MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: Local Health Department 03-01
Medicaid Health Plan 03-01
Practitioner 03-01

Issued: January 1, 2003

Subject: Blood Lead
EPSDT Periodicity Schedule
Other Insurance

Effective: February 1, 2003

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

This bulletin, effective for dates of service on and after January 1, 2003, transmits policy relative to a local health department obtaining a blood lead specimen, providing a blood lead analysis, and filing cost reports. It also distributes a new EPSDT periodicity schedule and a reminder about other insurance.

EPSDT PERIODICITY SCHEDULE

Exhibit 1 (EPSDT Components by Age of Beneficiary) of bulletin MSA 02-10 has been changed. The changes do not add or delete previous information; it rearranges the listings. Please use Attachment 1 of this bulletin rather than the exhibit in bulletin MSA 02-10.

BLOOD LEAD

In an effort to increase the proportion of children receiving age-appropriate tests for blood lead, the Michigan Department of Community Health (MDCH) encourages all Medicaid health plans and Children's Special Health Care Services (CSHCS) special health plans (SHPs) to establish contractual or other coordinating relationships with local health departments for blood lead testing of health plan enrollees. **NOTE:** These contracts or other coordinating relationships must include mechanisms for service authorization and payment. Standing orders may be used rather than a separate referral for each child. Results MUST be shared as required by the health plan (e.g., one plan may want results to go to the primary care provider while another plan wants results to go to the plan office as well as to the primary care provider).

In the absence of a contract or other coordinating relationship, the local health department must refer the child to the primary care provider to receive a draw for blood lead testing.

If the child has other insurance, the local health department must first seek reimbursement through that source. For example: A child is covered through a commercial health maintenance organization (HMO) by an absent parent. If that HMO covers blood lead draws or tests, the local health department must follow the processes and procedures required by that plan and seek reimbursement through the commercial HMO prior to approaching Medicaid for reimbursement. Please refer to the Third Party Billing section in Chapter IV of your Medicaid Manual.

Other than the changes in this bulletin, the information contained in bulletin MSA 02-10 remains in effect.

Local Health Department Obtaining the Blood Lead Specimen Only

If the local health department is obtaining a blood lead specimen (capillary or venipuncture), the local health department will no longer submit quarterly reports to the MDCH for reimbursement.

Fee for Service

If a venipuncture is performed as the only service for the beneficiary on that date of service, the local health department may bill the MDCH for Procedure Code 36415 to seek Medicaid's maximum allowable amount using the Professional 837 (ASC X12N 837, version 3051 or 4010) for electronic submission or the HCFA 1500 (12-90) for paper claim submission. Your Medicaid Manual presents documentation requirements for blood handling.

Medicaid Health Plan or Children's Special Health Care Services (CSHCS) Special Health Plan (SHP)

The local health department must follow the plan's billing processes and procedures when seeking reimbursement for authorized draws.

Cost Reports/Federal Financial Participation (FFP)

The local health department may include capillary or venipuncture blood lead draws for fee-for-service or MHP/SHP authorized beneficiaries in its annual cost report. The MDCH will collect and reimburse any applicable FFP amount for the difference between reimbursement received and costs for eligible Medicaid beneficiaries. This reimbursement applies to blood lead activities that are in compliance with this bulletin only. **NOTE:** While the draws are included in the full cost report, they must not be included on form MSA-1751 (Exhibit 8 of bulletin MSA 02-10).

Local Health Department Analyzing Blood Lead Samples

If the local health department has Clinical Laboratory Improvement Act (CLIA) certification to perform blood lead analyses, it may apply to enroll with the MDCH as a laboratory (Provider Type 16) to bill the MDCH for blood lead analyses.

Fee for Service

Reimbursement will be in the same manner as an independent laboratory (i.e., the MDCH may be billed for blood lead analyses performed for fee-for-service children) using the Professional 837 (ASC X12N 837, version 3051 or 4010) for electronic submission or the HCFA 1500 (12-90) for paper claim submission. Reimbursement for the fee-for-service children will be made up to the maximum allowable amount for the blood lead analyses. This payment includes reimbursement for the capillary or venipuncture blood draw.

Medicaid Health Plan or CSHCS SHP

For blood lead analyses performed for health plan enrollees, the local health department must seek reimbursement from the appropriate plan using Procedure Code 83655 if a contract/coordinating relationship is in place to perform lead analyses. An analysis includes reimbursement for the capillary or venipuncture blood lead draw. The local health department must follow the plan's billing processes and procedures when seeking reimbursement.

Cost Reports/FFP

Blood lead analyses for eligible Medicaid beneficiaries may be included in the local health department's annual cost report. The MDCH will collect and reimburse any applicable FFP amount for the difference between reimbursement received and costs for fee-for-service or MHP/SHP authorized beneficiaries. This reimbursement applies to blood lead activities that are in compliance with this bulletin only. **NOTE:** While the analyses are included in the full cost report, they must not be included on form MSA-1751 (Exhibit 8 of bulletin MSA 02-10).

Manual Update

Retain this bulletin for future reference.

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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EPSDT COMPONENTS BY AGE OF BENEFICIARY

	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																												
Blood Lead [13]									•			•	◄M	►	►													
Cholesterol [14]												H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H
Diabetes (Type 2) [15]																		H		H		H		H		H		H
Hematocrit or Hemoglobin [16]								◄•	►	◄H	►				►				F	F	F	F	F	F	F	F	F	F
Hereditary/Metabolic Screening																												
biotinadase [17]		•																										
congenital adrenal hyperplasia [17]		•																										
galactosemia [17]		•																										
hemoglobinopathies [17]		•																										
hypothyroidism [17]		•																										
maple syrup urine disease [17]		•																										
phenylketonuria (PKU) [17]		•																										
sickle cell [18]		•					◄•	►																				►
Pelvic Exam [19]																			H	H	H	H	H	H	H	•	•	•
STD Screening [20]																			H	H	H	H	H	H	H	H	H	H
Tuberculin (TB) Test [21]									H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H	H
Urine Test [22]															•				◄	►			•	►				►
GUIDANCE																												
Anticipatory Guidance [23]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Injury Prevention [24]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Interpretive Conference	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Nutritional Assessment [25]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Sleep Position Counseling [26]	•	•	•	•	•	•																						
Violence Prevention [27]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•

• = 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. 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.
14. 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.
15. 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.
16. 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.
17. By law, these newborn tests should be initiated before the child is discharged from the hospital.
18. 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.
19. 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.
20. All sexually active patients (high risk) shall be screened for sexually transmitted diseases (STDs).
21. 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.
22. A urinalysis (at a minimum, via dipstick) for all children at five years of age and for sexually active male and female adolescents.
23. Age-appropriate discussion and counseling should be an integral part of each visit per the AAP "Guidelines for Health Supervision III" (1994).
24. 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).
25. Age-appropriate nutrition counseling should be an integral part of each visit per the AAP *Pediatric Handbook of Nutrition* (1998).
26. 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.
27. 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.

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.