Handbook for Providers of Healthy Kids Services

Chapter HK-200
Policy and Procedures for Health Care for Children

Illinois Department of Healthcare and Family Services

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Chapter HK-200
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Foreword

This Handbook for Providers of Healthy Kids Services, Chapter HK-200 (pdf), specifically describes components and frequency that well child screening services are to be performed, in accordance with *Bright Futures, 4th Ed.* or subsequent updated guidelines and the medical home model. It also describes EPSDT benefits available to HFS' Medical Program participants who are under age 21, as mandated by the Social Security Act.

The Handbook for Providers of Medical Services, Chapter 100, provides General Policy and Procedures. A separate Chapter 200 Handbook 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:

Chapter 100	General Provider Handbook
A-200	Practitioner Handbook/Appendices (pdf)
D-200	Encounter Clinic Services
S-200	School-Based/Linked Health Center Services Handbook/Appendices
L-200	Laboratories Handbook/Appendices
U-200	Illinois Guide for SBHS Administrative Claiming Guide

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: 877-912-1999 (TTY: 866-565-8577) or All Kids at: 866-4-OUR-KIDS (866-468-7543) (TTY: 877-204-1012).

Bright Futures

Bright Futures is a set of principles, strategies, and tools that are theory based, evidence driven, and systems oriented that can be used to improve the health and well-being of all children. The mission of Bright Futures is to promote and improve health, education, and well-being of infants, children, adolescents, families, and communities.

Bright Futures uses a development based approach to address children's health needs in the context of family and community. The cornerstone of Bright Futures is a comprehensive set of health supervision guidelines developed by multidisciplinary child health experts – ranging from providers and researchers to parents and other child advocates – that provide a framework for well child care from birth to age 21. These guidelines are designed to present a single standard of care and a common language based on a model of health promotion and disease prevention. Released in 2008, *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, Third Edition (Bright Futures, 4th Ed.)*, is the most current version of guidelines and is considered the gold standard for pediatric care.

References to *Bright Futures, 4th Ed.*, are inclusive of subsequent revisions, pending any statement to the contrary in future revisions to this Handbook. Existing State law and regulations supersede these and other guidelines as the required standard.

HK-200 Basic Provisions

HK-200.1 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Children enrolled in HFS' All Kids Program are entitled to preventive health screening services under the EPSDT benefit, without patient co-payments.

Section 1905(r) of the Social Security Act (Act), 42 USC 1396d(r), sets forth basic requirements of EPSDT. The 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. EPSDT is not a separate program but simply a way to refer to the comprehensive benefit package to which Medicaid participants are entitled. The Department strives to ensure that children covered by medical programs receive preventive health screening services, including immunizations, objective developmental screening, dental care, lead screening, vision screening and risk assessments, through Illinois' EPSDT program.

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

- Assuring availability and accessibility of required health care resources, through a "medical home" as defined by the American Academy of Pediatrics (AAP) 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.

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 a 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. Five categories of screenings covered under this program are medical, vision, hearing, dental, and developmental.

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 including:

- 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
- Creation and maintenance of a medical record for storage, safekeeping and retrieval of all pertinent medical information, preferably in federally Certified Electronic Health Record Technology (CEHRT) format

HK-201 Provider Enrollment

HK-201.1 Enrollment Requirements

Illinois has an electronic provider enrollment system. The web-based system is known as Illinois Medicaid Program Advanced Cloud Technology (IMPACT).

Under the IMPACT system, category of service(s) (COS) is replaced with Specialties and Subspecialties. When enrolling in IMPACT, a Provider Type Specialty must be selected. A provider type subspecialty may or may not be required.

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

Physicians, clinics, and health centers enrolled in HFS programs who wish to enroll in Illinois Health Connect as a Primary Care Provider should call Illinois Health Connect Provider Services Helpdesk at 1-877-912-1999 (TTY: 1-866-565-8577). An application will be mailed or a Provider Service Representative will schedule a convenient time to meet with the provider, answer provider questions and help with the enrollment process.

Providers who do not enroll in Illinois Health Connect will not be able to provide primary care to their patients who are enrolled in Illinois Health Connect, unless they fall under the Direct Access exception noted below.

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 participant’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 Providers (PCP) to coordinate care for participants 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.

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)
- 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 enroll by mail, fax, or online.

Illinois Health Connect
1375 E. Woodfield Rd. Suite 600
Schaumburg, IL 60173
847-995-0827

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

Increased reimbursement rates for selected MCH services are available to PCPs who have signed agreements to be part of the Illinois Health Connect (PCCM) program 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, Form HFS 3411 (pdf) MCH Primary Care Provider Agreement, in addition to being enrolled as a Medical Assistance Provider. Providers must meet the participation requirements to enroll as an MCH Primary Care Provider in accordance with 89 Ill. Adm. Code 140.924.

HK-201.2 Participation Approval

When participation is approved, providers will receive a computer-generated notification, Provider Information Sheet, listing certain data on the Department's computer files. Providers must review this information for accuracy immediately upon receipt.

If all information is correct, the provider is to retain 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 the Department files.

HK-201.3 Participation Denial

When participation is denied, the provider will receive written notification of the reason for denial.

Within ten (10) calendar days after the date of this notice, the provider may request a hearing. The request must be in writing and must contain a brief statement of the basis upon which the Department's action is being challenged. If such a request is not received within ten (10) calendar days, or is received, but later withdrawn, the Department's decision shall be a final and binding administrative determination.

Department rules concerning the basis for denial of participation are in 89 Ill. Adm. Code 140.14. Department rules concerning the administrative hearing process are in 89 Ill. Adm. Code 104 Subpart C.

HK-201.4 Provider File Maintenance

Information in the Department's files for participating providers must be maintained on a current basis. The provider and the Department share responsibility for keeping the file updated.

Provider Responsibility

Information contained on the Provider Information Sheet is the same as in the Department's files. Each time the provider receives a Provider Information Sheet, it is to be reviewed carefully for accuracy. The Provider Information Sheet contains information to be used by the provider in the preparation of claims; any inaccuracies found must be corrected and the Department notified immediately via IMPACT. Failure of a provider to properly update the IMPACT with corrections or changes may cause an interruption in participation and payments.

Department Responsibility

When there is a change in a provider's enrollment status or the provider submits a change, the Department will generate an updated Provider Information Sheet reflecting the change and the effective date of the change. The updated sheet will be sent to the provider's office address and to all payees listed if the payee address is different from the provider address.

HK-202 Provider Reimbursement

Providers must determine the enrollment, and therefore the payer source, for their patients prior to services being rendered. This information is available through the HFS Medical Electronic Data Interchange System (MEDI) system or through the Department's Automated Voice Response System (AVRS) at 800-842-1461.

Providers should check eligibility prior to providing services to determine if a patient is enrolled with a managed care entity.

HK-202.1 Charges

Charges billed to the Department must be the provider's usual and customary charge billed to the general public for the same service or item. Providers may only bill the Department after the service has been provided.

To be paid for services, all claims, including claims that are corrected and resubmitted, must be received within 180 days of the date of service. The Department must receive a claim after disposition by Medicare or its fiscal intermediary no later than twenty-four (24) months from the date of service.

It is the provider's responsibility to verify claims are received by the Department, whether submitted electronically or on paper, and to check claim status.

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/s

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, physical, developmental and mental/psychological examination, counseling and anticipatory guidance/risk factor reduction interventions and ordering of appropriate immunizations(s) and laboratory/diagnostic procedures.

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 Healthcare Common Procedure Coding System (HCPCS) 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 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.

- Perinatal Depression - use code H1000 for prenatal risk assessment and 96127, with the HD modifier (96127 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.

- 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 screening, with interpretation and report, per standardized instrument form".

- Objective Vision Screening - use the appropriate CPT code for the vision screening service when a separate objective vision screening is provided at visits annually from age 3 through 6 years, and again at ages 8, 10, 12, 15 and 18 years.

- Objective Hearing Screening - use the appropriate CPT code for the objective hearing screening service when a separate objective hearing screening is provided, at the newborn visit, at visits annually from age 4 through 6 years, and again at 8 and 10 years.

- 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 through the Illinois Department of Public Health (IDPH) Vaccine for Children Program (VFC), or in Chicago, the Chicago Department of Public Health Vaccine for Children Program.

- Fluoride Varnish Application – use code D1206 for application of fluoride varnish on children under 36 months. Also refer to the American Academy of Pediatrics Illinois Chapter for Fluoride Varnish additional information.

Providers of laboratory services must be in compliance with CLIA. For more information refer to the Laboratories Handbook. Providers billing an encounter rate **must** detail all components of the screening provided during the visit.

HK-202.2 Electronic Claims Submittal

Services that do not require attachments or accompanying documentation may be billed electronically. Further information concerning electronic claims submittal can be found in Chapter 100, and Chapter 300. Please note that the specifications for electronic claims billing are not the same as those for paper invoices. Providers must 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.

Form DPA 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.

HK-202.3 Paper Claims Preparation and Submittal

Refer to Chapter 100, for general policy and procedures regarding claim submittal. For specific billing instructions, refer to A-200, Handbook for Practitioners Rendering Medical Services (pdf).

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 Fee Schedule website. The fee schedule also contains special billing information.

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.

HK- 202.4.1 Fee-for-Service

Participants in HFS' Medical Programs can 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 any setting acceptable to HFS such as a hospital, outpatient, medical office etc.

Primary Care Case Management Program (Illinois Health Connect)

The Primary Care Case Management (PCCP) program, called Illinois Health Connect, operates in regions of the state where there is not mandatory managed care. Illinois Health Connect is based on the American Academy of Pediatricians' initiative to create medical homes to make sure that preventive healthcare is provided in the best setting. In Illinois Health Connect, participants have a "medical home" with a PCP, such as a doctor's office. The PCP also provides care coordination and case management.

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. Enrollees who do not choose a PCP will be assigned to one.

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 (IHC) will receive regular HFS medical cards. For more information, visit the Illinois Health Connect website.

Referrals for Primary and Specialty Care

For information on specialty care referrals, please visit the Illinois Health Connect website Frequently Asked Questions page.

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

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 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

An MCO may be a Health Maintenance Organization (HMO) or Managed Care Community Network (MCCN). Under a MCO, health services are prepaid, based on a per member, per month (PMPM) capitation. The MCO is responsible for providing or arranging and reimbursing for all covered services as defined in their contract with HFS. Participants enrolled in MCOs will receive medical cards with the following message:

Services may require payment authorization. Refer to the Managed Care Manual (pdf) for additional information.

HK-203 Covered Services

HK-203.1 Well-Child Examination

The five categories of preventive health care screening services for children under All Kids are physical/mental health, vision, hearing, dental, and developmental. Screening components are described in the sections to follow.

HK-203.1.1 Health Screening

It is recommended that health screenings be provided to children on the periodicity schedule recommended by Bright Futures/the AAP.

- Under age one:
  - Within 24 hours of birth in hospital
  - 3-5 days of life and within 48-72 hours after discharge
  - 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 twenty-one:
  Annually, per provider

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

HK- 203.1.2 Inter-periodic Screenings

Inter-periodic screenings may be provided as medically necessary, or when required or mandated for admission to day care; enrollment in an early childhood education program; participation in school; attendance at camp; participation in a sports program; placement in a licensed child welfare facility including foster home, group home or institution; adoption; prior to medical or dental procedures; enrollment in the Special Supplemental Nutrition Program for Women, Infants and Children (WIC); in cases of trauma, accident, or suspected abuse or domestic violence; as required by the child's Individual Education Plan (IEP, Individual Family Service Plan (IFSP); or at the request of the parent or guardian. Forms completion relative to these types of

screenings or examinations is covered by the reimbursement arrangement between HFS and the provider. Charging enrollees a fee only for completion of forms without an examination or other services being provided is therefore prohibited.

In order to receive reimbursement for an inter-periodic 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). One inter-periodic screening visit is permitted per year. A provider may be reimbursed for an evaluation and management visit using the CPT code under Office or Other Outpatient Services, as appropriate.

HK-203.1.3 Health History

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

- Obtain information about previous health care and health problems.
- Obtain information about family medical history.
- 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, homelessness, hunger, and instances of violence, abuse, bullying, etc. to understand particular needs and provide appropriate care.

Information should be obtained from the eligible participant, when appropriate, and parents or guardians who are familiar with the child's health history. Attempts should be made and documented to obtain additional information and records 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.

HK-203.1.4 Nutritional Assessment

There is no one laboratory or physical measurement that will allow a positive statement of nutritional health. Instead, there are a number of assessments and measurements, which, when indicated, may collectively allow an estimate of such. Components of a nutritional assessment are defined in the *Bright Futures, 4th Ed. Nutrition pocket guide.*

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, trauma, or combination.

The unclothed physical examination serves as a general health evaluation and provides important information for other components of the well child screening.

Health care providers should consider the age of the eligible participant when conducting the physical examination. Health care providers are mandated to report suspicious injuries, abuse, neglect, or other similar conditions to:

Illinois Department of Children and Family Services
Child Abuse and Neglect Hotline
1-800-25-ABUSE (1-800-252-2873) 1-217-785-4020

HK-203.2 Immunizations

The EPSDT Program and All Kids Program require immunizations appropriate for a child's age and health history. The Recommended Child and Adolescent Immunization Schedule and the Recommended Adult Immunization Schedule (for 19-20 year olds) are annually updated, as approved by the Advisory Committee on Immunization Practices (ACIP) of the U.S. Department of Health & Human Services, CDC, AAP and the AAFP.

Immunization Resources

Providers seeking resources should refer to the AAP's Immunizations website for best practices and implementation resources from the AAP's Childhood Immunization Support Program (CISP). The CISP Immunization Training Guide is available for download and can be used to educate and properly train physicians, nurse practitioners, physician assistants, nurses, medical assistants, office managers, and other office staff.

Families and community members can be directed towards other immunization resources such as the CDC Teen Vaccine website, the National Network for Immunization Information, and the AAP's parent website, which has a large section on vaccines.

Vaccines for Children (VFC) Program

Health care providers serving VFC eligible children through age 18 can enroll in the VFC program and will receive vaccines free of charge for their VFC eligible patients.

Providers may charge HFS for the administration of the vaccine to program participants. Refer to Topic HK- 207.2.

Immunization Billing Instructions

Billing information is included in the Handbook for Providers Rendering Medical Services (Practitioners' Handbook) Chapter A-200 and Vaccine Billing Instructions are provided in Appendix A-9 (pdf) of the Practitioners' Handbook.

Participation in the VFC Program requires that the provider complete a Provider Enrollment Form and a Provider Profile Form.

Participation in the VFC Program for *Chicago* providers:

- Occurs through the Chicago VFC Program Phone: 312-746-6358

Participation in the Illinois VFC Program for providers in *Illinois* (outside the City of Chicago):

- Occurs through the Illinois Department of Public Health (IDPH)
- For more information on how to enroll to be a VFC Provider in Illinois (outside Chicago)
- Phone: 217-786-7600 E-mail: dph.vaccines@illlinois.gov

Once the provider has submitted required enrollment forms, the Chicago VFC program meets in person with potential providers and physically inspects the vaccine storage appliance to determine adequacy. Once enrolled, providers are assigned an order frequency consistent with their forecasted volume of vaccines. This may mean that providers order monthly, bimonthly or quarterly.

Upon submittal of required enrollment forms, IDPH will perform an enrollment visit at the practice to assure appropriate capacity for vaccine storage and handling and address required provider documentation. VFC providers should only order enough vaccine for one month at a time. The Illinois VFC Program requires VFC providers to be enrolled and active users of the Illinois Comprehensive Automated Immunization Registry Exchange (I-CARE). Additional information and forms for I-CARE are available on the ICARE website. The Illinois VFC Program has integrated its VFC enrollment and vaccine management functions into I-CARE. This integration allows for greater accountability and programmatic oversight. All Illinois VFC providers must provide individual patient immunization records on how each VFC vaccine was administered. The individual patient immunization records can either be manually entered directly into I-CARE or can be electronically transmitted to I-CARE from the provider's electronic medical record (EMR) system.

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

HK-203.3 Laboratory Procedures

For more information about policy and procedures regarding laboratory services, refer to the Handbook for Providers of Laboratory Services. The laboratory procedures that follow 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

It is recognized that there is no safe level of lead. Updated (2012) guidelines from the CDC recommend enhanced follow up for children with a blood lead level (BLL) greater than or equal to 10 μg/dL. Additionally, young children (under age five) with blood lead levels of 5 to 9 μg/dL should also be considered for repeat blood lead level testing sooner than is routinely recommended. All parents should receive education about primary prevention of lead exposure.

Federal mandates and HFS policy require that all children enrolled in HFS' Medical Programs be considered at risk for lead poisoning and receive a blood lead test at age 12 and 24 months. If a child is 3-6 years of age and has not been tested, a blood lead test is required. 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 a 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. Recent immigrants, refugees, or international adoptees from 6 months to 16 years should be tested within 90 days of arrival in the U.S. Repeat BLL testing of all refugee children aged 6 months to 6 years, 3 to 6 months after arrival is necessary regardless of initial results.

HFS requires that lead testing be conducted in accordance with the state regulations and guidelines stipulated in the "Lead Poisoning Prevention Act," 410 ILCS 45/1 et seq..

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.

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 should follow the CDC and IDPH guidelines covering eligible participant management and treatment. The IDPH Lead Program has identified physicians willing to act as medical consultants on any issues related to evaluation, testing, 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 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 elevated blood lead levels. Additional information regarding lead poisoning, including copies of the guidelines, or educational materials, may be obtained by calling, emailing, or faxing the request to the:

Illinois Department of Public Health Lead Program
Phone: 217-782-3517 or 866-909-3572 TTY: 800-547-0466
Email: DPH.lead@illinois.gov

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.

Illinois law requires physicians to report to the IDPH Lead Program all blood lead results greater than or equal to10 µg/dL within 48 hours; blood lead results less than 10 µg/dL must be reported within 30 days after the end of the month in which the blood lead levels less than the permissible limits set forth in the rule are obtained. 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 clinician should check with the laboratory they use to see if the laboratory automatically reports to IDPH. If not, the physician is responsible and should report every blood lead level

according to the aforementioned reporting requirements. Physicians using in-office lead testing systems should contact the state to identify the most expedient method for reporting the lead test results from samples run in their in-office laboratory. Many laboratories in Illinois have electronic reporting to the state lead program of all the lead tests done at their laboratory.

Reporting forms are available on the IDPH website and may be faxed to 1-217-557-1188. The IDPH Lead Program may be contacted by calling or emailing:

Illinois Department of Public Health Lead Program
Phone: 217-782-3517 or 1-866-909-3572 TTY: 800-547-0466
Email: DPH.Lead@illinois.gov

When reporting lead poisoning to IDPH, the child's Recipient Identification Number must be provided. The IDPH 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:

Illinois Department of Public Health Division of Laboratories
Mail: 825 North Rutledge
Springfield, Illinois 62702-4910
Phone: 217-782-6562 Fax: 217-524-7924

To obtain information on specimen pickup 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 has 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 younger than 36 months 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.
- A child has three successive confirmed blood lead results of 15 μg/dL to 19 μg/dL with no time requirement between tests.
- A child has a single confirmed blood lead level at or above 10μg/dL and the child's physician requests an investigation to determine if the child should be removed from the regulated facility because of the lead hazard,
- Mitigation notices are issued for two or more dwelling units in a building within a five year time period. The Department may inspect common areas in the building and shall inspect units where children 6 years of age or younger reside, at the request of a parent or guardian of the child, or where a pregnant woman resides, at the pregnant woman's request.

HFS reimburses IDPH 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 Department supports Hemoglobin or Hematocrit testing recommendations found in the *Bright Futures, 4th Edition*.

HK-203.3.3 Sickle Cell Disease, Sickle Cell Trait and Hemoglobinaopathies

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 Newborn Metabolic Screening

Newborn metabolic screening is required by state mandate to screen all Illinois newborns for over 40 life threatening metabolic, endocrine and hemoglobin disorders soon after birth to prevent death and/or developmental disabilities. All newborn

screening blood specimens are collected 24 hours after birth and submitted to the Illinois Department of Public Health (IDPH) centralized laboratory. Testing for biotinidase deficiency, congenital adrenal hyperplasia, congenital hypothyroidism, galactosemia, sickle cell disease, fatty acid oxidation and organic acid disorders, phenylketonuria and other amino acid disorders and cystic fibrosis is performed on every sample submitted. Testing for severe combined Immunodeficiencies and statewide screening for certain lysosomal storage disorders is available.

Abnormal test results are reported to the physician of record by the IDPH follow up staff who facilitate retesting and referral of the family to a medical specialist if needed. In addition, legislation passed in August 2013 mandates that all birth hospitals conduct pulse oximetry screening of newborns for the detection of critical congenital heart disease.

PCPs should verify documentation of newborn metabolic screening results, assure that appropriate rescreening is done when needed, and that referrals to medical specialists are made when required. If newborn screening has not been previously completed, for example, if the newborn delivered at home or if the newborn was discharged without testing, the PCP should conduct screening as required by the IDPH Newborn Screening and Genetics Program.

The PCP can contact the IDPH newborn screening follow up program to obtain results by calling 217-785-8101. If there are any abnormal results, the PCP should ensure that appropriate rescreening has been performed or referrals are made to appropriately credentialed subspecialists. IDPH Newborn Screening and Genetics Program staff is available for assistance with parent and provider education, completing subspecialist referrals and long term follow up through 15 years of age for children with diagnosed disorders.

HK-203.3.5 Tuberculosis Screening

Tuberculosis screening is recommended to be done at the provider's discretion based on medical indication or using *Bright Futures, 4th Ed.* guidelines. On recognition of risk factors, children should be tested with a Tuberculin Skin Test (TST).

Individuals who should have annual tuberculin skin testing include children infected with HIV and 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- alpha antagonist, or immunosuppressive therapy in any child requiring these treatments.

HK-203.3.6 Dyslipidemia Risk Assessment and Laboratory Screening

Atherosclerosis begins in youth. Prevention of risk factors development and management of identified risk factors are key to prevention of future cardiovascular disease. A risk assessment including family history of cardiovascular disease should be done starting at age 2 and updated at each well child visit until age 21. Laboratory screening should be initiated for children at risk starting at age 2.

Individuals at risk include children:

- With a positive family history (myocardial infarction, angina, coronary artery bypass graft/stent/angioplasty, sudden cardiac death in parent, grandparent. aunt, or uncle at <55 y for males, <65 y for females).
- Who have high-level risk factors (hypertension that requires drug therapy [BP ≥ 99th percentile + 5 mm Hq], current cigarette smoker, BMI at the ≥97th percentile, presence of high-risk conditions).
- Who have moderate-level risk factors (hypertension that does not require drug therapy, BMI at the ≥95th percentile, <97th percentile, HDL cholesterol <40 mg/dL, a child born premature, presence of moderate-risk conditions)
- With the presence of high risk conditions (T1DM and T2DM, chronic kidney disease/end-stage renal disease/post-renal transplant, post-orthotopic heart transplant, Kawasaki disease with current aneurysms).
- With the presence of moderate risk conditions (Kawasaki disease with regressed coronary aneurysms, chronic inflammatory disease [systemic lupus, erythematosus, juvenile idiopathic arthritis], HIV infection, nephrotic syndrome).

Universal laboratory screening is recommended at least once between the ages of 9 and 11 years and between the ages of 17 to 21.

For the most current recommendations and guidelines for cardiovascular risk reduction in children and adolescents, visit the National Heart, Lung, and Blood Institute (NHLBI) website.

HK-203.3.7 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-203.3.8 Reproductive Health and Sexually Transmitted Diseases

Enrolled providers shall ensure that the full spectrum of family planning options and reproductive health services are appropriately provided with no cost sharing. Family planning and reproductive health services are defined as those services offered, arranged or furnished for the purpose of preventing an unintended pregnancy, and to improve health and birth outcomes. Family planning and reproductive health services shall be provided by, or administered under the supervision/collaboration of a physician (MD or DO), advanced practice nurse or physician assistant, and must follow the most current nationally recognized evidence-based standards of care and guidelines for sexual and reproductive health, such as those established by the Centers for Disease Control and Prevention (CDC) (pdf) or the American Congress of Obstetricians and Gynecologists. Information about contraception from most effective to least effectiveness, medical eligibility criteria, use of contraceptives during the postpartum period, long-acting reversible contraceptive resources, etc is available on HFS' Illinois Family Planning Provider website.

Medicaid's free choice of providers statute in 42 CFR 431.51 allows participants to see any Medicaid provider of their choice when seeking family planning and reproductive healthcare services. Thus, participants can access contraceptive services and supplies without managed care network restrictions. Additionally, provider policies/protocols shall not present barriers that delay or prevent access, such as prior authorizations or step-therapy failure requirements. Participants should receive education and counseling on all FDA-approved birth control methods (pdf) from most effective to least effective, and have the option to choose the preferred birth control method that is most appropriate for them – CDC Guidance (pdf).

Sexually active young adults are at high risk of unintended pregnancy and STDs. Education and counseling should include abstinence, delaying sexual activity, and barrier protection; however, clients requesting birth control should be offered the most effective form with discussion about emergency contraception. See HFS' family planning services and reproductive health services in the Handbook for Practitioners Rendering Medical Services for more information.

Providers should refer to CDC's website for contraceptive effectiveness. Contrary to commonly held belief, intrauterine devices and the implant are the most effective forms of long acting reversible contraception and generally are safe and efficacious for use in nulliparous adolescents.

Visit the ACOG Committee on Adolescent Health Care website or USPSTF Screening for Cervical Cancer website for more information regarding cervical cancer screening guidelines.

The CDC recommends that all sexually active youth be screened for gonorrhea and chlamydia annually. For high risk youths (e.g., recent incarceration, males having

sex with males, IV drug use) and those who screen positive for chlamydia or gonorrhea, hepatitis B, HIV and syphilis tests also should be performed each year, and testing should be considered as often as every three to six months or with onset of new symptoms.

Health care professionals in Illinois (licensed physicians, physician assistants and advanced practice nurses) have the option of providing antibiotic therapy, otherwise known as expedited partner therapy (EPT), for the sex partners of individuals infected with chlamydia and gonorrhea, even if they have not been able to perform an exam on the infected patient's partner(s) (Public Act 96-613). Informational brochures in English and Spanish are available by visiting IDPH's "Expedited Partner Therapy for Chlamydia and Gonorrhea in Illinois" website

Reproductive and sexual coercion is where one asserts power or abuse to control the relationship; from tampering with birth control to pressuring one to become pregnant. Providers should discuss and document intimate partner violence screening, establish safety plans, and provide harm reduction strategies such as discreet forms of contraception (e.g., implant, injection, or intrauterine device).

HK-203.4 Developmental Milestones

Developmental and behavioral surveillance and screening are recommended across the Bright Futures visits, with specific screening at certain visits.

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.

HK-203.5 Developmental Surveillance

Developmental surveillance is a structured evaluation of a child's competencies (including knowledge, skills, and 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 developmentally delayed and at risk children who would benefit from further evaluation and services.

Refer to the Appendices Internet Quick Reference Guide for information on referral sources including the Standardized Illinois Early Intervention Referral form (HFS Form 650) and and the Early Intervention Care Coordination Provider Toolkit.

Developmental Milestones

Developmental milestones are recommended as minimal to be assessed through surveillance, observation, and inquiry/discussions with parent(s), guardian(s), and caretaker(s). For information on developmental milestones, visit the following recommended resources: AAP's *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 4th Edition* (2008)

CDC "Learn the Signs. Act Early." campaign and resources

Healthy Steps for Young Children Program

HK-203.5.1 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 and emotional – and is performed by the PCP or other trained provider. Screening may be tailored to a child's suspected problem or delay. Children should be referred for a comprehensive evaluation and services if indicated by the results of a well child visit, or by the results of an objective developmental screening tool.

HK-203.5.2 Objective Developmental Screening and Evaluation

Providers are encouraged to follow at minimum the recommendations in 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 (reaffirmed December 2009).

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, the AAP recommends that objective screening tests should be administered regularly at the 9- and 18-month visits, and at the 24- and/or 30-month visits and more frequently when there is parental or physician concern. Autism Spectrum Disorder screenings should be administered at the 18- and 24-month visits. Objective developmental screening should include all domains, including social and emotional development. Current detection rates of developmental disorders by surveillance alone are lower than their actual prevalence when assessed with appropriate standardized screening instruments.

Standardized developmental screening tools can detect risks for developmental delays and disabilities and can help to effectively monitor and record a child's development. 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. Developmental screening often can be performed by an office nurse or other trained non-physician personnel under the direction of the PCP. However, the billing code (96110) and reimbursement level is the same regardless of the individual administering the screen. Only an appropriately trained health professional, however, may interpret the results.

A list of objective developmental screening tools approved by HFS for reimbursement can be found in the Appendices. An approved objective developmental screening tool may be used to evaluate levels of:

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

Objective developmental testing 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. Providers using electronic health records (EHR) must ensure that screening or evaluation tools used are noted in the electronic record. Notations shall include the name of the developmental tool administered and the screening or evaluation results, and the subsequent anticipatory guidance provided and referrals made. Providers may use the screening or evaluation tool as a teaching tool and may give the tool itself to the parents for reference. In these instances, when there is a paper file, providers must keep the scoring sheet in the hard copy record, as evidence of the screening. Appropriate documentation must also be kept in the hard copy record, e.g., the scoring sheet, and analysis of the child's developmental needs and referral, if any, as a result of the screening; or follow up plans. If providers are using an electronic medical record, documentation as indicated above will be needed, however, a separate paper file does not need to be maintained. Documentation should cover all components of the tool. For purposes of this Handbook, developmental screening tools (96110) and testing tools (96111) will be referred to collectively as assessment tools.

Reimbursement

In order to be reimbursed for using an objective developmental assessment tool, providers must bill under the proper CPT code (see Appendices), 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 assessment shall be documented. For auditing purposes, providers using an EHR must ensure that assessment tools used are noted in the electronic record. Notations shall include the name of the developmental tool administered and the results, and the subsequent anticipatory guidance provided and referrals made. There must be sufficient documentation that the tool used and follow up occurred to warrant HFS payment for the assessment. Providers with the capacity to scan the assessment tool may do so and keep the scanned tool in the EHR as documentation. However, scanning the assessment tool is not required. Providers who scan the tool(s) used also must maintain notations in the EHR regarding the resulting anticipatory guidance provided and referrals made. Providers billing an encounter rate, such as FQHCs, RHCs and ERCs will not receive a separate reimbursement but must detail the objective developmental assessment performed on the encounter claim.

Additional Developmental Tests

Providers may request additions to the list of objective developmental tools recognized by HFS for payment. The Provider must document that an instrument is:

- Listed in the Mental Measurement Yearbook Series
- Nationally distributed
- Age appropriate
- Formally validated
- Individually administered

Requests must be submitted using Form HFS 724 (pdf) "Screening, Assessment and Evaluation Tool Approval Request Form".

Developmental assessment tools may be updated to reflect new advances. Revisions to previously approved screening and assessment tools listed in the appendices are approved for reimbursement by HFS. However, HFS reserves the right to periodically review revisions to previously approved tools to assure they continue to meet the reimbursement approval criteria. If the revision does not meet the criteria, HFS can deny approval for reimbursement for the updated tool. It is the responsibility of the provider to consult the list of approved tools on the website from time to time, especially if there is doubt the tool continues to be approved for reimbursement.

HK-203.6 Autism Spectrum Disorder (ASD) Screening

Bright Futures, 4th Ed., recommends that an autism spectrum disorder-specific screening be conducted for all children at the 18- and 24-month visits or at any encounter when a parent raises a concern about possible ASD symptoms.

The Autism Program (TAP) is a network of resources for Autism Spectrum Disorders in Illinois. TAP 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. TAP has developed an infrastructure to train, support, and coordinate the linkage of an informed provider network to help Illinois families.

HK-203.6.1 Developmental Resources

The Illinois Department of Human Services, Division of Developmental Disabilities (IDHS/DD) is the state agency for operating the waiver programs for children with developmental disabilities. IDHS/DD's *Home and Community-Based Services Waivers for Children* may provide services and supports to keep children with developmental disabilities, including autism, in home or community settings. Two home and community based services waivers for children with developmental disabilities, including autism, are available. The waiver programs provide services and supports to keep children in home or community settings. Information can be found on the Developmental Disabilities How Can We Help website. The toll-free telephone number is: 888-DDPLANS (888-337-5267) or 866-376-8446 (TTY)

Reach Out and Read Program

The Reach Out and Read model is an evidence-based strategy with 14 peer-reviewed and published studies available for review on the Reach Out and Read: The Evidence (pdf). The body of published research supporting efficacy of the Reach Out and Read model is more extensive than for any other psychosocial intervention in general pediatrics.

Reach Out and Read is recommended as a strategy for use during well child visits from ages 6 months to 5 years, and is endorsed by the American Academy of Pediatrics and the National Association of Pediatric Nurse Practitioners.

For more information about the Reach Out and Read program in Illinois, please visit the Illinois Chapter, American Academy of Pediatrics Reach Out and Read Illinois website.

HK-203.7 Vision and Hearing Screening

Assessing for risk of vision and hearing impairment, based on family history and parent observations should be a part of every well child visit. Assessing risk is not separately reimbursable or reported by a CPT code.

Objective vision screening and objective hearing screening using valid, age appropriate instrument(s) are to be provided in the primary care medical home according to the Bright Futures periodicity schedule and are separately reimbursable services. In cases where the provider does not perform an objective vision screening

or an objective hearing screening, a referral for the screening should be made in accordance with the periodicity schedule and child's 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 age appropriate, valid screening instrument is utilized and results are documented in the child's medical record. The encounter rate clinic (e.g., FHQC, RHC or ERC) does not receive separate reimbursement for the vision or hearing screening, but **must** detail the services provided during the visit on their encounter claim. Refer to the Appendices for the CPT codes appropriate for billing and reporting hearing and vision screening using an age appropriate, valid screening instrument.

HK-203.7.1 Vision Screening

Public Act 95-0671 mandates children entering kindergarten must 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 guidelines. Assessing risk for ocular problems and vision impairment should begin with the newborn exam and continue at each well child visit. *Bright Futures, 4th Ed.,* recommends that all children have formal vision screening as part of their health supervision visit annually from 3 through 6 years of age, and again at ages 8, 10, 12, 15 and 18 years. Vision screening should be conducted at other health supervision visits as necessary based on risk assessment or any concern on the part of the family or child. The goals of vision screening are to:

- Refer children who do not pass 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. For information relating to 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 in the Primary Care Medical Home

Vision screening should be conducted in the medical home by a PCP (or the PCP's staff, under the direct supervision of the PCP) enrolled in the HFS Medical Assistance Program.

Subjective surveillance and vision risk assessment should occur in the primary care setting and be recorded in the medical record for all infants, toddlers, and children as a component part of the EPSDT screening. Surveillance and risk assessment 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 risk assessment and both should be performed at every well child visit from age 3 through 6 years of age, and again at ages 8, 10, 12, 15 and 18 years in accordance with the Bright Futures Clinical Practice periodicity schedule.

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.

Vision Screening in Other Settings

When conducted in school or local health department settings, vision screening should be administered by nurses or technicians certified by the IDPH. Non-physician personnel working in a certified local 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.

Community based objective screening is valuable for children who miss well child visits and should follow the schedule described below. Ideally, the results of community screening should be communicated to the PCP and care coordination should occur. 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.

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
- To school aged children who are in kindergarten, second and eighth grades
- Annually for all children who are in special education classes
- Upon teacher referral and upon admission of transfer students

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.

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

Approved Vision Screening Instruments for use with Preschool-aged Children in the School or through the Certified Local Health Departments

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

- Good-Lite Insta-Line with HOTV crowded faceplate test instrument and the Michigan Preschool Slides (MPS) for use with a stereoscopic instrument are approved for preschool testing beginning at age 3 years
- 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 and the 20/40-symbol size is used for three and four year old children.

Approved Vision Screening Instruments for use with Children Kindergarten to Grade 7 in the School or through the Certified Local 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.

Approved Vision Screening Instruments for use beginning at Grade 7 in the School or through the Certified Local Health Department

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.

Children with Special Needs

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 photorefraction alone. If photorefraction is unavailable, refer the child to an optometrist or ophthalmologist appropriately trained to test and treat pediatric patients.

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

HK-203.7.2 Hearing Screening

The Hearing Screening for Newborns Act requires all newborns receive an objective hearing screening, using an electro-physiological testing methodology, otoacoustic emission (OAE) or auditory brainstem (ABR), for identifying congenital hearing loss. Surveillance 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:

Illinois Department of Public Health, Vision & Hearing Program
535 West Jefferson, 4th Floor
Springfield, IL 62761
Phone: 217-524-2396 782-4733 Fax: 217-524-4201 557-5324

The IDPH Child Vision and Hearing Test Act and Hearing Screening Rules and Regulations state that hearing screening services be provided annually to all preschool 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 kindergarten through 3; annually for all children who are in special education classes; upon teacher referral and upon admission of transfer students; and recommended for school age children who are in grades 4, 6, 8,10 and 12.

Hearing Screening in the Primary Care Medical Home

Regular surveillance of auditory skills, parental concern, and middle ear status should be a part of every well child visit within the medical home consistent with the Bright Futures periodicity schedule (available on the Bright Futures Clinical Practice website).

PCPs, or their staff working under the direct supervision of the PCP, do not need to be certified by IDPH.

Hearing Screening in Other Settings

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

All newborns should 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 one diagnostic audiology assessment by 24-30 months of age. Early and more frequent assessment may be indicated for children with Congenital Cytomegalovirus (CMV) infection, syndromes associated with progressive hearing loss, neurodegenerative disorders, trauma, or culture-positive postnatal infections associated with sensori-neural hearing loss; for children who have received extracorporeal membrane oxygenation (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.

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

Hearing Screening by Schools and Certified Local 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.

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.

Method and Criteria for Referral

A referral for medical and/or audiology 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 failed 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.

HK-203.8 Oral Health Screening/Fluoride Varnish

Beginning at the six-month visit, physicians should counsel caregivers on oral health, perform a dental screening for visual signs of decay and assess the child's oral health, and provide anticipatory guidance. Physicians should refer children to a dental home for routine and periodic preventive dental care within six months of the eruption of the first tooth or by age 1, as per recommendations by the American Academy of Pediatrics (AAP), the American Dental Association (ADA), and the American Academy of Pediatric Dentists (AAPD).

The AAP's *Bright Futures, 4th Ed.* recommends oral health assessments begin at 6 months and continue at well child visits at 9-, 12-, 18-, 24-, 30-, and 36-months and 6 years.

Physicians must be trained in an HFS-approved training program to be eligible for reimbursement for applying fluoride varnish. The procedure code for application of varnish is D1206. Information about HFS' reimbursement rates is available on the HFS Fee Schedule website. The Bright Smiles from Birth training program can be found on the American Academy of Pediatrics Illinois Chapter website. Physicians trained in the program must perform the oral health assessment themselves. The fluoride varnish application may be delegated to ancillary medical staff that have been either trained in an HFS-approved training program themselves or trained by another provider who has been trained through the program.

An oral health screening is part of the physical examination, but does not replace referral to a dentist. Dental benefits for children include services for treatment of early childhood caries, relief of pain and infections, restoration of teeth, dental sealants, prophylaxis, 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 DentaQuest of Illinois.

HK-203.9 Behavioral Health

As stated on the Health Resources and Services Administration website, "[behavioral health and physical health are inter-related and providing behavioral health care in a primary medical care setting can reduce stigma and discrimination, be cost effective and lead to improved patient outcomes." Behavioral health surveillance is an essential part of a preventive health care visit. This section focuses on promoting behavioral health in the primary care setting while a separate section in the Handbook focuses specifically on developmental screening, which is another component of behavioral health.

HK-203.9.1 Risk Assessment for Children and Adolescents

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:

Division of Mental Health and Addiction Recovery Services - 866-213-0548

Parent(s) who indicate the need for mental health or substance abuse treatment services for themselves or their family members may contact Division of Mental Health and Addiction Recovery Services at the number below. Coverage for services extends to eligible participants in HFS' Medical Programs.

Division of Mental Health and Addiction Recovery Services - 866-213-0548

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) Program for children, including adolescents, experiencing a mental health crisis. The SASS Program features a single point of entry called the CARES Line, for all children using this system that will ensure that children receive crisis services in the most appropriate setting. A child experiencing a crisis and in need of SASS services, should be referred to the CARES Line at
1-800-345-9049.

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 Tool MAYSI-2
- GAIN-Q GAIN-SS (Recency)
- GAIN-SS (Past Year)

Primary Care Practitioner Behavioral Health Support

The Illinois DocAssist Program is a primary care psychiatric consultation line facilitated by the University of Illinois – Chicago, School of Psychiatry. Administered by HFS in collaboration with the Division of Mental Health and Addiction Recovery Services and the Illinois Children's Mental Health Partnership (ICMHP), the Illinois DocAssist program is designed to deliver direct physician-to-physician support for diagnosis and treatment of behavioral health conditions and for prescription of psychotropic medication. Supported by Board Certified Psychiatrists with specialization in Child and Adolescent Services, the Illinois DocAssist program provides physicians with clinical consultation within one business day of their call. Illinois DocAssist: 866-986-2778

HK-203.9.2 Perinatal Depression

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 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 to 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 must invite the women to complete a questionnaire to assess whether they suffer from perinatal mental health disorders.

Perinatal Depression Screening

Often, perinatal depression may not be apparent without specific screening. Information about perinatal depression risk factors is available on HFS' Risk Factors Associated with Perinatal Depression website. Information about identifying women who may be at risk of prenatal or postpartum (perinatal) depression is available on HFS' Maternal and Child Health Promotion Perinatal Depression website.

To promote early identification and treatment of perinatal depression, providers are encouraged to screen women for perinatal depression and make appropriate referrals. Screening should be provided to women during prenatal and postpartum visits and with the mother when she is present during well-baby visits provided prior to the infant's first birthday.

Screening for perinatal depression using an approved instrument is a reimbursable service to HFS-enrolled providers for screening HFS-enrolled women. The instruments approved for HFS reimbursement are listed in the Appendices. Please be aware that reimbursement will only occur for screenings using one of the listed and approved tools.

Perinatal Depression Referral Resources

IDHS supports screening, assessment and treatment of women with Perinatal Mental Health Disorders. All IDHS funded case management programs are required to conduct screenings for Perinatal Mental Health Disorders at or after 25 weeks of pregnancy, and at least once during a child's first year of life. A referral mechanism is in place for women who have been identified needing further care. IDHS provides partial funding to support a 24-hour Perinatal Hotline at NorthShore Hospital. Any person who desires more information about Perinatal Mental Health Disorder may use this Hotline to obtain general education, referral information, or provider support.

Provider support: 866-364-MOMS (866-364-6667)

Patients may also get referrals through the DHS Helpline**:**

- Phone: 800-843-6154 TTY: 800-447-6404

Reimbursement for Perinatal Depression Screening

In recognition of the importance of screening, identifying and treating women suffering from perinatal depression, HFS provides reimbursement for perinatal depression screening. Reimbursement is available for both prenatal and postpartum depression screening for up to one year after delivery. Providers billing an encounter rate (FQHCs, RHCs, ERCs) will not receive separate reimbursement but must detail each service performed during the encounter.

The following codes should be used for perinatal depression screening:

- Prenatal screening: H1000
- Postpartum screening: 96127 with HD modifier – this code should be used when billing for any postpartum screening, whether it occurs during a well-child or episodic visit for an infant (under age one) or during any visit for the postpartum woman up to one year after delivery.

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 96127 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.

If the woman is postpartum and covered by HFS' Medical Programs, the perinatal depression screening should be billed using procedure code 96127 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.

Providers should be aware that reimbursement will only occur for screenings conducted using one of the listed and approved tools. Information about reimbursement rates is available on HFS' Fee Schedule website.

The perinatal depression screening instruments approved for HFS reimbursement are listed in the Appendices. Please be aware that reimbursement will only occur for screenings conducted using one of the listed and approved tools.

Providers must obtain approval from HFS prior to using a perinatal depression screening instrument other than those approved by HFS in order to obtain reimbursement for the screening. Providers must request additions to the list of approved developmental screening and evaluation tools, health risk assessment tools, and perinatal depression screening tools to be recognized by the Department for payment using Form HFS 724 "Screening, Assessment and Evaluation Tool Approval Request Form". Providers are encouraged to access the form on-line at HFS' Medical Programs Listing of Forms website and to complete the form electronically. The form and other requested information must be submitted following the instructions provided on the form.

HK-203.10 Anticipatory Guidance

A Bright Futures well child visit is an age specific health supervision visit that is

family-driven and is designed to allow practitioners to improve their desired standard of care. This family centered emphasis is demonstrated through several features:

- Solicitation of parental and child concerns.
- Surveillance and screening.
- Assessment of strengths.
- Discussion of certain visit priorities for improved child and adolescent health and family function over time. Sample questions and anticipatory guidance for each priority are provided as starting points for discussion. These questions and anticipatory guidance points can be modified or enhanced by each health care professional using *Bright Futures, 4th Ed.*

Anticipatory guidance is a required component of every well child visit and not a separate billable service. Health education provided to both families 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 interaction with the child 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 at each well child visit.

HK-203.10.1 Promoting Healthy Weight

Providers are encouraged to follow recommended clinical guidelines for evaluation and management of overweight and obesity. The American Medical Association (AMA) published the *Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report*. The USPSTF released its recommendation on Screening for Obesity in Children and Adolescents that can be found on its website.

Primary Care Physicians and other providers are encouraged to routinely assess and document children's weight status and weight trajectory, and counsel parents about how to help their children achieve and maintain a healthy weight. The CDC's Research to Practice series, available through their Nutrition Resources for Health Professionals website, provides information for practitioners regarding the use of therapeutic lifestyle changes, and guidance for encouraging modifications around nutrition and physical activity.

Body Mass Index Assessment Documentation in Claims

In accordance with expert committee recommendations, referred to above, providers are encouraged to assess and document BMI percentile at least one time per year

for pediatric patients ages 2 through 20. BMI assessment may be done during any visit, whether sick child or preventive.

Claims for an episode or encounter where BMI is assessed must include the appropriate CPT or UB-04 revenue code, and ICD-10 codes as appropriate. Providers should append a BMI-related diagnosis code for every episode or encounter of care during which BMI was assessed, documented, and addressed, if indicated.

Documentation must include a note in the patient's record indicating:

- The date on which the BMI percentile was assessed.
- One of the following measurements:
  - BMI percentile, or
  - BMI percentile plotted on age-growth chart
- If indicated, pertinent recommendation or a plan of management consistent with the codes used.

Weight Management Visits: BMI >85th Percentile

Providers may bill for weight management visits for children with a BMI greater than the 85th percentile. The BMI percentile must be measured and documented during that visit.

Visits addressing problem focused care delivered by a physician or an advance practice nurse or physician's assistant billing under a physician may be billed for care delivered and documented using evidence based clinical guidelines.

For children whose BMI is greater than the 85th percentile, payable weight management visits may include a maximum of three visits spread over a course of six months; follow up visits after the initial visit must include, in the patient's record, a note addressing the patient's/parent's readiness to change and outcomes of intervention to date.

Diagnosis codes for obesity related co-morbid conditions, if present and addressed at the visit, need to be listed on the claim form for each visit.

Each visit should include, in patient record, documentation of educational handouts given, care plan and outcomes based on specific treatment and behavior changes (e.g., nutrition, physical activity, etc.) recommended and made, compliance with past recommendations, results of screening laboratory tests, reports of referrals and consultations if any, and time spent by provider with patient and family during the visit.

No further visits related to weight management will be payable after a maximum of three visits over a six month period, unless improvement in BMI percentile is evident based on the diagnosis code submitted on the claim or documentation of favorable outcome is attached to the paper form HFS 2360 (pdf) claim.

Additional Notes on Payment Policies Related to Weight Management

Weight management visits cannot be billed on the same day as a Preventive Medicine visit.

Weight management counseling services can be billed as part of a problem focused evaluation and management visit. CPT guidance on this topic allows for this provision when counseling and/or care coordination dominates (more than 50%) face-to-face encounter time with the patient and/or family. The extent of counseling and/or coordination of care (time as well as content of care, coordination and counseling) must be documented in the medical record.

HK-203.10.2 Smoking and Tobacco Use Cessation

Tobacco cessation counseling services for children through age 20 and for women who are pregnant, or within the 60-day post-partum period may be a separately billable service. Both counseling and pharmacotherapy are covered without cost sharing.

Duration of Counseling

For pregnant and up to 60-day post-partum women age 21 and over, the Department will reimburse up to a maximum of three quit attempts per calendar year, with up to four individual face-to-face counseling sessions per quit attempt. The 12 maximum counseling sessions include any combination of the two procedure codes listed in the fee schedule. Please note, children through age 20 are not restricted to the maximum twelve counseling sessions.

These counseling sessions must be provided by, or under the supervision of, a physician, or by any other health care professional who is legally authorized to furnish such services under State law, and who is authorized to provide Medicaid covered services other than tobacco cessation services.

The patient's medical record must be properly documented with the provider signature, and include the total time spent and what was discussed during the counseling session, including cessation techniques, resources available and follow-up.

Pharmacotherapy

The Department covers FDA-approved nicotine replacement therapy in multiple forms, as well as two prescription medications indicated as an aid to tobacco use cessation. Providers may refer to the Department's Drug Prior Authorization webpage to determine specific drug coverage and prior approval requirements. Nicotine replacement duration of therapy is normally limited to three months in a

year; however, duration limitations may be overridden by the Department through the prior approval process on an individual patient basis. To request prior approval for a specific drug, please link to the Drug Prior Approval Information website.

Please note, per U.S. Public Health Service published guidelines, pharmacotherapy for tobacco cessation is not recommended for pregnant women due to lack of evidence regarding its safety and effectiveness in pregnant women; however, its use may be evaluated on an individual basis by the woman and her physician.

HFS does not cover tobacco use cessation techniques such as hypnosis, acupuncture, herbal remedies, ear clips, or any other technique that does not conform to a medical model. Use of e cigarettes is also not recognized or covered by HFS for purposes of smoking cessation or harm reduction due to lack of such evidence.

Illinois Tobacco Quitline

HFS encourages all providers to take advantage of the resources available to address tobacco use cessation including information provided by the Illinois Department of Public Health (DPH) available through the Illinois Tobacco Quitline website. The Illinois Tobacco Quitline is a free service funded by the DPH and managed by the American Lung Association of Illinois. Quitline staff includes registered nurses, registered respiratory therapists and counselors who have years of experience and are trained in all aspects of tobacco cessation. The Quitline also has a full time Spanish speaking interpreter. Callers who speak other languages, an interpretation service with access to more than 200 other languages is used. Hours of operation are from 7:00 a.m. to 11:00 p.m., daily. The Quitline services are available through the toll-free number at 866-QUIT YES (866-784-8937).

For more information about the harmful effects of tobacco use and resources to prevent tobacco use initiation refer to the CDC Smoking and Tobacco Use website.

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 Social Security Act (Act), to correct or ameliorate defects; physical and mental illnesses; and conditions discovered by the screening services, including treatment for pre-existing conditions.

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.

HK-203.11.1 Quality Monitoring

HFS is committed to monitoring the quality of its programs and the care provided to its beneficiaries. Quality monitoring ensures program goals are met and provides tools to providers to improve care. Quality monitoring uses pediatric quality indicators including Healthcare Effectiveness Data and Information Set (HEDIS®) measures, the Children's Health Insurance Program Reauthorization Act (CHIPRA) core measure set, and other indicators to assess HFS and provider performance. The pediatric quality indicators include, but are not limited to percentage of:

- Children with various numbers of well child visits in the first 15 months of life
- Children who receive appropriate lead screening
- Percentage of two year olds with appropriate immunizations
- Children who are 3, 4, 5 or 6 years of age who received one or more well child visits
- Children with objective vision screening
- Children with appropriate medication management for asthma
- Children ages 3-17 with BMI percentile documented at an outpatient visit reflected in the claim submittal
- Children with an ambulatory care emergency department visit
- Adolescent females with a chlamydia screening
- Children with a follow-up visit after hospitalization for mental illness
- Adolescent females with HPV vaccination

Specific measures tracked and how feedback is reported to providers vary depending on the program. As a component of the PCCM program, Illinois Health Connect tracks pediatric quality indicators such as those above and provides feedback to providers regarding their performance on these individual indicators via panel rosters, provider profiles and bonus payments. Information and additional resources are found on the Illinois Health Connect Quality Tools website.

Information on quality indicators and the external quality review of the MCO programs can be found through the HFS Care Coordination website. Providers should contact the specific Health Maintenance Organization (HMO), Managed Care Organization (MCO), with which they are enrolled for information on quality tools and reporting.

HK-204 Non-Covered Services

Services for which medical necessity is not clearly established are not covered in HFS' Medical Programs.

Services that are available at no cost to the general public will not be supported by HFS for HFS enrolled participants; for example:

- Local health department vaccination clinics
- Communicable disease clinics

Exceptions include the following, which are covered by HFS:

- 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 who meet the financial qualifications. Certified Local Health Departments and other public health agencies generally receive those grant dollars. IDPH 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 website.
- The service is "bundled" as part of another service when billed to other payers 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 Handbook for specific provider or service type.

HK-205 Record Requirements

The Department regards the maintenance of adequate records essential for the delivery of quality medical care. In addition, providers should be aware that medical records are key documents for post-payment audits. In the absence of proper and complete medical records, no payment will be made, and payments previously made will be recouped. Lack of records or falsification of records may also be cause for a referral to the appropriate law enforcement agency for further action. See Chapter 100 for record requirements applicable to all providers. The retention requirements are not intended to replace professional judgment, nor do they supersede record retention requirements under law or regulations of other agencies. The provider may choose to retain records beyond the Department's required period.

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

- Problem list
- Medication list
- 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, including documentation and interpretation of BMI for children starting at 2 years of age
- Hospital admission and discharge, if any
- Family planning services, if any
- Referral information and specialty consultation reports, if any

All services provided must be documented in the permanent medical record. Medical records 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 those services in the medical record.

For children with chronic diseases, providers 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 may 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:

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 and specialty consultation reports.

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 Assessments 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 – Objective 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 also must 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

Information and claim history also can be obtained through the MEDI system.

Providers can access MEDI via the Illinois Health Connect website 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 medical records 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 the MEDI/IEC Training website 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, e.g. HEDIS®.

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

- Well child visits in 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
- Percent of children ages 3-17 with BMI percentile documented at an outpatient visit

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 the allowed scope of 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 Department's Medical Director), may perform well child physical examinations in the clinic as defined by the Certified Local Health Department's 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 primary care 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

Beyond the traditional primary care that is essential for all children, families also may benefit from a broad range of community based services such as family support (housing, employment, and social services), educational services, mental health services, substance abuse treatment, language assistance, respite care, recreation opportunities, and services for children and youth with special health care needs.

HK-207.1 Transportation Assistance

Transportation is a covered service for an eligible All Kids beneficiary (whose family income is under 200 percent of the federal poverty level) and if necessary, for an attendant, to or from a source of medically necessary care when a cost free mode of transportation is not available or is not appropriate. Medically necessary care is defined as any medically necessary service covered under the Medical Assistance Program.

HFS has a contractor to handle the prior approval of non-emergency transportation services covered under the Non-Emergency Transportation Services Prior Approval Program (NETSPAP). The contractor does not provide transportation services under NETSPAP. Prior approval from the HFS contractor is required for all non-emergency medical transportation. Prior approval is not needed for emergency medical transportation.

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. For more information about prior approval, visit the NETSPAP website.

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

- Provided to or from a covered source of 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

If the child is enrolled in a 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 VFC Program is administered by the Chicago Department of Public Health for the city of Chicago and the Illinois Department of Public Health for the state of Illinois outside of the city of Chicago to:

- Provide federally purchased vaccines, for children through age 18 who are uninsured (no insurance coverage), Medicaid Title XIX eligible, or American Indian/Alaskan Native. Underinsured children whose insurance does not cover ACIP recommended vaccines or only covers select vaccines may be eligible to receive the non-covered vaccines at VFC enrolled FQHCs, RHCs and certified local health departments (LHDs) under an approved deputization agreement.
- Provide vaccines recommended by the Advisory Committee on Immunization Practices (ACIP).
- Reduce referrals of children eligible to receive VFC vaccines from private providers to local health departments for vaccination.
- Save VFC-enrolled providers out of pocket expenses for vaccine purchases for VFC eligible children.

Participation in the VFC Program requires that the provider complete an annual enrollment. Participation in the VFC Program for *Chicago* providers occurs through the Chicago VFC Program. Participation in the Illinois VFC Program for providers outside the city of Chicago is administered by the Illinois Department of Public Health (IDPH). The Illinois VFC annual enrollment is completed in I-CARE. Providers interested in enrolling in the Illinois VFC Program must register for I-CARE access first. I-CARE registration information is available the ICARE website.

The HFS Medical Electronic Data Interchange System (MEDI) provides comprehensive data on childhood immunizations from various sources. These include childhood immunizations paid by HFS, or reported through encounter data by the child's MCO; recorded on the 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 recorded on IDPH's *I-CARE (*Illinois Comprehensive Automated Immunization Registry Exchange) registry system.

HFS strongly encourages PCPs to participate in I-CARE, the Illinois' immunization registry maintained by IDPH. HFS also strongly encourages PCPs to utilize I-CARE for functions such as conducting reminder and recall functions to improve practice-based immunization coverage levels.

HK-207.3 Eye Care – Glasses

Children less than 21 years of age do not have limits on glasses. Eyeglasses may be replaced as needed without prior approval if there is a change in the prescription meeting HFS' requirements or if they are broken beyond repair, lost, or stolen.

The Department regards the maintenance of adequate records essential for the delivery of quality medical care. Providers must maintain an office record for each patient. The record maintained by the provider is to include the essential details of the patient's condition and of each service or material provided. The signature of the provider is required for the record of the service/visit to be complete. If there is no signature, then the record is incomplete.

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 (pdf), to order lenses, frames, or both. The OPO is attached to the Provider Invoice Form HFS 1443 (pdf)and submitted to HFS in the usual manner for claim submittals. The Provider Invoice should show charges only for 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.

Charges for examinations and office visits should be submitted on the Form HFS 2360 (pdf), Health Care Claim Form, in accordance with the Chapter A- 200, Handbook for Practitioners Rendering Medical Services, or electronically utilizing the 837 Professional.

For additional information regarding prescription requirements, record requirements and other information consult the Chapter 200, Optometrist Services Handbook on HFS' website.

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, in accordance with current IDHS policies governing same.

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

Case management services also are 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 youth in care 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 youth in care, and children of older youth in care, 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 participants in receiving needed services. For more information about the Family Case Management Program, contact:

Illinois Department of Human Services
Helpline: 800-323-4739 TTY: 800-447-6404

HK-207.5 Special Supplemental Nutrition Program for Women, Infants and Children (WIC)

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC), administered by IDHS, seeks to stress the relationship between proper nutrition, physical activity and health of women, infants and children; promote exclusive breastfeeding; and assist individuals at nutritional risk in achieving positive changes in dietary and physical activity habits to prevent nutrition related problems through optimal use of the supplemental foods and breastfeeding.

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. 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 categorically eligible patients for a WIC nutrition assessment and potential certification to the program. For the location of the nearest

WIC clinic, use the IDHS Office Locator.

Certified Local 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. WIC is a public health nutrition program under the USDA providing nutrition education, nutritious foods, breastfeeding support, and healthcare referrals for income-eligible women who are pregnant or postpartum, infants, and children up to age five. 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.

To find a local WIC office:

DHS Office Locator State WIC office: 217-782-2166
DHS hotline: 800-843-6154 or 800-447-6404 (TTY)

For more information about the WIC program:

- General WIC website
- WIC "Make a Difference"
- Make a Difference Brochure (pdf)
- Make a Difference Brochure Spanish (pdf)

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 a 30% or greater level of delay in at least one of these areas:
  - Cognitive development
  - Physical development, including vision and hearing
  - Language, speech, and communication development
  - Social-emotional development
  - Adaptive self-help skills
- Or are diagnosed with a physical or mental condition which typically results in developmental delays, such as Spina Bifida, Down Syndrome.
- Or are determined at risk of substantial developmental delay because the child is experiencing either:
  - A parent who has been medically diagnosed as having a severe mental disorder as set forth under axis I and axis II of the Diagnostic and Statistical Manual (DSM) IV or a developmental disability.

  or
  - three or more of the following risk factors as defined by IDHS' EI program:
    - Current alcohol or substance abuse by the primary caregiver.

- Primary caregiver who is currently less than 15 years of age.
- Current homelessness of the child. Homelessness is defined as children who lack a fixed, regular and adequate nighttime residence, in conformity with the McKinney Vento Homeless Assistance Act.
- Chronic illness of the primary caregiver.
- Alcohol or substance abuse by the mother during pregnancy with the child.
- Primary caregiver with a level of education equal to or less than the 10th grade, unless that level is appropriate to the primary caregiver's age, or
- An indicated case of abuse or neglect regarding the child and the child has not been removed from the abuse or neglect circumstances.

Families access the Illinois Early Intervention Services System through the Child and Family Connections (CFC) office, which serves their local area. 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. Refer to the Appendices Care Coordination Information and Resources for EI referral resources.

To obtain resource information for the nearest CFC office, use the IDHS Office Locator, or contact:

Illinois Department of Human Services
Helpline: 800-843-6154 or 800-323-4769
TTY: 800-447-6404

HK-207.7 Special Education Services

The Illinois State Board of Education serves as the lead agency to implement Special Education services. Special Education services are provided for children ages three through twenty-one with an educationally related disability, or developmental delay for children three through nine, (Part B of the Individuals with Disabilities Education Act.) Local school districts evaluate children to determine eligibility and if eligible, create an Individual Education Program (IEP) to identify special education and related services. Key services provided are individually determined based on the child's needs but may include:

- Assistive technology (durable medical equipment and supplies)
- Audiology, aural rehabilitation, and other related services

- School nurse or school health services
- Occupational therapy
- Physical therapy
- Psychological and other counseling services
- Speech/language therapy
- Transportation
- Vision services
- Parent counseling and training

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 the Illinois State Board of Education Special Education Services website.

HK-207.8 Rehabilitation Services

Throughout the State, services are available to families of youth with disabilities through the IDHS Division of Rehabilitation Service website. For general information, contact:

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

HK-207.9 UIC – Division of Specialized Care for Children (DSCC)

UIC-Specialized Care for Children's mission is to partner with Illinois families and communities to help children with special healthcare needs connect to services and resources.

The UIC Core Program offers care coordination and cost supported diagnosis and treatment for children with chronic health impairments determined eligible for program support. The program supports non-investigational treatment recommended by physician specialists, such as therapy, medications, specialized equipment and supplies. Application forms are available on the How We Help/How to Apply page of the website or by calling 1-800-322-3722. To make a referral for a child, go to the website and select For Providers/Refer a Family.

The UIC Home Care Program offers care coordination for medically fragile/technology dependent children residing in the community setting. UIC-Division of Specialized Care for Children operates this program on behalf of HFS. Application forms are available on the How We Help/How to Apply page of the website or call 800-322-3722. To make a referral for a child, go to the website and select For Providers/Refer a Family.

The Supplemental Security Income - Disabled Children's Program is administered by UIC-Division of Specialized Care for Children to provide rehabilitative services to children under 16 years of age who are eligible for the Supplemental Security Income (SSI) program. The Division provides information about and referral to community

resources, including referrals to Early Intervention or preschool programs when appropriate, and Core Program services as described above. Information is available on the UIC Specialized Care for Children website. Application forms are available on the UIC Specialized Care for Children How to Apply website.

HK-207.10 Electronic Health Record Medicaid Incentive Payment Program (eMIPP)

CMS has implemented, through provisions of the American Recovery and Reinvestment Act of 2009 (ARRA), incentive payments to eligible professionals (EP) and eligible hospitals (EH), including critical access hospitals (CAHs), participating in Medicare and Medicaid programs that are meaningful users of certified EHR technology. The incentive payments are not a reimbursement, but are intended to encourage EPs and EHs to adopt, implement, or upgrade certified EHR technology and use it in a meaningful manner.

The Illinois EHR Medicaid Incentive Program (eMIPP) provides incentive payments to eligible professionals, eligible hospitals and critical access hospitals (CAHs) as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology.

The CMS Medicare and Medicaid EHR PIP program is voluntarily offered by individual states and territories. States must have a CMS approved infrastructure in place to manage the program. The program will continue until 2021.

HK-207.11 Text4baby

HFS and EverThrive encourage use of Text4baby, a free mobile texting service designed to promote maternal and child health. EverThrive serves as the Illinois state affiliate of Text4baby outreach campaign. Text4baby is an educational program of the National Healthy Mothers, Healthy Babies Coalition and provides pregnant women and new moms with information to help them care for their health and give their babies the best possible start in life. Women who sign up for the service by texting BABY to 511411(or BEBE for Spanish) will receive free text messages each week, timed to their due date or baby's date of birth. These messages focus on a variety of topics critical to maternal and child health: immunization, nutrition, seasonal flu, mental health, birth defects prevention, oral health and safe sleep. Text4baby messages also connect women to prenatal and infant care services.

EverThrive has posters, tear-offs and other materials for distribution. They also can assist you with ideas for encouraging women to sign up for Test4baby.

To order free Text4baby materials please contact:

- Website: EverThrive website Phone: 312-491-8161