

## CHAMPVA POLICY MANUAL

**CHAPTER:** 2  
**SECTION:** 12.1  
**TITLE:** WELL-CHILD CARE

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**AUTHORITY:** P.L. 104-106, Section 701; 38 CFR 17.270(a) and 17.272(a)(31)(i)

**RELATED AUTHORITY:** 32 CFR 199.4(c)(2)(xiii) and (c)(3)(xi)

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### I. EFFECTIVE DATE

- A. October 4, 1990, haemophilus influenza type B.
- B. Effective January 1, 1992, the American Medical Associate Current Procedural Terminology (CPT) evaluation and management service codes (i.e., visit codes) were revised. The former CPT 90000 series codes for office visits were replaced by a new CPT 99000 series. These new codes were adopted for claims submitted on or after January 1, 1992.
- C. April 4, 1992, hepatitis B vaccine.
- D. October 6, 1997, expanded benefits per P.L. 104-106, Section 701.

### II. PROCEDURE CODE(S)

54150, 54160, 81000-81015, 81099, 83655, 84030, 84035, 85014, 85018, 86580, 86585, 86762, 90471-90474, 90645-90648, 90700-90708, 90710-90713, 90719, 90720, 90744-90747, 92002, 92004, 92012, 92014, 92015, 92551, 92587, 92588, 99172-99173, 99381-99383, 99391-99393, 99431, 99433, 99499

### III. DESCRIPTION

Well-child care includes routine newborn care, routine physical examinations, routine immunizations, periodic health screening, and developmental assessment in accordance with the American Academy of Pediatrics (AAP) guidelines.

### IV. POLICY

Well-child care is covered for beneficiaries from birth to age six when services are provided by the attending physician, family physician, certified nurse midwife, certified nurse practitioner, or certified physician assistant.

## V. POLICY CONSIDERATIONS

A. Visits for diagnosis or treatment of an illness or injury are not included in the well-child benefit. Benefits should be extended on the basis of the medical necessity for the services.

B. For children whose health screening and immunizations may not be current, payment may be made for well-child visits and immunizations up to midnight of the day prior to the day the child turns six years old.

C. Well-child immunizations are covered when administered according to the current Centers for Disease Control (CDC) recommendations. The physician will determine the appropriateness of immunizations for the patient based on CDC recommendations and other specific factors. The following is a current list of immunizations that are recommended by the CDC (see [Chapter 2, Section 23.3, Immunization Injections](#)): (This list is also available for review on the CDC home page at <http://www.cdc.gov/nip>.)

1. diphtheria, pertussis, tetanus (DPT): three doses at 4-8 week intervals, 4th dose 1 year after third;

2. oral polio (OPV): 2 doses at 6-8 week intervals, 3rd dose at least 6 weeks and preferably 8-12 months after the second;

3. measles, mumps, rubella (MMR): 2 doses, first dose given between 12-15 months, second dose should be given between 4-6 years of age; and

4. haemophilus influenza type B, (HIB) immunization schedule is listed below:

a. All children should be immunized with an H influenza type B conjugate vaccine at 2 months of age or as soon as possible thereafter.

b. Routine immunization should begin at 2-3 months of age, and should be administered in a three dose series with the doses given at 2 month intervals.

c. Administration of a fourth dose is recommended at 15 months of age or as soon as possible thereafter. For this dose, the use of any FDA approved licensed conjugate vaccine is acceptable.

d. Unimmunized children between 3 and 6 months of age should receive a four-dose regimen. Optimally, the first three doses should be given at 2-month intervals with a minimum of 1 month between doses. A fourth dose of any FDA approved licensed conjugate vaccine should be given a 15 months of age or as soon as possible thereafter.

e. Unimmunized children between 7 and 11 months of age should receive a four-dose regimen. Optimally, the first two doses should be given at 2-month intervals with a minimum of 1 month between doses. A third dose of any FDA approved licensed conjugate vaccine should be given at 15 months of age or as soon as possible thereafter.

f. Unimmunized children 12 to 14 months of age should receive a two-dose regimen at an optimal interval of 2 months with a minimum of 1 month between doses. In this situation, HBOC is given for the first dose. Any FDA approved licensed conjugate vaccine is appropriate for the second dose. No additional doses are indicated for these children.

g. Unimmunized children, 15 to 24 months of age, should receive one dose of any conjugate vaccine.

5. **H**epatitis B vaccine immunization schedule is listed below:

a. All children should be immunized with a hepatitis B vaccine at birth before hospital discharge or as soon as possible thereafter.

b. Routine immunization should begin at birth and should be administered in a 3 dose series dependent on the mother's screening serology. It may be given at the same time as DPT, HIB, polio, and/or MMR vaccines, but should not be mixed in the same syringe with any other vaccine or medication.

c. For infants born to hepatitis B surface antigen HbsAg-negative mothers the first dose should be administered at birth, the second dose should be given at 1-2 months of age and the third dose should be given at 6-18 months of age. An acceptable alternate dose schedule for this group is a three dose series administered at 2 months, 4 months and 6-18 months of age.

d. For infants born to HBsAg-positive mothers, the first dose should be administered at birth, the second dose given at 1 month of age and, the third dose given at 6 months of age. A fourth dose of the vaccine should be administered to HBsAg-negative infants of HBsAg-positive mothers who have titers of anti-HBs less than 10mIU/ml. Additional doses (up to two more) may be considered for infants of HBsAg-positive mothers who have titers of anti-HBs less than 10 mIU/ml and have failed to respond after 4 doses of the vaccine.

e. For infants born to mothers who have an unknown HBsAg status, immunization should begin at birth with a dose of vaccine recommended for infants of HbsAg- positive mothers. The additional administration of the vaccine should depend on the results of the serologic screening of the mother. The mother should be screened for HBsAg as soon as possible. If the mother is HBsAg-positive, hepatitis bimmune globulin (BIG) should be administered immediately to the infant, provided the infant is less than one week old. The HBsAg status of the mother also determines the subsequent vaccine dose and schedule, as previously described above.

D. Well-child care for newborns includes **but is not limited to** the routine care of the newborn in the hospital, testing for hypothyroidism, phenylketonuria (PKU), hemoglobinopathies (refer to paragraph G. 2. below for further detail), **galactosemia**, and newborn circumcision. Only routine well-child care for newborns is covered as part of the mother's maternity episode, i.e., a separate cost-share is not required for the infant. If a circumcision is performed after the child has been discharged from the hospital, the service is cost-shared as an outpatient service (unless it qualifies for the special cost-sharing for ambulatory surgery). Separate professional claims must be submitted for the newborn and the mother.

E. A program of well-child care conducted according to the most current Guidelines for Health Supervision, AAP, is covered. Significant deviation from the guidelines requires justification. In any case, no more than nine well-child visits in two years are covered.

F. Each office visit for well-child care includes the following services:

1. history and physical examination and mental health assessment; and
2. developmental and behavioral appraisal:
  - a. height and weight to be measured regularly throughout infancy and childhood;
  - b. head circumference to be measured for children through 24 months of age; and
  - c. sensory screening: vision, hearing (by history):

(1) Eye and vision screening by primary care provider is covered during routine examination at birth, approximately 6 months, 3 years, and 5 years of age. Additionally, coverage is allowed for ages 3-6 for comprehensive eye examinations to rule out amblyopia and strabismus.

(2) All high risk neonates (as defined by the Joint Committee on Infant Hearing) should undergo audiology screening before leaving the hospital. If not tested at birth, high-risk children should be screened before three years of age as part of routine examinations.

Note: For further clarification, newborn hearing screening may be conducted within the first 3 months of life and preferably before hospital discharge, using otoacoustic emission technique, thereafter using pure-tone audiometry.

- d. dental screening; and
- e. discussion with parents, anticipatory guidance.

- G. The following specific procedures are covered in a program of well-child care:
1. heredity and metabolic screening;
  2. immunizations, when administered according to the schedule in paragraph C, above:
    - a. All infants should be screened twice for PKU. Once prior to hospital discharge or transfer regardless of age and again within 1 or 2 weeks after hospital discharge.
    - b. All neonates should be screened for congenital hypothyroidism prior to discharge from the hospital nursery but not later than day 6 of life.
    - c. Screening for hemoglobinophies should be accomplished for those in high-risk ethnic groups:
      3. tuberculin test at 12 months of age and once during second year of age;
      4. hemoglobin or hematocrit testing once during first year of age and once during second year of age;
      5. urinalysis once during first year of age and once during second year of age;
      6. annual blood pressure screening for children between 3 and 6 years of age;
      7. blood lead test (CPT code 83655) performed for the assessment of risk for lead exposure by structured questionnaire, based on Center of Disease Control and Prevention, Preventing Lead Poisoning in Young, (October 1991), during each well-child visit from age 6 months to under 6 years of age;
      8. health guidance and counseling, including breast feeding and nutrition counseling; and
      9. additional services or visits required provided that they are medically necessary and otherwise authorized.
- H. Well-child services are considered preventive and are subject to the same cost sharing and copayment as those services provided under [Chapter 2, Section 23.1, Preventive Services](#).

**\*END OF POLICY\***