



CARE FOR KIDS



Early & Periodic Screening, Diagnosis & Treatment

Volume 7 • Number 3 • Fall 2000

EPSDT Care for Kids Screenings:

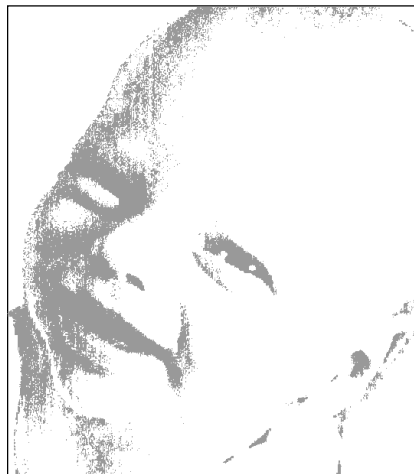
Children from Birth to 24 Months

EPSDT CARE FOR KIDS is an Iowa Medicaid program that provides children from low-income families with good health care.

Why do Iowa kids need EPSDT? In 1997, even though Iowa had one of the highest proportions of working parents of any state, 13% of our children younger than 18 lived in households whose incomes were below the federal poverty level. Today, right here in Iowa, the highest rate of poverty — 16% — is found among our most vulnerable citizens, children younger than five (Kids Count, Annie E. Casey Foundation, <http://www.aecf.org>).

During the first two years of life, good health care can help create a sound foundation for a child's development. EPSDT recom-

mends that a child have 9 health care visits during these years. Each visit offers you an ideal op-



portunity not only to monitor the child's development, but also to provide information and encouragement to the child's parents.

EPSDT Screening

The components of EPSDT — Early and Periodic Screening, Diagnosis, and Treatment — are summarized below. For a detailed and highly useful description of each of these components, you can review your *EPSDT Provider Manual*. If your office participates in the EPSDT program, you have a copy of this manual. Often, it is kept with billing information; your office manager can probably locate it. Or you can find a copy online. The *Provider Manual: Physician Services* is at www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Provman/phys.pdf. The *Provider Manual: Screening Centers* is at http://www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Provman/scenter.pdf.

(continues on page 4)

Screening components

Medical history. Take a child's medical history at the first visit, and update this at subsequent visits. Include medical history, social history, family history, and a review of symptoms. Record keeping should demonstrate that appropriate histories have been taken.

Measurements. Basic measurements provide an essential baseline for assessing a child's growth. To avoid errors, record all measurements as you take them. Use the National Center for Health Statistics (NCHS) Growth Charts for the appropriate age and gender (online at http://www.cdc.gov/nchs/about/major/nhanes/growthcharts/clinical_charts.htm). Special charts are also available for specific populations, such as non-Caucasian children (<http://fwcc.org/growthchart.html>), children born preterm, and children with Down syndrome (see http://depts.washington.edu/nutrpeds/FUG_assessment/anthro.htm#specialtygrowthcharts). These special charts are used in combination with the NCHS charts.

For each child, measure:

Height

- **Recumbent length** (child younger than 24 months or <35.5 inches tall) - Lay the child on a horizontal measuring board. This board should have a fixed headboard and sliding footboard securely attached at right angles to the surface. Record the measurement to the nearest 1/4-inch.

- **Standing height** (child 24 months old and older or >35.5 inches tall) - Measure using a standing height board or stadiometer. Children less than 35.5 inches tall should be measured on the recumbent board. Again, record the height to nearest 1/4-inch. (Don't use measuring rods attached to scales. The surface the child stands on is not stable, and the rod hinge has tendency to loosen, so measurements are inaccurate.)

Weight

Use a balance beam scale with sliding, non-detachable weights. Recalibrate the scale once a year. Infants can be weighed on an infant scale, or on a cradle that attaches to the adult scale. Weigh infants who are wearing a minimal amount of clothing. Record the weight to the nearest ounce.

Head circumference

Measure an infant's head circumference at each visit until the child is two years old. Use a non-stretchable measuring tape. Begin just above the nose between the eyebrows, travel over the ear with the tape, around the back of the head where it is widest, and then over the other ear and back to where you began.

If any measurements cannot be taken, document why—for example, "child uncooperative" or "child unable to fully extend legs for measurement of height." For additional information about measurement, see insert page 1.

Vision. At each visit, examine a child's eyelids and orbits, eye muscle balance, pupils, red reflex, and motility. Ask caregivers about any family history of such disorders as congenital cataracts, retinoblastoma, and metabolic or genetic conditions that affect vision. Beginning at age three, use objective tests to assess the child's vision.

Hearing. All babies born in Iowa should receive objective hearing screening shortly after birth (see the winter '99 issue of this newsletter, online at <http://www.medicine.uiowa.edu/uhs/epsdt/win99/hearing.cfm>). A child who has not had a hearing screen by the age of 3 months should be referred to an audiologist who specializes in infant hearing screening.

Neonatal screening identifies children with congenital hearing loss, but children can also experience progressive hearing loss. For this reason, you should also refer a child to an audiologist for screening if you find:

- Congenital anomaly of the ear, nose, throat, or kidney
- Delayed onset of speech
- Family history of hearing loss
- Lack of response to pure tone testing at any level
- Parental concern about the child's hearing

Development and behavior. No specific tool is required for assessing a child's development, mental health, and behavior. Clinical assessment begins with taking the child's history, performing the physical exam, and observation. At each visit, it is a good idea to ask parents, "Do you have any concerns about your child's learning, behavior, or development?" In some cases you may also administer a Denver Development Screening Test (DDST); however, public health nurses often do DDST screening. If you review their results, you do not need to repeat the screening, but you need to document your review of their evaluation.

Physical exam. Examination of an unclothed child should be appropriate for the child's age, and consistent with professional standards and judgement. For example, a female child would not be given a pelvic exam unless it was medically indicated. Briefly document normal findings; describe abnormal findings as fully as necessary.

Required EPSDT procedures

Metabolic screening. About 99% of Iowa newborns receive metabolic screening for branched-chain keto-acidemia, hypothyroidism, galactosemia, phenylketonuria, hemoglobinopathies, and congenital adrenal hyperplasia. For this reason, Medicaid does not require specific documentation. In some situations, however, you may want to determine or confirm a child's status.

Children born before 1987 who have racial or ethnic backgrounds that put them at risk for hemoglobinopathies should be offered screening and genetic counseling. Documentation is needed only if testing is ordered.

Immunizations. Review the child's status and provide immunizations as appropriate [see "Recommended Childhood Immunizations," insert page 2.]

Hemoglobin/hematocrit. Take one hemoglobin/hematocrit during the child's first year, and in each of the following intervals:

- 6 months if needed for WIC
- 9-12 months for children who: Qualify for EPSDT, have low socioeconomic status, had a birth weight of less than 1500 grams, were given whole milk before the age of 6 months, or were given low-iron formula

Test for anemia at any age if medically indicated, or if a child's history indicates inadequate iron in diet, blood loss, or family history of anemia.

Lead testing. During a five-year period that ended in 1998, 93,229 Iowa children younger than six were tested for lead poisoning. Of these, 12.3% were identified as lead-poisoned, nearly three times the national average. As a result, the Iowa Department of Public Health (IDPH) recommends routine blood lead testing of all children younger than 6 years. As per CDC recommendations, you should assess the risk of lead exposure when a child is six months old.

If you determine the child is at high risk, you should perform blood lead testing when the child is one year old, every six months thereafter until they are two years old, and then yearly through the

fifth birthday. Children at low risk should have blood lead assessed at 12 months. State regulations require blood lead testing for all children younger than 6 years of age who are enrolled in Medicaid. In addition, Iowa law requires that all blood lead-testing results, for both children and adults, be reported to IDPH. For more information about identifying and managing children with lead exposure, see the summer '99 issue of this newsletter (online at <http://www.medicine.uiowa.edu/uhs/epsdt/sum99/index.cfm>).

Tuberculin testing. Annual testing is recommended for high-risk groups, and documentation in these cases is needed. This can be billed for in addition to the screening charge.

Anticipatory guidance. Anticipatory guidance is an important part of each visit. Documentation, while not required, ideally notes topics discussed and the responses of the child or caregiver. You will find developmentally appropriate topics for such guidance in the *Bright Futures Pocket Guide — Guidelines for the Health Supervision of Infants, Children, and Adolescents*, online at <http://www.brightfutures.org/pocketguide/>. The *American Academy of Pediatrics Health Supervision Guidelines III* is another useful resource.

Nutrition. At each visit, determine whether the child is getting adequate nutrition. You can also offer caregivers basic information about nutrition. For children enrolled in the WIC program, a simple review with the caregiver is adequate, and provides the information needed for documentation: Feeding amounts and methods for infants; variety and quantity for normally developing children.

Oral health. Oral health screening should include gathering a basic dental history and inspection of the child's mouth and teeth. Ask if an infant is being allowed to fall asleep with the bottle, and talk about infant caries. Recommend that the child begin receiving regular dental care at age one year. Document your inspection of the child's mouth and teeth; make age-appropriate referrals. For more information, see the fall '99 issue of this newsletter (online at <http://www.medicine.uiowa.edu/uhs/epsdt/fa99/index.cfm>).

EPSDT Screening for children from birth to 24 months

These recommendations are for children who are growing and developing as they should, who are receiving competent parenting, and who have no significant health concerns.

	AGE: Infancy (Prenatal to 12 months)										Early childhood		
	Pre-natal ¹	New-born	1st wk	by 1 mo	2 mo	3 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo
History ²	■	■	■	■	■	■	■	■	■	■	■	■	■
Measurements													
Height, weight, height:weight		■	■	■	■	■	■	■	■	■	■	■	■
Head circumference		■	■	■	■	■	■	■	■	■	■	■	■
Sensory screening													
Vision		S	S	S	S	S	S	S	S	S	S	S	S
Hearing		O											
Developmental/behavioral assessment		■	■	■	■	■	■	■	■	■	■	■	■
Physical Examination Procedures (General)													
Hereditary/metabolic screening													
Immunization		■	■	■	■	■	■	■	■	■	■	■	■
Hematocrit / hemoglobin													
Lead screening													
Procedures (At-risk patients ★)													
Tuberculin test★													
Cholesterol screening★													
Anticipatory Guidance													
Injury prevention		■	■	■	■	■	■	■	■	■	■	■	■
Violence prevention		■	■	■	■	■	■	■	■	■	■	■	■
Sleep positioning ³		■	■	■	■	■	■	■					
Nutrition		■	■	■	■	■	■	■	■	■	■	■	■
Dental referral													

KEY

- To be performed
- S Subjective (*history*)
- O Objective (*standard testing method*)
- ★ Carried out for children who are at risk
- ➔ Range at which service may be provided with ■ indicating preferred age

¹ Prenatal care is an essential component of early childhood health care.
² Intermittent care - When an older infant enters your care, or if a child misses visits, it is important to bring the child's care up to date as quickly as possible.

³ Sleep positioning of infants should be discussed with caregivers. Infants should sleep on their backs. Side positioning is an alternative, but it does carry a slightly higher risk of SIDS.

A child's **first postnatal visit** takes place before the newborn leaves the hospital. At this visit, you can ensure that the child has received a hepatitis B immunization, had a hearing assessment, been evaluated for hyperbilirubinemia, has good cardiopulmonary function, and is eating well. This is also a good time to talk with the parents, observe parent-infant attachment, and monitor for signs of stress within the family.

The **two-week visit** also focuses on the child's feeding patterns and growth. A breast-fed baby should regain its birth weight by 2 weeks of age. Bottle fed babies should gain an ounce a day. It is also important to assess how the parents are adjusting to their new family member.

2-, 4-, and 6-month visits focus on the infant's neuromotor development, gains in length and weight, and sleep patterns. Babies on formula typically double their weight by about the third month; breastfed babies, by about the fourth month. During these visits, you will plot the baby's growth, including head circumference. You will also give the child these immunizations:

- Diphtheria, tetanus, and acellular pertussis (DTaP)
- Haemophilus influenza B (HIB)
- Hepatitis B
- Pneumococcal conjugate vaccine (Pevnar)
- Poliomyelitis (IPV)

9- and 12-month visits are an opportunity to review good nutrition with parents as their baby

transitions from breast or bottle to solid foods. Cow's milk can cause microhemorrhage in the gastrointestinal tract, so infants should not be given cow's milk until they are a year old. During these visits, the child can complete the hepatitis B vaccine series. A hematocrit or assessment of hemoglobin level is required at 9-12 months; lead assessment at 12 months; and a skin test for TB at 12 months for children at high risk. Refer the child for an initial dental exam at 12 months.

15- to 18-month visits allow for the assessment of the child's

social and verbal development. At 15 months, the child should be inoculated for measles, mumps, and rubella (MMR), be given the DtaP booster, and the pneumococcal conjugate vaccine (Pevnar).

The **24-month visit** allows you to assess the child's growth and development. No immunizations are usually given at this visit. Talk with parents about their child's growing independence, and how to provide effective guidance and discipline.

How to bill for EPSDT Care for Kids screenings in the first two years

Use the preventive medicine CPT codes with a modifier; you can find these in your *Provider Manual*. The modifier indicates whether vision and hearing were included in the exam, and whether an abnormality was detected during the exam. It is important to record abnormalities when they are identified. In recent Iowa Annual EPSDT reports to HCFA, the number of abnormalities reported has been unrealistically low.

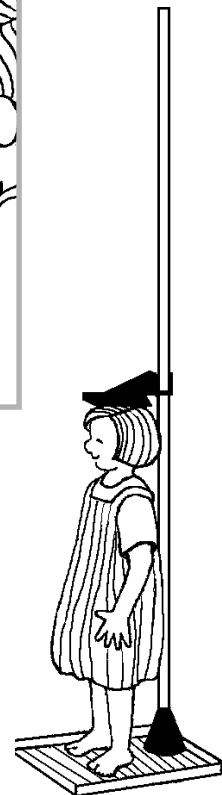
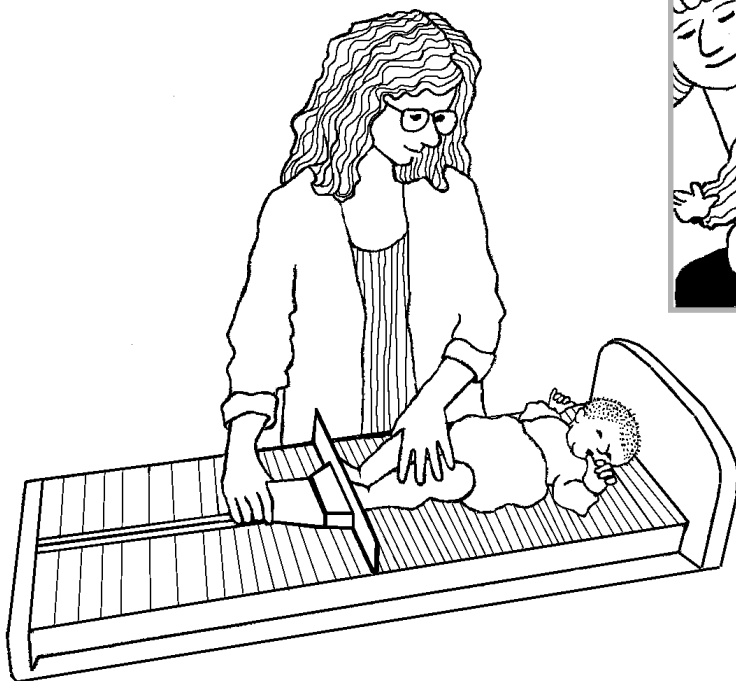
Please return your reader survey

If you haven't returned your copy of the Reader Survey from the last issue of the EPSDT Care for Kids Newsletter, please take a moment to do so. You can return the print survey by mail, or complete the survey online at <http://www.medicine.uiowa.edu/uhs/epsdt/survey.cfm>. What we learn from the survey will help us gauge the usefulness of the newsletter.

To all of you who have already returned your surveys, thank you!

Accurate measurements provide crucial information

Assessing whether a child is growing normally requires accurate measurements in early infancy. Below are guidelines for measuring an infant's recumbent length, head circumference, and, for older children, standing height.



Recumbent length -

Children younger than 24 months or less than 35.5 inches tall.

Lay the child on a horizontal measuring board. This board should have a fixed headboard, and a sliding footboard that is securely attached at right angles to the surface. Record the measurement to the nearest 1/4-inch.

Head circumference -

Measured at each visit until a child is two years old.

Use a non-stretchable measuring tape. Begin just above the child's nose between the eyebrows, travel over the ear with the tape, around the back of the head where it is widest, and then over the other ear and back to where you began.

Standing height -

Children older than 24 months or more than 35.5 inches tall.

Measure using a standing height board or stadiometer. Record the height to nearest 1/8-inch. Don't use measuring rods attached to scales. The surface the child stands on is not stable, and the rod hinge has a tendency to loosen, so measurements are inaccurate.

Recommended Schedule of Childhood Immunizations

With several of the vaccinations below, a range of several months is given during which certain doses in the sequence may be administered. A practitioner can simplify this process somewhat by determining that, in the normal run of things, children seen in his or her clinic will routinely receive a particular dose at a specific visit. For example, that children will be vaccinated for measles, mumps, and rubella (MMR) at the 12-month visit; that children will receive the third dose of IPV at the 6-month visit; etc.

Approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).¹

Age Vaccine	Birth	1 mo	2 mo	4 mo	6 mo	12 mo	15 mo	18 mo	24 mo	4-6 yrs	11-12 yrs	14-16 yrs
DTaP			Dose 1	Dose 2	Dose 3	Dose 4				Booster	Td	
Hep A										in selected areas		
Hep B												
Newborns with HbsAg-negative mothers		Dose 1	Dose 2			Dose 3						
Infants born to HbsAg-positive mothers	Dose 1 within 12 hours of birth	Dose 2			Dose 3							
Infants born to mothers w/unknown HbsAg status	Dose 1 within 12 hours of birth	Dose 2			Dose 3							
Children through age 18 years	Children not immunized as infants should receive a complete series of three immunizations by 11 to 12 years of age. Give the second and third doses at least 1 and 4 months, respectively, after the first dose .											
HiB PedvaxHIB ComVax Other conjugate HiB vaccines			Dose 1	Dose 2		Dose 3						
			Dose 1	Dose 2	Dose 3	Dose 4						
IPV			Dose 1	Dose 2		Dose 3				Booster		
MMR						Dose 1				Dose 2		
Pneumococcus Pneumococcal conjugate vaccine (Prevnar)			Dose 1	Dose 2	Dose 3	Dose 4						
Varicella Infants						Dose 1						
Children >13 years												2 doses, 4 wks apart

DTaP (diphtheria, tetanus, acellular pertussis)

Dose 4 of DTaP (diphtheria and tetanus toxoids and acellular pertussis vaccine) should be given 6 months after Dose 3; child may be as young as 12 months old.

Tetanus and diphtheria toxoids (Td) are recommended at 11-12 years of age, if at least 5 years have passed since last dose of DTP, DtaP, or DT. Routine boosters recommended every 10 years.

HepA (hepatitis A)

Recommendations vary by state and region; consult your local public health authority.

HepB (hepatitis B)

Vaccination recommendations for Hep B vary depending on the HbsAg status of the child's mother:

Infants born to HbsAg-negative mothers:
First dose: By age 2 months.

Second dose: At least one month after first dose.
Third dose: At least four months after the first dose and at least two months after the second dose, but not before infant is 6 months old.

Infants born to HbsAg-positive mothers:
First dose: Within 12 hours of birth, and at separate site, 0.5mL hep B immune globulin (HBIG)
Second dose: 1 month of age
Third dose: 6 months of age

Infants born to mother with unknown HbsAg status:
First dose: Within 12 hours of birth

Maternal blood should be drawn at time of delivery; if HbsAg test is positive, infant should receive HBIG before one week old.

All children and adolescents through 18 years old who have not been immunized may begin HepB series at any visit. Immunization is especially important for children who were born, or whose parents were born, in areas of the world where hepatitis B has moderate or high endemicity.

HiB (haemophilus influenzae type b)

Three HiB conjugate vaccines are licensed for infant use: If PRP-OMP (PedvaxHIB or ComVax [Merck]) is given at 2 and 4 months, a dose at 6 months is not required. With other conjugate vaccines, give Dose 3 at 6 months. DTaP/HiB combination products should not be used for primary immunization in infants at 2, 4, or 6 months of age, as a lower immune response to the HiB component can result.

IPV (polio)

To reduce the risk of vaccine-associated paralytic polio (VAPP), all-IPV immunization is now recommended for routine childhood vaccination in the US. Children should be vaccinated at 2 months, 4 months, 6-18 months, and 4-6 years. Oral polio vaccine (OPV) may be used only when:

1. Mass vaccination campaigns are enacted to control outbreaks of paralytic polio.

2. Unvaccinated children will be traveling in <4 weeks to areas of endemic/epidemic polio.
3. Parents won't accept the recommended number of IPV injections. These children may receive OPV only for the third or fourth dose or both. Administer OPV only after assessing risk of VAPP for others in the child's environment.

MMR (measles, mumps, and rubella)

The MMR vaccine should be given at 12-15 months. Dose 2 should be given at 4-6 years of age, but no sooner than one month after Dose 1. Children who did not receive dose 2 at 4-6 years should get it at the 11-12 year visit.

Varicella

Varicella vaccine is recommended on or at any visit after the first birthday. Children 13 years old and older who don't have a reliable history of chickenpox should receive two doses, four weeks apart.

EPSDT Care for Kids in Iowa, 1999

Sally Nadolsky, EPSDT Specialist

Division for Medical Services, Iowa Department of Human Services

In FY 1999, more than 90% of Iowa children who were eligible for EPSDT Care for Kids services participated in the program. The highest rates of participation were found among infants in their first year, and among children from 6 to 14 years old. The age group that showed the lowest rate of participation was children between the ages of 1 year and 5 years.

The chart at the right shows the percent of eligible Iowa children, grouped by age, who participated in at least one annual EPSDT screening each year from 1995 to 1999. Participation rates for 15- to 21-year-olds are high because, although the current Medicaid schedule calls for a health care visit every other year, most practitioners follow the Academy of Pediatrics schedule, which calls for yearly visits.

Areas of concern

Dental care. Participation rates in FY99 for dental screening were 38%. Although this is an increase from FY98, with a participation rate of 33%, access to dental care continues to be an issue for children in the state.

Children 1 to 5 years old. The participation rate for children between the ages of 1 year and 5 years fell below 80% last year; this is cause for concern because these early years lay the foundation for a child's future development.

Percent of eligible children participating in the Iowa EPSDT Care for Kids Program

AGE GROUP	YEAR				
	1999	1998	1997	1996	1995
Birth to 1 year	89%	84%	84%	89%	80%
1 to 5 years	79%	93%	81%	65%	48%
6 to 14 years	89%	167%	74%	85%	49%
15 to 21 years	136%	208%	125%	158%	85%
Percent of all eligible children who participated	91%	122%	84%	83%	57%

Background

The annual EPSDT report to HCFA uses a variety of codes to capture preventative and treatment visits (referred to as initial or periodic screens) to a child's medical or dental home. The word *eligible* refers to the number of children enrolled in Medicaid for the fiscal year being measured.

The rate of participation in medical services is determined by dividing the number of eligible children who receive at least one initial or periodic EPSDT screen by those who are expected to receive at least one EPSDT screen. The formula adjusts the raw number of eligible children to account for those who move into and out of eligibility status during the year. The formula also adjusts for the number of screens expected, based on the periodicity schedule. (The quality or comprehensiveness of the screening itself is not assessed for this report.)

The participation rate for dental services is determined by dividing the number of eligible children who have at least one preventative or treatment visit to a dentist by the total number eligible for Medicaid during the year. This number is not adjusted by eligibility time frames.

This year the way that the annual participation of eligible children in EPSDT is calculated has been modified to improve the accuracy of Iowa's participation report, HCFA-416. Due to the methods used in past years to adjust the expected number of children eligible for a visit, participation rates sometimes exceeded 100%. For example, participation rates could include a number of adolescents who visit a physician yearly, while the expected number of visits, based on the periodicity schedule, was once every two years. The new formula for calculating participation rates will eliminate participation levels that exceed 100%.

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If you have questions about **billing** related to EPSDT Care for Kids services, please call
Provider Services: **1-800-338-7909**

If you have questions about **clinical issues** and EPSDT Care for Kids services, please call
Edward Schor, MD: **1-800-383-3826**

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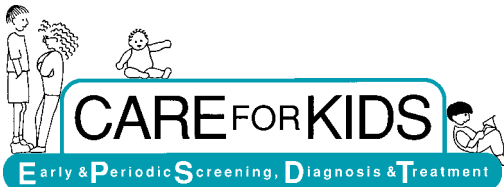
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