

**Bulletin Number:** MSA 14-30

**Distribution:** All Providers

**Issued:** October 9, 2014

**Subject:** Addition of Early and Periodic Screening, Diagnosis and Treatment Chapter to the Medicaid Provider Manual

**Effective:** December 1, 2014

**Programs Affected:** Medicaid, Healthy Michigan Plan

The purpose of this bulletin is to announce the addition of an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Chapter to the Medicaid Provider Manual. The chapter enables providers to locate information more efficiently. The layout of the EPSDT chapter follows the order of the periodicity schedule by the American Academy of Pediatrics (AAP). Pending implementation of project #1435-Dental, revisions will be made to the chapter.)

Federal regulations require state Medicaid programs to offer EPSDT to eligible Medicaid beneficiaries younger than 21 years of age. The intent of EPSDT is to correct or ameliorate defects and conditions discovered through the screening services. EPSDT visits and follow-up services are covered by Medicaid.

The periodicity schedule by the AAP was updated to include changes of previously endorsed ages and recommendations, and includes additions of new screenings and testing procedures. The 2014 version of the periodicity schedule by the AAP can be found at: <http://brightfutures.aap.org>. The EPSDT chapter incorporates the following changes made as part of the AAP's 2014 recommendations:

- Depression: Annual screening for depression from 11 through 20 years of age was added, along with suggested screening tools.
- Dyslipidemia screening: An additional screening between 9 and 11 years of age and between 17 and 21 years of age was added.
- Sexually transmitted infection/ human immunodeficiency virus (STI/HIV) screening: A screen for HIV was added for youths between 16 and 18 years of age.
- Cervical dysplasia: Females younger than 21 years of age should no longer be routinely screened for cervical dysplasia.
- Critical Congenital Heart Disease: Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital.

Previously, children were identified as having a blood lead "level of concern" if the test result was 10 or more micrograms per deciliter ( $\mu\text{g}/\text{dL}$ ). A new reference level of 5  $\mu\text{g}/\text{dL}$  is now used to identify children with elevated blood lead levels. Screening for cervical cancer is no longer recommended for females younger than 21 years of age except in cases when the female is at risk for certain conditions.

## Manual Maintenance

Retain this bulletin until the information has been incorporated into the Michigan Medicaid Provider Manual.

## Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at [ProviderSupport@michigan.gov](mailto: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.

## Approved

A handwritten signature in black ink that reads "Stephen Fitton". The signature is written in a cursive, flowing style.

Stephen Fitton, Director  
Medical Services Administration

## EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT

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**SECTION 1 – GENERAL INFORMATION**

Federal regulations require state Medicaid programs to offer early and periodic screening, diagnosis, and treatment (EPSDT) services to Medicaid eligible beneficiaries younger than 21 years of age; however, beneficiary participation is voluntary. The intent of EPSDT is to correct or ameliorate defects and physical and mental illnesses and conditions discovered by screening services. Accordingly, EPSDT well child visits and any needed follow-up services are covered by Medicaid.

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

- Well child visits, including immunizations and developmental screening, using a validated and standardized screening tool at specified intervals as defined in the periodicity schedule by the American Academy of Pediatrics (AAP) (hereafter referred to as the “AAP periodicity schedule”). A copy of the AAP periodicity schedule is available on the AAP website. (Refer to the Directory Appendix for website information.)

**NOTE:** The AAP periodicity schedule requires a risk assessment to be performed for vision, hearing, and blood lead screening at the specified intervals. Michigan Department of Community Health (MDCH) requires vision, hearing, and blood lead testing to be performed at the specific ages indicated on the AAP periodicity schedule. A parent/guardian (or person in loco parentis) applying to register a child for the first time in kindergarten or first grade in a school in this state shall present to school officials, at the time of registration or no later than the first day of school, a certificate of hearing and vision testing or screening or a statement of exemption. Refer to the appropriate section within this chapter for MDCH requirements regarding vision, hearing, and blood lead screening.

- Referrals for:
  - Other preventive health care;
  - Medically necessary follow-up services to treat detected conditions; and
  - Transportation for health care services.

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**SECTION 2 – AAP PERIODICITY SCHEDULE AND COMPONENTS**

The AAP periodicity schedule and its components are available on the AAP website, and they are to be followed for well child visits. (Refer to the Directory Appendix for AAP website information.)

Head Start agencies are directed by federal regulation to meet state EPSDT standards for health screening. MDCH urges providers to cooperate with these agencies. If providers receive authorization, results of well child visits may be shared with Head Start agencies.

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

The following sections follow the AAP periodicity schedule and are meant to provide further guidance to providers. The sections include additional policies and procedures to be performed that are beyond the AAP periodicity schedule guidelines.

### **SECTION 3 – HISTORY AND WELL CHILD VISITS**

An initial history must be obtained for each new patient at the first well child visit, with an update (interval history) at each subsequent well child visit. MDCH supports the concept of a medical home for each Medicaid beneficiary. A medical home is a primary care provider (PCP) who assumes responsibility for assuring the overall care of a beneficiary, and for the maintenance and updating of a beneficiary's medical record. When a PCP accepts a child in a primary care relationship, the provider takes responsibility for arranging or providing EPSDT well child visits.

Well child visits are the health check-ups, newborn, well baby, and well child exams represented by appropriate Current Procedural Terminology (CPT) preventive medicine services procedure codes and are used in conjunction with International Classification of Diseases (ICD) diagnosis codes V20.0 - V20.2, V70.0, and/or V70.3 - V70.9.

The AAP periodicity schedule indicates all components and age-specific indicators for performing the various components. Developmental screening, using an objective validated and standardized screening tool as recommended by the AAP, should be performed at the specified intervals.

## **SECTION 4 – MEASUREMENTS**

### **4.1 LENGTH/HEIGHT AND WEIGHT**

Length, height, and weight must be measured using standardized techniques each time the PCP conducts a well child visit, with good practice requiring graphing of the measurements. A suitable graphing document may be found on the Centers for Disease Control and Prevention (CDC) website. (Refer to the Directory Appendix for website information.)

### **4.2 HEAD CIRCUMFERENCE**

A head circumference measurement is required at each well child visit through 24 months of age.

### **4.3 WEIGHT FOR LENGTH**

Weight for length must be measured each time the PCP conducts a well child visit through 18 months of age, with good practice requiring graphing of the measurements. A suitable graphing document may be found on the CDC website. (Refer to the Directory Appendix for website information.)

### **4.4 BODY MASS INDEX (BMI)**

Body mass index (BMI) must be measured each time the PCP conducts a well child visit for children 24 months of age and older, with good practice requiring graphing of the measurements. A suitable graphing document may be found on the CDC website. (Refer to the Directory Appendix for website information.)

### **4.5 BLOOD PRESSURE**

PCPs must obtain a blood pressure reading at each well child visit beginning at 3 years of age. Blood pressure measurement in infants and children with specific risk conditions should be performed at well child visits before 3 years of age.

## **SECTION 5 – SENSORY SCREENING**

### **5.1 VISION SCREENING**

PCPs must perform a subjective vision screening (i.e., by history) at each well child visit. For asymptomatic children 3 years of age and older, an objective screening must occur as indicated on the AAP periodicity schedule. For children of any age, referral to an optometrist or ophthalmologist must be made if there are symptoms or other medical justification (e.g., parent/guardian has suspicions about poor vision in the child). The AAP requires a vision risk assessment at each well child visit. MDCH requires vision testing at specific well child visits for children 3 years of age and older.

#### **5.1.A. PRESCHOOL**

Due to behavior and comprehension ability of children younger than 3 years of age, the standard screening is subjective. An objective screening should begin at 3 years of age. An objective vision screening is accomplished using a standardized screening tool and may be performed on Medicaid eligible preschool-age children each year beginning at 3 years of age through 6 years of age by qualified Local Health Department (LHD) staff. If the child is uncooperative, the screening should be re-administered within six months. LHDs may provide objective vision screening services and accept referrals for screening from the PCP and from Head Start agencies. In an effort to promote communication with the child's medical home, the objective vision screening results must be reported to the child's PCP. In the event the LHD is unable to report the objective vision screening results to the child's PCP, the LHD must clearly document why this could not be accomplished. If the LHD receives authorization, the results may be shared with the Head Start agency if that agency was the referral source.

#### **5.1.B. SCHOOL AGE**

A subjective vision screening must be performed at each well child visit; an objective screening shall be performed as indicated on the AAP periodicity schedule.

#### **5.1.C. PERIODICITY SCHEDULE FOR VISION SCREENING**

A vision screening is to be performed at 3, 4, 5, 6, 8, 10, 12, 15, and 18 years of age. A risk assessment is to be performed, with appropriate action to follow if positive, for newborns and during the ages of:

- 3 to 5 days
- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 24 months
- 30 months
- 7 years
- 9 years
- 11 years
- 13 years
- 14 years
- 16 years
- 17 years
- 19 years
- 20 years

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## **5.2 HEARING SCREENING**

Providers must perform a subjective hearing screening (i.e., by history) at each well child visit. For asymptomatic children 4 years of age and older, an objective screening must occur as indicated on the AAP periodicity schedule. The AAP requires a hearing risk assessment at each well child visit.

### **5.2.A. NEWBORNS/INFANTS**

All newborns must be screened using evoked otoacoustic emissions (EOAE) and/or auditory brainstem response (ABR) methods. The hospital must provide newborn hearing screenings for Medicaid-covered newborns as indicated by the AAP. If the newborn fails the first screening, another screening must be conducted prior to the newborn's discharge. Coverage for the EOAE and ABR newborn hearing screenings is included within the applicable diagnosis related group (DRG) payment for the newborn's inpatient stay. If the hospital is not equipped for EOAE and/or ABR, the newborn's PCP must be made aware of this fact by the hospital so the newborn can be referred for a hearing screening prior to 1 month of age.

For infants who do not pass ABR testing in the neonatal intensive care unit (NICU), a referral should be made directly to an audiologist for rescreening and, when indicated, a comprehensive evaluation including ABR. For rescreening, a complete screening on both ears is recommended, even if only one ear failed the initial screening. For readmissions in the first month of life for all infants, when there are conditions associated with potential hearing loss, a repeat hearing screening is recommended before discharge. All infants who do not pass the initial hearing screening and the subsequent rescreening should have appropriate audiological and medical evaluations to confirm the presence of hearing loss at no later than 3 months of age. All infants with confirmed permanent hearing loss should receive early intervention as soon as possible after diagnosis but at no later than 6 months of age.

The results of all hearing tests and screenings conducted on infants who are younger than 12 months of age must be reported to the MDCH Early Hearing Detection and Intervention (EHDI) program. The Audiological/Medical Follow-up Services Report form (DCH-0120) is to be completed and shall include the type, degree, and symmetry of the diagnosis, along with where and when the diagnosis was made. The form is to be submitted to the EHDI program. (Refer to the Directory Appendix for contact and form information.)

### **5.2.B. PRESCHOOL**

A subjective hearing screening (i.e., by history) must be performed at each well child visit. An objective hearing screening may be performed on Medicaid eligible preschool-age children by qualified LHD staff. LHDs may provide objective hearing screening services and accept referrals for screening from the PCP and from Head Start agencies. In an effort to promote communication with the child's medical home, the objective hearing screening results must be reported to the child's PCP. In the event the LHD is unable to report the objective hearing screening results to the child's PCP, the LHD must clearly document why this could not be accomplished. The results of all hearing tests and screens conducted on children who have been diagnosed with hearing loss who are

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younger than 3 years of age must be reported to the EHDI program. If the LHD receives authorization, the results may be shared with the Head Start agency if that agency was the referral source.

**5.2.C. SCHOOL AGE**

A subjective hearing screening (i.e., by history) must be performed at each well child visit. Children with symptoms or risk factors should be referred to a hearing center, audiologist, otologist, or CSHCS-sponsored otology clinic at a LHD for further objective testing or diagnosis.

**5.2.D. ALL AGES**

For children of any age, a subjective hearing screening (i.e., by history) must be performed at each well child visit. A referral to a hearing center, audiologist, otologist, or CSHCS-sponsored otology clinic at a LHD should be made if there are symptoms (e.g., parent/guardian 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.

**5.2.E. PERIODICITY SCHEDULE FOR HEARING SCREENING**

A hearing screening is to be performed for newborns and during 4, 5, 6, 8, and 10 years of age. A risk assessment is to be performed, with appropriate action to follow if positive, within 3 to 5 days of birth and during the ages of:

- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 24 months
- 30 months
- 3 years
- 7 years
- 9 years
- 11 years
- 12 years
- 13 years
- 14 years
- 15 years
- 16 years
- 17 years
- 18 years
- 19 years
- 20 years

## **SECTION 6 – DEVELOPMENTAL/BEHAVIORAL ASSESSMENT**

A developmental/behavioral assessment is required at each scheduled EPSDT well child visit from birth through adolescence as recommended by the AAP periodicity schedule. The PCP should screen all children for developmental and behavioral concerns, including engaging in risky behavior, using a validated and standardized screening tool as indicated by the AAP periodicity schedule.

A maximum of three objective standardized screenings may be performed in one day for the same beneficiary by a single provider. (Refer to the Billing & Reimbursement for Professionals Chapter for billing instructions.) If the screening is positive or suspected problems are observed, further evaluation must be completed by the PCP, or the child should be referred for a prompt follow-up assessment to identify any further health needs. The provider may administer additional screenings, surveillance, or assessments as described in the following subsections.

### **6.1 DEVELOPMENTAL SCREENING**

A developmental screening using an objective validated and standardized screening tool must be performed following the AAP periodicity schedule at 9, 18 and 30 (or 24) months of age, and during any other preventive health care well child visits when there are parent/guardian and/or provider concerns. Developmental screening may be accomplished by using a validated and standardized developmental screening tool such as the Ages and Stages Questionnaire (ASQ) or Parents' Evaluation of Developmental Status (PEDS). If the screening is positive, PCPs should further evaluate the child, provide counseling, and refer the child as appropriate.

### **6.2 AUTISM SCREENING**

A validated and standardized screening tool must be administered as part of the well child visit by a physician. Proper assessment of autism is accomplished by administering a validated and standardized screening tool, such as the Modified Checklist for Autism in Toddlers (M-CHAT), at 18 and 24 months of age as indicated by the AAP periodicity schedule. Surveillance for Autism Spectrum Disorder (ASD) must be completed during other well child visits beginning at 12 months of age by listening for parent/guardian concerns and by watching for red flag abnormalities, such as no babbling by 12 months of age. Children 24 months of age and older who have not been screened may be screened during preventive health care well child visits using a validated and standardized screening tool such as the M-CHAT or the Social Communication Questionnaire (SCQ).

The screening tool may be completed by the parent/guardian and reviewed/verified by the PCP. The M-CHAT is validated for children 16 through 30 months of age. For children 4 years of age and older (mental age greater than 2 years of age), the SCQ may be utilized. For children 30 months through 4 years of age, the more applicable of the two screening tools should be administered (M-CHAT if mental age is younger than 2 years of age; SCQ if mental age is greater than 2 years of age). If the screening is positive, the PCP should contact the Pre-paid Inpatient Health Plan (PIHP) directly to arrange for a follow-up evaluation. (Refer to the Directory Appendix for the National Autism Center contact information and for additional resources regarding ASD.)

### **6.3 DEVELOPMENTAL SURVEILLANCE**

Developmental surveillance should occur at every well child visit throughout childhood and must be performed as indicated by the AAP periodicity schedule. Developmental surveillance includes eliciting and attending to parent/guardian concerns, maintaining a developmental history, making accurate and informed observations of the child, identifying the presence of risk and protective factors, and documenting the process and findings. Further investigation, an appropriate referral, and/or an early return visit should be scheduled for children whose surveillance raises concerns that are not confirmed by a developmental screening tool.

### **6.4 PSYCHOSOCIAL/BEHAVIORAL ASSESSMENT**

Children should be observed to detect psychosocial and behavior issues. A psychosocial/behavioral assessment should occur during every well child visit and may be accomplished by surveillance or by using a validated and standardized screening tool such as the Ages and Stages Questionnaire – Social-Emotional (ASQ-SE) or Pediatric Symptom Checklist (PSC), with appropriate action to follow if the assessment is positive. The use of validated and standardized screening tools improves the detection rate of social-emotional problems in children compared to the reliance on subjective clinical judgment. Social-emotional screening for children from birth to 5 years of age should be performed whenever there are general development delays; at any time the clinician observes poor growth, poor attachment, or symptoms such as excessive crying, clinginess, or fearfulness for developmental stage, or regression to earlier behavior; and/or at any time the parent/guardian identifies psychosocial/behavioral concerns. If the assessment is positive, the PCP should further evaluate the child, provide counseling, and refer the child as appropriate. Refer to the Children in Foster Care Section of this chapter for more information regarding the administration of a psychosocial/behavioral assessment for children in foster care.

### **6.5 ALCOHOL AND DRUG USE ASSESSMENT**

An alcohol and drug use assessment must be performed annually at each preventive health care well child visit beginning at 11 years of age or when there are circumstances suggesting the possibility of substance abuse beginning at an earlier age. A risk assessment should be administered and, if necessary, the child should be screened for tobacco, alcohol, and other drug use with a validated and standardized screening tool, such as the CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble) screen. If the assessment and screening are positive, the PCP should further evaluate the child, provide counseling, and refer the child as appropriate.

### **6.6 DEPRESSION SCREENING**

A depression screening is to be performed annually for all children and adolescents who are 11 years of age and older as indicated by the AAP periodicity schedule. A depression screening may be accomplished using a standardized screening tool such as the Patient Health Questionnaire-2 (PHQ-2), Patient Health Questionnaire (PHQ-9), or other screening tools available in the Guidelines for Adolescent Depression in Primary Care (GLAD-PC) toolkit and the Mental Health Screening and Assessment Tools for Primary Care. (Refer to the Directory Appendix for website information.)

## **SECTION 7 – PHYSICAL EXAMINATION**

A complete physical examination must be performed at each well child visit. Infants are to be totally unclothed and older children must be undressed and suitably draped. If the patient is an adolescent or young adult and the examination requires inspection or palpation of anorectal or genital areas and/or the female breast, a chaperone is recommended. The use of a chaperone should be a shared decision between the patient and the PCP. If the patient declines the use of a chaperone, the provider should document this fact in the medical record. The purpose of the well child examination is to promote health, detect medical problems, and to counsel in order to prevent injury and future health problems. The physical examination also provides opportunities to educate children, adolescents, and their parents/guardians about the body and the growth and development process. The physical examination must be comprehensive and appropriate for the infant's, child's, or adolescent's age, gender, and developmental status, and should build on the history gathered during previous medical and well child visits. The provider should review the scope and findings of the examination with the patient and parents/guardians at the completion of the examination. This review should be documented in the medical record.

## **SECTION 8 – PROCEDURES**

### **8.1 NEWBORN BLOOD SCREENING**

A provider in charge of the care of a newborn child shall administer or cause to be administered to the newborn child a newborn blood screening test. Hospitals must test newborns for over 50 disorders as indicated by the AAP periodicity schedule and as required by Michigan law. The complete list of disorders is determined by MDCH. If the results of a test administered are positive, the results shall be reported to the newborn child's parents/guardians. Blood samples are to be sent to the MDCH Bureau of Laboratories Newborn Screening Section. If further sickle cell testing is appropriate, a capillary blood sample may be mailed to the Sickle Cell Disease Association of America, Michigan Chapter (SCDAA-MI). Tubes, forms, and envelopes may be obtained from SCDAA-MI. (Refer to the Directory Appendix for contact information.)

### **8.2 CRITICAL CONGENITAL HEART DEFECT SCREENING**

A critical congenital heart defect (CCHD) screening is to be administered to the newborn child as indicated by the AAP periodicity schedule. The screening should not be performed until 24 hours after the birth of the child and should be performed as late as possible if an early discharge is planned in order to reduce the number of false positive results. The screening should be performed with motion-tolerant pulse oximeters using either disposable or reusable pulse oximetry probes.

Oxygen saturations should be obtained from the right hand and one foot. Screening that has a pulse oximetry reading of  $\geq 95\%$  in either extremity with a  $\leq 3\%$  absolute difference between the upper and lower extremity is considered a passing result. It is recommended that repeated measurements be performed in those cases in which the initial screening result was positive in an effort to reduce false-positive results. Infants with saturations  $< 90\%$  should receive an immediate evaluation. It is important to note that the oxygen saturation thresholds for a positive screening result may vary at high altitude. If the screening is positive, CCHD needs to be excluded with a diagnostic echocardiogram. Infectious and pulmonary causes of hypoxemia should also be excluded. Every hospital is required to report each newborn's pulse oximetry screening results to the Newborn Screening Program. (Refer to the Directory Appendix for contact information.)

### **8.3 IMMUNIZATIONS**

A review of immunization status shall be performed at each well child visit, with immunizations administered according to recommendations and standards of practice recognized by the AAP and the Advisory Committee Immunization Practices (ACIP). Providers are reminded that all immunizations must be reported to the Michigan Care Improvement Registry (MCIR). (Refer to the Directory Appendix for contact information.)

Immunizations are covered when administered according to ACIP recommendations. MDCH encourages providers to immunize all Medicaid beneficiaries.

- For Medicaid eligible children 18 years of age and younger, the Vaccines for Children (VFC) Program provides covered immunizations at no cost to the provider.
- Medicaid covers immunizations for beneficiaries 19 years of age and older.
- Any LHD in the state can be contacted for specifics about the VFC program.

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For immunizations available free of charge under the VFC program, the amount a provider may charge for vaccine administration may be limited. Providers cannot charge more for services provided to Medicaid beneficiaries than for services provided to their general patient population. For example, if the charge for administering a vaccine to a private-pay patient is \$5.00, then the charge for immunization administration to the Medicaid beneficiary cannot exceed \$5.00.

Medicaid Health Plan (MHP) providers enrolled in the VFC program are encouraged to immunize and are discouraged from referring beneficiaries to a LHD for these services. (Refer to the Practitioner Chapter for additional information.)

#### **8.4 HEMATOCRIT OR HEMOGLOBIN**

The child's hematocrit or hemoglobin must be tested according to the AAP periodicity schedule.

#### **8.5 BLOOD LEAD SCREENING**

All children covered by Medicaid are considered at high risk for blood lead poisoning. The AAP periodicity schedule requires children to be tested for blood lead poisoning at 12 and 24 months of age. In addition, the Centers for Medicare & Medicaid Services (CMS) mandates that if a child is covered by Medicaid, is between 36 and 72 months of age, and has not been tested for blood lead, the child must be tested. The AAP also requires a blood lead risk assessment to be performed during specific visits as indicated by the AAP periodicity schedule. If the parent/guardian is unsure if the child was previously tested, the child must be tested.

For children who have been tested, the following questions are intended to assist the PCP 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 blood lead poisoning?
- Does the child live with an adult whose job or hobby involves lead? (The chart following these questions presents examples.)
- Does the child's family use any home remedies that may contain lead? (The chart following these questions presents examples.)

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Possible means of exposure to lead hazards:

Occupational	Hobbies	Environmental	Other
<ul style="list-style-type: none"> <li>▪ Battery manufacturing or repair</li> <li>▪ Bridge reconstruction worker</li> <li>▪ Chemical manufacturing</li> <li>▪ Construction worker</li> <li>▪ Glass manufacturing</li> <li>▪ Industrial machine operator</li> <li>▪ Migrant farm worker</li> <li>▪ Painting</li> <li>▪ Plastics manufacturing</li> <li>▪ Plumber, pipe fitter</li> <li>▪ Police officer</li> <li>▪ Printing</li> <li>▪ Radiator repair</li> <li>▪ Rubber products manufacturing</li> <li>▪ Steel welding and cutting</li> <li>▪ Vehicle repair</li> </ul>	<ul style="list-style-type: none"> <li>▪ Brass/copper/aluminum processing</li> <li>▪ Casting lead figures (e.g., toy soldiers)</li> <li>▪ Furniture refinishing</li> <li>▪ Jewelry and pottery making</li> <li>▪ Lead soldering (e.g., electronics)</li> <li>▪ Making lead shot, fishing sinkers, bullets</li> <li>▪ Painting</li> <li>▪ Stained glass making</li> <li>▪ Target shooting at firing ranges</li> <li>▪ Vehicle repair</li> </ul>	<ul style="list-style-type: none"> <li>▪ Burning lead-painted wood</li> <li>▪ Ceramic ware/pottery</li> <li>▪ Lead crystal</li> <li>▪ Lead-soldered cans (imported)</li> <li>▪ Lead paint</li> <li>▪ Lead-painted homes</li> <li>▪ Living near lead-related industries</li> <li>▪ Renovating/remodeling older homes</li> <li>▪ Soil/dust near industries and roadways</li> <li>▪ Use of water from lead pipes</li> </ul>	<ul style="list-style-type: none"> <li>▪ Asian cosmetics</li> <li>▪ Folk remedies and/or food additives (e.g., Greta, Azarcon, pay-loo-ah, ghasard, Hai ge fen, Bali Goli, Kandü, Kohl, X-yoo-Fa, Mai ge fen, poying tan, lozeena)</li> </ul>

Publications and other materials concerning blood lead may be obtained from the MDCH Childhood Lead Poisoning Prevention Program. The MDCH Bureau of Laboratories – Trace Metals Section can also be contacted. (Refer to the Directory Appendix for contact information.)

There are providers in all areas of the state who have expertise in the treatment of blood lead and are available to discuss blood lead issues with other providers. Providers with questions concerning blood lead testing or treatment should contact the Childhood Lead Poisoning Prevention Program to obtain contact information for these providers. (Refer to the Directory Appendix for contact information.)

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 MDCH Bureau of Laboratories – Trace Metals Section or to any Michigan Medicaid-enrolled laboratory qualified to perform blood lead testing. If the MDCH Bureau of Laboratories – Trace Metals Section is used, blood lead testing supplies may be obtained from the laboratory. (Refer to the Directory Appendix for contact information.)

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

- If blood lead samples are sent to the MDCH Bureau of Laboratories – Trace Metals Section:
  - Providers must obtain a Submitter Clinic Code prior to sending blood lead samples
  - The “Blood Lead Test Requisition” form (DCH-0696) must be used

Providers may obtain a Submitter Clinic Code and a supply of DCH-0696 forms by contacting the MDCH Bureau of Laboratories – Trace Metals Section. (Refer to the Directory Appendix for contact information.)

- If blood lead samples are sent to a private laboratory or if the private laboratory draws and tests the sample, the provider must complete the MDCH “Blood Lead Analysis Report” form (DCH-0395) (obtained from the MDCH Childhood Lead Poisoning Prevention Program) or develop a form that includes all of the information from the DCH-0395 form and submit it to the laboratory. When testing is completed, the laboratory completes the required information and submits it to the blood lead registry.

PCPs are encouraged to draw blood in their offices for all children needing blood lead testing, but may refer children to a lab if necessary. There may be instances when a blood draw is not accomplished. If this occurs and the child resides in a jurisdiction where the LHD agrees to obtain a blood sample for blood lead testing, the PCP may refer a child to the LHD for the service. (Refer to the Local Health Department Chapter for additional information.)

The MDCH Bureau of Laboratories – Trace Metals Section reports all results to the child’s ordering provider if the information about the ordering provider is included. When ordering provider information is not included, results are sent to the appropriate LHD. All clinical laboratories in Michigan that analyze blood samples for lead shall report all blood lead results, rounded to the nearest whole number, to the MDCH Childhood Lead Poisoning Prevention Program/Community Public Health Agency (CLPPP/CPHA). Reports shall be made within five working days after test completion. If a blood lead test has been completed but is not displayed in the MCIR, the LHD or PCP should contact the MDCH CLPPP to report the blood lead results. (Refer to the Directory Appendix for contact information.)

**Recommendations on Medical Management of Childhood Lead Exposure and Poisoning\***

Blood Lead Level	Action
< 5 mcg/dL	<ul style="list-style-type: none"> <li>▪ Review lab results with family.</li> <li>▪ Repeat the blood lead level in 6-12 months if the child is at high risk or risk changes during the time frame.</li> <li>▪ For children screened at &lt;12 months of age, consider retesting in 3-6 months.</li> <li>▪ Perform routine health maintenance, including assessment of nutrition, physical and mental development, as well as iron deficiency risk factors.</li> <li>▪ Provide anticipatory guidance on common sources of environmental lead exposure: paint in homes built prior to 1978, soil near roadways or other sources of lead, take-home exposures related to adult occupations, imported spices, cosmetics, folk remedies, and cookware.</li> </ul>

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**Recommendations on Medical Management of Childhood Lead Exposure and Poisoning\***

Blood Lead Level	Action
5-14 mcg/dL	<ul style="list-style-type: none"> <li>▪ Perform steps as described above for blood lead levels &lt; 5 mcg/dL.</li> <li>▪ Obtain venous blood lead level within 1-3 months of the initial blood lead test to ensure the lead level is not rising. If it is stable or decreasing, retest the blood lead level in 3 months.</li> <li>▪ Refer the patient to the LHD to determine if blood lead poisoning follow-up services are available.</li> <li>▪ Perform an environmental history to identify potential sources of exposure and provide preliminary advice about reducing/eliminating exposure. Consider other children who may be exposed.</li> <li>▪ Provide nutritional counseling related to calcium and iron. Encourage the consumption of iron-enriched foods (e.g., cereals, meats). Some children may be eligible for the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) or other nutritional counseling. All children younger than 5 years of age and enrolled in Medicaid are eligible for the WIC Program.</li> <li>▪ Ensure iron sufficiency with adequate laboratory testing (e.g., CBC, Ferritin, CRP) and treatment per AAP guidelines. Consider recommending a multivitamin with iron.</li> <li>▪ Perform structured developmental screening evaluations at well child visits.</li> </ul>
15-44 mcg/dL	<ul style="list-style-type: none"> <li>▪ Perform steps as described above for blood lead levels 5-14 mcg/dL.</li> <li>▪ Refer to the LHD for blood lead poisoning follow-up services.</li> <li>▪ Confirm the blood lead level with repeat venous sample within 1 to 4 weeks.</li> <li>▪ A specific evaluation of the child, such as an abdominal x-ray, should be considered based on the environmental investigation and history (e.g., pica for paint chips, mouthing behaviors). Gut decontamination may be considered if leaded foreign bodies are visualized on x-ray.</li> <li>▪ Any treatment for blood lead levels in this range should be performed in consultation with an expert.</li> </ul>
>44 mcg/dL	<ul style="list-style-type: none"> <li>▪ Follow guidance for blood lead levels 15-44 mcg/dL as listed above.</li> <li>▪ Confirm the blood lead level with repeat venous lead level within 48 hours.</li> <li>▪ Consider hospitalization and/or chelation therapy (managed with the assistance of an experienced provider). Safety of the home with respect to lead hazards, isolation of the lead source, family social situation, and chronicity of the exposure are factors that may influence management.</li> </ul>
<p>* Notes:</p> <ul style="list-style-type: none"> <li>▪ Table and recommendations adopted from the AAP.</li> <li>▪ No level of lead in the blood is safe.</li> </ul>	

## **8.6 TUBERCULOSIS TESTING**

Medicaid covers tuberculosis (TB) testing according to the AAP periodicity schedule, and upon the recognition of high risk factors. Coverage for the TB test includes any return visit to read the results of the TB test. A risk assessment must be completed at each well child visit. Mantoux testing is the preferred testing method. For assistance in determining high risk and testing, providers may refer to the AAP Red Book: Report of the Committee on Infectious Diseases, or contact the MDCH Division of Communicable Diseases and/or the Division of Immunization. (Refer to the Directory Appendix for contact information.)

## **8.7 DYSLIPIDEMIA SCREENING**

All children and adolescents should undergo a cholesterol screening once between 9 and 11 years of age and once between 17 and 21 years of age. For children with a significant family history or other risk factors, a lipid assessment should be considered as early as 2 years of age. If a family history cannot be ascertained and other risk factors exist, testing is at the provider's discretion. The lipid assessment should include a fasting or non-fasting lipid profile. Children and adolescents identified as being high risk should be counseled on lifestyle changes in an effort to reduce the risk of Cardiovascular Disease (CVD). Children younger than 10 years of age should not be treated with medication unless they have a severe hyperlipidemia or a high-risk condition that is associated with serious medical morbidity. Decisions regarding the need for medication therapy should be based on the average of results from two fasting lipid profiles obtained at least two weeks but no more than three months apart.

## **8.8 SEXUALLY TRANSMITTED INFECTIONS (STI)/HUMAN IMMUNODEFICIENCY VIRUS (HIV) SCREENING**

All sexually active individuals must be screened for sexually transmitted infections (STIs) and human immunodeficiency virus (HIV) according to the AAP periodicity schedule. A routine HIV screening should be offered to all individuals at least one time between 16 to 18 years of age. Individuals at high risk should be tested yearly. HIV-infected individuals should be referred to, and cared for, by providers with expertise in HIV medicine.

## **8.9 CERVICAL DYSPLASIA SCREENING, BREAST EXAMS, COUNSELING AND RISK FACTOR INTERVENTIONS**

Screening for cervical cancer in females younger than 21 years of age is not recommended unless a patient has an immune suppression or infection with HIV, in which case an annual Pap test should be administered with the onset of sexual activity. Females previously screened who had a documented cervical intraepithelial neoplasia (CIN) 2 or 3 or carcinoma will require continued screening. Clinical breast exams and the teaching of breast self-examinations for women younger than 21 years of age is not recommended as part of the routine physical examination; breasts should be examined in the female adolescent as part of the assessment of sexual maturity and in the male adolescent to observe for gynecomastia. Whenever a screening for cervical dysplasia as part of a pelvic examination and Pap smear is provided, a breast exam, counseling, and risk factor interventions must be provided.

### **8.10 DIABETES (TYPE 2)**

High-risk children must be tested according to the AAP periodicity schedule. Beginning at 10 years of age (or at the onset of puberty if it occurs at a younger age), a risk assessment must be performed at each well child visit. Children at risk should be tested in accordance with the AAP periodicity schedule guidelines.

A child is considered high risk if he is overweight (i.e., BMI >85th percentile for age and sex, weight for height >85th percentile, or weight >120 percent of ideal for height) and has any two of the following factors:

- A family history of Type 2 diabetes in first- and second-degree relatives;
- Belongs to a certain race/ethnic group (e.g., Native American, African-American, Hispanic, Asian/Pacific Islander); or
- Signs of insulin resistance or conditions associated with insulin resistance (e.g., acanthosis nigricans, hypertension, dyslipidemia, polycystic ovarian syndrome).

## **SECTION 9 – ORAL HEALTH**

The dental health of the beneficiary begins with an oral health risk assessment by the child's PCP and should be administered according to the AAP periodicity schedule. 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 or not.
- Each child should receive an oral health risk assessment by 6 months of age by a qualified pediatrician or a qualified pediatric health care professional. It is recommended that a child should have a dental home established by 1 year of age.
- Beginning at 3 years of age (younger if the individual child exhibits needs), a child should visit a dentist every six months for examination, prophylaxis, and other preventive care. If the child does not have their next preventive care dental appointment scheduled, the provider must make a referral. When restorative dental care is needed, the child must be referred for treatment.
- A separate periodicity schedule for dentists is established.

### **9.1 ORAL HEALTH SCREEN AND FLUORIDE VARNISH**

Providers should follow the AAP periodicity schedule in the oral health screen and development of caries risk assessment for beneficiaries beginning at 1 year of age. (Refer to the Directory Appendix for AAP website information.) As an oral health intervention, providers should apply fluoride varnish to high risk children from birth to 35 months of age up to four times in a 12-month time period.

Providers must complete the online Children's Oral Health training modules and obtain certification prior to providing oral health screenings and fluoride varnish applications. Providers who complete the certification requirements are allowed to bill Medicaid for these services. Specific certification requirements are available on the MDCH Oral Health website. (Refer to the Directory Appendix for website information.)

### **9.2 PERIODICITY SCHEDULE FOR DENTAL PROVIDERS**

The periodicity schedule for dental providers is as follows:

- An oral health examination is recommended by 1 year of age.
- An oral health examination by a dentist is required by 3 years of age.
- A child should visit a dental provider every six months, depending on need, for examination, risk assessment, prophylaxis, and/or other preventive care.

(Refer to the Dental Chapter for additional information.)

## **SECTION 10 – ANTICIPATORY GUIDANCE**

Anticipatory guidance provided by the AAP 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/adolescent's life. Anticipatory guidance gives the PCP, parent(s)/guardian(s), and the child/adolescent an opportunity to ask questions and to discuss issues of concern. Anticipatory guidance focuses on five priority areas including physical growth and development, social and academic competence, emotional well-being, risk reduction, and violence and injury prevention. The PCP is encouraged to inquire about these priority areas, and to adapt questions and discussion points to meet the specific needs of the families and communities to whom they provide care.

An interpretive conference should also be included to explain the results of the well child visit. Depending on the age and/or family status of the child/adolescent, the conference may be held directly with the child/adolescent, the child/adolescent and parent/guardian, or only with the parent/guardian. If a child/adolescent has a potential or apparent abnormality, the PCP is responsible for providing, or referring for, follow-up diagnostic services and treatment.

### **10.1 SLEEP POSITION COUNSELING**

Positioning of infants on their backs on a firm sleep surface and discussing recommendations for creating a safe sleeping environment with the parent(s)/guardian(s) must occur at each well child visit through 12 months of age. Infants should be placed on their back unless a medical condition warrants that a provider recommends otherwise after weighing the relative risks and benefits. (Refer to the Maternal-Child Educational Resources portion of the Directory Appendix for additional sources regarding infant sleep positioning and to the AAP for recommendations for a safe infant sleeping environment.)

### **10.2 NUTRITIONAL ASSESSMENTS**

Age-appropriate nutrition counseling must be provided at each well child visit. Nutritional assessments must be based on:

- Height, weight, and their relatedness;
- The most recent hematocrit/hemoglobin value;
- Physical examination; and
- Health history.

### **10.3 VIOLENCE AND INJURY PREVENTION**

Violence and injury prevention must be discussed at each well child visit. Providers should become familiar with Connected Kids: Safe, Strong, Secure, the AAP's primary care violence prevention protocol. This resource gives providers recommendations and resources to incorporate preventive education, screening for risk, and linkages to community-based counseling and treatment resources. Treatment and/or a referral for violence and injury related problems identified should be appropriate and timely. (Refer to the Provider Resources portion of the Directory Appendix for additional sources regarding youth violence and injury.)

## **SECTION 11 – CHILDREN IN FOSTER CARE**

Medical interventions, screenings, and various preventive health care services are to be up-to-date for all children in foster care. For purposes of this section, any reference to “child” or “children” in foster care includes any individual in foster care who is younger than 21 years of age. The care of children should be comprehensive, well-coordinated, and fully documented throughout their stay in foster care. All children in foster care younger than 21 years of age must receive a full medical examination and screening for potential mental health issues by a PCP within the first 30 days after entering foster care once the PCP verifies the child in foster care’s eligibility and enrollment status. The PCP must complete the health maintenance visit regardless of whether or not the child in foster care recently received a health maintenance visit prior to entry into the foster care system. The PCP’s office staff should obtain the completed Department of Human Services (DHS) "Consent to Routine, Non-surgical Medical Care and Emergency Medical or Surgical Treatment" form (DHS-3762) from the foster care parent, or consent from the child in foster care if the child is at least 18 years of age, before the child is seen by the PCP. This form provides the PCP with informed consent to routine, non-surgical medical care and emergency medical or surgical treatment and provides the child’s foster care worker’s contact information. This form does not grant informed consent for the physician to provide psychotropic medication treatment. The DHS "Psychotropic Medication Informed Consent" form (DHS-1643) must be completed to receive informed consent to provide psychotropic medication treatment. (Refer to the DHS website for copies of forms and form information. Refer to the Directory Appendix for website information.)

The court includes in an order placing a child in foster care an order directing the release of information concerning the child. When a child is placed in foster care, within 10 days after receipt of a written request, the supervising agency shall provide the foster care parent with copies of all initial, updated, and revised case service plans and court orders relating to the child and all of the child’s medical, mental health, and education reports, including reports compiled before the child was placed with the foster care parent. In an order placing a child in foster care, the court shall include an order that the child’s parent/guardian or custodian provide the supervising agency with the name and address of each of the child’s medical providers, and an order that each of the child’s medical providers release the child’s medical records. The order may specify providers by profession or type of institution.

The supervising agency shall obtain from the parent/guardian of each child who is placed in its care the name and address of the child’s medical provider and a signed document for the release of the child’s medical records. The supervising agency shall require that a child’s medical and behavioral health provider remain constant while the child is in foster care, unless the child’s current primary medical provider is a managed care health plan or unless doing so would create an unreasonable burden for the relative, foster parent, or other custodian. The foster parent shall receive a **mihealth** card, or alternate verification of the child’s Medicaid status and number, as soon as it is available but in no case later than 30 days of the child’s entry into foster care.

The supervising agency shall develop a medical passport for each child who comes under its care. The medical passport provides a record of the child’s medical and physical status upon entry into foster care. The medical passport shall contain all medical information required by policy or law to be provided to the foster care parent, a basic medical history, a record of all immunizations, a complete and regularly updated statement of all medications prescribed to and given to the child, and any other information concerning the child’s physical and mental health. The medical passport should be shared with the child’s provider even if there is missing medical information and the form is not complete. The medical passport should be updated and shared with the provider when new medical information is obtained. Each foster care worker who transfers a child’s medical passport to another foster care worker shall sign and date the

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passport to verify that the necessary information was obtained. The supervising agency shall provide a copy of each medical passport and any updates which are to be maintained in a central location.

The medical evaluation must follow the AAP periodicity schedule and Medicaid EPSDT policy. The examination should be completed according to the recommendations for the nearest or most appropriate periodic examination age. The PCP will assess the child for medical, dental, developmental, and mental health needs. The full medical evaluation will include an immunization review, health history, and physical examination. The medical examination and screenings should be documented for the initial and for all subsequent well child visits and will become a part of the child's medical record. PCPs may reference the age appropriate DHS Well Child Exam form and use their own Well Child Exam form or electronic medical record (EMR) if the form or EMR contains all of the elements of the AAP periodicity schedule. (Refer to the Directory Appendix for AAP and DHS website information.)

All children who are 3 years of age or older at the time of entry into foster care will receive a dental examination within 90 days of entry into foster care unless the child had a dental exam in the six months prior to foster care placement. It is the responsibility of the foster care parent to take the child to the dentist.

A developmental/behavioral assessment must be completed according to the recommendations of the AAP. A developmental/behavioral assessment includes developmental screening, autism screening, developmental surveillance, psychosocial/behavioral assessment, alcohol and drug use assessment, and depression screening. Screening for potential mental health issues of the child within 30 days of entering foster care may be accomplished by using an objective validated and standardized screening tool and will be completed with the assistance of a person who knows the child best (preferably for at least 30 days) before the child is seen by the PCP. This may be the child's biological parent, foster care parent, caregiver, or other adult who knows the child. The child in foster care's case worker should assist the foster care parent and the person who knows the child best in completing the screening tool and the foster care parent should present the completed screening tool to the PCP at the initial appointment. The foster care worker will be responsible for identifying the individual who is to complete the screening tool. The PCP is responsible for scoring and interpreting the results of the screening tool and proposing recommendations regarding follow-up. A psychosocial/behavioral assessment must be completed at each scheduled well child visit and may be accomplished by surveillance or by using a validated and standardized screening tool such as the ASQ-SE or PSC with appropriate action to follow if the assessment is positive. PCPs should use a validated and standardized screening tool for all children in foster care and for children with mental health conditions. The use of validated and standardized screening tools improves the detection rate of social-emotional problems of children in foster care compared to the reliance on subjective clinical judgment. (Refer to the Directory Appendix for foster care resources.)

The PCP will recommend to the foster care worker, the birth parents, and the foster care parents (when applicable) when the child in foster care may benefit by visiting with a mental health professional. The child will be referred for a prompt follow-up assessment by an appropriate medical, dental, developmental, or mental health professional for any further identified health needs. For more information, refer to the Developmental/Behavioral Assessment Section of this chapter.

### **11.1 PSYCHOTROPIC MEDICATION TREATMENT**

A psychiatric diagnosis using the Diagnostic and Statistical Manual (DSM) of Mental Disorders (published by the American Psychiatric Association) must be made before prescribing psychotropic medications to any child in foster care. When the physician determines that the child requires psychotropic medication

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treatment, the prescribing physician must obtain a written and signed informed consent from the child's birth parent (when the child is a temporary court ward), the child (if the child is at least 18 years of age), or other legal guardian (for state or permanent court wards) before treatment with any psychotropic medication begins. Other legal guardians for state or permanent court wards may be the foster care worker for the child/youth in guardianship of the Michigan Children's Institute (MCI) or the court of jurisdiction for the child/youth in guardianship of the county. Foster care parents cannot consent to administration of psychotropic medication. For questions regarding who may provide consent for treatment with psychotropic medications, the physician may contact the child's foster care worker.

Informed consent must be documented by completion of the DHS "Psychotropic Medication Informed Consent" form (DHS-1643). (DHS forms are available on the DHS website. Refer to the Directory Appendix for website information.) Informed consent includes an explanation from the prescribing physician regarding the child's diagnosis, proposed treatment, expected outcomes, any side effects, risks involved, discussion of laboratory findings and ongoing monitoring, uncommon but potentially severe adverse events, a discussion of alternative treatments, the risks associated with no treatment, and the overall potential benefit-to-risk ratio of treatment. If consent is denied by the child's birth parent or legal guardian, or the consent cannot be obtained, a court order shall be obtained by the foster care worker to authorize the administration of the psychotropic medication to the child held in legal custody based on the physician's attestation that treatment with psychotropic medication is medically necessary. If a child is prescribed psychotropic medication prior to enrollment in the foster care system, the DHS-1643 must be completed within 45 days of a child's entry into the foster care system to assure uninterrupted psychotropic medication treatment. The child in foster care who is at least 18 years of age is able to consent to and/or refuse medical treatment. A new DHS-1643 will be required if there is a new psychotropic medication prescribed, a discontinuation of the psychotropic medication, a change in dosage that exceeds the limits of the provided consent, or if the child is at least 18 years of age. The DHS-1643 must be renewed annually.

## **11.2 ENROLLMENT AND BILLING**

DHS has designated a Health Liaison Officer (HLO) or an HLO point person to every county in Michigan to assist children in foster care with health plan enrollment/disenrollment, facilitate the timely completion of an initial medical examination, and generally provide technical support to foster care workers. Until HLO positions are allocated for complete statewide coverage, each local office has an assigned supervisor to serve as the point person for obtaining any health-related information or for resolving health-related issues.

PCPs may complete and bill for an EPSDT/preventive health care well child visit for any child who must be seen within 30 days of entering the foster care system, and for any additional follow-up visits the PCP believes are necessary. The PCP may bill for the visit even if the child in foster care received a recent preventive health care service prior to entry into the foster care system. The PCP may bill for up to three screenings administered during a well child visit using the appropriate developmental screening codes for scoring and interpreting developmental, autism, and behavioral health screens for beneficiaries younger than 21 years of age.

Children in foster care not enrolled with a health plan by the time a full medical examination is provided within the 30 day requirement will be considered Fee for Service (FFS). Children in foster care residing in detention facilities, child care institutions, or out-of-state placements will be considered FFS and will not be transitioned to a health plan. PCPs must verify eligibility and enrollment status prior to providing services to children in foster care. If the child in foster care is enrolled in an MHP, prior authorization requirements may apply.

## **SECTION 12 – REFERRALS**

If a medical issue is determined or suspected during a well child visit, the (suspected) issue must be diagnosed and treated as appropriate. This determination may result in a referral to another provider or a self-referral for further diagnosis and treatment. Referrals must be made based on standards of good practice and the AAP Recommendations for Preventive Pediatric Health Care or presenting need, if outside the normal schedule.

When a FFS provider performs medically necessary treatment involving diagnostic or therapeutic procedures for a medical condition found during a well child visit (e.g., wart removal), these procedures are covered in addition to the well child visit. For information regarding billing a well child evaluation and management (E/M) visit and other E/M visits occurring on the same date of service, refer to the Evaluation and Management Services Section of the Practitioner Chapter. If the provider cannot perform the needed treatment, a referral must be made to an appropriate provider. If providers are not familiar with other providers in the area, the LHD can be of assistance with referrals. MHP providers must follow the referral procedures for the specific health plan in which the beneficiary is enrolled.

### **12.1 PSYCHIATRIC SERVICES**

Limited psychiatric services are available for Medicaid FFS beneficiaries younger than 21 years of age with mild/moderate mental health conditions or suspected behavioral disorders. (Refer to the Psychiatric and Substance Abuse Services Section of the Practitioner Chapter for specific coverages.) MHP contracts include limited mental health benefit coverage for beneficiaries with mild/moderate mental health conditions.

PIHPs/Community Mental Health Services Programs (CMHSPs) are responsible for the provision of covered specialty mental health services necessary for the treatment of Medicaid beneficiaries who have more significant and/or complex psychiatric conditions.

### **12.2 AUTISM SPECTRUM DISORDERS**

The PCP who screened the child for ASD and determined a referral for further evaluation was necessary will contact the PIHP directly to arrange for a follow-up evaluation. The PCP must refer the child to the PIHP in the geographic service area for Medicaid and MIChild beneficiaries. (Refer to the Mental Health/Substance Abuse Chapter for information/policy regarding the treatment of children with autism.)

### **12.3 SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS AND CHILDREN (WIC)**

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) program is located in each county in Michigan at LHDs, Tribal Health Centers, and federally funded clinics. WIC is a special health and nutrition program that has demonstrated a positive effect on pregnancy outcomes and child growth and development. WIC provides supplemental healthy foods, nutrition counseling and education, breast feeding support, immunization screening, and referrals to other helpful services to pregnant women, breastfeeding and post-partum women, infants, and children younger than 5 years of age. The PCP is expected to make referrals to a WIC site for eligibility determination if appropriate. (Refer to the Directory Appendix for website and contact information.)

## **12.4 BLOOD LEAD POISONING FOLLOW-UP SERVICES**

Many LHDs provide blood lead poisoning follow-up services which consist of environmental investigations and blood lead nursing assessment visits. The PCP must contact the LHD to determine if blood lead services are available in the area and the blood lead levels at which referrals are accepted. In locations where LHDs do not provide this service, the MDCH Healthy Homes Section can be contacted to perform the environmental investigation. (Refer to the Additional Information on Blood Lead Testing Section of the Local Health Departments Chapter for additional information and to the Directory Appendix for contact information.)

### **12.4.A. ENVIRONMENTAL INVESTIGATIONS**

MDCH covers one initial and one follow-up environmental investigation. Environmental investigations are covered for the LHD if the LHD health officer completes the "Blood Lead Poisoning Follow-Up Services Assurance of Provision" form (DCH-1530). If more than one child in the home has blood lead poisoning, the LHD must select one child's Medicaid ID Number and report a single initial and a single follow-up environmental investigation visit. (Refer to the Local Health Departments Chapter for additional information on blood lead testing.)

### **12.4.B. BLOOD LEAD NURSING ASSESSMENT VISITS**

MDCH covers up to two blood lead nursing assessment visits and in-home education visits for children determined to be lead burdened. If more than one child in the home has blood lead poisoning, the blood lead nursing assessment visits are covered for each child.

Blood lead nursing assessment visits must be provided in the child's home. A Medicaid-enrolled home health agency or an LHD may conduct the visits. This procedure is not covered under the Maternal Infant Health Program (MIHP). Blood lead nursing assessment visits provided to an MHP beneficiary are covered by the individual MHP.

The first blood lead nursing assessment visit focuses on:

- Assessment of the 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 of 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.

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- Development of a family plan of care to increase the safety of the child from lead hazards.
- Facilitating blood lead follow-up testing and treatment recommended by the PCP.

The second blood lead nursing assessment 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 of care to minimize lead risks, as needed.
- Facilitating blood lead follow-up testing and treatment recommended by the PCP.

#### **12.4.C. BLOOD LEAD RESOURCE DOCUMENTS**

Providers are encouraged to obtain and review materials and resources concerning blood lead poisoning from the MDCH Childhood Lead Poisoning Prevention Program. (Refer to the Directory Appendix for contact information.)

#### **12.5 OTHER PROGRAMS**

There are other programs that could benefit Medicaid beneficiaries such as Head Start, intermediate school district/regional education service agency services, genetics counseling, nutrition programs, and public health nursing. Providers are encouraged to become familiar with available programs and make full use of the programs whenever referrals are appropriate.

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## **SECTION 13 – OUTREACH**

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

When the beneficiary's **mihealth** card is issued, it is mailed with the MDCH publication "Michigan Free Health Check-Ups." The publication explains the benefits of a well child visit, describes procedures included in the free health check-up, and presents information about medical transportation options available to beneficiaries for travel to and from well child visits.

Soon after the **mihealth** card is issued, the beneficiary will receive a monthly outreach list, a letter that stresses the importance of well child visits, and medical transportation information.

### **13.1 FEE-FOR-SERVICE (FFS)**

For beneficiaries younger than 2 years of age, a letter stressing the importance of well child visits is sent to the parent/guardian every six months as a reminder to schedule a well child visit with the PCP. The parent/guardian of the beneficiary is encouraged to schedule the well child visits recommended during those six months with the beneficiary's PCP. For beneficiaries 2 years of age and older, if a claim for a well child visit has not been processed by Medicaid by the time the child is halfway to their next well child visit due date (according to the AAP periodicity schedule), the parent/guardian will receive a second letter. A list of FFS beneficiaries who did not have a claim for a well child visit processed will be generated and issued to each LHD. LHDs may assist Medicaid in informing parents/guardians of the EPSDT program, scheduling appointments, and arranging medical transportation options.

### **13.2 MEDICAID HEALTH PLANS (MHP)**

Each MHP is able to download an electronic monthly outreach list of enrollees due or overdue for a well child visit. The MHP must either, directly or through the LHD, notify the parent/guardian of the required action or assist in scheduling appointments or arranging medical transportation options. The "Michigan Free Health Check-ups" publication is mailed to the Medicaid beneficiary once each year.

## **SECTION 14 – MEDICAL TRANSPORTATION**

Medical transportation is available free of charge to the beneficiary and parent/guardian for travel to and from well child visits if requested by the family.

- For beneficiaries enrolled in an MHP, the parent/guardian of the beneficiary should make arrangements directly through the MHP.
- The parent/guardian of the beneficiary not enrolled in an MHP should contact their local DHS directly, or with the assistance of the LHD, to make transportation arrangements for the EPSDT well child visit. DHS should be contacted as soon as the date and time of the appointment are known.

MDCH contracts with a transportation brokerage company to arrange and provide Non-Emergency Medical Transportation (NEMT) for beneficiaries residing in Wayne, Oakland and Macomb counties. Transportation may be provided when the beneficiary qualifies for the service and has no other means of transportation. (Refer to the Directory Appendix for contractor contact information.)