



Handbook For Providers of Healthy Kids Services

Chapter HK-200
Policy and Procedures for
Preventive Health Care for **All Kids**



Illinois Department of Healthcare and Family Services

CHAPTER HK-200
Handbook for Providers of Healthy Kids:
Preventive Health Care Services for All Kids

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FOREWORD

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

Become an Active Provider in our All Kids Program

MEDICAL HOME

Every child deserves a medical home. The American Academy of Pediatrics (AAP) describes the medical home as a model of delivering primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. The AAP believes that everyone should have a patient-centered medical home with a well-trained quality driven, safety conscious, team-based, physician-directed practice and providing or coordinating all needed care.

In 2006, the State of Illinois implemented a mandatory managed care program for most persons covered by Illinois Department of Healthcare and Family Services' (HFS') Medical Programs. HFS participants must select either the new program called [Illinois Health Connect](#), which is a statewide Primary Care Case Management (PCCM) Program, or an existing Managed Care Organization (MCO). Children who are enrolled in Illinois Health Connect or with an MCO will have a "medical home" through a Primary Care Provider (PCP) where they will receive all of their well child visits, immunizations and follow-up care, as needed. Having a single PCP will ensure children have access to quality care from a provider that understands their unique health care needs. PCPs will make referrals to specialists for additional care or tests as needed.

The goals of managed care are to:

- Improve the quality of health care and child health outcomes
- Assure appropriate utilization of health care services
- Reduce the usage of the emergency room for routine medical care
- Improve access to care through the availability of a provider network and expansion of providers
- Provide the most appropriate and cost-effective level of care

In recent years, HFS provided health care benefits to approximately 2.3 million beneficiaries, of which approximately 1.4 million were under the age of 21. In 2005, HFS covered approximately 95 percent of all Illinois teen births, and approximately 51 percent of all Illinois births.

It is our goal to ensure that the highest quality health care is afforded to our most precious, yet most vulnerable resource, Illinois children. Protecting and improving the health of Illinois children is one of the State's highest priorities.

Disease Management for Children with Asthma or are High Emergency Room Users

The Disease Management Program, “[Your Healthcare Plus](#)” is a free, voluntary program that helps families with children who are frequent emergency room users or have persistent asthma to:

- Stay healthier
- Understand their disease better
- Understand more about medicines prescribed and how to take them
- Understand how to work better with their doctor or clinic

Your Healthcare Plus does not replace or change what is covered under the HFS medical card or replace the care provided by the PCP. **Your Healthcare Plus** is meant to enhance and augment the care provided by the PCP. For information, call **1-800-973-6790**.

Participants selecting a Managed Care Organization (MCO) can reach their MCO any time for disease management, case management or other member services. The toll-free number is listed on the beneficiary card from the respective MCO.

Nurse on Call:

All HFS participants can reach a nurse helpline by calling **1-800-571-8094 (TTY: 1-800-571-8419)**. Participants can call the nurse helpline if they have a medical problem and are not able to reach their doctor after-hours or on the weekends. The hours of operation are 6:00 p.m. to 7:00 a.m., Monday through Friday, and 24 hours a day on weekends.

Participants selecting a Managed Care Organization (MCO) can reach their MCO any time for nurse triage services. The toll-free number is listed on the beneficiary card from the respective MCO.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program is the nation’s largest preventive child health initiative. It is a comprehensive child health program that provides initial and periodic examinations and medically necessary follow-up care. Illinois strives to ensure that children covered by HFS’ Medical Programs (All Kids) receive preventive health screening services, including immunizations, developmental screening, lead screening and risk assessments, through Illinois’ EPSDT program. It is HFS’ commitment to families to establish access to quality primary and preventive health care services. A primary goal is to “put prevention into practice”. Through partnership with you, Illinois’ children can be provided with “a medical home” for efficient, high quality health care, and receive needed referrals for health and health-related services, including specialty care.

This Handbook for Providers of Healthy Kids: Preventive Health Care for All Kids, Chapter HK-200, specifically describes the components and frequency that well-child screening services are to be performed. It also describes the EPSDT benefits available to HFS' Medical Program participants who are under the age of 21, as mandated by the Social Security Act.

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

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

<http://www.hfs.illinois.gov/handbooks/chapter200.html>

Chapter 100	Handbook for Providers of Medical Services
A-200	Handbook for Physician
N-200	Handbook for Advanced Practice Nurse
S-200	Handbook for School-Based/Linked Health Clinics
L-200	Handbook for Providers of Laboratory Services
U-200	Handbook for Local Education Agencies

Some handbooks are available for downloading from HFS' Web site. As others are revised, those handbooks will also be available on HFS' Web site. Refer to Topic HK-207.9.1, Web site Locations. Paper copies are available upon request. Requests for all handbooks may be directed to the Provider Participation Unit (PPU). Requests may be made by mail, e-mail or fax at:

e-mail: HFS.PPU@ILLINOIS.GOV

Mail: Illinois Healthcare and Family Services
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114

Fax: (217) 557-8800

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

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

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

HK-200 BASIC PROVISIONS

HK-200.1 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT)

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

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

HFS requires all preventive health services be delivered consistent with guidelines published by the Committee on Practice and Ambulatory Medicine; American Academy of Pediatrics (AAP) or the American Academy of Family Physicians (AAFP); the Advisory Committee on Immunization Practices (ACIP); and procedures and protocols established by HFS.

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

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

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

Medical guidelines, policy statements and current schedules and recommendations can be found on each professional group's Web site. Refer to Topic HK-207.9.1, for Web site information.

HK-200.2 EPSDT DEFINITION

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

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

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

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

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

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

These include:

- Preventive care (periodic health screening), including health supervision and anticipatory guidance
- Diagnosis and treatment of acute and chronic illness – ambulatory and inpatient care
- Care over an extended period of time
- Identification of need for subspecialty consultation and referrals
- Interaction with other involved health, social, environmental and educational entities
- Maintenance of a central medical record for all pertinent medical information

HK-201 PROVIDER PARTICIPATION

HK-201.1 PARTICIPATION REQUIREMENTS

It is an HFS requirement that each provider enroll with HFS as a Medical Assistance Provider to be considered for participation and agree to all requirements listed in Chapter 100, Topic 101.1. For information about provider enrollment or to receive handbooks for the HFS' Medical Programs, refer to the address, fax number and e-mail address located on page 200 (vi).

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

Physicians, clinics, and health centers who are enrolled in the HFS program and wish to enroll in Illinois Health Connect as a Primary Care Provider should call the Illinois Health Connect Provider Services Helpdesk at **1-877-912-1999 (TTY: 1-866-565-8577)**. The hours of operation for the Provider Services Helpdesk are **Monday – Friday, 7 a.m. to 6 p.m.** An application will be mailed or a Provider Service Representative will schedule a convenient time to meet with the provider, answer all of the provider's questions and help with the enrollment process.

Providers who do not enroll in Illinois Health Connect will no longer be able to provide primary care to their patients who are enrolled in Illinois Health Connect. The provider types listed below may serve as PCPs:

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

Providers can also [enroll online as an Illinois Health Connect PCP.](#)

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

Increased reimbursement rates for selected maternal and child health (MCH) services are available to all PCPs who have signed agreements to be part of the PCCM program (Illinois Health Connect). Providers outside of the Illinois Health Connect Program may be eligible for these enhanced rates as well but must meet the criteria of, and sign HFS' MCH Primary Care Provider Agreement (Form IL 478-2191), in addition to being enrolled as a Medical Assistance Provider. Providers must meet the following participation requirements to enroll as an MCH Primary

Care Provider:

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

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

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

A separate handbook is available for each type of provider or category of service.

Information specific to Certified Local Health Departments in relation to well child screening services is contained within this Handbook for Providers of Healthy Kids Services, Chapter HK-200, Policy and Procedures for Preventive Healthcare for All Kids.

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

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

For individuals under age 21, direct access providers include Certified Local Health Departments, school-based/linked clinics, local education agencies (LEAs), Early Intervention (EI) agencies and women's health care providers.

HK-201.2 PARTICIPATION APPROVAL

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

Appendix A-7.

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

A change in ownership or corporate structure terminates current participation. New ownership or corporate structure requires new enrollment.

HK-201.3 PARTICIPATION DENIAL

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

HK-201.4 PROVIDER FILE MAINTENANCE

The information carried in HFS files for all participating providers (including PCCM and MCO providers) must be maintained on a current basis. The provider and HFS share responsibility for keeping the file updated.

Provider Responsibility:

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

Any time a provider effects a change to information on the Provider Information Sheet, such as a physical move, HFS is to be notified. When possible, notification should be made in advance of a change, as a minimum of 30 days is needed to update HFS files.

A copy of the Provider Information Sheet may be obtained from the Provider Participation Unit (PPU). Requests may be made by mail, e-mail or fax at:

e-mail: HFS.PPU@ILLINOIS.GOV

Mail: Illinois Healthcare and Family Services
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114

Fax: (217) 557-8800

Procedure: The provider is to enter the correct data in the space below the incorrect data, sign and date the Provider Information Sheet in the space provided and forward the corrected Provider Information Sheet to HFS.

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

HFS Responsibility:

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

HK-202 PROVIDER REIMBURSEMENT

HK-202.1 CHARGES

Providers may bill HFS only after services have been provided. Charges for detailed services are at the provider's established usual and customary rate for the services provided. Covered services must be billed to HFS on the appropriate form (see Chapter 200 for the form and billing instructions for each specific provider type) or claims may also be submitted electronically.

Diagnoses Code(s)

Refer to the most current International Classification of Diseases 9th Revision, Clinical Modification 6th Edition (ICD-9-CM) for the description of the diagnosis code(s). When billing, enter the specific ICD-9-CM diagnosis code without entering the decimal point, (e.g., V20.2 should be entered as V202). When billing the Evaluation and Management Code, or Preventive Medicine Code, it is recommended that the appropriate "v" diagnosis code be used for comprehensive medical screening.

Procedure Code(s)

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

Comprehensive Health Screening

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

Preventive Medicine CPT Code

When using the Preventive Medicine Services CPT codes to bill for a well child visit, the following components must be performed according to the CPT guidelines: evaluation and management of a patient including an age and gender appropriate history, examination, counseling and anticipatory guidance/risk factor reduction interventions and ordering of appropriate immunizations(s) and laboratory/diagnostic procedures. The Preventive Medicine Services CPT codes are listed in Appendix 8.

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

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

- Objective Risk Assessment - use the appropriate CPT code for administration and interpretation of a health assessment instrument (refer to Topic HK-203.9 and Appendix 8)
- Perinatal Depression - use code H1000 for prenatal risk assessment and 99420, with the HD modifier (99420 HD) for postpartum depression screening, up to a year after the infant's birth; may be billed on the infant's recipient number, if infant is the patient (refer to Topic HK-203.9 and Appendix 8)
- Objective Developmental Screening – performed no less than at priority intervals (e.g., based on the recommended periodicity schedule), with surveillance during all well-child visits in order to identify children with developmental and social-emotional delays and make referrals to Early Intervention or other agencies as may be appropriate
 - For children under age three, providers should administer an objective developmental screening using a standardized instrument approved by HFS, according to the AAP guidelines, at 9 months, 18 months and 24/30 months of age
 - Objective developmental screening specific to Autism should be conducted for all children at the 18-month and 24-month visits
 - CPT codes differentiate developmental screening instruments as to whether the recognized developmental screening instrument meets the criteria of “developmental testing – limited,” or “developmental testing - extended” (refer to Topic HK- 203.5 and Appendix 8)
- Objective Vision Screening - use the appropriate CPT code for the vision screening service when a separate objective vision screening, is provided (refer to Topic HK-203.7.1 and Appendix 8)
- Objective Hearing Screening - use the appropriate CPT code for the objective hearing screening service when a separate objective hearing screening is provided (refer to Topic HK-203.7.2 and Appendix 8)
- Laboratory procedures - to receive reimbursement for laboratory services, all providers, regardless of type of business or professional licensure, must have a current Clinical Laboratory Improvement Amendments (CLIA) certificate on file with HFS
 - Payment will not be made for laboratory services performed by a provider if HFS does not have on file the required CLIA certification as described below, unless the laboratory procedure is CLIA waived
 - CLIA certification may be waived on blood lead analysis, depending on the laboratory process for the analysis
- Immunizations – use the appropriate CPT code for the specific immunization given
 - Vaccines should be ordered by the Illinois Department of Public Health (IDPH) Vaccine for Children Program, or in Chicago, the Chicago Department of Public Health Vaccine for Children Program (refer to Topic HK-207.2 and Appendix 8)

Note: Providers of laboratory services must be in compliance with the Clinical Laboratory Improvement Amendments (CLIA). For more information refer to the Handbook for Providers of Laboratory Services:

<http://www.hfs.illinois.gov/handbooks/chapter200.html>

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

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

HK-202.2 ELECTRONIC CLAIMS SUBMITTAL

Any services that do not require attachments or accompanying documentation may be billed electronically. The specifications for billing are found in [Chapter 300](#) of the Provider Handbook for Electronic Processing. Please note that the specifications for electronic claims billing are not the same as those for paper invoices. Please follow the instructions for the media being used. If a problem occurs with electronic billing, providers should contact HFS in the same manner as would be applicable to a paper claim. It may be necessary for providers to contact their software vendor if HFS determines that the service rejections are being caused by the submission of incorrect or invalid data.

Providers should take special note of the requirement that Form HFS 194-M-C, Billing Certification Form, must be signed and retained by the provider for a period of three years. Failure to do so may result in revocation of the provider's right to bill electronically, recovery of monies, or other adverse actions (refer to Chapter 100, Topic 130.5 for further details).

HK-202.3 PAPER CLAIMS PREPARATION AND SUBMITTAL

Refer to Chapter 100, Topic 112, for general policy and procedures regarding claim submittal. For specific billing instructions, refer to A-200, Handbook for Physicians, Appendix A-1.

HK-202.4 PAYMENT

Payment made by HFS for allowable services provided to eligible participants is based on the individual provider's usual and customary fees, within the limitations established by HFS. The payment made is the lesser of the provider's charge or the maximum amount established by HFS. HFS' maximum reimbursement rates are available on the HFS Web site: <http://www.hfs.illinois.gov/feeschedule/>. The fee schedule also contains an indicator as to whether a prior authorization is required for a particular procedure.

Payments made by HFS to providers for services to eligible participants are considered payment in full. If a provider accepts the patient as a Medical Programs participant, the provider may not charge eligible participants for co-payments,

participation fees, deductibles, completing forms, or any other form of patient cost-sharing, except as specifically allowed in Chapter 100, Topics 113 and 114 and Appendices 12, 13 and 14.

HK- 202.4.1 FEE-FOR-SERVICE

Most of the participants in HFS' Medical Programs receive services from enrolled providers under a fee-for-service arrangement between HFS and participating providers. Fee-for-service refers to payment for services that are provided in hospital outpatient and office settings.

Illinois Health Connect (PCCM Program)

HFS operates a statewide mandatory Primary Care Case Management (PCCM) Program called Illinois Health Connect. Most people with an HFS medical card (referred to as All Kids/FamilyCare/Moms & Babies medical card) must select a primary care provider (PCP) and health plan. Illinois Health Connect participants will have a medical home through a PCP who will coordinate and manage their care.

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

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

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

Participants enrolled in Illinois Health Connect will receive regular HFS medical cards. For more information, visit the HFS Web site at <http://www.hfs.illinois.gov/managedcare/>, or the Illinois Health Connect Web site at <http://www.illinoishealthconnect.com>.

Referrals for Specialty Care

Until the referral system is fully implemented, claims will continue to be processed without a referral. Providers will be notified at least three (3) months prior to the full implementation of the Illinois Health Connect referral system. For information on specialty care referrals, please visit the Illinois Health Connect Web site at http://www.illinoishealthconnect.com/downloads/IHC_ProviderFAQ.pdf

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

Incentive Payments

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

HK- 202.4.2 MANAGED CARE

The [voluntary managed care program](#) operates in eight Illinois counties: Cook, Madison, St. Clair, Randolph, Washington, Williamson, Jackson and Perry. A person in these counties may opt out of the PCCM program to enroll with a voluntary Managed Care Organization (MCO) under contract with HFS. An MCO may be a Health Maintenance Organization (HMO) or Managed Care Community Network (MCCN). Under an MCO, health services are prepaid, based on a per member, per month capitation. The MCO is responsible for providing or arranging and reimbursing for all covered services as defined in their contract with HFS. Participant enrolled in MCOs will receive medical cards with the following message:

MANAGED CARE ENROLLEE(S): Services may require payment authorization.

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

Incentive Payments

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

HK-203 COVERED SERVICES

HK-203.1 WELL-CHILD EXAMINATION

Four categories of preventive health care screening services for children under All Kids are: **medical/health, vision, hearing and dental**. Screening components are described in the sections to follow. Unless otherwise specified, the source document for the recommendations herein are taken from the American Academy of Pediatrics' (AAP's) Policy Statements and *Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents; Recommendations for Preventive Pediatric Health Care, 3rd Edition, 2008* published by the Committee on Practice and Ambulatory Medicine, in consultation with national committees and sections of the AAP; and treatment guidelines published by the Illinois Department of Public Health (IDPH) or the Illinois Department of Human Services (IDHS).

The Recommendations for Preventive Pediatric Health Care ([2007 Periodicity Schedule](#)) can be found at <http://practice.aap.org/content.aspx?aid=1599>. It is intended to serve as a guide to Healthy Kids Screening suggested Periodicity Schedule. Consult the appropriate chapter of this Handbook for Providers of Healthy Kids Services for specific guidelines. Refer to Topic HK-203.1.1 Health Screening for HFS' minimum requirements for physicals for children ages 6-20 years. The AAP and AAFP periodicity schedule guidelines may vary slightly. Providers are encouraged to use the periodicity schedule that best meets the needs of the child. HFS will pay for other screenings when medically necessary, regardless of a child's age or medical history.

HK-203.1.1 HEALTH SCREENING

It is recommended that health screenings be provided to children, on a periodicity schedule based on acceptable medical practice standards, such as the schedule recommended by the AAP or the AAFP, or the following schedule provided by HFS as a minimum guideline.

- Under Age One: Birth
 - During first 2 weeks
 - 1 month
 - 2 months
 - 4 months
 - 6 months
 - 9 months
- One to Three:
 - 12 months
 - 15 months
 - 18 months
 - 24 months/30 months
- Three to Six: Annually
- Six to twenty-one: Every other year, at a minimum, or more often if medically recommended, or if following an acceptable medical practice standard for the periodicity schedule.

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

A well child visit should include all of the following components:

- A comprehensive health and developmental history (including assessment of physical health, mental health [including social, emotional and behavioral issues], development and nutrition)
- A comprehensive unclothed physical examination (Note: The comprehensive examination performed as part of the Preventive Medicine Evaluation and Management Service codes are further explained in the *Current Procedural Terminology* (CPT) reference book. In order to bill for these services, the guidelines set forth in the CPT reference book must be met and documented in the child's medical record.)
- Appropriate immunizations based on age and health history and the correction of immunization deficiencies (according to the schedule established by the Advisory Committee on Immunization Practices [ACIP] for pediatric vaccines)
- Laboratory tests (including blood lead level assessment appropriate to age and risk)
- Health education (including anticipatory guidance)

In addition, age appropriate objective vision and hearing screening; risk assessment (such as mental health, tobacco/substance abuse screening, perinatal depression, Guidelines for Adolescents Preventive Services [GAPS]), as appropriate; age appropriate objective developmental screening and assessment, including social-emotional development; oral health screenings and referrals for dental care and other needed medical services should be performed.

HK- 203.1.2 INTERPERIODIC SCREENINGS

Interperiodic Screenings may be provided as medically necessary, or when required or mandated for: participation in school; enrollment in the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) (refer to Topic HK-207.5); admission to day care; placement in a licensed child welfare facility including foster home, group home or institution; attendance at camp; participation in a sports program; enrollment in an early childhood education program; required by the child's Individual Education Plan (IEP) or Individual Family Service Plan (ISFP), or at the request of the parent or guardian.

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

HK-203.1.3 HEALTH HISTORY

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

- Obtain information about previous health care and health problems
- Evaluate the risk for health problems
- Obtain information about the child's academic performance, peer relationships and overall functioning within the community
- Obtain information about the eligible participant's family and social environment to understand particular need and provide appropriate care

Information should be obtained from the eligible participant and parents or guardians who are familiar with the child's health history. Additional information and records should be acquired from health care professionals or organizations that have provided health care services to the eligible participant.

A complete written history is required during the initial health screening. Interval histories will be maintained for the period between subsequent screening visits by the participating provider for the child. As medically and age appropriate, the following topics should be included in the health history:

Current complaints	Medications taken and any adverse effects
Social, cultural	Allergies
Environmental	Immunizations
Family health history	Illnesses and Accidents
Prenatal, birth, neonatal	Communicable diseases
Development	Hospitalizations
Physical growth	Health habits
Fluoridation status, oral health	Parent concerns
Nutrition Screening	Substance Abuse history
Hearing/communication/language development	
Adolescents: risk taking behaviors; the use or need for contraceptives, as applicable	

HK-203.1.4 NUTRITIONAL ASSESSMENT

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

- Health History
- Dietary Evaluation - including record of food intake, diet history including questions to identify unusual dietary practices or eating habits (e.g. prolonged use of bottle feedings, eating non-food items, etc.) or food frequency to identify the frequency of consumption of foods grouped together based on their principal nutrient contribution; evaluation of breastfeeding
- Anthropometric Measurements - length or height, weight and head circumference, weight for length under age two and body mass index (BMI) for age two and older measured and plotted on a standardized growth chart

- Biochemical Measurements - screening test for iron deficiency (hemoglobin or hematocrit) and cholesterol screening for children at risk
- Clinical Evaluation - complete physical examination including an oral examination as covered in Topic HK-203.1.5; special attention should be paid to such general features as apathy or irritability

Follow-up is indicated for the children exhibiting the following:

- Dietary intake inadequate/inappropriate for age or physical condition including inappropriate feeding practices; evaluation of breastfeeding
- Height less than the 5th percentile on a standardized growth chart (i.e. National Center for Health Statistics)
- Weight for age less than the 5th percentile on a standardized growth chart or change in percentile (up or down greater than 10%)
- Weight for height less than the 5th percentile or greater than the 95th percentile on a standardized growth chart or Body Mass Index (BMI) for age greater than 95th percentile
- Diseases in which nutrition plays a key role such as early childhood caries, diabetes, allergies, metabolic disorders, and physical or mental disabilities affecting feeding

Assess iron status for all children based on the periodicity schedule outlined in Section 203.3.2.

Children should be tested at other times if clinically indicated.

HK-203.1.5 COMPREHENSIVE UNCLOTHED PHYSICAL EXAMINATION

The comprehensive preventive child health physical examination:

- Evaluates the form, structure and function of particular body regions and systems
- Determines if these regions and systems are normal for the child's age and background
- Discovers those diseases and health problems for which no standard screening test has been developed, including evidence of child abuse, neglect or both

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

- Measurements - vital signs, height, weight and head circumference; **measurements are to be plotted on a standardized growth chart, as appropriate**; BMI should be determined for children age two and above
- Height and weight should be measured at each visit; head circumference is measured at each screening visit until the child reaches 24 months of age; children age three and above are recommended to have an annual blood pressure screening; children under age three should be tested if a risk assessment indicates risk for hypertension
- General appearance - body shape and proportions, gait and posture; skin evaluation (color, texture, rash, deformities, and birthmarks); hair and nails; speech pattern (vocalization and speech appropriate for age); orientation and mental alertness; parent and child interaction and behavior

- Head and Neck - facial features and head shape; presence of lymphadenopathy; nose and throat evaluation: includes inspection of nasal mucous membranes; mouth, teeth, gums evaluation: palate, uvula, pharynx, dental ridge, oral membranes and dental caries
- Eyes and Ears - eyelids, extraocular motion; conjunctiva, cornea, iris, and red reflex; examination of conjugate eye movements and pupillary reaction to light; external and otoscopic examination of ear canals and drums
- Cardiovascular - palpation of the heart, auscultation for rate, rhythm, valvular sounds, murmurs; evaluation of peripheral vasculature and presence of edema
- Respiratory - inspection and palpation of the chest: shape, symmetry, respiratory rate, rhythm, and effort; thoracic condition; chest movements; percussion, auscultation, and measurement of the chest
- Gastrointestinal - palpation of organs and masses, hernias, tenderness
- Reproductive Systems and Breasts – genitalia inspection and palpation of breasts; Tanner Stage; testicular examination in males
- Nervous System - neurological evaluation: including reflexes, gross/fine motor coordination
- Musculoskeletal - scoliosis screen, muscle strength evaluation, evaluation of hips and gait, gross and fine motor coordination
- Lymphatic System - lymph nodes, spleen, thymus and bone marrow; superficial lymph nodes and the spleen are accessible for assessment by inspection and palpation; most common causes of visible lymphatic activity are infection and neoplasm; lymphadenopathy in children's necks is commonly caused by infection
- Integument - assessment of the skin should be an integral part of every health assessment; many common pathologic disorders have associated integumentary disorders, for example, many contagious childhood diseases have associated characteristic rashes

Health care providers should consider the age of the eligible participant when conducting the physical examination. Some of the inspections mentioned above may not be appropriate at particular levels. Additionally, health care providers are mandated to report suspicious injuries or conditions to the:

Illinois Department of Children and Family Services
Child Abuse and Neglect Hotline
1-800-25-ABUSE

HK-203.2 APPROPRIATE IMMUNIZATIONS

The All Kids Program requires immunizations appropriate for a child's age and health history. **The Recommended Childhood Immunization Schedule** is annually updated, as approved by the Advisory Committee on Immunization Practices (ACIP) of the U.S. Department of Health & Human Services, Centers for Disease Control and Prevention (CDC), the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP).

The most current **Childhood Immunization Schedule** can be found at the National Immunization Program Home Page. Refer to Topic 207.9.1 for Web site locations. Additionally, the immunization schedule is published in the Morbidity and Mortality Weekly Report (MMWR) in January. Information can also be obtained by contacting

the CDC Hotline:

1-800-CDC-INFO (1-800- 232-4636)

Providers should use the most current Childhood [Immunization Schedule](#) as recommended by the CDC. The Immunization Schedule is updated annually. Providers may refer to the CDC Website at <http://www.cdc.gov/vaccines/recs/schedules/default.htm> to obtain the Childhood Immunization Schedule. The Childhood Immunization Schedule is also located at: http://www.cispimmunize.org/IZSchedule_Childhood.pdf
http://www.cispimmunize.org/IZSchedule_Adolescent.pdf
http://www.cispimmunize.org/IZSchedule_Catchup.pdf

The current immunization schedule is also available on the AAP's Web site. Refer to topic HK-207.9.1, Resources and Referrals, for Web site Locations. Providers should use the most recent published immunization guidelines.

The Omnibus Budget Reconciliation Act of 1993 (OBRA) created the **Vaccines for Children (VFC) Program** as Section 1928 of the Social Security Act in August 1993, to ensure that children from low-income families receive immunization services. For more information on the VFC Program, refer to topic HK-207.2.

HK-203.3 LABORATORY PROCEDURES

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

HK-203.3.1 LEAD RELATED EVALUATIONS AND BLOOD LEAD TESTING

Guidelines from the CDC define lead poisoning as a blood lead level greater than or equal to 10 µg/dL. Federal mandates and HFS policy require that **all children** enrolled in HFS' Medical Programs be considered at risk for lead poisoning and receive a screening blood lead test prior to age **12 and 24 months**. Children over the age of 24 months, up to 72 months of age, for whom no record of a previous screening blood lead test exists, should also receive a screening blood lead test. **All children enrolled in HFS' Medical Programs are expected to receive a blood lead test regardless of where they live.** Children at highest risk should be assessed on a regular basis. The city of Chicago requires blood test to be performed at 6, 12, 18, 24 and 36 months or 9, 15, 24 and 36 months. Blood lead testing for diagnostic reasons (e.g., history of exposure, follow-up of past test results) is always indicated.

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

Blood lead draw is the only laboratory draw fee that may be billed. HFS reimburses fee-for-service providers who do not receive an encounter rate for the blood lead draw (CPT 36415, with the U1 modifier, [36415U1] - venous blood lead draw, and CPT 36416, with the U1 modifier, [36416 U1] – capillary blood lead draw). The blood

lead analysis using the ESA Biosciences LeadCare II Blood Lead Testing System does not require CLIA certification (CPT 83655, with the QW modifier [83655QW]). HFS reimburses fee-for-services providers who do not receive an encounter rate for the blood lead analysis performed in their office, with the appropriate CLIA certification (CPT 83655). Encounter rate clinics **must** report in detail the services performed during the office visit on the encounter claim.

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

Diagnosis, Treatment and Follow-Up

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

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

Illinois Department of Public Health
Illinois Lead Program
(217) 782-3517 (phone)
(217) 557- 1188 (fax)

Reporting

The Illinois Lead Poisoning Prevention Act **requires** reporting by laboratories of all blood lead test results to the IDPH Illinois Lead Program. Any blood lead test conducted within the practice laboratory by any method falls under the reporting requirement. Physicians are required to report to the IDPH Illinois Lead Program all results greater than or equal to 10 µg/dL. If the physician uses the IDPH (State) laboratory for blood analysis (which is highly encouraged by HFS), the physician reporting of elevated blood lead levels is waived, since the results of the blood lead levels are already known to the IDPH Illinois Lead Program. However, if the physician uses a private laboratory, the physician must report all results of 10 µg/dL and above to the IDPH Illinois Lead Program. The IDPH Illinois Lead Program may be contacted by calling or faxing the information to:

Illinois Department of Public Health
Illinois Lead Program
(217) 782-3517 phone
(217) 557-1188 fax

When reporting lead poisoning to IDPH, the child's Recipient Number must be provided. The IDPH Illinois Lead Program will ensure that children with elevated blood lead levels are referred to a Certified Local Health Department for public health nurse intervention. As a delegate agency of IDPH, the Certified Local Health Department provides care coordination by the public health nurse, which may include follow-up testing, referrals to other services, and further investigation.

Specimen Handling and Provider Feedback

Blood specimens for lead analysis should be sent to:

The Illinois Department of Public Health
Division of Laboratories
825 North Rutledge, P.O. Box 19435,
Springfield, Illinois, 62794-9435
(217) 782-6562

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

Environmental Assessment to Determine the Source of Lead Exposure

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

- A child 36 months or younger has a confirmed blood lead level (venous) at or above 10 µg/dL
- A child 36 months or older has a confirmed blood lead level at or above 20 µg/dL
- Three consecutive blood lead results of 15 µg/dL to 19 µg/dL
- The physician requests an inspection to determine if the child should be removed from the dwelling as a result of the identified lead hazard

The Certified Local Health Department or IDPH will be reimbursed by HFS for the environmental assessment of the child's home (or primary residence), to determine the source of lead for children participating in HFS' Medical Programs. Reimbursement for this investigation is limited to a health professional's time and activities during the on-site investigation of a child's home. The testing of environmental substances, such as dust, water, soil, or paint is not covered by HFS, but sample analysis is performed by IDPH. The established procedure code for environmental assessment is: T1029.

HK-203.3.2 ANEMIA TEST

Iron deficiency is the most prevalent form of nutritional deficiency in this country. The risk of anemia is highest during infancy and adolescent because of the increased iron requirements from rapid growth. (In full term infants, iron stores are adequate until age 4 to 6 months). The following information is from *Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents, Recommendations for Preventive Pediatric Health Care, 3rd Edition, 2008*. A risk assessment for anemia should be conducted at 4, 18 and 24 months and all ages three years and above.

Hemoglobin or Hematocrit testing is recommended for persons:

- Age 9 months to 12 months
- Age 15 months to 18 months, as medically necessary
- At any age with a history of iron-deficiency anemia
- Whose history or risk assessment identifies a medical need

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

HK-203.3.3 SICKLE CELL DISEASE, SICKLE CELL TRAIT AND HEMOGLOBINOPATHIES

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

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

HK-203.3.4 TUBERCULOUS SCREENING

Tuberculosis screening is recommended to be done at the provider's discretion based on medical indication. AAP guidelines recommend the following children be considered for testing.

Simple questionnaires can identify children with risk factors for Latent TB Infection (LTBI) who then should be tested with a Tuberculin Skin Test (TST). Risk assessment for tuberculosis should be performed at first contact with a child and every 6 months thereafter for the first 2 years of life (e.g. 2 weeks and 6, 12, 18 and 24 months of age). If at any time, risk of tuberculosis disease is determined, a TST should be performed, although this test is unreliable in infants younger than 3 months of age. After 2 years of age, risk assessment for tuberculosis should be performed annually, if possible.

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

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

Children for whom immediate tuberculin skin testing is indicated:

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

Children who should have annual tuberculin skin testing:

- Children infected with HIV
- Incarcerated adolescents

Risk for Progression to Disease

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

HK-203.3.5 DYSLIPIDEMIA SCREENING

A risk assessment including family history should be done at ages 2, 4, 6, 8, 10 years and at each periodic well child exam thereafter. High-risk children should have laboratory assessment. Between the ages 18 and 21 years, a dyslipidemia screening should be done once during this period.

HK-203.3.6 URINALYSIS

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

HK-203.3.7 CERVICAL DYSPLASIA SCREENING/PAP TESTS AND TESTS FOR SEXUALLY TRANSMITTED INFECTIONS

Pelvic examinations are recommended by the AAP for adolescent girls who have menstrual problems, or a history of maternal use of diethylstilbestrol (DES), or who are sexually active. If sexually active, the AAP recommends a Papanicolaou (PAP) test, (cervical dysplasia screening) culture for gonococci, Chlamydia; and microscopic examination of vaginal discharge. Eligible participants should be informed about all tests performed, given test results, and educated about sexually transmitted infections and the availability of family planning/birth control. All sexually active girls should have a screening for cervical dysplasia as part of a pelvic exam beginning within three years of onset of sexual activity or age 21 (whichever comes first).

HK-203.3.8 OTHER LABORATORY TESTS

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

HK-203.4 DEVELOPMENTAL MILESTONES

Appendix 2 provides a sample of the developmental milestones for screening purposes. Referral information is located in Topic HK-207.9.2, Other Related Agencies and Referral Sources, *Handbook for Providers of Healthy Kids Services, Policy and Procedures for Preventive Health Care for All Kids, HK-200*.

If the child does not appear to be progressing through basic developmental milestones as expected, it is recommended that monitoring become more vigilant, with further screening, evaluation or assessment, and referrals, as appropriate (refer to Topic HK-207.6), see [Appendices](http://www.hfs.illinois.gov/handbooks/chapter200.html) at <http://www.hfs.illinois.gov/handbooks/chapter200.html>.

HK-203.5 DEVELOPMENTAL SCREENING AND ASSESSMENT

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

HFS has partnered with public and private entities as a means to implement the Enhancing Developmentally Oriented Primary Care (EDOPC) Project. EDOPC is an initiative to support developmentally oriented primary care and thus, assists HFS enrolled providers to comply with comprehensive well-child exams and needed follow-up, as federally required under the EPSDT program.

The EDOPC Project staff will provide training to HFS enrolled providers serving HFS enrolled pregnant women and children on topics, which include perinatal depression, Autism, developmental, and social-emotional screening. EDOPC staff train on the use of validated screening and evaluation tools based on evidence-based practices. In-

office provider training is available through the Illinois Chapter, American Academy of Pediatrics (ICAAP) and the Advocate Health Care Healthy Steps Program. On-site training in medical offices, clinics and hospitals is geared toward the entire staff in order to facilitate a comprehensive team approach to patient care.

More information about the EDOPC project and the provider training available under the project is located at the following Web sites:

www.edopc.org/
<http://www.illinoisAAP.org/DevelopmentalScreening.htm>

The training programs will provide information regarding when (and to whom) to refer a mother and/or child if there are concerns with their development or social-emotional health and well-being. In addition, information is provided regarding billing procedures for the use of screening tools.

HK-203.5.1 COMPONENTS

Developmental surveillance is a structured evaluation of a child's competencies (including knowledge, skills, aptitude) gathered through skilled observations of knowledgeable professionals during provision of health care services, e.g., well-child visits. Subjective developmental surveillance is performed at each well-child visit as part of the well-child examination, and is not a separate billable service. Subjective developmental surveillance alone has been shown to miss a significant number of mildly delayed and at-risk children who would benefit from further evaluation and services. Therefore, it is strongly recommended that objective screening tools should be used at well-child visits at no less than priority intervals (e.g., based on the recommended periodicity schedule), in order to screen for developmental and social-emotional delays, with referrals made to Early Intervention or other agencies as indicated through the results of the screening or due to parent/clinician concerns, refer to Topic HK-203.5.2.

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

Developmental surveillance should be culturally sensitive. The following elements are recommended to be included in the developmental surveillance of children of all ages:

- Gross motor development, focusing on strength, balance, coordination and locomotion
- Fine motor development, focusing on eye-hand coordination
- Communication skills or language development, focusing on expression, comprehension and speech articulation (Any time there is parent/guardian or school concern about language development and/or hearing loss, the child should be referred for a standard audiometric evaluation by an audiologist)
- Self-help and self-care skills

- Social-emotional development, focusing on the ability to engage in social interaction with other children/adolescents, parents and other adults
- Cognitive skills, focusing on problem solving or reasoning
- Parenting and family functioning
- Visual-motor integration appropriate for age

The following areas should be used for assessments of school-aged children:

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

The following areas should be used for assessments of adolescents:

- Potential presence of learning disabilities or problems with school
- Peer relations
- Psychological/psychiatric problems
- Vocational skills

HK-203.5.2 OBJECTIVE DEVELOPMENTAL SCREENING AND EVALUATION TOOLS

Providers are encouraged to follow the recommendations on AAP's Policy Statement "Identifying Infants and Young Children with Developmental Disabilities in the Medical Home: An Algorithm for Developmental Surveillance and Screening", July 2006, Volume 118, Issue 1, pages 402-420. It is recommended that developmental surveillance be incorporated at every well-child preventive care visit. Any concerns raised during surveillance should be promptly addressed with standardized objective developmental screening tests in order to identify children with developmental and social-emotional delays and make referrals to Early Intervention or other agencies as indicated through screening results or due to a parent/clinician concerns. **In addition, objective screening tests should be administered regularly at the 9-, 18-, and 24-30-month visits** and more frequently as medically indicated. Objective developmental screening must include all domains, including social and emotional development. Current detection rates of developmental disorders are lower than their actual prevalence, which suggests that the challenges to early identification of children with developmental disorders have not been overcome.

Screening tools state their norms explicitly and can help to effectively monitor and record a child's development and detect developmental delays and disabilities early. Screening tools also serve as a reminder to providers to observe development and clearly communicate their interest in development as well as the physical health of the child.

An objective developmental screening tool, approved by HFS, may be used to evaluate levels of:

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

Objective developmental testing (limited or extended) must meet the definition provided by CPT and must be provided according to the guidelines provided for the instrument, including use of the instrument form, as applicable. If a parent or caregiver checklist is the screening instrument, the provider must interpret and document the findings in the medical record in order to bill for the objective developmental screening. For purposes of this Handbook, these testing instruments that are “limited” are referred to as **screening** tools. Those that are “extended” are referred to as **evaluation** tools.

HK-203.5.3 DEVELOPMENTAL SCREENING TOOLS

Screening tools for developmental testing; limited, with interpretation and report, CPT code 96110, approved by HFS include:

- Ages & Stages Questionnaires (ASQ)
- Ages & Stages Questionnaires: Social-Emotional (ASQ: SE)
- Battelle Developmental Screener
- Bayley Infant Neurodevelopment Screener
- Brief Infant Toddler Social and Emotional Assessment (BITSEA)
- Brigance Early Preschool
- Chicago Early Developmental Screening Inventory
- Denver DST/Denver II
- Developmental Profile II
- Dial-R Developmental Assessment
- Dial - 3
- Early Language Milestone Scales Screen
- Early Screening Inventory
- Early Screening Profiles
- Infant-Toddler Symptom Checklist
- Minneapolis Preschool Screening Instrument
- Modified Checklist for Autism in Toddlers (M-CHAT)
- Parents' Evaluation of Developmental Status (PEDS)
- Parents' Evaluation of Developmental Status -- Developmental Milestones (PEDS: DM)
- Parents' Observations of Infants and Toddlers (POINT)
- Project Memphis DST
- Revised Developmental Screening Inventory
- Revised Parent Developmental Questionnaire
- Temperament and Atypical Behavior Scale (TABS) Screener

HK-203.5.4 DEVELOPMENTAL EVALUATION TOOLS

Developmental evaluation is performed when results of screening indicate a more detailed evaluation is needed or when high-risk conditions (e.g. prematurity) are present. Evaluation tools which are defined in the CPT as developmental testing; extended, with interpretation and report, (e.g., includes assessment of motor, language, social adaptive or cognitive functioning by standardized developmental instrument), CPT code 96111, that have been approved by HFS include:

- Battelle Developmental Inventory
- Bayley Scales of Infant Development
- Child Behavior Checklist 2-3 and Caregiver-Teacher Report Form, Ages 2-5

- Child Development Inventory
- Conner's Rating Scales
- Early Coping Inventory
- Erhardt Development Prehension Assessment
- Hawaii Early Learning Profile
- Infant-Toddler Developmental Assessment
- Infant-Toddler Social and Emotional Assessment (ITSEA)
- McCarthy Screening Test
- Otis-Lenon School Ability Test
- Piers-Harris Children's Self Concept Scale
- Temperament and Atypical Behavior Scale (TABS) Assessment Tool
- Vineland Adaptive Behavior Scales
- Vineland Social-Emotional Early Childhood Scales
- Vineland Social Maturity Scale

Reimbursement: In order to be reimbursed for using a screening or evaluation tool, providers must bill under the proper CPT code (see Topic HK-202.1 and Appendix 8 for billing procedures), maintain the tool and document results in the child's medical file for auditing purposes. Anticipatory guidance and referrals made as a result of the screening shall be documented. Providers billing an encounter rate, such as FQHCs, RHCs and ERCs will not receive a separate reimbursement but must detail the objective developmental screening or evaluation performed on the encounter claim.

Additional Developmental Tests - Providers may request additions to the list of developmental screening and evaluation tools recognized by HFS for payment. The Provider must document that an instrument meets the following criteria: It is:

- listed in the Mental Measurement Yearbook Series
- nationally distributed
- formally validated
- individually administered

Requests must be submitted in writing to the:

Illinois Healthcare and Family Services
Bureau of Maternal and Child Health Promotion
607 East Adams Street, 4th Fl
Springfield, IL 62701

HK-203.6 AUTISM SCREENING

CDC released through its Morbidity and Mortality Weekly Report (MMWR) [February 9, 2007 / 56(SS01); 1-11] Surveillance Summaries that 1 in 150 children in America today have an autism spectrum disorder (ASD). CDC estimates that 1.5 million Americans and their families are now affected. Autism is a national health crisis, costing the U.S. at least \$35 billion annually.

According to a policy statement distributed by the American Academy of Pediatrics in November 2007, an autism-specific screening should be conducted for all children at the 18-month and 24-month visits.

See Topic HK-203.5.3, Topic HK-203.5.4 and Appendix 8 for a list of HFS-approved objective developmental screening and evaluation tools.

[Public Act 93-0395](#) created the Autism Program and the establishment of three Regional Centers. The Autism Program is a network of resources for Autism Spectrum Disorders in Illinois. The Autism Program provides the strategy and framework for Illinois to address the complex issues involved in diagnosis, treatment and research for the thousands of children in Illinois with ASD.

The Autism Program has developed an infrastructure to train, support, and coordinate the linkage of an informed provider network to help Illinois families. Resources are as follows:

[The Autism Program Metro-Chicago Regional Training and Service Center at The University of Illinois at Chicago](#)

[The Autism Program Central Illinois Regional Training and Service Center at The Hope Institute for Children and Families \(HICF\)](#)

[The Autism Program Southern Illinois Regional Training and Service Center at Southern Illinois University at Carbondale](#)

[The Autism Program Affiliate at The University of Illinois at Urbana-Champaign](#)

The Autism Program Affiliate Illinois State University in Normal

The Illinois General Assembly provides funding through the [Illinois Department of Human Services](#). [The Hope Institute for Children and Families](#) in Springfield, Illinois provides administration for The Autism Program.

Illinois Department of Human Services, Division of Developmental Disabilities

The Illinois Department of Human Services, Division of Developmental Disabilities (DHS/DD) is the state agency for operating the waiver programs for children with developmental disabilities. DHS/DD's *Home and Community-Based Services Waivers for Children* provide services and supports to keep children with developmental disabilities, including autism, in home or community settings. Effective July 1, 2007, two home and community-based services waivers for children with developmental disabilities, including autism, were approved. The waiver programs provide services and supports to keep children in home or community settings. Information on these services can be found at: <http://www.dd.illinois.gov> The toll-free telephone line is: 1-888-DDPLANS (1-888-337-5267), or 1-866-376-8446 (TTY).

HK-203.7 VISION AND HEARING SCREENING

Subjective vision and subjective hearing screening, based on health history and parent report, is a part of each well child visit, and is not separately reimbursable or reported by a CPT code.

Periodic objective vision screening, using an HFS-approved instrument(s), and periodic objective hearing screening, using an HFS-approved instrument(s), are to be provided, according to clinical guidelines. If the provider does not perform an objective vision screening, or an objective hearing screening, a referral for the objective vision screening or objective hearing screening should be made at certain periods in the child's life, based on age and health history, and that referral should be

recorded in the child's medical record. A copy of the screening results should be requested by the provider for inclusion in the medical record and appropriate follow-up and care coordination should occur.

To bill a separate objective screening CPT code, the vision or hearing screening criteria must be met. HFS allows reimbursement for vision or hearing screening, if an HFS-approved screening instrument is utilized and results are documented in the child's medical record (e.g., for vision – the Snellen Chart, the Good-Lite Insta-Line with HOTV, the Michigan Preschool Slides; for hearing – the otoacoustic emission [OAE]). The encounter rate clinic (e.g., FHQC, RHC or ERC) does not receive separate reimbursement for the vision or hearing screening using an HFS-approved instrument, but **must** detail the services provided during the visit on their encounter claim. Refer to Appendix 8 for the CPT codes appropriate for billing and reporting hearing and vision screening using an HFS-approved instrument.

HK-203.7.1 VISION SCREENING

[Public Act 95-0671](#) requires any child entering kindergarten to receive an eye examination by an optometrist or ophthalmologist. However, one encounter with the eye specialist during childhood is not adequate and should not replace current American Academy of Pediatrics' (AAP's) guidelines for specific vision screening, beginning with the newborn exam and continuing at each well child visit. It is recommended that subjective vision screening (by history, observation and non-quantitative tests) be conducted for all infants and toddlers in the primary care setting. Beginning at age three, an additional objective vision screen, using an age appropriate method consistent with AAP guidelines is recommended annually for children between the ages of 3 through 6; and again at ages 8, 10, 12, 15 and 18 years, according to AAP recommendations. Vision screening guidelines can be found in American Academy of Pediatrics, *Policy Statement on Eye Examination in Infants, Children and Young Adults by Pediatricians*, Pediatrics, Vol. III, No.4, (902-907), April, 2003.

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

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

- Annually to all pre-school-aged children, beginning at age three years, in any public or private educational program or licensed child care facility
- School aged children who are in kindergarten, second and eighth grades
- Annually for all children who are in special education classes

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

Guidelines

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

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

An objective (quantitative) vision screening is billable if it meets HFS criteria. Encounter rate reimbursed providers (e.g.) FQHCs, RHCs and ERCs) **must** detail the services provided on the encounter rate form. Objective vision screening should be added to subjective vision screening and both be performed at every well child visit beginning at age 3 years.

Community-based objective screening is valuable for children who miss well child visits and should follow the schedule in the above box. Ideally, the results of community screening should be communicated to the PCP. Vision screening should occur more often than the scheduled vision screening if indicated by appearance, behavior, complaints or health history.

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

Vision Screening Procedures

The objectives of vision screening are to:

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

Vision screening should be administered by nurses or technicians certified by the IDPH for the purpose of vision screening in school or local health departments, or by a PCP (or the PCP's staff, under the direct supervision of the PCP) enrolled in the HFS Medical Assistance Program.

Non-physician personnel working in a local county health department and administering vision-screening tests to preschool and school age children must be certified by the IDPH. Certification is awarded upon successful completion of specialized training in the use of vision screening instruments and in working with children.

Objective screening should follow procedures established by the IDPH. Each child, regardless of age or grade, is to be carefully observed to identify any problems. Non-physicians who observe eye or vision problems in children who pass quantitative

screening should immediately refer the child to their PCP so that appropriate preventive care can be rendered and referrals can be made.

Subjective Vision Screening

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

1. Ocular history
2. Age - appropriate vision assessment
3. External inspection of the eyes and lids
4. Ocular motility assessment
5. Pupil examination
6. Red reflex examination
7. Age-appropriate test of alignment (corneal light reflex test, cover test, or quantitative test of depth perception)
8. Photoscreening is an acceptable quantitative method to screen children who are not yet ready for visual acuity testing (AAP Policy Statement, Use of Photoscreening for Children's Vision Screening, *Pediatrics*, Vol.109, No.3, March 2002, pp.524-525)

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

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

Vision Developmental Milestones	
0-3 months	<ul style="list-style-type: none"> • Turns eyes and head to look at light sources • Briefly holds gaze on bright light or objects • Stares at surroundings • Blinks at camera flash • Moves eyes and head together • Tracks vertically and horizontally • Begins eye contact at 6-8 weeks
3-6 months	<ul style="list-style-type: none"> • Follows adults or moving objects with eyes across midline • Begins moving eyes with less head movement • Watches own hands before face • Looks at hands, food, bottle when sitting • Watches face when spoken to • Briefly fixes still objects • Reaches for small objects
7-12 months	<ul style="list-style-type: none"> • Orients to objects in home • Notice small objects, like cereal • Interested in pictures • Enjoys hide and seek (recognizes partially hidden objects) • Inspects toys held in hand • Responds to smiles and voices • Sweeps eyes across room
1-1½ Years	<ul style="list-style-type: none"> • Uses “pincer grasp” to hold objects between forefinger and thumb • Looks for toys that fall out of sight • Builds tower with 3 blocks • Enjoys picture books and points to pictures • Uses both hands • Holds objects close to eyes to inspect
2-3 Years	<ul style="list-style-type: none"> • Builds tower with 6 blocks • Imitates vertical line • Recognizes people in photographs • Begins to inspect objects without touching objects • Smiles and face brightens when looking at favorite people or objects • Likes to watch movements of objects, such as wheels on toy vehicle • Watches and imitates other children • “Reads” pictures in books • Begins to control hand movement while coloring or drawing

Pre-school Children (Age 3-5)

The US Preventive Services Task Force (USPTFS) and AAP, *Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents, Recommendations for Preventive Pediatric Health Care, 3rd Edition* recommend screening to detect amblyopia, strabismus, and defects in visual acuity in children younger than five years. Screening for amblyopia should begin at age 3. Amblyopia must be treated or vision will be permanently impaired. However, early testing and treatment can restore full vision. Treatment for amblyopia is best when started before a child is age 5.

After age 5, vision in the eye that does not see clearly may never fully develop and fewer children will respond to treatment.

Pre-school children (ages three and older) are to be evaluated for visual acuity (AAP Committee on Practice and Ambulatory Medicine, Section on Ophthalmology) using the Illinois Child Vision and Hearing Test Act approved symbols at a distance only. The test is presented binocularly to train the child and then monocularly for testing. Per the AAP guidelines, children aged 3 through 5 must pass the 20/40 symbol sizes. Children who do not pass the 20/40 symbol sizes may be rescreened once within one month. Children of any age may be referred after the initial screening, but *must* be referred after the second failed test (rescreening). Referrals must be made within one month of the decision to refer. These guidelines apply to all providers.

PCPs and their Staff Performing Objective Vision Screening under EPSDT may:

- Use the Snellen Notation 20/40-symbol size for three and four year old children at a distance position of 20 feet
- Use the Snellen Notation 20/30-symbol size for five-year-old children at a distance position of 20 feet

The PCP may elect to conduct objective vision screening in accordance with guidelines established by the IDPH, as found in Illinois Administrative Code, Title 77, Chapter 1, Part 685, and at a minimum, should follow the guidelines established by the Academy of Pediatrics, *Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents, Recommendations for Preventive Pediatric Health Care, 3rd Edition* (or most recent release).

For Local Health Departments:

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

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

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

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

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

Special Needs Children

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

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

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

School-age Children (Grades K-6)

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

Color vision screening is an optional test that should be given once during a child's school career. It is recommended that color screening be done at the second grade level. Note: State law now requires any child entering kindergarten to receive an eye examination by a licensed optometrist or ophthalmologist.

Approved Vision Screening Instruments for Screening Performed in the School or through the Local County Health Departments:

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

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

PCPs and their Staff Performing Objective Vision Screening:

The Snellen Notation 20/30-symbol size for school age children is acceptable. PCPs may elect to conduct objective vision screening in accordance with guidelines established by the IDPH, as found in Illinois Administrative Code, Title 77, Chapter 1, Part 685, and at a minimum, should follow the guidelines established by the Academy of Pediatrics, *Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents, Recommendations for Preventive Pediatric Health Care, 3rd Edition* (or most recent release).

School-age Children (Grades 7-12)

Approved Vision Screening Instruments for Screening Performed in the School or through the Local County Health Departments:

The substitution of the BRL slide (both right and left) is acceptable beginning at grade 7. It is an alternative test, which evaluates monocular acuity and binocular fusion. This test replaces the Massachusetts Battery and allows for an age appropriate substitute means of making the required evaluations. Visual acuity and fusion are screened using the 20/30 size symbols as based on Snellen Notation. The approved instrumentation remains the same as for the Massachusetts Battery. The required group of slides is changed.

PCPs and their Staff Performing Objective Vision Screening:

The Snellen Notation 20/30-symbol size for school age children is acceptable. PCPs may Conduct an objective vision screening in accordance with guidelines established by the IDPH, as found in Illinois Administrative Code, Title 77, Chapter 1, Part 685, and should follow, at a minimum, should follow the guidelines established by the Academy of Pediatrics, *Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents, 3rd Edition* (or most recent release).

Children Wearing Glasses or Contact Lenses

The screening battery for children wearing glasses or contact lenses should consist of observation; inspection of the lenses and frames and determination of the child's last

vision test or visit. Instrument screening of children while wearing glasses or contact lenses is not appropriate.

Vision Rescreening and Referral Guidelines

Rescreening and referral standards are those that have been established by the Children's Vision Services Advisory Committee. The standards are presented in the vision screening training classes offered by the IDPH. Questions relating to vision screening may be directed to:

Illinois Department of Public Health, Vision and Hearing Section
(217) 782-4733

Pass/Fail and Referral Criteria

School children beginning at grade 1 shall be screened at the 20/30 line for visual acuity and the 20/20 line for hyperopia. Both tests are performed at the far distance position. Pass/Fail criteria shall refer to the initial screening test. Referral criteria shall refer to the rescreening test. The Pass/Fail and Referral Criteria are identical and are listed below:

School Aged Children

1. Phoria Near and Far
 - a. For children in first grade, target alignment outside the defined area for both Near and Far modes shall constitute a failure.
 - b. For children in second grade and above, target alignment outside a Defined area for either Near or Far Modes shall constitute a failure.
2. Visual Acuity: The correct identification of less than four out of six of the monocular symbols constitutes a failure. (This criteria applies to both pre-school and school-age children in evaluating visual acuity.)
3. Hyperopia: The correct identification of four or more of the six monocular symbols constitutes a failure. (This test is given with the application of corrective lenses. If the child is able to correctly identify four or more with corrective lenses, it is felt that the child may need corrective lenses and requires further evaluation.)
4. Optional Color Test: The correct identification of less than six of the eight binocular symbols constitutes a failure.
5. Optional BRL (Monocular Acuity/Binocular Fusion): The correct identification of less than four of the five symbols in any of the three columns at either the near or far position on the BRL test constitutes a failure.

Preschool and Kindergarten Grade Children

1. Michigan Preschool Test: The correct identification of fewer than four of a maximum six presentations in each eye independently on monocular constitutes a failure.
2. HOTV (stereoscopic or distance screening): The correct identification of fewer than four of a maximum of six presentations in each eye independently on monocular presentation constitutes a failure.

Referrals

Referrals for professional eye care are made after failure has been confirmed by rescreening. Criteria for failure of rescreening are the same as the criteria for failure of the initial screening. Rescreening procedures are identical to initial screening, and recommended to be conducted within one month after the initial screening.

HK-203.7.2 HEARING SCREENING

[State law](#) requires all newborns receive an objective hearing screening, using an electro-physiological testing methodology, otoacoustic emission (OAE) or automated auditory brainstem (AABR) for identifying congenital hearing loss. A subjective screening or risk assessment is recommended as part of each well-child visit. If a child did not pass his/her newborn hearing screening, the child should be tested by or referred for an objective electro-physiological hearing screening. Reports of follow-up screening from a newborn hearing screening referral must be reported to IDPH and may be faxed to: (217) 557-5324. More information on hearing screening may be obtained from Division of Specialized Care for Children (DSCC), by calling (217) 793-2350.

According to the AAP recommendations, objective hearing screening, using standard testing methodology, is recommended annually for children between the ages of 4 through 6, and at 8 and 10 years of age.

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

Subjective Hearing Screening

At a well-child screening visit in which an objective hearing screening using a standard testing methodology does not occur, hearing should be screened subjectively and by history with the findings recorded in the child's medical record.

For all infants, regular surveillance of developmental milestones, auditory skills, parental concerns, and middle ear status should be performed in the medical home, consistent with the AAP pediatric periodicity schedule. All infants should have an objective standardized screening of global development with a validated assessment tool at 9, 18, and 24 to 30 months of age, or at any time if the health care professional or parent/caretaker or family has concerns.

Infants who do not pass the speech language portion of a medical home global screening, or for whom there is a concern regarding hearing or language, should be referred for speech-language evaluation and audiological assessment.

Guidelines

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

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

The timing and number of hearing re-evaluations for children with risk factors should be customized and individualized depending on the relative likelihood of a subsequent delayed-onset hearing loss. Infants who pass the neonatal screening but have a risk factor should have at least 1 diagnostic audiology assessment by 24-30 months of age. Early and more frequent assessment may be indicated for children with CMV infection, syndromes associated with progressive hearing loss, neurodegenerative disorders, trauma, or culture-positive postnatal infections associated with sensorineural hearing loss; for children who have received ECMO or chemotherapy; and when there is a caregiver concern or a family history of hearing loss.

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

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

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

A single list of risk indicators is presented in the Joint Committee on Infant Hearing (JCIH) 2007 statement because there is a significant overlap among those indicators associated with congenital/neonatal hearing loss and those associated with delayed-onset/acquired or progressive hearing loss. Therefore, heightened surveillance of all infants with risk indicators is recommended.

RISK INDICATORS ASSOCIATED WITH PERMANENT CONGENITAL, DELAYED-ONSET, OR PROGRESSIVE HEARING LOSS IN CHILDHOOD

Risk indicators that are marked with * are of greater concern for delayed-onset hearing loss:

1. Caregiver concerns* regarding hearing, speech, language or developmental delay
2. Family history* of permanent childhood hearing loss
3. Neonatal intensive care of more than 5 days or any of the following regardless of the length of stay: ECMO (extracorporeal membrane oxygenation); * assisted ventilation; exposure to ototoxic medications (gentamycin and tobramycin) or loop diuretics (furosemide/Lasix) and hyperbilirubinemia that requires exchange transfusion
4. In utero infections, such as CMV (cytomegalovirus); * herpes; rubella; syphilis; and toxoplasmosis
5. Craniofacial anomalies, including those that involve the pinna, ear canal, ear tags, ear pits and temporal bone anomalies

6. Physical findings, such as white forelock, that are associated with the syndrome known to include a sensorineural or permanent conductive hearing loss
7. Syndrome associated with hearing loss or progressive or late-onset hearing loss, * such as neurofibromatosis; osteoporosis and Usher syndrome; other frequently identified syndromes include Waardenburg, Alport, Pendred and Jerver and Lange-Nielson
8. Neurodegenerative disorders, * such as Hunter syndrome or sensory motor neuropathies, such as Friedreich ataxia and Charcot-Marie-Tooth syndrome.
9. Culture positive postnatal infections associated with sensorineural hearing loss, *including confirmed bacterial and viral (especially herpes viruses and varicella) meningitis
10. Head trauma, especially basal skull/temporal bone fracture* that requires hospitalization
11. Chemotherapy

(Source: *Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detections and Intervention Programs*, Joint Committee on Infant Hearing (JCIH), Pediatrics, Vol. 120, No.4, (898-921), October, 2007.)

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

Objective Hearing Screening Procedures

The objectives of the hearing screening are to:

- Refer children who either by screening or observation need a professional (medical or audiological) ear/hearing examination/evaluation
- Identify children who have correctable hearing loss who may be in need of medical intervention
- Identify children who have non-correctable hearing loss and may be in need of amplification systems and make these children known to school personnel
- Refer those children whose hearing is not sufficient to function in the typical educational setting for possible special education services

Hearing Screening by Schools and Local County Health Departments:

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

Screening should include the following:

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

Sample Questions

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

Instrumentation

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

Pure-tone audiometers utilized for identification audiometry must undergo an electro-acoustic coupler calibration check a minimum of once per calendar year.

Method and Criteria for Referral

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

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

Hearing Screening by PCP

PCPs, or their staff working under the direct supervision of the PCP, do not need to be certified by IDPH. PCP should follow the hearing screening recommendations by the AAP found in Pediatrics Vol III Number 2 February 2003; pp 436-440.

For children 4 years and older, conventional screening audiometry can be used. The child is asked to raise the right or left hand when a sound is heard in the respective ear. The test should be performed in a quiet environment using earphones. Ambient noise can affect test performance significantly, especially at lower frequencies (i.e., 500 and 1000 Hz). Each ear should be tested at 500, 1000, 2000 and 4000Hz. Air conduction hearing threshold levels of >20 dB at any of these frequencies indicate possible impairment.

Audiometric evidence of hearing loss should be substantiated by repeat screening. Earphones should be removed and repositioned, and instructions should be carefully

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

HK-203.8 ORAL HEALTH/DENTAL SCREENING

At age two, or earlier as needed, it is recommended that children be referred to a dentist for routine and periodic preventive dental care. HFS encourages parents or guardians to obtain for their child (or children) one clinical oral examination per year, and routine prophylaxis and topical fluoride treatment once every six months.

An oral screening is part of the physical examination but does not replace referral to a dentist. For children under age two, the dental screening is to identify children who require evaluation by a dentist. Oral health screening for children should be provided as part of the physical examination. The following conditions will be cause for referral to a dentist:

- Any developmental abnormalities of the oral cavity
- Evidence of infection
- Bleeding or inflammation of the gums
- Dental decay
- Early childhood caries

Dental services include services for relief of pain and infections, restoration of teeth, dental sealants, prophylaxis, fluoride supplementation and maintenance of dental health including instruction in self-care oral hygiene procedures. Dental care for children is NOT limited to emergency services. For assistance in finding a dentist for referral, contact:

Doral Dental of Illinois
1-888-281-2076 (provider service)
1-888-286-2447 (customer service for clients and referrals)

HK-203.9 RISK ASSESSMENT

Administration of an approved Risk Assessment instrument is essential in early identification of physical and mental problems in all age groups. A Risk Assessment tool assists the health care provider in objectively identifying the factors that predispose an individual to make decision(s) leading to risk-taking behavior, as well as take preventive action by addressing the situation promptly either by treatment or referral to an appropriate agency for support and services.

HK-203.9.1 RISK ASSESSMENT FOR CHILDREN

During a well-child health examination, youth who show signs or symptoms of mental or emotional problems, or indicate signs of substance abuse, should be screened using the *Mental Health Screening Instrument* or *Substance Abuse Screening*

Instrument. *The Experience Questionnaire (EQ)* is another tool that may be used to identify the need for referral to substance abuse treatment and may be obtained from the:

Illinois Department of Human Services
Division of Alcoholism and Substance Abuse
1-866-213-0548

Additionally, HFS recognizes the American Medical Association's (AMA) Guidelines for Adolescent Preventive Services (GAPS) as an approved health risk assessment instrument. Reimbursement is available for completion of either the Younger Adolescent Questionnaire or the Middle-Older Adolescent Questionnaire. The *GAPS questionnaire*, as well as the [GAPS Recommendations Monograph](http://www.ama-assn.org/ama/pub/category/1980.html), is available on the AMA's Web site at www.ama-assn.org/ama/pub/category/1980.html.

Parent(s) who indicate the need for mental health or substance abuse treatment services for themselves or their family members may also be referred for services (see Appendix 3 for a complete list of mental health referral resources by county, and Appendix 4 for a complete list of substance abuse referral resources by county). Coverage for services extends to eligible participants in HFS' Medical Programs.

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

Mental Health Screening

In an effort to improve children's mental health, Illinois has developed an enhanced [screening, assessment and support services \(SASS\) system for children](#), including adolescents, experiencing a mental health crisis. The system emphasizes a family-friendly, single point of entry for all children using this system and will ensure that children receive crisis services in the most appropriate setting. A child in need of a Screening and Assessment Service or experiencing a crisis, should be referred to the CARES line at **1-800-345-9049**. Refer to Appendix 3 for *HFS' Mental Health Screening Instrument*.

Substance Abuse Screening

Screening refers to a brief procedure used to determine the probability of the presence of a problem, substantiate that there is a reason for concern, or identify the need for further evaluation. It should focus on the adolescent's substance use severity (primarily consumption patterns) and a core group of associated factors such as legal problems, mental health status, educational functioning and living situation. It must have peer-reviewed published data on the reliability and validity of the measure. The following are the substance abuse screening tools approved by HFS for adolescents:

- [CRAFFT Screening Test](#)
- [MAYSI-2](#)
- [GAIN-Q](#)
- [GAIN-SS \(Recency\)](#)
- [GAIN-SS \(Past Year\)](#)

HFS' Substance Abuse Screening Instrument is found in Appendix 4. For information regarding smoking cessation, refer to Topic HK-203.10.

Comprehensive Assessment of Substance Abuse

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

The HFS approved comprehensive assessment substance abuse tool for adolescents is the Global Appraisal of Individual Needs (GAIN).

Providers performing the administration and interpretation of a health assessment instrument (CPT code 99420), other than those instruments specifically identified in this Handbook for Providers of Healthy Kids Services, should request HFS' approval for recognition of the risk or developmental screening assessment instrument (refer to Topic HK-203.5.4).

HK-203.9.2 Perinatal Depression

HFS covers approximately 51 percent of Illinois births (Calendar Year 2005), and an estimated 61 percent of those births are unintended (PRAMS 2003). HFS covers approximately 95 percent of teen births in Illinois (Calendar Year 2005). It is estimated that 10-20 percent of women in the United States who give birth experience a major depression during pregnancy or within a year after delivery; the prevalence may be higher in women with low socioeconomic status.

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

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

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

A statewide **Perinatal Mental Health Consultation Service** has been established for providers to use when a screening indicates that a pregnant or postpartum woman may be suffering from depression. This service provides telephone or online consultation with mental health professionals who have expertise in diagnosing and treating perinatal psychiatric disorders. The service is free of charge to health care providers. It is not a hot line, and is not intended for use by patients. The Perinatal Mental Health Consultation Service's toll-free telephone number is **1-800-573-6121**.

For more information, visit the following Web site:

[University of Illinois at Chicago's Perinatal Mental Health Project](http://www.psych.uic.edu/research/perinatalmentalhealth/)
<http://www.psych.uic.edu/research/perinatalmentalhealth/>

HK-203.9.3 PERINATAL DEPRESSION SCREENING/RISK ASSESSMENT

HFS provides reimbursement for "risk assessment" of women who are pregnant or post-partum. Reimbursement is available for perinatal depression screening as a "risk assessment" to identify women who may be at risk of, or who are experiencing, perinatal depression.

A list of [risk factors](#) for identifying women who may be at risk of prenatal or postpartum (perinatal) depression is available on HFS' Web site at <http://www.hfs.illinois.gov/mch/risk.html>

Often, risk factors may not be evident and depression may not be apparent without specific screening. The Edinburgh Postnatal Depression Scale (EPDS) was developed to assist primary care health professionals detect whether mothers are suffering from postnatal depression. It can be used effectively as a screen during pregnancy as well. HFS has reviewed the [Edinburgh Postnatal Depression Scale](#) (EPDS) and finds it to be an appropriate tool for screening pregnant and postpartum women for perinatal depression. Used with the woman's prior knowledge and consent, the EPDS is a reliable scale that is recognized as an appropriate screening instrument for early identification of depression during both the prenatal and postpartum periods. The EPDS contains ten questions and can usually be quickly administered and scored. A copy of the [EPDS](#) and its scoring guidelines can be found on HFS' Web site at <http://www.hfs.illinois.gov/mch/edinburgh.html>

Other screening tools that have been validated for use in obstetric populations may also be used to conduct perinatal "risk assessment" for women covered by HFS' Medical Programs. These include the Beck Depression Inventory, Primary Care Evaluation of Mental Disorders Patient Health Questionnaire, Postpartum Depression

Screening Scale and Center for Epidemiologic Studies Depression Scale. (Refer to the EDOPC website at <http://www.edopc.org/> or the ICAAP website at <http://www.illinoisAAP.org> for more information on these tools).

The provider must obtain written approval from HFS prior to using a perinatal depression screening instrument other than the EPDS, the Beck Depression Inventory or the Primary Care Evaluation of Mental Disorders Patient Health Questionnaire in order to obtain reimbursement for the screening. Providers must include documentation that the screening instrument has been formally validated, is nationally distributed, and is individually administered.

Requests must be submitted in writing to the:

Illinois Healthcare and Family Services
Bureau of Maternal and Child Health Promotion
607 East Adams Street, 4th Fl
Springfield, IL 62701

Please be aware that reimbursement will only occur for screenings using one of the listed and approved tools.

HK-203.9.4 REIMBURSEMENT FOR PERINATAL DEPRESSION SCREENING/RISK ASSESSMENT

Reimbursement is available for both prenatal and postpartum depression screening, as a "risk assessment." Providers billing an encounter rate (FQHCs, RHCs, ERCs) will not receive separate reimbursement but must detail each service performed during the encounter.

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

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

The procedure codes for prenatal risk assessment, including prenatal risk assessment is H1000 and 99420 with an HD modifier (99420HD). Information about HFS' [reimbursement rates](http://www.hfs.illinois.gov/feeschedule/) is available on HFS' Web site at <http://www.hfs.illinois.gov/feeschedule/>

HK 203.9.5 PERINATAL DEPRESSION RESOURCES

A statewide Perinatal Mental Health Consultation Service has been established for providers to use when a screening indicates that a pregnant or postpartum woman may be suffering from depression. This service provides consultation with psychiatrists, and other mental health professionals with expertise in perinatal mental health. Consultation includes information about medications that may be used in the management of perinatal depression both during and after pregnancy.

HFS has identified several [peripartum depression resources](http://www.hfs.illinois.gov/mch/resources.html) for providers, on the HFS Web site: <http://www.hfs.illinois.gov/mch/resources.html>

- The UIC Perinatal Depression Consult Service at **1-800-573-6121** has trained staff and is available free of charge as a resource to providers.
- The UIC has developed training programs for providers working with individuals being screened for perinatal depression. For further information, please review the material located at:

<http://www.psych.uic.edu/research/perinatalmentalhealth>

<http://www.hfs.illinois.gov/mch/resources.html>

- Health care providers who have questions about screening, assessment or treatment of peripartum depression can call the UIC Perinatal Mental Health Consultation Service, free of charge, by calling **1-800-573-6121**, or online at <http://www.psych.uic.edu/research/perinatalmentalhealth> to speak with a perinatal mental health expert. Providers can also request basic or advanced training workshops, free of charge, related to screening, assessment and treatment of peripartum depression. For further information, please review the material located at:

<http://www.psych.uic.edu/research/perinatalmentalhealth>

<http://www.hfs.illinois.gov/mch/resources.html>

- Patients may also be referred to the **DHS Helpline at 1-800-843-6154 or TTY 1-800-447-6404** for additional resource information.
- For other office based training, visit EDOPC <http://www.edopc.org/>
- For client hotline and referral services, contact ENH at:
<http://www.enh.org/clinicalservices/maternityservices/postpartum/>

HK-203.10 ANTICIPATORY GUIDANCE

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

HFS' recommended minimum topics to be covered by the provider's anticipatory guidance are listed in Appendix 1.

HK-203.10.1 SMOKING CESSATION

HFS covers prescription and over-the-counter smoking cessation products for All Kids participants. These products include nicotine replacement patches, gum, lozenges, inhalers, and nasal spray. HFS also covers oral medications that aid in smoking cessation, i.e., Chantix and bupropion. HFS does not cover smoking cessation techniques such as hypnosis, acupuncture, herbal remedies, ear clips, or any other smoking cessation technique that does not conform to a medical model.

Smoking cessation information provided to children and adolescents or parent(s) and guardian(s) who smoke is recommended as part of anticipatory guidance. Anticipatory guidance is considered to be included in the office visit fee; it is not separately reimbursed, refer to Appendix 1. For information and resources on Smoking Cessation, refer to Appendix 1.

For more information regarding Smoking Cessation programs in your area, contact the local health department or call the Tobacco Quit Line at the toll free number:

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

HK-203.10.2 CHILDHOOD OBESITY

The prevalence of obesity among children aged 6 to 11 more than doubled in the past 20 years, going from 7% in 1980 to 18.8% in 2004. The rate among adolescents ages 12 to 19 years, more than tripled, increasing from 5% to 17.1%. Currently, one child in five is overweight. The increase is in both children and adolescents, and in all age, race and gender groups.

Obese children now have diseases like Type 2 diabetes that used to occur only in adults. Overweight children tend to become overweight adults, continuing to put them at greater risk for heart disease, high blood pressure and stroke. Perhaps more devastating to an overweight child than the health problems is the social discrimination often experienced by an overweight child leading to low self-esteem or depression.

Because obesity is difficult to treat, efforts need to focus on prevention. Although genetic influences largely determine whether a child or adolescent will become overweight, environmental influences may play a key role in the extent of obesity. Prevention of obesity begins with breastfeeding, healthy eating behaviors, regular physical activity, and reduced sedentary behaviors (e.g., watching television and videotapes, playing computer games). These strategies are part of a healthy lifestyle that should be developed during early childhood.

The AAP, *Bright Futures Guidelines for Health Supervision for Infants, Children, and Adolescents, 3rd Edition, (2008)* suggest that parents need information on how to encourage their children and adolescents to practice healthy eating behaviors, beginning in childhood. Suggestions include:

- Gradually weaning infants from the bottle at about 9 to 10 months of age
- Switching children from whole milk to reduced-fat, low-fat, or fat-free milk after 2 years of age

- Gradually reducing children's fat intake to no more than 30 percent of their daily calories by age 5
- Limiting the consumption of high-sugar foods, including juices
- Being aware of portion sizes, especially of high-fat and high-sugar foods
- Limiting the consumption of convenience and fast foods
- Encouraging family members to drink water
- Encouraging children and adolescents to make healthy food choices based on the Dietary Guidelines for Americans and the U.S. Department of Agriculture's MyPyramid or MyPyramid for Kids, at: <http://www.mypyramid.gov/>
- Recommending moderate amounts of physical activity on most, if not all, days of the week
 - Preschool and elementary age children should be encouraged to participate in active play for at least one hour per day
 - Children and adolescents can achieve this level of activity through intense activities (e.g., hiking for 30 minutes) or through shorter, more intense activities (e.g., jogging or playing basketball for 15 to 20 minutes)
 - Parents, recreation program staff, and health professionals need to promote physical activity in children and adolescents and help them increase their physical activity levels and decrease sedentary activities

HK-203.11 OTHER SERVICES

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

Prior approval may be required for some of the covered items or services. Services or items requiring prior approval are identified in Chapter 200 of the handbook that pertains to that type of service. Most physical, occupational and speech therapies do not require prior authorization for children and youth under age 21 years.

HK-203.11.1 Quality Monitoring

As a component of the PCCM program, Illinois Health Connect and HFS will be examining a number of pediatric quality indicators (HEDIS or HEDIS-like measures). HFS will also provide feedback to providers regarding their performance on these individual indicators. The pediatric quality indicators include, but may not be limited to:

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

HK-204 NON-COVERED SERVICES

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

HFS will not pay for a service that is offered free to patients who are not covered by All Kids **unless:**

- The Maternal and Child Health (MCH), Title V Block Grant, pays the provider (in whole or in part) for that service. The MCH Title V Block Grant supports certain services for children from families with an annual income less than 300% of the federal poverty level (\$50,100 for a family of 4). Certified Local Health Departments and other public health agencies generally receive those grant dollars. IDHS administers the MCH Title V Block Grant.
- The service is provided pursuant to an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) as set forth under the Individuals with Disabilities Act (IDEA), under the School Based Health Services Program. The Web site is located at: < <http://www.sbhsillinois.com/> >.
- The service is “bundled” as part of another service when billed to other payors and the service is requested by HFS to be “unbundled” and individually billed, or in the case of an encounter rate clinic (e.g., FQHC, RHC or ERC) specifically detailed on the encounter claim (e.g., risk assessment or objective developmental screening).

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

HK-205 RECORD REQUIREMENTS

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

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

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

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

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

For children with chronic diseases, the provider must develop and use treatment plans that are tailored to the individual child and conform to accepted clinical guidelines and best practices. The plan includes appropriate ongoing treatment reflecting the prevailing community standards of medical care designed to minimize further deterioration or complications of the child's health. Treatment plans should be on file with the permanent record for each child with a chronic disease.

HFS and its professional advisors regard the preparation and maintenance of adequate medical records as essential for the delivery of quality medical care. In

addition, providers should be aware that medical records are a key document for post payment audits and quality of care reviews.

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

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

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

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

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

- A case note indicating an EPSDT exam was completed, the findings of the exam, any referrals made, and the name of the person who conducted the examination
- A completed growth chart that is stored in the child's chart
- Documentation of abnormal findings that are reported to the child's medical provider or the local health department medical director for follow-up
- A copy of the screening instrument, and results of the screening as appropriate.
- Documentation of appropriate referrals

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

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

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

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

HK 205.1 Child Health Profiles

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

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

- 9-, 10- or 12-digit Medicaid Provider Number
- 9-digit Recipient Identification Number (RIN) or the participant's name and date of birth or the participant's name and Social Security Number
- Child claims history information can also be obtained through the MEDI system. All providers can access MEDI via the Illinois Health Connect website at www.IllinoisHealthConnect.com or myHFS

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

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

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

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

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

HK-205.2 Illinois Health Connect Provider Profiles

To help support the PCP's quality assurance efforts, Illinois Health Connect will provide Provider Profiles to PCPs on a semi-annual basis. This report will provide information to each PCP on their achievement of patient care goals compared to statewide average achievement on the same goals. These quality indicators will be

compiled using administrative data based on industry standards for each quality indicator, such as HEDIS.

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

- Well Child Visits for the first 15 months of life
- Childhood Immunization Rates for two year olds
- Objective Developmental Screening
- Well Child Visits at ages three, four, five and six
- Well Child Visits for adolescents
- Percent of first trimester prenatal entry into care
- Percent of women who have delivered that have received a postpartum visit
- Adult preventive screening — Cervical Cancer Screening
- Diabetes measures

Measures reported on the profiles are subject to change.

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

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

HK-206 CERTIFIED LOCAL HEALTH DEPARTMENTS

HK-206.1 STANDING PROTOCOLS

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

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

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

HK-207 OTHER RELATED AGENCIES AND REFERRAL SOURCES

HK-207.1 TRANSPORTATION ASSISTANCE

Transportation of an eligible All Kids participant covered for transportation assistance (whose family income is under 200 percent of the federal poverty level) and if necessary, an attendant, to and from a source of medically necessary care is a covered service when a cost-free mode of transportation is not available or is not appropriate. A **non-employee attendant** is a family member or other individual who may accompany the participant when there is a medical need for an attendant. An **employee attendant** is a person, other than the driver, who is an employee of a Mediacar company. An **employee attendant** is a covered service when the mode of transportation is a Mediacar or Service Car and the circumstances constitute a medical necessity. Transportation to and from a source of medically necessary care requires prior approval. Prior approval is not needed for emergency medical transportation.

HFS has a contractor to handle the Non-Emergency Transportation Services Prior Approval Program (NETSPAP). Prior approval is required for all non-emergency medical transportation from the HFS contractor.

The participant, medical provider or transportation provider may call to receive prior approval for single trips. Requests for standing orders must be made in writing to the HFS contractor and can be made by anyone for all services. The standing prior approval may be faxed to: **(312) 327-3855**.

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

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

Prior Approval Process

The request for transportation must be made, by calling toll-free:

- **1-866-503-9040 for providers or 1-877-725-0569 for participants.**
(TTY: 1-800-526-0844 for the hearing impaired)
8 a.m. to 5 p.m. - Monday through Friday (closed on State holidays)
- The request must be made at least two business days (excluding weekends and holidays) prior to the trip
- When calling for a prior approval, the following information must be provided to the HFS contractor:
 - The participant's name, address and telephone number
 - Recipient Identification Number
 - The name and address of the medical provider
 - The date, time and reason for the appointment
 - The name of the transportation provider

- The HFS contractor will review the request and take one of the following actions:
 - If the request is approved, the approval will be posted in HFS' prior approval system and will give the transportation provider the request tracking number. Transportation for the participant may then be arranged. HFS will mail a Notice of Approval letter that contains information necessary to bill HFS for the service. **To ensure accurate billing, the transportation provider must wait for the approval notice before submitting a bill to HFS.** The transportation provider should bring errors on the Notice of Approval to the attention of HFS contractor.
 - If the request is denied, the denial will be posted in HFS' prior approval system along with the reason for the denial. HFS will mail a denial letter to the participant and the transportation provider.

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

HK-207.2 VACCINES FOR CHILDREN PROGRAM

The Omnibus Budget Reconciliation Act (OBRA) of 1993, created the Vaccines for Children (VFC) Program, as Section 1928 of the Social Security Act, to ensure that children from low-income families receive immunization services. The Illinois VFC Program:

- Provides state purchased vaccine, for HFS eligible children, through the age of 20 years, at no charge to public and private providers
- Provides federally purchased vaccines, for children whose insurance does not cover routinely recommended vaccines, in FQHCs and RHCs
- Covers vaccines recommended by the Advisory Committee on Immunization Practices (ACIP)
- Saves enrolled provider's out-of-pocket expenses for vaccine purchases
- Reduces the practice of referring children from the private sector to the public sector for vaccination, keeping children in their "medical home" for comprehensive health care

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

- Receiving Medical Assistance or All Kids
- Without health insurance
- With health insurance that does not cover immunizations
- Native American or Alaskan Native

Providers may not charge for the cost of the childhood vaccine provided by the VFC Program. The provider may charge HFS for the administration of the vaccine to program participants. Providers enrolled in the VFC Program are supplied by IDPH or the Chicago Department of Public Health (CDPH) with ACIP recommended vaccines and are reimbursed by HFS with an administration fee. The amount charged to HFS for the administration of the vaccine should be the provider's usual and

customary fee for administration of the vaccine (refer to Topic HK-202, Billing).

Providers report the immunization given to the All Kids participant by identifying each immunization provided, using the CPT-specific immunization code, (not the generic CPT code for the administration of an immunization).

All Healthcare and Family Services (HFS) enrolled participants ages 19 and 20 years are covered for childhood vaccines through an Interagency Agreement between HFS and IDPH. ACIP recommended vaccines for all HFS eligible clients under age 21 should be ordered from the Illinois Vaccines for Children Program or the Chicago Vaccines for Children Program.

While there is no additional payment for administration of a vaccine to providers serving managed care enrollees or to encounter rate clinics (e.g., FQHCs, RHCs, or ERCs) the detail regarding the specific vaccination defined by the CPT code must be reported on the encounter claim so that an accurate immunization history is recorded by HFS and is available to the child's PCP, parent/caretaker relative or guardian.

Participation in the VFC Program requires that the provider complete a Provider Enrollment Form and a Provider Profile Form. An enrollment packet can be requested by calling:

The Illinois Department of Public Health
Vaccines For Children Plus Program
1-800-526-4372 or (217) 785-1455

Once the provider is enrolled and has completed the Provider Profile Form, IDPH will send the provider a three-month supply of vaccines. Each quarter the provider will be required to fill out an Accountability Form and a Vaccine Order Form to receive additional vaccines.

In Chicago

Participation in the VFC Program for Chicago providers occurs through the Chicago VFC Program. For more information on how to enroll as a VFC Provider in Chicago, call: **312- 746-6358**.

Childhood Immunization History Information

Childhood immunizations paid by HFS, or reported through encounter data by the child's MCO; recorded on IDHS' *Cornerstone* system, which tracks immunizations and other services provided by the public health system; recorded on Global, the immunization tracking system in Cook County; or recording on IDPH's *TOTS (Tracking Our Toddlers Shots)* subsequent or other IDPH tracking system, are available through the HFS Medical Electronic Data Interchange System (MEDI). For more information on MEDI visit [myHFS](#) - the secure Web site for the HFS. This Web site allows authorized users on-line access to departmental information on the following HFS programs:

- Medical Assistance Information for Medicaid Providers
- All Kids and FamilyCare Programs
- Child Support Case Information

- Cost Calculation for Medicaid School-Based Health Services

Select the “Getting Started” topic for more information on how to use this system. To access the MEDI/IEC training materials, please refer to [MEDI/IEC training](#).

HFS strongly encourages PCPs to participate in Illinois’ Immunization Registry maintained by IDPH. Contact IDPH for more information (refer to Topic HK 207.9.1).

HK-207.3 EYE CARE - GLASSES

Providers obtain lenses and frames from the Illinois Department of Corrections/Illinois Correctional Industries (IDOC/ICI) laboratory at Dixon Correctional Facility. Providers use the Optical Prescription Order (OPO), Form HFS 2803, to order lenses, frames, or both. The OPO is attached to the Provider Invoice Form HFS 1443 and submitted to HFS in the usual manner for claim submittals. The Provider Invoice should show charges only for an examination and a dispensing fee, not lenses and frames. IDOC/ICI will mail the eyeglasses directly to the ordering provider. HFS provides reimbursement to IDOC/ICI for the lenses and frames. For additional information, consult the [Handbook for Optometrists](#), Chapter 0-200, on HFS’ Web site at [<http://www.hfs.illinois.gov/handbooks/chapter200.html>](http://www.hfs.illinois.gov/handbooks/chapter200.html)

HK-207.4 FAMILY CASE MANAGEMENT

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

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

- Local Health Departments
- Federally Qualified Health Centers
- Local community-based agencies in Cook County

Case management services are also provided to:

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

Case managers are responsible for:

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

Providers are encouraged to work closely with Family Case Management staff to assist clients in receiving needed services. For more information about the Family Case Management Program, contact IDHS at 217/524-3319.

HK-207.5 SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS AND CHILDREN (WIC)

WIC, administered by IDHS, seeks to improve the health status of women, infants and children; promote breastfeeding; reduce the incidence of infant mortality, premature births and low birth weight; and to aid in the development of children. The WIC target populations are low-income, nutritionally at risk:

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

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

Providers are encouraged to refer patients included in the targeted population for WIC evaluation. For the location of the nearest WIC clinic, call the Automated Office Locator for WIC and Early Intervention Services at **1-800-323-4769**.

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

HK-207.6 EARLY INTERVENTION (EI) SERVICES

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

Children eligible for EI services experience delays in at least one of these areas:

- Cognitive development
- Physical development, including vision and hearing
- Language and speech development; psychosocial development
- Self-help skills
- Diagnosed with a physical or mental condition with a high probability of resulting in developmental delays
- Mother diagnosed with a major depression

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

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

Under Part C of the Individuals With Disabilities Education Act health care providers are required to make a referral to Early Intervention within two working days after a child has been identified with a disability or possible developmental delay.

To obtain resource information for the nearest CFC office, refer to Appendix 5 or contact:

Illinois Department of Human Services
Automated Office Locator Help Line
1-800-323-4769
or
The Bureau of Early Intervention
217-782-1981

Information about intervention services for children who are age three and over can be accessed through contacting the child's local school district office, or:

Illinois State Board of Education
Division of Early Childhood
(217) 524-4835

HK-207.7 REHABILITATION SERVICES

Throughout the State, services are available to families of youth with disabilities through the IDHS, [Division of Rehabilitation Services](#). Phone numbers for specific programs can be found in Appendix 6. For general information, contact:

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

HK-207.8 DIVISION OF SPECIALIZED CARE FOR CHILDREN (DSCC)

[DSCC's](#) mission focuses on public service, education and research as a basis to provide, promote and coordinate family-centered, community-based, culturally competent care for eligible children with special health care needs in Illinois.

The Core Program <http://internet.dsccl.uic.edu/dscclroot/core_prog.asp> is the major focus of DSCC and offers care coordination and cost-supported diagnosis and treatment for children with chronic health impairments determined eligible for program support. DSCC supports non-investigational treatment recommended by physician

specialists, such as therapy, medications, specialized equipment and supplies. Application forms are available on the Core Program page of the DSCC Web site.

The Home Care Program <http://internet.dsc.uic.edu/dscroot/home_care.asp>

Offers coordination and support for in-home medical care of technology-dependent children who would otherwise have to remain in a hospital or skilled nursing facility. The Division of Specialized Care for Children (DSCC) operates this waiver program on behalf of HFS.

The Children’s Habilitation Clinic <<http://internet.dsc.uic.edu/dscroot/chc.asp>>

The clinic provides comprehensive diagnostic services to children with complex disabling conditions and provides ongoing rehabilitation and developmental management to those children up to age 21.

The Supplemental Security Income - Disabled Children’s Program is

administered by DSCC to provide rehabilitative services to children under 16 years of age who are eligible for the Supplemental Security Income (SSI) program. DSCC provides information about and referral to community resources, including referrals to Early Intervention or preschool programs when appropriate, and DSCC Core services as described above.

Application forms are available on the DSCC Web site. Refer to Topic HK-207.9.1 for Web site locations. For general information about DSCC, contact:

University of Illinois Chicago
Division of Specialized Care for Children (UIC-DSCC)
1-800-322-3722 or 217-793-2350
<http://www.uic.edu/hsc/dsc/>

For information on DSCC’s 13 Regional Offices, refer to Appendix 7.

HK-207.9 REFERENCED RESOURCES AND REFERRALS

HK-207.9.1 WEB SITE LOCATIONS

American Academy of Pediatrics (AAP)	http://www.aap.org/
Illinois Chapter (AAP)	http://www.illinoisAAP.org
American Academy of Family Physicians	http://www.aafp.org
Illinois Chapter IAFP	http://www.iafp.com/
Advisory Committee on Immunization	http://www.cdc.gov/vaccines/
American Medical Association	http://www.ama-assn.org/
Childhood Immunization Schedule	
http://www.cispimmunize.org/IZSchedule_Childhood.pdf	
http://www.cispimmunize.org/IZSchedule_Adolescent.pdf	
http://www.cispimmunize.org/IZSchedule_Catchup.pdf	
Division of Specialized Care for Children	http://www.uic.edu/hsc/dsc/

[Headstart Program](http://www.ilheadstart.org)
[Hearing Screening for Parents/Providers](http://www.illinoisoundbeginnings.org)

[Illinois Department of Healthcare and Family Services](http://www.hfs.illinois.gov)

[Illinois Department of Human Services](http://www.dhs.state.il.us)
[Early Intervention](http://www.state.il.us/agency/dhs/eisnp.html)
[Provider Connections \(Credentialing and Enrollment\)](http://www.wiu.edu/users/mimppc/providerconnections/)

[Division of Rehabilitation Services](http://www.dhs.state.il.us/ors/)

[Division of Alcoholism and Substance Abuse](http://www.dhs.state.il.us/page.aspx?item=29759)

[Division of Developmental Disabilities](http://www.dd.illinois.gov)

[Illinois Department of Public Health](http://www.idph.state.il.us/)

[Selected Screening Recommendation](http://www.illinoisaap.org/DevelopmentalScreening.htm#Resources)

HK-207.9.2 OTHER REFERRAL INFORMATION - PHONE NUMBERS

Illinois Department of Healthcare and Family Services

Automated Voice Response System (AVRS)	1-800-842-1461
Provider Eligibility Inquiry Hotline	
Child Health Profile	1-217-557-4567 (fax)
Bureau of Comprehensive Health Services	1-877-782-5565
Provider Participation Unit	1-217- 782-0258
Post Office Box 19114	1-217- 524-7232 (fax)
Springfield, Illinois 62704-0538	
All Kids Care Health Benefits Hotline	1-866-4-OUR-KIDS
	1-866-468-7543

HFS Contracted Vendors

Doral Dental of Illinois	
Provider Service	1-888-281-2076
Customer service for clients/referrals	1-888-286-2447
First Transit	1-877-725-0569
	1-800-526-0844 (TTY)
Fax for standing orders ONLY	1-312-327-3855

Automated Health System Illinois Health Connect	1-877-912-1999 1-866-565-8577 (TTY)
Illinois Client Enrollment Broker	1-877-912-8880 1-866-565-8576 (TTY)

Other State Agency Resources

Illinois Department of Children and Family Services

Child Abuse and Neglect Hotline	1-800-25-ABUSE
Medical Hotline	1-800-228-6533
Advocacy Office for Children and Families	1-800-232-3798

Illinois Department of Human Services	1-800-843-6154
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Illinois Department of Human Services Family Case Management Program	1-217-785-5900
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Illinois Department of Human Services Automated Office Locator	1-800-323-4769
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Illinois Department of Human Services Division of Alcoholism and Substance Abuse 100 West Randolph Chicago, Illinois 60601	1-866-213-0548
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Illinois Department of Human Services Division of Rehabilitation Services	1-800-843-6154
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Illinois Department of Human Services The Bureau of Early Intervention	1-217-782-1981
Provider Connections (Credentialing/Enrollment)	1-800-701-0995

Illinois Department of Public Health Illinois Lead Program	1-217-782-3517 1-217- 557-1188 (fax)
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Illinois Department of Public Health Vision and Hearing Section	1-217-782-4733
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Illinois Department of Public Health Division of Laboratories 825 North Rutledge, P.O. Box 19435, Springfield, Illinois, 62794-9435	1-217-782-6562
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Illinois Department of Public Health Smoking Cessation Tobacco Quit Line	1-866-QUIT YES (1-866-784-8937)
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Illinois Department of Public Health Vaccines for Children Plus Program	1-800-526-4372 or 1-217-785-1455
Vaccines For Children Plus Program Chicago VFC+ Program	1-312-746-5940
Illinois State Board of Education Division of Early Childhood	1-217-524-4835
National Immunization Hotline Program	1-800-CDC -INFO (1-800-232-4636)
Network of Child Care Resources and Referrals	1-877-202-4453
The Division of Specialized Care for Children (DSCC): University of Illinois	1-800-322-3722, or 1-217-793-2350