## *Chapter Nine*

# Working With Community Health Care Providers

Children in foster care need a primary health care provider, as well as specialists, including dentists, mental health professionals, optometrists, orthopedists, and others accessible within the surrounding community served by the foster care agency. In addition to identifying a range of health care providers, agencies often need to establish relationships with certain specialists according to the population served by the agency (e.g., an obstetrician-gynecologist for teens). This chapter explores the issues related to working with community health care providers.

As noted throughout this manual, children are best served when one primary care provider handles their health care throughout (and preferably after) placement – known as a "medical home." The medical home is enhanced when the provider also makes referrals to specialist(s) who come to know the child and his/her health care needs over time.

An important choice confronting agencies is whether to mandate the use of certain health care providers who have been identified in the community or to encourage foster parents to use providers they already know and trust. A third option may be to combine both approaches: Identify and establish or continue relationships with providers, including those already used successfully by foster parents.

Sections in this chapter include:

1. Identifying and engaging health care providers in the community
2. Establishing and maintaining relationships with health care providers
3. Service agreements
4. Billing policies and practices
5. Resources

# 1 Identifying and Engaging Health Care Providers in the Community

It is important to encourage the use of community health care providers that foster parents are comfortable using. Ideally, for continuity of services, the child will go to the same provider, throughout his or her placement.

Before identifying appropriate health care providers, the first step for the agency is to understand its own needs and be able to communicate them to prospective providers. It is also critical that representatives of the agency be able to explain the health program for children in foster care and how it differs from community health care.

### Health Care Coordination Activities

Meet with providers on a one-to-one basis to (1) explain your agency's needs and population; (2) discuss the unique situation presented by children in foster care; and (3) learn about the provider and his/her ability and willingness to treat children in care, as specified in the criteria listed below.

Although it takes time to meet with providers, in the long run the benefits to you, the agency, the children in care, and their caregivers will be apparent in terms of both continuity of care and ease of communication. Some foster parents will already have established relationships with certain providers. Meeting with these providers would be good practice as well.

## Laying the Groundwork

Establishing a relationship with providers is a process that occurs over a period of time. Make the effort to understand each other's perspectives, needs, and operational considerations. Here are some ways to lay the groundwork for a mutually positive and beneficial working relationship:

- Meet with all providers face to face, both initially and periodically.
- Describe your agency and its mission, functions, and organizational structure.
- Give providers a copy of Chapters 1, 2, and 3 from this manual or equivalent information (e.g., *Fostering Health*) that outlines the expectations for health care for these children.
- Review your agency's needs and the needs of the provider.
- Follow up on all outstanding issues raised during the initial and any follow-up meetings.

- Develop written service agreements as needed *(see section 3, Service Agreements*).
- Stress the importance of communication to reduce problems that may arise when caring for children in foster care (e.g., consent, reimbursement, missed appointments).
- Assure providers that you will be accessible, as needed.

## Criteria for Selecting a Community Health Care Provider

To determine whether health care providers are willing and qualified to treat children in foster care, consider the following criteria:

- Demonstrated competence in general medicine or in specialized pediatric or adolescent care.
- Demonstrated competence in the management of behavioral and developmental problems in children and adolescents.
- Willingness to see children for initial health assessments, court-ordered exams, AWOL exams, and discharge exams.
- Medical specialty board eligible or certified with admitting privileges at local hospital (for physicians) for complex cases and special health needs.
- Willingness to provide appropriate documentation for the court, and to testify, if needed.
- Willingness to invest the time necessary to involve birth parents, caregivers, caseworkers, school personnel, medical consultants, and others concerned with the health and well-being of the child.
- Willingness to report missed appointments or lack of treatment follow-through to agency staff.
- Availability for telephone advice during evenings and weekends.
- Sensitivity to cultural and ethnic differences.
- Stated willingness to participate in interdisciplinary meetings involving social workers, attorneys, psychologists, school personnel, and others concerned with the well-being of the child.
- Sensitivity to the special emotional needs of children in placement (e.g., feelings of loss and abandonment).
- Willingness to make referrals for specialty cases (e.g., sexual abuse assessments).
- Willingness to coordinate care among specialty providers (e.g. cardiology, ophthalmology).

- Willingness to develop a written health plan for each child.
- Willingness to provide timely and clearly written health information to the agency.

## Engaging Health Care Providers

To attract and engage health care providers the agency has selected to work with, inform them that you will:

- Negotiate fees that are competitive with local standards (through the Medicaid per diem).
- Guarantee a certain number of children or visits by working with caregivers to keep appointments.
- Be a contact person who is responsive to their needs.

The third point – being a resource for the provider – includes providing medical information and records, solving problems, and supporting the foster parent. Health care providers will want to know that they have a contact within the agency if the foster parent does not have the relevant information, is missing appointments, or is not following through with medications or other prescribed treatment.

In addition, let providers know that you will inform them of significant changes and events such as:

- Changes in the child's placement.
- Changes in the child's permanency status or goal.
- Emerging health and mental health issues not previously identified.
- Emergency room visits.

## Addressing Concerns About Foster Care

To attract some health care providers, it will be necessary to address their concerns about treating children in foster care. Health care providers may not wish to care for children in foster care for a number of reasons:

- Frequent missed appointments.
- Incomplete health history.
- No consent for care or for release of medical records.
- Inadequate reimbursement for the amount of work or time required to provide care.
- Misperceptions about children in the child welfare system.

Some providers may have experienced these situations in the past, while others may have heard about them from colleagues. By reducing or eliminating some of these concerns, you can help providers with their decision to treat children in foster care. For example, you can tell providers that you will

stress to foster parents the importance of keeping all health-related appointments (accompanying them on the first visit if possible), obtain complete past health records, and obtain consents. You can also inform providers that they will be reimbursed at competitive rates. By educating providers about foster care and its purpose, you will allay their concerns.

## Developing a List of Health Care Providers

The local department of social services is responsible for maintaining a current listing of the names and locations of medical providers who will treat children eligible for the Child/Teen Health Plan (Medicaid). This list must be available to foster parents and authorized agencies.[1] Voluntary agencies should also consider developing a list of providers with whom they have an ongoing working relationship. Practitioners should be located within a reasonable distance of most foster homes and other foster care facilities in your community. Although some specialists may be located farther away, it is critical to include specialist providers.

Whether or not they accept Medicaid, the providers should include those you have visited and with whom you have developed service agreements. Update the list regularly and give it to caregivers and agency staff. The list will help caseworkers learn how health services in the community are organized. Finally, tell providers you have a list. Share it with them so they can see that their colleagues are also working with children in foster care.

[1] 18 NYCRR 441.22(h)(2).

# 2 Establishing and Maintaining Relationships with Health Care Providers

An effective medical home facilitates a comprehensive, coordinated treatment approach by all professionals involved in the child's care. Establishing and maintaining ongoing relationships with community health care providers will facilitate the medical home process.

## Providing Information for Initial Health Evaluation

It is recommended that a caseworker or health staff accompany children on their initial health assessments. Agency staff will give the health care provider the consent form, release of medical records form, and medical records; if unaccompanied by the agency, the foster parent should have these materials and give them to the practitioner. Also consider giving the foster parent a cover letter that introduces them and the child to the provider on the first visit.

For each new admission, the health care provider should be given the following:

- Signed consent form.
- Signed release of health records forms.
- As much previous health history as possible (e.g., prior health records, immunization records, birth records for an infant, records from inpatient hospital stays) *(see Chapter 7, Confidentiality of Health Information).*
- Names and telephone numbers of previous health care providers.
- An overview of billing practices *(see section 4, Billing Policies and Practices).*
- Contact information for the caseworker or agency.

### Health Care Coordination Activities

Consider developing a "Health Care Provider Visit Record" form for the person accompanying the child to a medical appointment *(see Appendix A for sample visit record forms)*. On the visit record form, the health care provider lists his/her identifying information, the reason for the visit, the findings, and recommended treatment and follow-up, including return date. After the visit, the foster parent, if accompanying the child, should give the form to the caseworker or agency health staff. Having this information provided immediately in a concise manner will be helpful in coordinating health services for the child.

## Establishing Relationships with Emergency Rooms

There are several important issues to address when establishing a relationship with emergency rooms. Explain consent protocols and establish agreement on the type of documentation the emergency room will need to treat children in the care of your agency. Then be sure that as soon as they arrive, foster parents or childcare staff inform the emergency room that the child is in foster care, and have the appropriate information with them. Establish agreement with the emergency room regarding notification to the LDSS or voluntary agency and how this will be accomplished. Be clear that even if there are delays in establishing consent, they should proceed with necessary emergency care.

Explain that the billing protocol for emergency room services is to bill Medicaid (eMedNY). It is recommended that voluntary agencies with a Medicaid per diem provide the MA number to the emergency room when the agency is notified, rather than giving the number to foster parents.

In addition to consent and billing needs, communication is an important issue. Be sure to inform foster parents that they should always contact the agency in emergencies so that agency staff are aware of the health issues of the children in their care and why emergency room care was needed. This routine communication may also alert agencies to inappropriate use of the emergency room. In addition, try to establish agreement with the emergency room to routinely send ER records or summaries of treatment and follow-up to the agency medical director or the established health care provider (medical home) for the child.

## Follow-Up Activities

To coordinate follow-up care after the initial health assessments, review the health file to determine whether further diagnostic testing, referrals, or treatment have been recommended.

### Health Care Coordination Activities

In relation to the health care provider, health care coordination activities include: [2]

- Contacting the provider, if necessary, to obtain information on follow-up care and treatment.
- Offering to assist the foster parent with follow-up care and transportation.
- Encouraging the provider to contact the agency about follow-up, referrals, missed appointments, or other important information.

To maintain a good working relationship, re-assess your agency's needs and the needs of the health care provider regularly. Meet with practitioners on a regular basis (e.g., once a year) to confirm that

[2] 90 ADM-21 Foster Care: Medical Services for Children in Foster Care.

visits, billing procedures, and referrals are going smoothly and to provide updated information about the agency health program in general.

When meeting with foster parents or childcare staff, ask them about the quality of care being provided and their satisfaction with the provider and the service. For instance, does the provider listen to the child's as well as their concerns? Are appointment times honored? Is the location convenient? If there are problems, you may need to talk with the health care provider to identify reasons and solutions. Some agencies find that administering questionnaires to caregivers and providers is a useful way to gauge satisfaction with current provider arrangements. Your agency may wish to consider doing this. It is important to keep communication open to facilitate good working relationships with providers. Communication also gives you an opportunity to address concerns before they become insurmountable.

# 3 Service Agreements

In some circumstances it would be in the best interest of the agency as well as the health care provider to develop service agreements *(see Appendix A for a sample service agreement)*. Service agreements can help define the nature of the business relationship.

1. A service agreement can help negotiate a special financial relationship. For instance, voluntary foster care agencies operating with a Medicaid per diem may be able to negotiate less expensive rates for a large quantity of service needs (e.g., laboratory work).

2. If the agency has an arrangement with a community health care provider to serve children in foster care at a particular time and location, a service agreement may be of some value when unexpected circumstances arise. For instance, when the practitioner goes on vacation, a service agreement could ensure back-up coverage.

3. Service agreements with large medical organizations, including emergency rooms, may help clarify issues related to consent, billing, and sharing of records.

Services that may be specified in a provider agreement include:

- Basic service and benefits to be provided.
- Provisions for emergency care.
- Periodicity schedules for routine well child care.
- Protocols for the content of initial and follow-up assessments.
- Specifications for information to be included in medical records or reports to be submitted to the agency health record.
- On-call services, including evening and weekend coverage.
- Provision of specialty exams, such as those following AWOL or before discharge.

# 4 Billing Policies and Practices

## Tips for Foster Parents

Make sure that foster parents know that they should *not*:

- Put their own name on medical bills (always name the agency as the responsible party).
- Sign anything related to medical consent, treatment, or billing.

## Billing Arrangements

Financing of health care services for children in foster care is complex. Billing arrangements vary depending on whether the child is in the care of a local department of social services or a voluntary agency. Within the LDSS or voluntary agency, arrangements also vary depending on choices made by the district or agency, as described below.

Effective January 1, 2005, all children who are in the care and custody of the local district commissioner, and who are citizens or have satisfactory immigration status (with proper documentation), are eligible for Medicaid (MA). In addition, children adjudicated as juvenile delinquents pursuant to Article 3 of the Family Court Act (FCA) and placed in the custody of OCFS, pursuant to Section 353.3 of the FCA, and who are citizens or have satisfactory immigration status, are eligible for Medicaid.[3] As of January 1, 2009, final-discharged youth ages 18 to 21 who were in foster care on or after their eighteenth birthday remain eligible for Medicaid until their twenty-first birthday (*see Appendix B for 09-OCFS-ADM-15*).

Establishing eligibility for Medicaid is crucial for children in foster care to have access to health care and related case management services. In all cases, the local district is responsible for establishing the child's eligibility for Medicaid. If the child is deemed eligible, the district assigns a Medicaid number to the child.

All agencies need to have policies in place for this process. Local districts must have policies to facilitate timely MA eligibility determinations for children in foster care as well as redetermination policies to provide continuous coverage. Voluntary agencies need policies to establish that Medicaid is active when children come into foster care and to know who to contact for any issue related to the child's Medicaid eligibility.

[3] GIS 05 MA/041.

The local district is also responsible for the appropriate system entries into the Welfare Management System (WMS) to process payment to voluntary agencies with a Medicaid per diem rate (*see below Children in Indirect Care*)

### Children in Direct Care

Approximately one quarter of children in foster care in New York State are in the *direct care* of the local social services commissioner. In most counties, health care for children in direct care is reimbursed by Medicaid on a fee-for-service basis, and each child is issued a Medicaid card.[4] Access to health care services is limited to those practitioners enrolled in eMedNY. eMedNY is the name of the New York State Medicaid program claims processing system. The system allows New York Medicaid providers to submit claims and receive payments for Medicaid-covered services provided to eligible clients.

In 1997, New York State offered some counties the opportunity to enroll some or all children in direct foster care in Medicaid Managed Care. Several counties with smaller foster care populations chose this option in an effort to manage costs, improve access, and improve tracking. Counties must apply for and be approved by the Department of Health's Office of Managed Care before enrolling children in foster care in a managed care plan.

Therefore, the local social services commissioner has two options:

1. **Medicaid Fee-For-Service system (MA card).** Under the fee-for-service system, children are obligated to use Medicaid-enrolled providers, and the providers bill eMedNY directly. Children are issued a Medicaid card. It is important that local district staff communicate with one another so that the Medicaid eligibility determination is done and appropriate WMS systems entries are made, including the address where the card should be sent (the caseworker or the foster parent).

2. **Medicaid Managed Care.** For the local district to enroll a child, it first needs to obtain approval from the New York State Department of Health. The district will need to submit a "Foster Care Enrollment Plan," which describes the policies and processes that will be used to enroll direct care children in Medicaid managed care. The district may choose to enroll children on a case-by-case basis. For information, contact the Office of Managed Care at 518-473-0122. Once approved, district staff must communicate with one another so that the Medicaid eligibility determination is done and appropriate WMS systems entries are made, including proper enrollment and disenrollment entries.

### Children in Indirect Care
### (placed with voluntary child caring agencies)

The remaining children in foster care in New York State are in the care of voluntary agencies that operate their foster care programs under contract with individual local departments of social services (known as *indirect care).*

[4] Common Benefit Identification Card (CBIC).

Children in foster care placed with a voluntary child care agency are statutorily excluded from Medicaid managed care. Therefore, agencies have two options:

1. **Medicaid Per Diem Rate.** The agency pays for health care services out of the agency's Medicaid per diem rate. The child is not issued an MA card but has an MA number.

2. **Fee for Service.** The agency uses health care providers who accept Medicaid and bill directly to eMedNY. The child is issued an MA card.

In most cases, voluntary agencies are paid a Medicaid per diem rate to provide comprehensive health services to each child in their care. Out of the Medicaid per diem rate (established by the NYS Department of Health), the agency is expected to pay for most of the child's health care services. Certain services, including emergency room and hospitalization, are always billed directly to eMedNY. Refer to the *Child (Foster) Care Agency Provider Manual* at http://www.emedny.org/ProviderManuals/ChildCare/index.html for more information. Children are not issued a Medicaid card but have a Medicaid number. Since a per diem rate offers an agency the greatest flexibility and management over service utilization, agencies should be encouraged to obtain a per diem.

If your agency uses a Medicaid per diem, be aware that certain medications for foster children can be billed directly to eMedNY by the pharmacy. A list of these "carveout" prescriptions may be found on the Department of Health website: http://www.health.state.ny.us/health_care/medicaid/program/carveout.htm. Check this website regularly for updates to the list.

Voluntary agencies without a Medicaid per diem must use health care providers who accept Medicaid and bill directly to eMedNY.

**Tip:** It is good practice to obtain information about the visit from the health care provider before authorizing payment for a bill. If the provider does not include a summary with the bill, the agency may send the bill back with a note that the record must be enclosed. Consider having your agency implement this procedure, which would require a prior arrangement with the health care provider.

## How To Obtain a Medicaid Per Diem

As New York's Single State Medicaid agency, the Department of Health (DOH) determines Medicaid per diem rates for authorized foster care agencies. The health needs of children in foster care vary in severity across different agency programs; some programs within the agency spend more per child on health services than other programs. To support agencies in providing optimal care, a Medicaid per diem rate setting methodology has been established that includes a detailed application package and careful review by a panel of health professionals across relevant state agencies. The panel can request additional information, and OCFS provides a recommendation to DOH on the rate request.

The objectives of the Medicaid per diem methodology are to:

- Reflect costs that adequately reimburse agencies for medical services necessary to meet the needs of the children in care.

- Provide equitable distribution of available resources among all childcare agencies that are providing services in an efficient fashion.

- Be sensitive to the unique or unusual medical needs of certain groups of children with special medical conditions.

- Reflect reasonable costs of programs that are efficiently operated and should be relatively easy to administer.

To achieve these objectives, the foster care population is divided into two major groups for purposes of determining medical costs:

1. The General Care Population, representing children in foster care residing in institutions, group residences, group homes, agency-operated boarding homes, and foster boarding homes, whose medical and clinical needs are largely routine.

2. Special Populations, representing seven discrete groups of children with special medical needs.
   - AIDS children
   - Boarder babies
   - Diagnostic
   - Hard-to-place
   - Maternity
   - Therapeutic boarding home
   - Special other

   Agencies identifying such special populations for the first time are required to submit an Application for Discrete Medicaid Rate, providing programmatic and budget narrative justifying the need for a Special Population rate (*see Appendix A for the Application*). The Application is submitted to your OCFS Regional Office, along with a completed DOH-4224 NYS DOH *Medical Services Expenditure Distribution Sheet – General Care* (previously DSS 2660) or DOH-4225 NYS Department of Health *Medical Services Expenditure Distribution Sheet – Special Care* (previously DSS 2660-01).

   The Application for Discrete Medicaid Rate describes the clinical characteristics of the children and their medical needs, and a budget justification. The Medical Services Expenditure Distribution Sheets, which are completed annually by the child care agency and submitted to OCFS, are used for determining Medicaid per diem rates.

# 5 Resources

## Foster Care Coding Fact Sheet—Common Diagnoses

The following Foster Care Coding Fact Sheet from the American Academy of Pediatrics lists common diagnoses for children in foster care. The sheet is provided for informational purposes for staff with access to health records of children in foster care.

http://www.aap.org/fostercare/PDFs/HFCA_Coding_Facts.pdf

Healthy Foster Care America

## FOSTER CARE CODING FACT SHEET

Office visits for children in foster care require more time than standard well-child care visits, involve far more complex issues, and generally need to occur more frequently. Practices serving a large number of children in foster care may need to communicate directly with their local Medicaid and private third-party payers, since differences in immunizations and well-child care billing may inadvertently hurt practices in quality or pay-for-performance measures. Some of these visits may be more appropriately billed as evaluation and management visits rather than well-child care visits, when they are more in-depth than routine well-child care visits. Appropriate documentation of time, complexity, physical examination, and diagnosis is required.

### COMMON DIAGNOSES IN FOSTER CARE BY CATEGORY

| BLOOD | |
|---|---|
| 280.9 | Anemia-Iron Deficiency, unspec |
| 282.60 | Anemi-Sickle Cell, Unspec |
| 285.9 | Anemia-Unspec |
| 282.4 | Thalassemia minor |

| BEHAVIORAL | |
|---|---|
| 309.9 | Adjustment disorder |
| 760.71 | Alcohol Affected Fetus/Newborn |
| 314 | ADD, unspec |
| 314.01 | ADHD w/hyperactivity |
| 299.8 | Asperger's/PDD |
| 313.89 | Attachment disorder |
| 299.9 | Autism |
| 312.9 | Behavioral disorder |
| V65.40 | Counseling, unspec |
| 312.30 | Disorder of Impulse Control |
| 799.2 | Nervousness or irritability |
| 313.81 | Oppositional disorder of child |
| 782 | Sensation Disorder |
| 307.40 | Sleep: Nonorganic sleep disorder-NOS |

| CARDIOVASCULAR | |
|---|---|
| 746.9 | Congenital heart disease |
| 780.2 | Faint, syncope |
| 785.2 | Heart murmur |
| 401.9 | Hypertension, unspec |

| CHILD ABUSE AND NEGLECT | |
|---|---|
| 949.0 | Burn, unspec site |
| 995.50 | Child abuse/neglect (cont'd) |

| CHILD ABUSE AND NEGLECT (cont'd) | |
|---|---|
| V71.8 | Child abuse/neglect suspected |
| 924.9 | Contusion, hematoma |
| 829.0 | Fracture, bone unspec |
| 854.01 | Head trauma |
| 989.0 | Ingestion/poisoning |
| V63.9 | Lack of medical attention |
| 995.53 | Sexual abuse |
| V71.5 | Sexual abuse, suspected |
| 959.9 | Trauma, unspec |
| 873.8 | Wound, unspec |

| DENTAL | |
|---|---|
| 521.0 | Dental caries |

| DEVELOPMENTAL | |
|---|---|
| 299.8 | Asperger's/PDD |
| 313.89 | Attachment disorder |
| 299.9 | Autism |
| 315.9 | Developmental delay, mod/severe |
| 315.3 | Language: Developmental speech or language disorder |
| 315.2 | Learning disorder, specific |
| 315.8 | Other specific delays in development |
| V62.3 | School problem-NOS |
| 784.5 | Speech delay |

| ENDOCRINE/METABOLISM | |
|---|---|
| 250 | Diabetes mellitus |
| 244.9 | Hypothyroidism |
| 259.1 | Precocious puberty |
| 783.3 | Short stature |

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**Foster Care Coding Fact Sheet** **2**

| ENT/ORAL | |
|---|---|
| 289.3 | Cervical adenitis |
| 381.81 | Eustachian tube dysfunction |
| 388.70 | Ear pain, undiagnosed/foreign body |
| 784.7 | Epistaxis |
| 389.9 | Hearing deficit |
| 112.0 | Monilia, oral |
| 771.7 | Neonatal candidal infection (thrush) |
| 380.10 | Otitis externa |
| 382.9 | Otitis media-acute |
| 381.01 | Otitis media-serous |
| 462 | Pharyngitis-NOS |
| 034.0 | Pharyngitis-Strep |
| 461.9 | Sinusitis-acute |
| 473.9 | Sinusitis-unspec, chronic |

| EYE | |
|---|---|
| 373.2 | Chalazion |
| 372.30 | Conjunctivitis, unspec |
| 930.9 | Foreign body, eye |
| 375.55 | Nasolacrimal duct obstruction |
| 378.9 | Strabismus |
| 369.9 | Vision deficit |

| GASTROINTESTINAL/NUTRITION | |
|---|---|
| 789.00 | Abdominal pain or colic |
| 783.1 | Abnormal weight gain |
| 564 | Constipation |
| 276.5 | Dehydration |
| 787.91 | Diarrhea/gastroenteritis |
| 787.6 | Encopresis |
| 783.4 | Failure to thrive |
| 783.3 | Feeding problem, infant/older child |
| 536.9 | Functional GI complaints |
| 530.81 | GERD |
| 041.86 | H. Pylori |
| 550.90 | Hernia, inguinal |
| 129 | Intestinal parasites |
| 263.1 | Malnutrition, mild |
| 263.0 | Malnutrition, moderate |
| 262.0 | Malnutrition, severe |
| 278.8 | Obesity |
| 553.1 | Umbilical hernia |
| 787.03 | Vomiting |

| GYNECOLOGY | |
|---|---|
| V25.09 | Birth control counseling |
| 616.0 | Cervicitis |
| V72.31 | GYN examination, routine |
| 626.9 | Menstruation disorder |
| 614.9 | PID |
| V72.41 | Pregnancy Exam Test, Negative |
| OPG | Pregnant |
| 616.10 | Vaginitis, vulvovaginitis |

| HEALTH MAINTENANCE | |
|---|---|
| V20.2 | WCC/Health Supervision (birth through 17 yrs) |
| V70.0 | WCC/age 18yrs+ |
| V68.0 | WIC recertification |
| V20.1 | RN WCC visit |
| 964.9 | RN lead follow-up |
| V67.9 | Generic follow-up (useful code for the half year check) |

| INFECTIOUS DISEASE | |
|---|---|
| 099.50 | Chlamydia trachomatis, uspec |
| 780.6 | Fever |
| 098.0 | Gonorrhea |
| 573.3 | Hepatitis, unspec |
| 042 | HIV positive |
| V65.41 | HIV post-test counseling |
| V75.9 | HIV screening |
| 487.1 | Influenza |
| 127.4 | Pinworms |
| 795.5 | Positive PPD |
| 133.0 | Scabies |
| V01.1 | TB exposure |
| 057.9 | Viral exanthema, unspec |
| 079.99 | Viral infection, unspec |

| MUSCULOSKELETAL | |
|---|---|
| 829.0 | Fracture of unspec bone |
| 724.2 | Low back pain |
| 729.1 | Musculoskeletal pain |
| 268.0 | Rickets |
| 737.30 | Scoliosis, kyphoscoliosus |
| 848.9 | Sprain/strain |
| 719.00 | Swelling of joint |

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**Foster Care Coding Fact Sheet** 3

| NEUROLOGIC | |
|---|---|
| 781.3 | Coordination, lack of |
| 307.23 | Gilles de la Tourette disorder |
| 784 | Headache |
| 331.4 | Hydrocephalus |
| 742.9 | Hydrocephalus, congenital |
| 781.3 | Hypotonia/hypertonia |
| 742.1 | Microcephaly |
| 346.9 | Migraine, unspec |
| 780.31 | Seizure, febrile |
| 345.90 | Seizure disorder, epilepsy |
| V45.2 | Shunt, cerebrovascular |

| NEWBORN | |
|---|---|
| V50.2 | Circumcision |
| 774.6 | Jaundice |
| 760.72 | Prenatal drug exposure |
| 760.79 | Positive Toxicology Screen |
| 765.10 | Premature infant (1000-2999grams) |
| 764.00 | SGA |

| PSYCHIATRIC | |
|---|---|
| 309.9 | Adjustment reaction, NOS |
| 307.1 | Anorexia nervosa |
| 300.0 | Anxiety, unspec |
| 311 | Depression, NOS |
| 305.90 | Substance abuse |
| 309.81 | Post-traumatic Stress Disorder |
| 300.9 | Psychiatric problems-child |
| V61.8 | Psychiatric problems-parent |
| V70.2 | Psychosocial evaluation |

| PSYCHOSOCIAL | |
|---|---|
| V23.89 | Adolescent mother |
| V70.2 | Psychosocial evaluation |

| RENAL/GENITOURINARY | |
|---|---|
| 788.36 | Enuresis |
| 599.7 | Hematuria |
| 791.00 | Proteinuria |
| 597.80 | Urethritis, unspec |
| 599.0 | Urinary tract infection |

| RESPIRATORY/ALLERGY | |
|---|---|
| 477.9 | Allergic rhinitis, NOS |
| 493.90 | Asthma, chronic, unspec |
| 466.11 | Bronchiolitis |
| 464.4 | Croup |
| 786.02 | Cough |
| 995.3 | Drug allergy |
| 486 | Pneumonia, unspec |
| 465.9 | Upper respiratory infection |

| SKIN/LYMPHATICS | |
|---|---|
| 706.1 | Acne |
| 112.89 | Candidiasis |
| 582.9 | Cellulitis |
| 591.0 | Diaper rash |
| 691.8 | Eczema/atopic dermatitis |
| 684 | Impetigo |
| 132.9 | Lice |
| 683 | Lymphadenitis |
| 785.6 | Lymph node enlargement |
| 782.1 | Rash, NOS |
| 133 | Scabies |
| 110 | Tinea capitis |
| 110.9 | Tinea, other |

| TRAUMA/ACCIDENTS/POISONING | |
|---|---|
| 919.0 | Abrasion |
| 949.0 | Burn, unspec site |
| 924.9 | Contusion, hematoma |
| 010.6 | Foreign body/splinter |
| 829.0 | Fracture, bone unspec |
| 854.01 | Head trauma |
| 989.0 | Ingestion/poisoning |
| 919.4 | Insect bite |
| 879.8 | Laceration/animal or human bite |
| 984.9 | Lead poisoning |
| 959.9 | Trauma, unspec |
| 873.8 | Wound, unspec |

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