# State of New Mexico Medical Assistance Program Manual
# Supplement

**DATE: November 15, 2017** **NUMBER: 17-11**

**TO:** ALL MAD STAFF, PHYSICIANS AND PHYSICIAN GROUPS, CERTIFIED NURSE PRACTIONERS, CLINICS, FQHCS, RURAL HEALTH CLINICS AND INDIAN HEALTH SERVICE CLINICS

**FROM:** NANCY SMITH-LESLIE, DIRECTOR
MEDICAL ASSISTANCE DIVISION

**SUBJECT: EARLY PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT) SCREENING SERVICES**

## I. Federally Mandated Services

The federally mandated Early Periodic Screening, Diagnostic, and Treatment (EPSDT) program covers preventive and treatment services to improve the health of New Mexico children and youth. Through preventive medicine (well child check-ups, early and continuous screening, diagnostic testing), services for eligible Medicaid recipients are delivered through the EPSDT program. EPSDT services cover four health-related areas: Medical, Vision, Hearing, and Oral Health.

Unlike the other three types of screenings, medical screenings have components specifically required by statute. Complete medical screenings under the EPSDT benefit must include the following five components: (1) a comprehensive health and developmental history (including assessment of both physical and mental health development); (2) a comprehensive unclothed physical examination; (3) appropriate immunizations; (4) appropriate laboratory tests; and (5) health education or anticipatory guidance.

New Mexico's EPSDT screening component is known as the "Tot to Teen Healthcheck" (8.320.2.10 NMAC). Eligible children and adolescents receive well-child examinations at recommended intervals to include diagnostic, treatment, and other necessary health care measures needed to correct or ameliorate physical and behavioral health disorders or conditions.

New Mexico has adopted the examination and screening guidelines recommended by the American Academy of Pediatrics (AAP) and Bright Futures. Detailed information regarding anticipatory guidance and screening tools can be found at: https://brightfutures.aap.org/Pages/default.aspx. Periodicity Schedules for physical, behavioral, and oral health specifying the intervals children and adolescents should be seen for the Tot-to-Teen Healthcheck are included herein as **Attachment 1**.

## II. What Does EPSDT Include?

EPSDT examinations include all preventive services for children and adolescents, including services for treatment and amelioration of health problems.

The EPSDT program is monitored by The Centers for Medicare and Medicaid Services (CMS) to ensure states comply with examinations and screening mandates. States are required to report all visits and screening data. The federal government requires that states meet an 80% participation rate for eligible children. Most states fall below this rate, which indicates many children who should be receiving EPSDT services are not.

There are several reasons why the data reflects that EPSDT services are not being provided such as parents' non-participation in making and keeping a well child appointment and improper coding by a clinic of the visit. **HSD encourages providers to take advantage of these visits to minimize missed opportunities in providing EPSDT examinations, screenings, and preventive care by providing EPSDT services during other visits including sick visits and school and sports physicals.**

## III. EPSDT Coding

When EPSDT services are provided during any visits other than a well child appointment, other components of EPSDT services such as a standardized developmental screening, Blood Lead Level (BLL) screening test, may be performed and billed separately on the same day (i.e., a provider may perform and bill for an EPSDT screening or health check as an additional service if the illness does not interfere with the health check.)

The well child check-up should include:

- Medical history
- Measurements of height, weight and BMI
- Unclothed physical examination
- Nutrition screening
- Vision and hearing screenings
- Developmental/behavioral assessment: AAP and Bright Futures recommend that developmental surveillance be incorporated at every well child visit. In addition, standardized developmental screening tests should be administered regularly at the 9-, 18-, and 24- or 30-month visits. Screening tests should be both reliable and valid, with good sensitivity and specificity (sensitivity and specificity levels of 70% to 80% have been deemed acceptable for developmental screening tests). The tests must also be culturally and linguistically sensitive. The U.S. Department of Health and Human Services published a compendium of screenings containing both summary tables and individual instrument profiles of commonly-used developmental screening tools available at: https://www.acf.hhs.gov/sites/default/files/ecd/screening_compendium_march2014.pdf
- Hematocrit/hemoglobin at 9 months and 13 years
- Lead screening at 12 months and 24 months- filter paper test may be used (see provider letter included herein as **Attachment 2**)
- Immunizations - according to the most current ACIP schedule
- Any screenings necessary according to risk factors
- Anticipatory Guidance: One of the provider's roles is continuous education through anticipatory guidance, which is another federally mandated component of the EPSDT program. Age-appropriate education and counseling provided during a well child checkup is intended for the parent/caretaker or adolescent in order to understand expected growth and development in terms of physical, emotional, and oral health.

The codes to be used to document the receipt of an initial or periodic screen are as follows:

| CPT Codes: Preventive Services* | Description |
|---|---|
| 99381 | New Patient under one year |
| 99382 | New Patient (ages 1-4 years) |
| 99383 | New Patient (ages 5-11 years) |
| 99384 | New Patient (ages 12-17 years) |
| 99385 | New Patient (ages 18-39 years) |
| 99391 | Established patient under one year |
| 99392 | Established patient (ages 1-4 years) |
| 99393 | Established patient (ages 5-11years) |
| 99394 | Established patient (ages 12-17 years) |
| 99395 | Established patient (ages 18-39 years) |
| 99460 | Initial hospital or birthing center care for normal newborn infant |
| 99461 | Initial care in other than a hospital or birthing center for normal newborn infant |

*These CPT codes do not require use of a "Z" code.

| CPT Codes: Evaluation and Management Codes** | Description |
|---|---|
| 99202-99205 | New Patient |
| 99213-99215 | Established Patient |

**The above CPT codes must be used in conjunction with at least one of the following "Z" diagnosis codes:
Z00.00 through Z00.129, Z00.8, Z02.89, and Z76.1 – Z76.2

If the child is enrolled in Centennial Care on the date of service, please submit claims to the appropriate managed care organization. Fee-for-service claims shall be submitted directly to HSD's fiscal agent, Conduent: https://nmmedicaid.acs-inc.com/static/providerlogin.htm.

For more information about EPSDT services, refer to New Mexico Medicaid's Keeping Kids Healthy web page at: http://www.hsd.state.nm.us/LookingForInformation/keeping-kids-healthy.aspx.

The Medical Assistance Division program policy manual can be accessed at: http://www.hsd.state.nm.us/mad/policymanual.html.

Thank you for participating in the Medicaid program.

HUMAN SERVICES DEPARTMENT

**Attachment 1**

## NEW MEXICO PREVENTIVE PEDIATRIC HEALTH CARE PERIODICITY SCHEDULE (recommended by the Bright Futures/American Academy of Pediatrics)

The federal Health Resources and Services Administration (HRSA) established Bright futures in 1990 to improve the standard of care for children and adolescents. Since 2002 the American Academy of Pediatrics (AAP) has overseen development and dissemination of these guidelines. Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents provides pediatric care providers and families with tools for evidence-based care for children from birth to age 21. The New Mexico Human Services Department has adopted these guidelines. For additional information, see the Bright Futures Guidelines, 4th Edition, Evidence and Rationale chapter: https://brightfutures.aap.org/Bright%20Futures%20Documents/BF4_Evidence_Rationale.pdf.

| | INFANCY | | | | | | | EARLY CHILDHOOD | | | | | | | MIDDLE CHILDHOOD | | | | | | ADOLESCENCE | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| AGE[1] (Prenatal Visits)[2] | Newborn[3] | 3-5 d | By 1 mo | 2 mo | 4 mo | 6 mo | 9 mo | 12 mo | 15 mo | 18 mo | 24 mo | 30 mo | 3 y | 4 y | 5 y | 6 y | 7 y | 8 y | 9 y | 10 y | 11 y | 12 y | 13 y | 14 y | 15 y | 16 y | 17 y | 18 y | 19 y | 20 y | 21 y |
| HISTORY Initial/Interval | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| MEASUREMENTS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| L/Ht/Wt | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| Head Circumference | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | | | | | | | | | | | | | | | | | | | | |
| Weightt for Length | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | | | | | | | | | | | | | | | | | | | | | |
| BMI[4] | | | | | | | | | | | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| BP[5] | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| SENSORY SCREENING | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Vision[6] | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ● | ● | ● | ● | ⊙ | ● | ⊙ | ● | ⊙ | ● | ⊙ | ⊙ | ● | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ |
| Hearing[7] | ● | ● ⟶ | ⟶ | ⟶ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ● | ● | ● | ⊙ | ● | ⊙ | ● | ⟵ | ⟷ | ● | ⟶ | ⟵ | ● | ⟶ | ⟵ | ⟷ | ● | ⟶ |
| DEVELOPMENTAL/BEHAVIORAL | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Dev Screening[8] | | | | | | | ● | | | ● | | ● | | | | | | | | | | | | | | | | | | | |
| Autism Spectrum Disorder Screening[9] | | | | | | | | | | ● | ● | | | | | | | | | | | | | | | | | | | | |
| Dev Surveillance | ● | ● | ● | ● | ● | ● | | ● | ● | | ● | | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| Psychosocial / Behavioral Assessment[10] | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| Tobacco, Alcohol, or Drug Use Assessment[11] | | | | | | | | | | | | | | | | | | | | | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ |
| Depression Screening[12] | | | | | | | | | | | | | | | | | | | | | | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| Maternal Depression Screening[13] | | | ● | ● | ● | ● | | | | | | | | | | | | | | | | | | | | | | | | | |
| PHYSICAL EXAMINATION[14] | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| PROCEDURES[15] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Newborn Blood[16] | ● | ● ⟶ | ⟶ | ⟶ | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Newborn Bilirubin[17] | ● | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Critical Congenital Heart Defect[18] | ● | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Immunization[19] | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| Anemia[20] | | | | | ⊙ | | | ● | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ |
| Lead[21] | | | | | | ⊙ | ⊙ | ● or ⊙ | | ⊙ | ● or ⊙ | | ⊙ | ⊙ | ⊙ | ⊙ | | | | | | | | | | | | | | | |
| Tuberculosis[22] | | | ⊙ | | | ⊙ | | ● | | | ⊙ | | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ |
| Dyslipidemia[23] | | | | | | | | | | | ⊙ | | | ⊙ | | ⊙ | | ⊙ | ⟵ | ● | ⟶ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⟵ | ⟷ | ⟷ | ● | ⟶ |
| STIs[24] | | | | | | | | | | | | | | | | | | | | | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ |
| HIV[25] | | | | | | | | | | | | | | | | | | | | | ⊙ | ⊙ | ⊙ | ⊙ | ⟵ | ⟷ | ● | ⟶ | ⊙ | ⊙ | ⊙ |
| Cervical Dysplasia[26] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ● |
| ORAL HEALTH[27] | | | | | | ● | ● | ⊙ | | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | | | | | | | | | | | | | | | |
| Fluoride Varnish | | | | | | ⟵ | ⟷ | ⟷ | ⟷ | ● | ⟷ | ⟷ | ⟷ | ⟷ | ⟶ | | | | | | | | | | | | | | | | |
| Fluoride Supplementation | | | | | | ⊙ | ⊙ | ⊙ | | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | ⊙ | | | | | |
| ANTICIPATORY GUIDANCE | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● |

● To be performed ⊙ Risk assessment to be performed with appropriate action to follow, if positive ⟵ ● ⟶ Range during which a service may be provided

[1] If a child comes under care for the first time at any point on this schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date as soon as possible.

[2] Prenatal visits are not shown on this schedule; however, the AAP recommends a prenatal visit and anticipatory guidance for parents who are at high risk, for first-time parents, and for those who request it. Refer to: http://pediatrics.aappublications.org/content/124/4/1227.full

[3] A newborn evaluation should be performed 3-5 days after birth and within 48-72 hours after hospital discharge or home birth to include evaluation for feeding and jaundice. Breastfeeding newborns should receive a breastfeeding evaluation, and the mother should receive instruction as recommended in "Breastfeeding and the Use of Human Milk," http://pediatrics.aappublications.org/content/129/3/e827.full. Newborns discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per "Hospital Stay for Healthy Term Newborns," http://pediatrics.aappublications.org/content/125/2/405.full

[4] The BMI screenings should be performed in accordance with the "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report," http://pediatrics.aappublications.org/content/120/Supplement_4/S164.full

[5] BP measurement in infants and children with specific risk conditions should be performed before age 3.

[6] A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3 year olds. Instrument based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at ages 3-5 years. See 2016 AAP, "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians," http://pediatrics.aappublications.org/content/137/1/1.51 and "Procedures for Evaluation of the Visual System by Pediatricians," http://pediatrics.aappublications.org/content/137/1/1.52

[7] Newborns should be screened with result verification as early as possible, follow up as appropriate. Refer to "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs," http://pediatrics.aappublications.org/content/120/4/898.full.
A screening with audiometry including 6,000 and 8,000 Hz high frequencies should be done once during each of three intervals: 11-14, 15-17, and 18-21 years of age. Refer to "The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies," http://www.jahonline.org/article/S1054-139X(16)00048-3/fulltext.

[8] Refer to "Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Development Surveillance and Screening," http://pediatrics.aappublications.org/content/118/1/405.full. The U.S. Department of Health and Human Services requires that periodic developmental and behavioral health screenings be conducted through the EPSDT (Early and Periodic Screening, Diagnostic, and Treatment) benefit and children enrolled in the Children's Health Insurance Program (CHIP). Refer to the" Birth to 5: Watch Me Thrive!" compendium for additional guidance, https://www.acf.hhs.gov/ecd/child-health-development/watch-me-thrive.

[9] Refer to "Identification and Evaluation of Children with Autism Spectrum Disorders," http://pediatrics.aappublications.org/content/120/5/1183.full

[10] Assessment should be family-centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health. Refer to "Promoting Optimal Development: Screening for Behavioral and Emotional Problems," http://pediatrics.aappublications.org/content/135/2/384 and "Poverty and Child Health in the United States," http://pediatrics.aappublications.org/content/137/4/e20160339

[11] Refer to http://www.ceasar-boston.org/CRAFFT/index.php for the CRAFFT screening tool for adolescents.

[12] Refer to the Mental Health Screening and Assessment Tools for Primary Care, http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf.

[13] Refer to "Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice," http://pediatrics.aappublications.org/content/126/5/1032.

[14] An age-appropriate, unclothed physical examination is essential at each visit. Refer to "Use of Chaperones During the Physical Examination of the Pediatric Patient," http://pediatrics.aappublications.org/content/127/5/991.full.

[15] Procedures in this section may be modified, depending upon the entry point and individual need of the patient.

[16] The provider shall confirm the initial screen was performed, verify results, and follow up as appropriate. Refer to "The Recommended Uniform Screening Panel," http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf and state newborn screening laws/regulations at http://genes-r-us.uthscsa.edu/sites/genes-r-us/files/nbsdisorders.pdf

[17] The provider shall confirm the initial screen was performed, verify results, and follow up as appropriate. Refer to "Hyperbilirubinemia in the Newborn Infant ≥35 Weeks' Gestation: An Update With Clarifications," http://pediatrics.aappublications.org/content/124/4/1193

[18] Screening using pulse oximetry should be performed in newborns, after 24 hours of age, before hospital discharge per "Endorsement of Health and Human Services Recommendations for Pulse Oximetry Screening for Critical Congenital Heart Disease." Refer to http://pediatrics.aappublications.org/content/129/1/190.full

[19] Refer to the "Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger," http://redbook.solutions.aap.org/SS/Immunization_Schedules.aspx

[20] Refer to "Diagnosis and Prevention of Iron Deficiency and Iron-Deficiency Anemia in Infants and Young Children (0-3 Years of Age)," http://pediatrics.aappublications.org/content/126/5/1040.full

[21] Providers shall perform risk assessments or screenings as appropriate, **based on universal screening requirements for Medicaid-enrolled children** or in high prevalence areas. For children at risk of lead exposure, see "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention," http://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf The Medicaid requirement is met only when the two blood screening tests (or a catch-up test) are conducted. The child's medical record must document all lead testing services rendered and the resulting values.

[22] Tuberculosis testing shall be performed according to the current edition of the AAP Red Book: Report of the Committee on Infectious Diseases, https://redbook.solutions.aap.org/book.aspx?bookid=1484. For additional information, refer to: https://redbook.solutions.aap.org/chapter.aspx?sectionid=88187074&bookid=1484

[23] Refer to "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents," http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm

[24] Adolescents should be screened for STIs per recommendations in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*.

[25] Adolescents should be screened for HIV according to the USPSTF recommendations, Human Immunodeficiency Virus (HIV) Infection: Screening, http://www.uspreventiveservicestaskforce.org/uspstf/uspshivi.htm

[26] Refer to USPSTF recommendations for cervical cancer screening at http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm . If a pelvic examination is indicated prior to age 21, refer to "Gynecologic Examination for Adolescents in the Pediatric Office Setting," http://pediatrics.aappublications.org/content/126/3/583.full

[27] Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment via the following tool: https://brightfutures.aap.org/Bright%20Futures%20Documents/OralHealthRiskAssessmentTool.pdf. For additional information on oral health risk assessment, refer to AAP Policy Statement, "Oral Health Risk Assessment Timing and Establishment of the Dental Home," http://pediatrics.aappublications.org/content/pediatrics/111/5/1113.full.pdf and "Policy on the Dental Home," 2015 Revision, http://www.aapd.org/media/Policies_Guidelines/P_DentalHome.pdf. For fluoride varnish, refer to "Maintaining and Improving the Oral Health of Young Children," http://pediatrics.aappublications.org/content/134/6/1224. If the child's primary water source is lacking fluoride, consider oral fluoride supplementation. Refer to "Fluoride Use in Caries Prevention in the Primary Care Setting," http://pediatrics.aappublications.org/content/134/3/626

Susana Martinez, Governor
Brent Earnest, Secretary
Nancy Smith-Leslie, Director

November 15, 2017

Dear Health Care Provider:

The Centers for Medicare and Medicaid Services (CMS) require that all children enrolled in Medicaid have a Blood Lead Level (BLL) screening test at 12 and 24 months of age. Children between the ages of 24 and 72 months of age with no record of a previous blood lead screening test must receive one, regardless of whether the child has been determined to be at low or high risk for lead exposure. Completion of a risk assessment questionnaire does not meet the Medicaid requirement and DOES NOT count as a lead screening. **The Medicaid requirement is met only when the two screening tests (or a catch-up test) are conducted. The child's medical record must document all lead testing services rendered and the resulting values.**

Historically, lead paint and older housing have been the major sources of lead exposure; however, children can be exposed to lead from other sources (lead smelters, lead pipes, solder, ethnic or folk medicine, toys, artificial turf, and candies produced outside the U.S.) and through different pathways such as air, food (lead could leach into food by pottery containing lead), water, dust, and soil.

Because no safe blood lead level in children has been identified and lead exposure can affect nearly any system in the body, the goal of lead screening is to identify children with elevated blood lead levels *before* harm occurs. Lead poisoning affects the brain and nervous system and can cause learning and behavior problems in children by slowing down growth and development, damage hearing and speech, and make it difficult to pay attention and learn. Some of the effects of lead poisoning never go away.

The Centers for Disease Control and Prevention (CDC) projects that there are approximately half a million children in the U.S. between the ages of one and five years whose BLLs are greater than 5 micrograms per deciliter (µg/dL), the threshold level at which the CDC now recommends actions be taken. While substantial improvements have been made to reduce children's exposure to lead, New Mexico has low BLL screening test rates even among children covered by Medicaid. The New Mexico Department of Health (NM DOH) recently published county level data containing the percentage of children screened and the percentage of children with elevated BLLs, available at: https://nmhealth.org/data/view/report/2006/. Many counties with a low screening rate are areas with risk factors per the NM DOH's prioritization matrix (housing built before 1980, brownfield sites, and areas with high rate of children in poverty).

**Attachment 2**

Four options for coding and billing exist, depending on office protocols which are supported by CLIA certification as appropriate:

| CPT Codes | Description |
|---|---|
| 83655 | **Lab** |
| 99381-99383 or<br>99391-99393 | **Include appropriate diagnosis code plus blood draw CPT Code**<br>36415 (venous draw)<br>36416 (capillary draw) |
| 99381-99383<br>99391-99393 | **Include appropriate diagnosis code*** |
| 99201-99205 or<br>99211-99215 | **Include appropriate sick visit ICD-10 code plus blood draw CPT Code and appropriate diagnosis code**<br>36415 (venous draw)<br>36416 (capillary draw) |
| 99201-99205<br>99211-99215 | **Include appropriate sick visit ICD-10 code plus blood lead CPT Code (83655) and appropriate diagnosis code** |

* Submission of 83655 requires CLIA Lab Certificate Code of (340) Chemistry-Toxicology.

The benefits of using the filter paper lead test are as follows:

- The test utilizes 2 drops of capillary blood from a finger stick.
- The test is accurate and simple to administer.
- The test causes minimal discomfort for the child.
- The same blood sample may be used to test both the lead and hematocrit levels.
- Children with an elevated blood lead level ($\geq$ 10 µg/L) must receive a venous test for confirmation.
- At no cost to the provider, two laboratories (Tamarac 1-800-842-7069 and Medtox 1-800-832-3244) will provide the necessary collection supplies, requisition forms, and pre-paid specimen shipping.
- For children enrolled in Medicaid fee-for-service, the laboratories will bill NM Medicaid directly.

The following laboratories provide services for Centennial Care members:

| | | |
|---|---|---|
| Blue Cross Blue Shield of NM | TriCore Reference Laboratories<br>Quest Diagnostics<br>Lab Corp of America | 1-800-245-3296 / 505-938-8888<br>1-800-999-5227<br>1-888-522-2677 |
| Presbyterian Health Plan | TriCore Reference Laboratories | 1-800-245-3296 / 505-938-8888 |
| Molina Health Care | TriCore Reference Laboratories<br>Quest Diagnostics | 1-800-245-3296 / 505-938-8888<br>1-800-999-5227 |
| United Healthcare | Quest Diagnostics | 1-800-999-5227 |

Another method of blood lead screening is the ***CLIA-waived LeadCare® II Point-of-Care System*** which can be purchased from ESA Inc. Information regarding this testing device can be found on the ESA, Inc. website: http://www.esainc.com/products/type/blood-lead_analyzers/clia-waived

The provider uses the ***LeadCare® II Point-of-Care System*** test and bills Medicaid or the MCO for the test. Note that any diagnostic testing conducted by Magellan Diagnostics is under review by the FDA. Magellan offers three systems, the LeadCare II, LeadCare Plus, and LeadCare Ultra.

Per the Notifiable Diseases or Conditions in New Mexico (New Mexico Administrative Code 7.4.3.13), *all* BLL test results must be reported to the Environmental Health Epidemiology Department (EHEB) of the New Mexico Department of Health (DOH). If a provider uses the ***CLIA-waived LeadCare® II Point-of-Care System*** or a similar system in the office, the provider must report the test result to the EHEB.

Attached to this letter is the "*Child Lead Exposure Questionnaire*" from the EHEB's Lead Poisoning Prevention Program. HSD hopes that you will share these guidelines with the parents of your young patients to determine who may benefit from BLL testing beyond the Medicaid screening requirements. These guidelines are based on recommendations by the CDC and consider New Mexico's diverse cultures, geography, and occupations. The questionnaire is available in Spanish from the EHEB. You may also access it through the EHEB website: http://www.health.state.nm.us/eheb/LeadFact.htm.

If you have questions or need additional information regarding the effects of lead toxicity, please contact the New Mexico Lead Poisoning Prevention program at 1-800-879-3421 or 1-505-476-3586. You may also contact Jackie Gonzales of the Medical Assistance Division at 505-476-7262.

Sincerely,

Nancy Smith-Leslie, Director
Medical Assistance Division

## Child Lead Exposure Questionnaire

Please answer these questions with: **Yes, No,** or **Don't Know**. The answers will help you and your health care provider decide if your child needs a blood test for lead.

| | Question | | | |
|---|---|---|---|---|
| 1. | **Is your child enrolled in or eligible for Medicaid?** *Children enrolled in Medicaid are required by law to be tested for lead at 12 months and again at 24 months of age, and between the ages of 36 months and 72 months of age, if not tested at 12 and 24 months of age.* | Yes | No | Don't know |
| 2. | **Is your child enrolled in any public assistance programs such as WIC or TANF?** | Yes | No | Don't know |
| 3. | **Does your child live in, or regularly visit (for daycare or babysitting), a house built before 1950?** *Older houses may have lead-based paint, which breaks down into dust that can be swallowed or inhaled by your child.* | Yes | No | Don't know |
| 4. | **Does your child live in or regularly visit a house that has recently been remodeled?** *Remodeling in an older house, or even one built as late as 1978, can create dust that contains lead, if lead-based paint is present.* | Yes | No | Don't know |
| 5. | **Does any other child of yours or a child of a relative or friend have an elevated blood lead level?** | Yes | No | Don't know |
| 6. | **Does your child live with or regularly visit an adult whose work or hobby uses lead?** | Yes | No | Don't know |
| 7. | **Do you (or any family members, or a curandera or sobador) give your child orange, red, or yellow powder such as Greta or Azarcon, or use "Navajo" clay for stomach ache, nausea, and diarrhea?** | Yes | No | Don't know |
| 8. | **Do you use Kohl, Alkohl, or Surma on your child's skin? Or use traditional Middle Eastern, Oriental, and Ayurevedic preparations?** | Yes | No | Don't know |
| 9. | **Does your home have imported plastic/vinyl mini-blinds?** *Some imported plastic mini-blinds made before 1996 have lead in them.* | Yes | No | Don't know |
| 10. | **Does your child eat, put things in his/her mouth, or chew on things that aren't food?** *Dirt, wood (especially window sills), paint chips, jewelry, shell casings, fishing sinkers, lead shot, shoes, or socks can have lead or lead dust on/in them.* | Yes | No | Don't know |
| 11. | **Do you use imported pottery for cooking, storing, or serving food?** *Some Mexican, Chinese, and Italian potteries have lead in the glaze, which can get into the food.* | Yes | No | Don't know |
| 12. | **Does your child live or play near a junkyard, dump, mine, smelter, busy street, or highway?** *These places can have lead dust in the air or in the dirt. Even if the smelter or mine is closed, lead can still be in the dirt.* | Yes | No | Don't know |
| 13. | **Does your child eat tamarind/chile candy or salt/lemon/chile seasonings or chapulines that are made in Mexico?** *Some of these products may contain lead.* | Yes | No | Don't know |

If you answered **Yes** to any of these questions, your child may be at risk for being exposed to lead! Your child's health care provider will need to order a blood test.

**NM Childhood Lead Poisoning Prevention Program**
Environmental Health Epidemiology Bureau
505-827-0006 • DOH-eheb@state.nm.us

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