code and Phone Number _____

Date of Birth _____ Patient's Social Security Number _____ Does this child have Medicaid? ☐ yes ☐ no

Sex
☐ Male
☐ Female

Race
☐ Native American (1)
☐ Asian/Pacific Islander (2)
☐ Black (3)
☐ White (5)
☐ Multiracial (7)

Ethnic Group
☐ Hispanic (1)

Parent/Guardian Name (please print) _____

Parent/Guardian Social Security Number _____ If Patient is an adult, list Employer _____

II. PHYSICIAN/PROVIDER INFORMATION

Physician or Clinic Name _____

Mailing Address _____ City _____ State _____ Zip Code _____

Area Code and Phone Number _____

IIa. SPECIMEN COLLECTION INFORMATION
To be Completed by Person who draws Specimen

Specimen Collection Date _____ Type of Specimen: ☐ Capillary ☐ Venous

III. LABORATORY INFORMATION
Completion required by testing laboratory

Specimen Number _____

BLOOD LEAD LEVEL_____MICROGRAMS PER DECILITER

Date of Analysis _____

Laboratory Name _____

Area Code and Phone Number _____

MDCH - Childhood Lead Poisoning Prevention Project, 3423 N. M.L. King, Jr. Blvd., Lansing, MI 48909 (517) 335-8885
Fax Number (517) 335-8509
DCH-0395 Lead\clplead.frm 6/98 Authority: Act 368, PA 1978

BLOOD LEAD DRAWS – QUARTERLY REPORT

Time Period: _____ through _____

Health Department Name _____
Contact Person's Name _____ Telephone #_____
Medicaid Provider I.D. # _____

CAPILLARY DRAWS					VENIPUNCTURE DRAWS			
Child's Medicaid I.D. #	D.O.B.	Date of Service	Referral Source*		Child's Medicaid I.D. #	D.O.B.	Date of Service	Referral Source*

_____ Total Number of Capillary Draws

_____ Total Number of Venipuncture Draws

_____ Total Cost of Capillary Draws

_____ Total Cost of Venipuncture Draws

_____ Total Number of Blood Lead Draws

_____ Total Cost of Blood Lead Draws

Submit this form to: Department of Community Health, Attention: EPSDT, P.O. Box 30479, Lansing, MI 48909-7979

*Enter the name of the MHP, SHP, or Fee-For-Service provider.

Exhibit 7

Exhibit 8 - Front

BLOOD LEAD TESTING, HEARING, and VISION SCREENING - ANNUAL COST REPORT
By Local Health Department

Michigan Department of Community Health

Report For:

Local Health Department Name		
Address (Number and Street, etc.)		
City	State	ZIP Code
Medical Director's Name		
REPORTING PERIOD: **From:**	**To:**	

Individual who can be contacted if information is needed concerning details of this report:

Person's Name	Title
Telephone Number ( )	FAX Number ( )
E-Mail Address:	

Certification by Officer or Administrator of Local Health Department:

I certify that I have examined this report for the period noted above, and it is a true, correct, and complete statement prepared from the records of the Local Health Department in accordance with applicable instructions.	
Signature (Officer or Administrator of Local Health Department)	
Title	Date Signed

INSTRUCTIONS:

- Send this completed report form to:

  HOSPITAL AND HEALTH PLAN REIMBURSEMENT DIVISION
  DEPARTMENT OF COMMUNITY HEALTH
  PO BOX 30479
  LANSING MI 48909-7979

- This cost report is **DUE 5 months** after your fiscal year end.

AUTHORITY:	PA 336 of 1998 and State Medicaid Manual section 5123.2.
COMPLETION:	Is Voluntary, but is required if Medical Assistance program payment is desired.

The Department of Community Health is an equal opportunity employer, services, and programs provider.

Exhibit 8 - Back

BLOOD LEAD TESTING, HEARING, and VISION SCREENING - ANNUAL COST REPORT
By Local Health Department

Michigan Department of Community Health

Report For:

Local Health Department Name	
REPORTING PERIOD: **From:**	**To:**

A. Capillary Draws:

1. Total Capillary Draws (All Children)	
2. Medicaid Capillary Draws (Medicaid Children)	
3. Cost per Capillary Draw	$
4. Total Medicaid Cost of Capillary Draws (Line 2 times Line 3)	$

B. Venipuncture Draws:

5. Total Venipuncture Draws (All Children)	
6. Medicaid Venipuncture Draws (Medicaid Children)	
7. Cost per Venipuncture Draw	$
8. Total Medicaid Cost of Venipuncture (Line 6 times Line 7)	$

C. Hearing Screens – Pure Tone – Air Only:

9. Total Air Only Hearing Screens (All Children)	
10. Medicaid Air Only Hearing Screens (Medicaid Children)	
11. Cost per Air Only Hearing Screen	$
12. Total Medicaid Cost of Air Only Hearing Screens (Line 10 times Line 11)	$

D. Pure Tone Audiometry (Threshold):

13. Total Pure Tone Screens (All Children)	
14. Medicaid Pure Tone Screens (Medicaid Children)	
15. Cost per Pure Tone Screen	$
16. Total Medicaid Cost of Pure Tone Screens (Line 14 times Line 15)	$

E. Vision Screens:

17. Total Vision Screens (All Children)	
18. Medicaid Vision Screens (Medicaid Children)	
19. Cost per Vision Screen	$
20. Total Medicaid Cost of Vision Screens (Line 18 times Line 19)	$

F. TOTALS:

21. Total Amount Due (Sum of Lines 4, 8, 12, 16, and 20)			$
22. PAYMENTS MADE DURING REPORTING PERIOD:			
Provider Number **(A)**	Date of Payment **(B)**	Payment Amount **(C)**	
a)			
b)			
c)			
d)			
23. Total Payments Made (Sum of Column **C**, Lines **a, b, c,** and **d**)			$
24. Net Amount Due Local Health Department (Line 21 minus Line 23)			$

Exhibit 9

ASSURANCE OF SERVICE PROVISION FOR BLOOD LEAD TESTING

This is to certify that as health officer of a local health department, I will assure that environmental investigations provided by this department as blood lead poisoning follow-up services will be conducted by qualified staff according to Medicaid published policies and procedures.

INSTRUCTIONS:

- **Photocopy this form**, complete it, then mail it to the address below:

  PROVIDER ENROLLMENT
  MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
  PO BOX 30238
  LANSING MI 48909

- A handwritten signature IS REQUIRED.

Enter all **Medicaid ID Numbers** under which blood lead poisoning follow-up services will be billed: *(Please Type or Print)*

Medicaid ID Number	Physician Name
Medicaid ID Number	Physician Name
Medicaid ID Number	Physician Name

Name of Local Health Department	Telephone Number
Address (Number and Street, City, State, ZIP Code)	

Handwritten Signature of Health Officer	Date Signed
Printed Name of Health Officer	

AUTHORITY:	Title XIX of the Social Security Act	The Department of Community Health is an equal opportunity employer, services, and programs provider.
COMPLETION:	Is voluntary, but is required if Medical Assistance Program payment is desired.	

MSA-1530 (Rev. 3/01) (W) Previous Edition Obsolete

FORM HCFA-416: ANNUAL EPSDT PARTICIPATION REPORT

State _____ FY_____		Age Groups							
		Total	<1	1 – 2*	3 – 5	6 – 9	10 – 14	15 – 18	19 - 20
1. Total Individuals Eligible for EPSDT	CN								
	MN								
	Total								
2.a State Periodicity Schedule									
2.b Number of Years in Age Group			1	2	3	4	5	4	2
2.c Annualized State Periodicity Schedule									
3.a Total Months of Eligibility	CN								
	MN								
	Total								
3.b Average Period of Eligibility	CN								
	MN								
	Total								
4. Expected Number of Screenings per Eligible	CN								
	MN								
	Total								
5. Expected Number of Screenings	CN								
	MN								
	Total								
6. Total Screens Received	CN								
	MN								
	Total								
7. Screening Ratio	CN								
	MN								
	Total								

* Includes 12-month visit

NOTE: "CN" = Categorically Needy
"MN" = Medically Needy

FORM HCFA-416: ANNUAL EPSDT PARTICIPATION REPORT

State _____ FY_____

		Age Groups							
		Total	<1	1 – 2*	3 – 5	6 – 9	10 – 14	15 – 18	19 - 20
8. Total Eligibles Who Should Receive at Least One Initial or Periodic Screening	CN								
	MN								
	Total								
9. Total Eligibles Receiving at Least One Initial or Periodic Screen	CN								
	MN								
	Total								
10. PARTICIPANT RATIO	CN								
	MN								
	Total								
11. Total Eligibles Referred for Corrective Treatment	CN								
	MN								
	Total								
12.a Total Eligibles Receiving Any Dental Services	CN								
	MN								
	Total								
12.b Total Eligibles Receiving Preventive Dental Services	CN								
	MN								
	Total								
12.c Total Eligibles Receiving Dental Treatment Services	CN								
	MN								
	Total								
13. Total Eligibles Enrolled in Managed Care	CN								
	MN								
	Total								
14. Total Number of Screening Blood Lead Tests	CN								
	MN								
	Total								

* Includes 12-month visit

NOTE: "CN" = Categorically Needy
"MN" = Medically Needy

FORM HCFA-416

Exhibit 10 - Back