

Oklahoma Health Care Authority



Child Health Services EPSDT Provider Manual



October 2006

PURPOSE OF MANUAL

This manual is intended as a reference document for Family Physicians, Pediatricians, Physician Assistants, Advanced Practice Nurses and other *SoonerCare Choice* or *Traditional* providers contracted with the Oklahoma *SoonerCare* program. The primary purpose of this manual is to assist providers who are serving *SoonerCare* children in a primary care capacity to provide child health screening and needed follow up care. It contains requirements for participation in and reimbursement of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. EPSDT is the name of the federally-mandated program. It is a component of Child Health services. Child Health services include the comprehensive set of services designed to improve children's health. This manual will refer to Child Health and EPSDT services with Child Health being the umbrella for EPSDT services. The manual explains covered services, screening components and requirements, periodicity schedules, and eligibility to receive and provide the services. The manual also includes a resource listing and other reference information.

Additional information about the *SoonerCare* program (including EPSDT and other children's benefits and eligibility policies) is contained in the *SoonerCare* State Plan and administrative rules. A copy of the applicable administrative rules can be obtained from the OHCA website at <http://www.okhca.org/providers/policyrules> Providers are responsible for ensuring compliance with current state/federal Medicaid policies pertaining to the services rendered. **This manual does not supersede state/federal Medicaid rules and is not to be used in lieu of them.**

Please send any comments, suggestions, or questions you have regarding this manual to the attention of:

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Your questions, comments and suggestions will help us to increase the usefulness of this manual.

The staff of the Oklahoma Health Care Authority (OHCA) thanks all of the physicians/practitioners who provide Child Health/EPSDT services to *SoonerCare* children and it is our hope that this manual makes that job a little easier.

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SOONERCARE OVERVIEW

Medicaid was created by Title XIX of the Social Security Act. It is a health program jointly funded between the federal Centers for Medicare and Medicaid Services (CMS) and the OHCA which is the single state agency that administers Oklahoma's Medicaid program, otherwise known as ***SoonerCare***.

The ***SoonerCare*** program eligibility guidelines target various low income populations which include children (and under certain circumstances, their parents), pregnant women, people with disabilities and the elderly.

Oklahomans who qualify for health care benefits through programs operated by OHCA receive those benefits as a member of one of the ***SoonerCare*** benefit plans. Each plan has different qualifications relating to age, custody status, institutional status, medical status (i.e. disabilities, pregnancy or diagnosis), and income.

SoonerCare Choice is a comprehensive medical benefit plan featuring a “medical home” or a Primary Care Provider (PCP) for each member. This plan is partially capitated in that primary care physicians/practitioners are paid a capitated rate for a fixed set of services. This fixed set of services includes routine visits, EPSDT screens, administration of immunizations and a case management component. The PCP arranges for referrals to specialized medical providers when a member has a condition that cannot be treated in the course of a routine office visit. Non-capitated services provided by the PCP are compensable on a fee-for-service basis.

SoonerCare Traditional is a comprehensive medical benefit plan that purchases health care for members on a fee-for-service basis. When members are enrolled in ***SoonerCare***, they are typically in the **Traditional** plan for one month before being enrolled into ***SoonerCare Choice***. But certain groups, as discussed below, may remain in the **Traditional** plan for as long as they are eligible for ***SoonerCare***.

Most children that qualify for ***SoonerCare*** are enrolled in the ***SoonerCare Choice*** benefit plan. However, children that have the following custody status, living arrangement, or additional health care coverage remain in the ***SoonerCare Traditional*** program.

- Children in the custody of the Oklahoma Department of Human Services (OKDHS) or Office of Juvenile Affairs (OJA) who are placed in out-of-home care, or tribal court ordered custody
- Children who are institutionalized
- Children who are dually eligible for Medicaid and Medicare
- Children who are enrolled in private health plans
- Adoption subsidy children
- Children who are receiving services in a home and community-based waiver

In addition to the *SoonerCare Choice* and *Traditional* programs, there are some programs that are administered by OHCA and serve primarily low income adults. They are:

SoonerPlan: a limited benefit plan covering services related to family planning.

O-EPIC (PA): a premium assistance plan that subsidizes the cost of employer-sponsored group health insurance.

O-EPIC (IP): is an individual plan of comprehensive medical benefits that requires members to share in the cost through premiums and co-pays.

SoonerCare Supplemental: a plan that provides medical benefits that supplement those services covered by Medicare.

Opportunities for Living Life: a program that offers additional benefits to certain members who are enrolled in one of the *SoonerCare* plans. Those benefits include:

- **Nursing Facility (NF) Services** – an inpatient benefit providing 24-hour nursing care.
- **Intermediate Care Facility Services for the Mentally Retarded (ICF-MR)** – an inpatient benefit providing 24-hour care and active treatment.
- **Personal Care Services** – an in-home benefit providing assistance with mobility, meals, hygiene, grooming and other non-skilled personal services.
- **Home and Community Based Services** – a community-based benefit that provides comprehensive medical and other supportive services as an alternative to NF and ICF-MR inpatient care.

***SOONERCARE* ELIGIBILITY**

OHCA contracts with the Oklahoma Department of Human Services (OKDHS) to certify **SoonerCare** eligibility. Applications are to be submitted to the local OKDHS County offices for eligibility determination. To access applications and instructions go to <http://204.87.68.21/medapp/download.htm>

Children residing in Oklahoma who are U.S. citizens are typically eligible for **SoonerCare** if they meet the established guidelines. The income guideline for children age 18 and under is 185 percent of the Federal Poverty Guidelines. Children 19 and 20 years of age, while qualifying for EPSDT, must also meet adult eligibility guidelines.

The Department of Health and Human Services (DHHS) (federal agency) revises the poverty guidelines annually to account for changes in the cost of living. To view the Federal Poverty Guidelines go to <http://aspe.hhs.gov/poverty/07fedreg.pdf>



In addition, there are some programs OHCA administers that are designed to “qualify” individuals for one of the **SoonerCare** plans. For example, the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) qualifies certain children with disabilities for the **SoonerCare Choice** plan.

ELIGIBILITY VERIFICATION

SoonerCare providers can verify a member’s eligibility status through one of the following methods:

- | | |
|---|--|
| ➤ Eligibility Verification System (EVS) | 800-767-3949 or 405-840-0650 |
| ➤ OHCA Secured Website | www.okhca.org |
| ➤ OHCA Call Tree Options | 405-522-6205 or 800-522-0114 |
| ▪ OHCA Call Center | (option 1) |
| ▪ Internet Help Desk | (option 2, 1) |
| ▪ EDI Help Desk | (option 2, 2) |
| ▪ Adjustments | (option 3, 1) |
| ▪ Third Party Liability | (option 3, 2) |
| ▪ Pharmacy Help Desk (issues) | (option 4) |
| ▪ Provider Contracts | (option 5) |

- Pharmacy Help Desk (authorizations) (option 6, 1)
- Behavioral Health Authorization (option 6, 2)
- Medical Authorizations (status) (option 6, 3)
- Medical Authorizations (PA requests) (option 6, 4)
- Dental Authorizations (option 6, 5)

It is important that those serving children who are *SoonerCare* members understand the following:

- Possession of the *SoonerCare* medical I.D. card does not guarantee eligibility.
- It is the provider’s responsibility to verify eligibility each time a member presents for services.
- Only claims from OHCA contracted providers will be considered for payment.
- If PCP information is not available and the member is eligible, then the member is fee-for-service.
- EVS will indicate the most recent EPSDT screening. The date of last EPSDT screening is shown by some swipe card vendors, on the PCP roster, and is available on the OHCA secure website.

MEDICAL ID CARDS

April 2006, OHCA began issuing the new Medical Benefits Identification Card to first-time enrollees and to current members needing replacement cards. Existing ID cards will remain valid as well. Below is an example of both cards.

Current ID Card



New ID Card



ELIGIBLE PROVIDERS

Payment is made to eligible contracted providers for Child Health services on behalf of eligible individuals younger than 21 years of age.

To allow members free choice of state contracted physicians/practitioners, the OHCA recognizes all licensed medical and osteopathic providers, certain physician assistants, and certain advanced practice nurses as being eligible to receive payment for compensable medical services rendered on behalf of a person eligible for such care in accordance with the rules and regulations covering the *SoonerCare* programs. Payment will be made to fully licensed physicians/practitioners who are participating in medical training programs as residents or fellows, or in any other capacity in training for services outside the training setting and are not in a duplicative billing situation. In addition, payment will be made to the employing facility for services provided by physicians/practitioners who meet all requirements for employment by the federal government as a physician and are employed by the federal government in an IHS facility or who provide services in a 638 Tribal Facility.

Payment to contracted providers under *SoonerCare* is made for services clearly identifiable as personally rendered services performed on behalf of a specific member. There are no exceptions to personally rendered services unless specifically set out in coverage guidelines.

Payment is made to the attending physician in a teaching medical facility for compensable services when he/she signs as claimant, and renders personal and identifiable services to the member in conformity with OHCA agency rules. Payment will be made to a physician for supervising the services of a Certified Registered Nurse Anesthesia (CRNA) unless the CRNA bills directly.

Eligible providers may include child health centers as safety-net providers which meet the standards and criteria for child health centers in Oklahoma as established by the Oklahoma State Department of Health (OSDH).

- The OSDH will provide to the OHCA the names of all qualified child health centers at the time of the initial qualification and at least annually thereafter. OSDH will notify OHCA when an existing center fails to meet the standards and criteria.
- Upon notice of a newly qualified center, OHCA may enter into a Title XIX contractual arrangement with the center to provide EPSDT services.

Payment will not be made to a provider who has been suspended or terminated from participation in the program.

To participate in *SoonerCare*, providers must have a contract on file with the OHCA. The Provider Enrollment Unit is responsible for validating that any provider meets all of the requirements of participation. To become a provider with the OHCA complete the appropriate contract for your provider type. Download contract at: <http://okhca.org/providers/enrollment>.

Requesting an Enrollment Packet

Physicians/Practitioners interested in becoming a *SoonerCare* provider should request an enrollment packet, which includes an enrollment application, Provider Agreement, Affidavit, Electronic Funds Contract and all the required attachments. Physicians/Practitioners may request a *SoonerCare* enrollment packet by:

- Downloading the required forms at www.okhca.org
- Contacting Provider Enrollment at:
 - (800) 522-0114, option 5 or;
 - (405) 522-6205, option 5
- Sending a request in writing to:
 - Oklahoma Health Care Authority
 - ATTN: Provider Enrollment
 - Post Office Box 54015
 - Oklahoma City, Oklahoma 73154

The request for an enrollment packet must include:

- Each applicant's name, Social Security number, address and telephone number.
- Type of provider (e.g., physician, physician clinic or group, speech pathologist, or hospital).
- The number of applications requested.
- Indication of previous approval in *SoonerCare* when applicable.
- The services the provider intends to provide.

Note: Application materials, including provider contracts, are periodically revised and submission of outdated materials may delay approval.

CHILD HEALTH/EPSTD PROGRAM INFORMATION

OVERVIEW

EPSTD a component of a comprehensive child-health program designed to ensure the availability of and access to required health care resources and to help parents and guardians of children enrolled in *SoonerCare* use these resources.

An effective Child Health/EPSTD program assures that health problems are avoided if possible (through anticipatory guidance, education, etc) and, if health problems exist, they are diagnosed and treated early before they become more complex and their treatment more costly. This process begins with a comprehensive health screening by a *SoonerCare* provider.

Federal regulations also require that the state set standards and protocols for each component of EPSTD screening services. The standards must provide for services at intervals which meet reasonable standards of medical and dental practice. The standards must also provide for services at other intervals as medically necessary to determine the existence of certain physical or behavioral health illnesses or conditions.

The receipt of an identified Child Health/EPSTD screening makes the *SoonerCare* child eligible for all medically necessary follow-up care that is within the scope of the *SoonerCare* program. Federal regulations require that diagnosis and treatment be provided for conditions identified during a screening whether or not they are covered under the current State Plan or benefit structure. Such services are allowable under federal regulations, and must be necessary to ameliorate or correct defects and physical or behavioral health illnesses or conditions, and will require prior authorization (see Appendix A “Other Necessary Health Care”).

SoonerCare providers who perform Child Health/EPSTD screenings must assure that the screenings they provide meet the minimum standards established by the OHCA, as outlined at OAC 317:30-3-65.2, in order to be reimbursed at the level established for EPSTD services. The federal requirements for the screening components of EPSTD contain some elements that are not included in the American Academy of Pediatrics (AAP) or other guidelines. Physicians/Practitioners are highly encouraged to review these rules.

A Child Health/EPSTD screening is considered a comprehensive examination. A provider billing the *SoonerCare* program for a Child Health/EPSTD screen may not bill any other Evaluation and Management Current Procedure Terminology (CPT) code for that member on that same day. It is expected that the screening provider will perform necessary treatment as part of the screening charge. However, there may be other additional diagnostic procedures or treatments not normally considered part of a comprehensive examination, including diagnostic tests and administration of immunizations, required at the time of screening. Additional diagnostic procedures or treatments may be billed independently from the screening. Some additional diagnostic procedures or treatment services needed by the child may require prior authorization.

An initial Child Health/EPSTDT screening may be requested by an eligible individual at any time and must be provided without regard to whether the individual's age coincides with the established periodicity schedule.

The OHCA requires that physicians/practitioners providing reimbursable Child Health/EPSTDT screens adopt and utilize the OHCA's Child Health/EPSTDT periodicity schedule for *SoonerCare* members. The periodicity schedule sets the minimum requirements for the frequency and content of the screening visits. Optional screenings are allowed and encouraged as needed to provide optimal care. At a minimum, physicians/practitioners are required to perform the recommended elements for each age-related visit, but more than the minimum screening elements may be performed based on the individual needs of the child and family.

Additionally, interperiodic screenings must be provided when medically necessary to determine the existence of suspected physical or mental illnesses or conditions. This may include, but not be limited to, physical, mental or dental conditions. The determination of whether an interperiodic screen is medically necessary may be made by a health, developmental or educational professional who comes into contact with the child outside of the formal health care system.

DOCUMENTATION OF SERVICES

OAC 317:30-3-65.6

For a Child Health/EPSTDT screening to be considered a completed reimbursable service, physicians/practitioners must perform and document all required components of the screening examination. Records for Child Health/EPSTDT screens must contain adequate documentation of services rendered. Such documentation must include the physician/practitioner signature or identifiable initials for every prescription or treatment. Documentation of records may be completed manually or electronically in accordance with guidelines found at OAC 317:30-3-15. Each required element of the age-specific screening must be documented with a description of any noted problem, anomaly or concern. In addition, a plan for following necessary diagnostic evaluations, procedures and treatments must be documented. Standardized forms may be used as long as they contain all required screening elements or are supported by additional written documentation.

CHILD HEALTH SCREENING FORMS

The OHCA has produced forms for documenting Child Health/EPSTDT screens that may be used by the provider. These forms may be accessed from the OHCA website: <http://okhca.org/providers.aspx?id=2517&menu=74>. These forms are not required, but when correctly used they assist the provider in covering all elements of the screen. These forms may be updated at times, so you may want to periodically check the OHCA website for the newest version. The physician/practitioner may choose to use other forms that are available. When using other forms, the physician/practitioner must ensure that the form contains all of the OHCA required elements or provide additional documentation of a complete screen.

OHCA Child Health/EPSDT SCREENING COMPONENTS

OAC 317:30-3-65.4

The screening must include health and physical history, physical examination, assessment and administration of necessary immunizations, check of nutritional status, appropriate lab and x-ray and anticipatory guidance.

At a minimum, regardless of the age of the child, the following are required Child Health/EPSDT screening components; however, for most ages of children, there are additional age specific requirements.

(1) Comprehensive Health and Developmental History. Health and developmental history information may be obtained from the parent or other responsible adult who is familiar with the child's history and include an assessment of both physical and mental health development. If the physician/practitioner has performed a prior Child Health/EPSDT screening on the child, then the history is updated.

(2) Comprehensive Unclothed Physical Examination. Comprehensive unclothed physical examination includes the following:

- **Physical Growth.** Record and compare height and weight with those considered normal for that age. Record head circumference for children under one year of age. Report height and weight over time on a graphic recording sheet. In addition, a Body Mass Index (BMI) measurement is required starting at age four and each subsequent year.
- **Unclothed Physical Inspection.** Check the general appearance of the child to determine overall health status and detect obvious physical defects; also do a physical examination to assess all organ systems such as pulmonary, cardiac, and gastrointestinal.
- **Developmental and Behavioral Health Surveillance and Screening.** Developmental and behavioral assessment includes a range of activities to determine whether an individual's developmental and behavioral processes fall within a typical range of achievement according to age group and cultural background. Eliciting developmental and behavioral concerns is a part of every screening examination. It is important to acquire information on the child's usual functioning as reported by the child, parent, teacher, health professional or other familiar person, and to review developmental progress as a component of overall health and well-being given the child's age and culture. For more information regarding developmental and behavioral surveillance and screening see, Appendix C. As appropriate, assess the following elements:
 - Gross and fine motor development;
 - Communication skills, language and speech development;
 - Self-help, self-care skills;

- Social-emotional development;
 - Cognitive skills;
 - Visual-motor skills;
 - Learning disabilities;
 - Psychological/psychiatric issues;
 - Family functioning;
 - Peer relations;
 - High risk behaviors; and
 - Vocational skills
- **Assessment of Nutritional Status.** Nutritional assessment may include preventive education and follow-up services including dietary counseling and nutritional education if appropriate. This is accomplished in the basic examination through:
- Questions about dietary practices and mealtime behaviors/interactions;
 - Complete physical examination, including an oral dental examination;
 - Height and weight measurements;
 - Laboratory test for iron deficiency;
 - Serum cholesterol screening, if feasible and appropriate; and
 - Age-appropriate education/anticipatory guidance

(3) Immunizations. The immunization status of the child must be checked at each visit. Immunizations should be administered according to the recommended childhood and adolescent immunization schedules set out by the Centers for Disease Control and Prevention (CDC) (see Appendix D for schedules). Providers who are enrolled in the Vaccine for Children Program (VFC) will be provided vaccines free of charge for *SoonerCare* eligible children.

(4) Appropriate Laboratory Tests. General procedures including immunizations and lab tests, such as blood lead, are outlined in the periodicity schedule. Medical judgment is used in determining the applicability of all other laboratory tests or analyses to be performed unless otherwise included on the periodicity schedule. If any laboratory tests or analyses are medically contraindicated at the time of the screening, they are to be provided when no longer medically contraindicated.

(5) Health Education/Anticipatory Guidance. Health education is a required component of screening services and includes anticipatory guidance. The physical and dental assessment or screening gives the initial context for providing health education. Health education is designed to assist in understanding expectations of the child's development and provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention.

Age-appropriate anticipatory guidance is required to be given to parents in the areas of injury/serious illness prevention, violence prevention, sleep counseling/interaction, and nutritional counseling.

Additionally, the following tests/assessments are required by either the OHCA or federal regulations at some but not all Child Health/EPSDT visits:

- A blood lead toxicity test (by either finger stick or venipuncture) is **required** for every *SoonerCare* enrolled child at 12 and 24 months of age.
- In addition, a blood lead test is required when a child is identified as being at high risk, beginning at six months of age. If the initial blood lead test results are less than (>) 10 micrograms per deciliter ($\mu\text{g}/\text{dL}$), a blood lead test is required at every visit prescribed in the Child Health/EPSDT periodicity schedule through 72 months of age. If a child between the ages of 36 months and 72 months has not received a blood lead screening test, then that child must receive it immediately, regardless of being determined high / low risk. Any additional lead toxicity testing will continue to be covered based on a provider's medical judgment.
- A Body Mass Index (BMI) is required at every Child Health/EPSDT visit beginning at age four and at every screening visit thereafter.
- Hematocrit or Hemoglobin is required at least once between nine – 12 months of age.
- Vision Screening/Testing is required at the newborn visit, at the one, two, four, and six month visits, at least once between nine-12 months, and at least once between three-five years of age (Note: the type of screenings varies for each age; see following charts for detail).
- A hearing test is required at the newborn visit, at the four-year-old visit, and at ages five, six, eight and 10 if not performed at school.

RECOMMENDATIONS FOR TIMING OF CHILD HEALTH/EPSDT PREVENTIVE HEALTH CARE

Each child and family is unique; the following recommendations for preventive pediatric health care are designed for the care of children who have no manifestations of any important health problems, and are growing and developing in satisfactory fashion. In addition to the required screenings, there are recommended optional screenings that should be performed (i.e. one week, 15 months, 11, 13, 15, 17 and 19 years of age). The required and recommended screenings combined constitute the screening periodicity recommended by the AAP schedule. Please note that elements required by Title XIX federal regulation and OHCA are not identical to the screening elements in the corresponding AAP visit for that age.

A provider may perform additional screenings as medically necessary. Additional visits or additional components of a screening visit may be necessary if circumstances suggest variations from normal.

Each compensable Child Health/EPSDT visit requires the elements as recommended in the following age specific categories. Contraindications may be cause for not completing an element. If any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time. The recommendations in this statement do no indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

NEWBORN VISIT

The newborn visit is an inpatient hospital visit. The visit consists of a prenatal history which may be obtained from the parent or guardian and must contain:

- ✓ Health History:
 - Present health status and past health history of member and/or mother if it is a review of prenatal history;
 - Developmental information;
 - Allergies and immunization history;
 - Family history;
 - Dietary history; and
 - Risk assessment of lead exposure.
- ✓ Age-appropriate developmental and a behavioral surveillance screening
- ✓ Vision: The provider also conducts a screening of vision that consists of an assessment of the anatomy of the lids, alignment of the eyes and clarity of the ocular media with particular attention to documenting the presence of a normal red reflex.
- ✓ Hearing: A newborn hearing screen is required.
- ✓ Exam: The provider also conducts a physical examination of all body systems to include measurements of height, weight and head circumference.
- ✓ Anticipatory Guidance: Age-appropriate anticipatory guidance is required to be given to parents in the areas of injury/serious illness prevention, violence prevention, sleep counseling/interaction, nutritional counseling and what to anticipate before the next visit.
- ✓ Lab: A Hereditary/Metabolic Screening is required between birth and one month; any other appropriate lab.
- ✓ Immunizations: The HepB immunization is required.

1-WEEK-VISIT - Optional

The one week visit occurs approximately one week from the hospital discharge date. This visit is designed for infants who were discharged early or have other health concerns.

- ✓ Health history: At a minimum, a maternal and birth history, initial/interval history and a family social history (FSH). Also a history of occurrence since the last screen visit.
- ✓ Age-appropriate developmental and a behavioral surveillance screening:
 - Motor Skills
 - Fine Motor Skills
 - Language/Social Emotional Skills
 - Parent-Infant Interactions
- ✓ Vision: The provider conducts a screening of vision that consists of an assessment of the anatomy of the lids, alignment of the eyes and clarity of the ocular media with particular attention to documenting the presence of a normal red reflex.
- ✓ Hearing: A hearing screen is required to be done if the child failed the newborn hearing screen or if there are parental concerns or any other indicator of potential problems.
- ✓ Exam: The provider also conducts a physical examination of all body systems to include measurements of height, weight, head circumference, temperature and pulse.
- ✓ Anticipatory Guidance: Age-appropriate anticipatory guidance is required to be given to parents in the areas of injury prevention, violence prevention, sleep counseling/interaction, nutritional counseling and what to anticipate before the next visit.
- ✓ Lab: A Hereditary/Metabolic Screening is required if not performed at the newborn visit.
- ✓ Immunizations: HepB if not given at newborn visit.

BY 1-MONTH-OLD VISIT

- ✓ Health history: At a minimum, a maternal and birth history, initial/interval history and a family social history (FSH). Also a history of occurrence since the last screen visit.
- ✓ Age-appropriate developmental and a behavioral surveillance screening:
 - Motor Skills
 - Fine Motor Skills
 - Language/Social Emotional Skills
 - Parent-Infant Interactions
- ✓ Vision: The provider conducts a screening of vision that consists of an assessment of the anatomy of the lids, alignment of the eyes and clarity of the ocular media with particular attention to documenting the presence of a normal red reflex.
- ✓ Hearing: A hearing screen is required if the child failed the newborn hearing screen or if there are parental concerns or any other indicator of potential problems.
- ✓ Exam: The provider also conducts a physical examination of all body systems to include measurements of height, weight, head circumference, temperature and pulse.
- ✓ Anticipatory Guidance: Age-appropriate anticipatory guidance is required to be given to parents in the areas of injury prevention, violence prevention, sleep counseling/interaction, nutritional counseling and what to anticipate before the next visit.
- ✓ Lab: A Hereditary/Metabolic Screening is required if not previously given.
- ✓ Dental screens by the Primary Care Provider begin at the first sign of tooth eruption and with each subsequent visit to determine if child needs a referral to dental provider.
- ✓ Immunizations: HepB if not previously given.

2-MONTH-OLD VISIT

- ✓ Health history: At a minimum, a maternal and birth history, initial/interval history and a family social history (FSH). Also a history of occurrence since the last screen visit.
- ✓ Age-appropriate developmental and a behavioral surveillance screening:
 - Motor Skills
 - Fine Motor Skills
 - Language/Social Emotional Skills
 - Parent-Infant Interactions
- ✓ Vision: The provider conducts a screening of vision that consists of a red reflex and external appearance exam.
- ✓ Hearing: A hearing screen is required if the child failed the newborn hearing screen or if there are parental concerns or any other indicator of potential problems.
- ✓ Exam: The provider also conducts a physical examination of all body systems to include measurements of height, weight, head circumference, temperature and pulse.
- ✓ Anticipatory Guidance: Age-appropriate anticipatory guidance is required to be given to parents in the areas of injury prevention, violence prevention, sleep counseling/interaction, nutritional counseling and what to anticipate before the next visit.
- ✓ Lab: A Hereditary/Metabolic Screening is required if not previously given.
- ✓ Dental screens by the Primary Care Provider begin at the first sign of tooth eruption and with each subsequent visit to determine if child needs a referral to dental provider.
- ✓ Immunizations: HepB #2 , DTaP #1, Hib #1, IPV #1 , Pneumococcal (PCV) #1 and Rotavirus.

4-MONTH-OLD VISIT

- ✓ Health history: At a minimum, a maternal and birth history, initial/interval history and a family social history (FSH). Also a history of occurrence since the last screen visit.
- ✓ Age-appropriate developmental and a behavioral surveillance screening:
 - Motor Skills
 - Fine Motor Skills
 - Language/Social Emotional Skills
 - Parent-Infant Interactions
- ✓ Vision: The provider conducts a screening of vision that consists of a red reflex and external appearance exam.
- ✓ Hearing: A hearing screen is required if the child failed the newborn hearing screen or if there are parental concerns or any other indicator of potential problems.
- ✓ Exam: The provider also conducts a physical examination of all body systems to include measurements of height, weight, head circumference, temperature and pulse.
- ✓ Anticipatory Guidance: Age-appropriate anticipatory guidance is required to be given to parents in the areas of injury prevention, violence prevention, sleep counseling/interaction, nutritional counseling and what to anticipate before the next visit.
- ✓ Lab: No required lab at this visit.
- ✓ Dental screens by the Primary Care Provider begin at the first sign of tooth eruption and with each subsequent visit to determine if child needs a referral to dental provider.
- ✓ Immunizations: DTaP #2, Hib #2, IPV #2, Pneumococcal (PCV) #2 and Rotavirus #2.
- ✓ Catch-up Immunizations – Heb #2.

6-MONTH-OLD VISIT

- ✓ Health history: At a minimum, a maternal and birth history, initial/interval history and a family social history (FSH). Also a history of occurrence since the last screen visit.
- ✓ Age- appropriate developmental and a behavioral surveillance screening:
 - Motor Skills
 - Fine Motor Skills
 - Language/Social Emotional Skills
 - Parent-Infant Interactions
- ✓ Vision: The provider conducts a screening of vision that consists of a red reflex and external appearance exam.
- ✓ Hearing: Infants with Joint Committee on Infant Hearing (JCIH) risk factors are screened with physiologic or behavioral measures including either visual reinforcement audiometry, auditory brainstem response testing or otoacoustic emissions testing. Infants without risk factors are screened subjectively with auditory behavior development checklist (refer to Appendix B for JCIH risk factors).
- ✓ Exam: The provider also conducts a physical examination of all body systems to include measurements of height, weight, head circumference, temperature and pulse.
- ✓ Anticipatory Guidance: Age-appropriate anticipatory guidance is required to be given to parents in the areas of injury prevention, violence prevention, sleep counseling/interaction, nutritional counseling and what to anticipate before the next visit.
- ✓ Lab: No required lab at this visit.
- ✓ Dental screens by the Primary Care Provider begin at the first sign of tooth eruption and with each subsequent visit to determine if child needs a referral to dental provider.
- ✓ Immunizations: HepB #3 , DTaP #3, Hib #3, IPV #3, Pneumococcal (PCV) #3, Rotavirus #3 and Influenza yearly.

9-MONTH-OLD VISIT

- ✓ Health history: At a minimum, an initial/interval history and a family social history (FSH). Also a history of occurrence since the last screen visit.
- ✓ Age-appropriate developmental and a behavioral surveillance screening:
 - Motor Skills
 - Fine Motor Skills
 - Language/Social Emotional/Cognitive Skills
 - Parent-Infant Interactions
- ✓ Vision: The provider conducts a screening of vision between the ages of nine and 12 months that consists of a red reflex and external appearance exam and evaluation of ocular alignment with a corneal light reflex test.
- ✓ Hearing: Infants with Joint Committee on Infant Hearing (JCIH) risk factors are screened with physiologic or behavioral measures including either visual reinforcement audiometry, auditory brainstem response testing or otoacoustic emissions testing. Infants without risk factors are screened subjectively with auditory behavior development checklist (refer to Appendix B for JCIH risk factors).
- ✓ Exam: The provider also conducts a physical examination of all body systems to include measurements of height, weight, head circumference, temperature and pulse.
- ✓ Anticipatory Guidance: Age-appropriate anticipatory guidance is required to be given to parents in the areas of injury prevention, violence prevention, sleep counseling/interaction, nutritional counseling and what to anticipate before the next visit.
- ✓ Lab: A Hematocrit or Hemoglobin test is required between the ages of nine months and twelve months; a blood lead test may be provided as early as nine months but is required at 12 and 24 months.
- ✓ Dental screens by the Primary Care Provider begin at the first sign of tooth eruption and with each subsequent visit to determine if child needs a referral to dental provider.
- ✓ Catch-up Immunizations: HepB, DTaP, Hib, IPV, Pneumococcal (PCV) and Influenza yearly.

12-MONTH-OLD VISIT

- ✓ Health history: At a minimum, an initial/interval history and a family social history (FSH). Also a history of occurrence since the last screen visit.
- ✓ Age-appropriate developmental and a behavioral surveillance screening:
 - Motor Skills
 - Fine Motor Skills
 - Language/Social Emotional/Cognitive Skills
 - Parent-Infant Interactions
- ✓ Vision: If screening not conducted at nine months, the provider conducts a screening of vision that consists of a red reflex and external appearance exam and evaluation of ocular alignment with a corneal light reflex test.
- ✓ Hearing: Infants with Joint Committee on Infant Hearing (JCIH) risk factors are screened with physiologic or behavioral measures including either visual reinforcement audiometry, auditory brainstem response testing or otoacoustic emissions testing. Infants without risk factors are screened subjectively with auditory behavior development checklist (refer to Appendix B for JCIH risk factors).
- ✓ Exam: The provider also conducts a physical examination of all body systems to include measurements of height, weight, head circumference, temperature and pulse.
- ✓ Anticipatory Guidance: Age-appropriate anticipatory guidance is required to be given to parents in the areas of injury prevention, violence prevention, sleep counseling/interaction, nutritional counseling and what to anticipate before the next visit.
- ✓ Lab: A Hematocrit or Hemoglobin test is required if not given at nine months; a blood lead test is required if not given at nine months and a tuberculin test for any at-risk child.
- ✓ Dental screens by the Primary Care Provider begin at the first sign of tooth eruption and with each subsequent visit to determine if child needs a referral to dental provider.
- ✓ Immunizations: DTaP #4, Hib #4, Pneumococcal (PCV) #4, MMRV#1, HepA #1 and Influence yearly.
- ✓ Catch-up Immunizations: HepB and IPV.

15-MONTH-OLD VISIT - Optional

- ✓ Health history: At a minimum, an initial/interval history and a family social history (FSH). Also a history of occurrence since the last screen visit.
- ✓ Age-appropriate developmental and a behavioral surveillance screening:
 - Motor Skills
 - Fine Motor Skills
 - Language/Social Emotional/Cognitive Skills
 - Parent-Infant Interactions
- ✓ Vision: Subjective by history.
- ✓ Hearing: Subjective by history.
- ✓ Exam: The provider also conducts a physical examination of all body systems to include measurements of height, weight, head circumference, temperature and pulse.
- ✓ Anticipatory Guidance: Age-appropriate anticipatory guidance is required to be given to parents in the areas of injury prevention, violence prevention, sleep counseling/interaction, nutritional counseling and what to anticipate before the next visit.
- ✓ Lab: Tuberculin test is required for any at-risk child; blood lead test is subjective by history.
- ✓ Dental screens by the Primary Care Provider begin at the first sign of tooth eruption and with each subsequent visit to determine if child needs a referral to dental provider.
- ✓ Immunizations: Influenza yearly.
- ✓ Catch-up Immunization: DTaP, HepB, Hib, IPV, MMRV, Pneumococcal (PCV) and HepA.

18-MONTH-OLD VISIT

- ✓ Health history: At a minimum, an initial/interval history and a family social history (FSH). Also a history of occurrence since the last screen visit.
- ✓ Age-appropriate developmental and a behavioral surveillance screening:
 - Motor Skills
 - Fine Motor Skills
 - Language/Social Emotional/Cognitive Skills
 - Parent-Infant Interactions
- ✓ Vision: Subjective by history.
- ✓ Hearing: Subjective screen to include a brief questionnaire regarding appropriate speech and language development.
- ✓ Exam: The provider also conducts a physical examination of all body systems to include measurements of height, weight, head circumference, temperature and pulse.
- ✓ Anticipatory Guidance: Age-appropriate anticipatory guidance is required to be given to parents in the areas of injury prevention, violence prevention, sleep counseling/interaction, nutritional counseling and what to anticipate before the next visit.
- ✓ Lab: The Hematocrit or hemoglobin and tuberculin test are required for any at-risk child; a blood lead test is subjective by history.
- ✓ Dental screens by the Primary Care Provider begin at the first sign of tooth eruption and with each subsequent visit to determine if child needs a referral to dental provider.
- ✓ Immunizations: HepA #2, Influenza yearly.
- ✓ Catch-up Immunizations: DTaP, HepB, Hib, IPV, MMRV, Pneumoccal (PCV).

24-MONTH-OLD VISIT

- ✓ Health history: At a minimum, an initial/interval history and a family social history (FSH). Also a history of occurrence since the last screen visit.
- ✓ Age-appropriate developmental and a behavioral surveillance screening:
 - Motor Skills
 - Fine Motor Skills
 - Language/Social Emotional/Cognitive Skills
 - Parent-Infant Interactions
- ✓ Vision: Subjective by history.
- ✓ Hearing: Subjective screen to include a brief questionnaire regarding appropriate speech and language development.
- ✓ Exam: The provider also conducts a physical examination of all body systems to include measurements of height, weight, head circumference, temperature and pulse.
- ✓ Anticipatory Guidance: Age-appropriate anticipatory guidance is required to be given to parents in the areas of injury prevention, violence prevention, sleep counseling/interaction, nutritional counseling and what to anticipate before the next visit.
- ✓ Lab: A blood lead test is required.
- ✓ Lab for at-risk: Hematocrit or Hemoglobin, tuberculin test and cholesterol screenings are required.
- ✓ Dental screens by the Primary Care Provider begin at the first sign of tooth eruption and with each subsequent visit to determine if child needs a referral to dental provider.
- ✓ Immunizations: Influenza yearly.
- ✓ Catch-up Immunizations: HepB DTaP, Hib, IPV, PCV, MMRV,
- ✓ Immunization Vaccine for High-Risk: MPSVH 4 (Meningococcal)

3-YEAR-OLD VISIT

- ✓ Health history: At a minimum, an initial/interval history and a family social history (FSH). Also a history of occurrence since the last screen visit.
- ✓ Age-appropriate developmental and a behavioral surveillance screening:
 - Motor Skills
 - Fine Motor Skills
 - Language/Social Emotional/Cognitive Skills
 - Parent-Infant Interactions
- ✓ Vision: The provider conducts one vision screening between ages three to five. The screening consists of an alignment and an acuity test e.g., Allen Cards, Snellen chart or HOTV Test in each eye.
- ✓ Hearing: Subjective by history. If history suggests testing is necessary a behavioral or physiologic screen including either conditioned play audiometry, acoustic immittance testing (including reflexes), pneumatic otoscopy, or otoacoustic emissions should be performed.
- ✓ Exam: The provider also conducts a physical examination of all body systems to include measurements of height, weight, temperature, and checking blood pressure.
- ✓ Anticipatory Guidance: Age-appropriate anticipatory guidance is required to be given to parents in the areas of injury prevention, violence prevention, sleep counseling/interaction, nutritional counseling and what to anticipate before the next visit.
- ✓ Lab: A blood lead test is required if not previously tested.
- ✓ Lab for at-risk child: Hematocrit or Hemoglobin, tuberculin test and cholesterol screening is required.
- ✓ Dental Reminder: Yearly dental reminder to take child to a qualified dental provider for a dental examination.
- ✓ Immunizations: Influenza vaccine is due yearly. Also check immunization status according to ACIP schedule.

4-YEAR-OLD VISIT

- ✓ Health history: At a minimum, an initial/interval history and a family social history (FSH). Also a history of occurrence since the last screen visit.
- ✓ Age-appropriate developmental and a behavioral surveillance screening:
 - Motor Skills
 - Fine Motor Skills
 - Language/Social Emotional/Cognitive Skills
 - Parent-Infant Interactions
- ✓ Vision: The provider conducts one vision screening between ages three to five. The screening consists of an alignment and an acuity test e.g., Allen Cards, Snellen chart or HOTV Test in each eye.
- ✓ Hearing: Behavioral or physiologic screen including either conditioned play audiometry, acoustic immittance testing (including reflexes), pneumatic otoscopy, or otoacoustic emissions.
- ✓ Exam: The provider also conducts a physical examination of all body systems to include measurements of height and weight, temperature, pulse, checking blood pressure, and determining a Body Mass Index (BMI).
- ✓ Anticipatory Guidance: Age-appropriate anticipatory guidance is required to be given to parents in the areas of injury prevention, violence prevention, sleep counseling/interaction, nutritional counseling and what to anticipate before the next visit.
- ✓ Lab: A blood lead test is required if not previously tested.
- ✓ Lab for at-risk child: Hematocrit or Hemoglobin, tuberculin test and cholesterol screening is required.
- ✓ Dental Reminder: Yearly dental reminder to take child to a qualified dental provider for a dental examination.
- ✓ Immunizations: DTaP #5, MMRV #2, IPV #4, and Influenza yearly.
- ✓ Catch-up Immunizations: Pneumococcal (PCV), HepB, HepA and Hib.
- ✓ Immunization Vaccine for High-Risk: MPSVH4 (Meningococcal)

5-YEAR-OLD VISIT

- ✓ Health history: At a minimum, an initial/interval history and a family social history (FSH). Also a history of occurrence since the last screen visit.
- ✓ Age-appropriate developmental and a behavioral surveillance screening:
 - Motor Skills
 - Fine Motor Skills
 - Language/Social Emotional/Cognitive Skills
 - Parent-Infant Interactions
- ✓ Vision: The provider conducts one vision screening between ages three to five. The screening consists of an alignment and an acuity test e.g., Allen Cards, Snellen chart or HOTV Test in each eye.
- ✓ Hearing: Behavioral screen if not completed at 4 years or in school including conventional behavioral pure tone screening.
- ✓ Exam: The provider also conducts a physical examination of all body systems to include measurements of height and weight, temperature, pulse, checking blood pressure, and determining a Body Mass Index (BMI).
- ✓ Anticipatory Guidance: Age-appropriate anticipatory guidance is required to be given to parents in the areas of injury prevention, violence prevention, sleep counseling/interaction, nutritional counseling and what to anticipate before the next visit.
- ✓ Lab: A blood lead test is required if not previously tested.
- ✓ Lab for any at-risk child: A tuberculin test and cholesterol screening are required.
- ✓ Dental reminder: Yearly dental reminder to take child to a qualified dental provider for a dental examination.
- ✓ Immunizations: Influenza yearly.
- ✓ Catch-up Immunizations: DTaP #5, MMRV #2, IPV #4, HepB and HepA.
- ✓ Immunizations for High-Risk: MPSVH4 (Meningococcal)

6-YEAR-OLD VISIT

- ✓ Health history: At a minimum, an initial/interval history and a family social history (FSH). Also a history of occurrence since the last screen visit.
- ✓ Age-appropriate developmental and a behavioral surveillance screening:
 - Motor Skills
 - Fine Motor Skills
 - Language/Social Emotional/Cognitive Skills
 - Parent-Infant Interactions
- ✓ Vision: The provider conducts one vision screening between ages six to 10. The screening consists of a visual acuity test e.g., Allen Cards, Snellen chart or HOTV Test in each eye.
- ✓ Hearing: Behavioral screen if not completed in school including conventional behavioral pure tone screening.
- ✓ Exam: The provider also conducts a physical examination of all body systems to include measurements of height and weight, temperature, pulse, checking blood pressure, and determining a Body Mass Index (BMI).
- ✓ Anticipatory Guidance: Age-appropriate anticipatory guidance is required to be given to parents in the areas of injury prevention, violence prevention, sleep counseling/interaction, nutritional counseling and what to anticipate before the next visit.
- ✓ Lab for at-risk child; a tuberculin test and cholesterol screening are required.
- ✓ Dental reminder: Yearly dental reminder to take child to a qualified dental provider for a dental examination.
- ✓ Immunizations: Influenza yearly.
- ✓ Catch-up Immunizations: Td, MMRV, IPV, HepB and HepA.
- ✓ Immunizations for High-Risk: MPSVH4 (Meningococcal).

8-YEAR-OLD VISIT

- ✓ Health history: At a minimum, an initial/interval history and a family social history (FSH). Also a history of occurrence since the last screen visit.
- ✓ Age-appropriate developmental and a behavioral surveillance screening:
 - Motor Skills
 - Fine Motor Skills
 - Language/Social Emotional/Cognitive Skills
 - Parent-Infant Interactions
- ✓ Vision: The provider conducts one vision screening between ages six to 10. The screening consists of a visual acuity test e.g., Allen Cards, Snellen chart or HOTV Test in each eye.
- ✓ Hearing: Behavioral screen if not completed in school including conventional behavioral pure tone screening.
- ✓ Exam: The provider also conducts a physical examination of all body systems to include measurements of height and weight, temperature, pulse, checking blood pressure, and determining a Body Mass Index (BMI).
- ✓ Anticipatory Guidance: Age-appropriate anticipatory guidance is required to be given to parents in the areas of injury prevention, violence prevention, sleep counseling/interaction, nutritional counseling and what to anticipate before the next visit.
- ✓ Lab for at-risk child: A tuberculin test and cholesterol screening are required.
- ✓ Dental reminder: Yearly dental reminder to take child to a qualified dental provider for a dental examination.
- ✓ Immunizations: Influenza yearly.
- ✓ Catch-up Immunizations: Td, MMRV, IPV, HepB and HepA.
- ✓ Immunizations for High-Risk: MPSVH4 (Meningococcal).

10-YEAR-OLD VISIT

- ✓ Health history: At a minimum, an initial/interval history and a family social history (FSH). Also a history of occurrence since the last screen visit.
- ✓ Age-appropriate developmental and a behavioral surveillance screening:
 - Motor Skills
 - Fine Motor Skills
 - Language/Social Emotional/Cognitive Skills
 - Parent-Infant Interactions
- ✓ Vision: The provider conducts one vision screening between ages six to 10. The screening consists of a visual acuity test e.g., Allen Cards, Snellen chart or HOTV Test in each eye.
- ✓ Hearing: Behavioral screen if not completed in school including conventional behavioral pure tone screening.
- ✓ Exam: The provider also conducts a physical examination of all body systems to include measurements of height and weight, temperature, pulse, checking blood pressure, and determining a Body Mass Index (BMI).
- ✓ Anticipatory Guidance: Age-appropriate anticipatory guidance is required to be given to parents in the areas of injury prevention, violence prevention, sleep counseling/interaction, nutritional counseling and what to anticipate before the next visit.
- ✓ Lab at-risk child: A tuberculin test and cholesterol screening are required.
- ✓ Dental reminder: Yearly dental reminder to take child to a qualified dental provider for a dental examination.
- ✓ Immunizations: Influenza yearly.
- ✓ Catch-up Immunizations: Td, MMRV, IPV, HepB and HepA.
- ✓ Immunizations for High-Risk: MPSVH4 (Meningococcal).

11-YEAR-OLD VISIT - Optional

- ✓ Health history: At a minimum, an initial/interval history and a family social history (FSH). Also a history of occurrence since the last screen visit.
- ✓ Age-appropriate developmental and a behavioral surveillance screening (HEADDSS):
 - Home
 - Activities
 - Suicide/Depression
 - Parent/Teen Interaction
 - Education
 - Danger/Drugs
 - Sexuality
- ✓ Vision: Objective visual acuity testing is to be provided once during ages 11 through 18. The screening consists of a visual acuity test e.g., Allen Cards, Snellen chart or HOTV Test in each eye.
- ✓ Hearing: Subjective by history to include concerns regarding school, home and communicative performance.
- ✓ Exam: The provider also conducts a physical examination of all body systems to include measurements of height and weight, temperature, checking blood pressure, pulse and determining a Body Mass Index (BMI).
- ✓ Anticipatory Guidance: Age-appropriate anticipatory guidance is required to be given to parents in the areas of injury prevention, violence prevention, family interaction/communication, and nutritional counseling and what to anticipate before the next visit.
- ✓ Lab: Hematocrit or hemoglobin is required for menstruating females and any at-risk child
- ✓ Lab for at-risk child: Urinalysis, tuberculin test, cholesterol screening and SDT screening are required; and pelvic exam for at-risk females.
- ✓ Dental reminder: Yearly dental reminder to take child to a qualified dental provider for a dental examination.
- ✓ Immunizations: Tdap, MCV4 (Meningococcal), HPV (Papilloma) and Influenza yearly.
- ✓ Catch-up Immunizations: MMR, HepB, Varicella, HepA, IPV and PPV (Pneumonia).
- ✓ Immunizations for High-Risk: PPV (Pneumonia)

12-YEAR-OLD VISIT

- ✓ Health history: At a minimum, an initial/interval history and a family social history (FSH). Also a history of occurrence since the last screen visit.
- ✓ Age-appropriate developmental and a behavioral surveillance screening (HEADDS):
 - Home
 - Activities
 - Suicide/Depression
 - Parent/Teen Interaction
 - Education
 - Danger/Drugs
 - Sexuality
- ✓ Vision: Objective visual acuity testing is to be provided once during ages 11 through 18. The screening consists of a visual acuity test e.g., Allen Cards, Snellen chart or HOTV Test in each eye.
- ✓ Hearing: Subjective by history to include concerns regarding school, home and communicative performance.
- ✓ Exam: The provider also conducts a physical examination of all body systems to include measurements of height and weight, temperature, pulse, checking blood pressure, and determining a Body Mass Index (BMI).
- ✓ Anticipatory Guidance: Age-appropriate anticipatory guidance is required to be given to parents in the areas of injury prevention, violence prevention, family interaction/communication, and nutritional counseling and what to anticipate before the next visit.
- ✓ Lab: Hematocrit or hemoglobin is required for menstruating females and any at-risk child
- ✓ Lab for risk child: Urinalysis, tuberculin test, cholesterol screening and SDT screening are required; and pelvic exam for at-risk females.
- ✓ Dental reminder: Yearly dental reminder to take child to a qualified dental provider for a dental examination.
- ✓ Immunizations: Tdap, MCV4 (Meningococcal), HPV (Papilloma) and Influenza yearly.
- ✓ Catch-up Immunizations: MMR, HepB, Varicella, HepA, IPV and PPV (Pneumonia).
- ✓ Immunizations for High-Risk: PPV (Pneumonia)

13-YEAR-OLD VISIT - OPTIONAL

- ✓ Health history: At a minimum, an initial/interval history and a family social history (FSH). Also a history of occurrence since the last screen visit.
- ✓ Age-appropriate developmental and a behavioral surveillance screening (HEADDSS):
 - Home
 - Activities
 - Suicide/Depression
 - Parent/Teen Interaction
 - Education
 - Danger/Drugs
 - Sexuality
- ✓ Vision: Objective visual acuity testing is to be provided once during ages 11 through 18. The screening consists of a visual acuity test e.g., Allen Cards, Snellen chart or HOTV Test in each eye.
- ✓ Hearing: Subjective by history to include concerns regarding school, home and communicative performance.
- ✓ Exam: The provider also conducts a physical examination of all body systems to include measurements of height and weight, temperature, pulse, checking blood pressure, and determining a Body Mass Index (BMI).
- ✓ Anticipatory Guidance: Age-appropriate anticipatory guidance is required to be given to parents in the areas of injury prevention, violence prevention, family interaction/communication, nutritional counseling and what to anticipate before the next visit.
- ✓ Lab: Hematocrit or hemoglobin is required for menstruating females and any at-risk child;
- ✓ Lab for at risk child: Urinalysis, tuberculin test, cholesterol screening and SDT screening are required to be given and pelvic exam for at-risk females.
- ✓ Dental reminder: Yearly reminder to take child to a qualified dental provider for a dental examination.
- ✓ Immunizations: Tdap, MCV4 (Meningococcal), HPV (Papilloma) and Influenza yearly.
- ✓ Catch-up Immunizations: MMR, HepB, Varicella, HepA, IPV and PPV (Pneumonia).
- ✓ Immunizations for High-Risk: PPV (Pneumonia)

14-YEAR-OLD VISIT

- ✓ Health history: At a minimum, an initial/interval history and a family social history (FSH). Also a history of occurrence since the last screen visit.
- ✓ Age-appropriate developmental and a behavioral surveillance screening (HEADDSS):
 - Home
 - Activities
 - Suicide/Depression
 - Parent/Teen Interaction
 - Education
 - Danger/Drugs
 - Sexuality
- ✓ Vision: Objective visual acuity testing is to be provided once during ages 11 through 18. The screening consists of a visual acuity test e.g., Allen Cards, Snellen chart or HOTV Test in each eye.
- ✓ Hearing: Subjective by history to include concerns regarding school, home and communicative performance.
- ✓ Exam: The provider also conducts a physical examination of all body systems to include measurements of height and weight, temperature, pulse, checking blood pressure, and determining a Body Mass Index (BMI).
- ✓ Anticipatory Guidance: Age-appropriate anticipatory guidance is required to be given to parents in the areas of injury prevention, violence prevention, family interaction/communication, nutritional counseling and what to anticipate before the next visit.
- ✓ Lab: Hematocrit or hemoglobin is required for menstruating females and any at-risk child
- ✓ Lab for at-risk child: Urinalysis, tuberculin test, cholesterol screening and SDT screening are required; and pelvic exam for at-risk females.
- ✓ Dental reminder: Yearly dental reminder to take child to a qualified dental provider for a dental examination.
- ✓ Immunizations: Tdap, MCV4 (Meningococcal), HPV (Papilloma) and Influenza yearly.
- ✓ Catch-up Immunizations: MMR, HepB, Varicella, HepA, IPV and PPV (Pneumonia).
- ✓ Immunizations for High-Risk: PPV (Pneumonia)

15-YEAR-OLD VISIT - OPTIONAL

- ✓ Health history: At a minimum, an initial/interval history and a family social history (FSH). Also a history of occurrence since the last screen visit.
- ✓ Age-appropriate developmental and a behavioral surveillance screening (HEADDSS):
 - Home
 - Activities
 - Suicide/Depression
 - Parent/Teen Interaction
 - Education
 - Danger/Drugs
 - Sexuality
- ✓ Vision: Objective visual acuity testing is to be provided once during ages 11 through 18. The screening consists of a visual acuity test e.g., Allen Cards, Snellen chart or HOTV Test in each eye.
- ✓ Hearing: Subjective by history to include concerns regarding school, home and communicative performance.
- ✓ Exam: The provider also conducts a physical examination of all body systems to include measurements of height and weight, temperature, pulse, checking blood pressure, and determining a Body Mass Index (BMI).
- ✓ Anticipatory Guidance: Age-appropriate anticipatory guidance is required to be given to parents in the areas of injury prevention, violence prevention, family interaction/communication, nutritional counseling and what to anticipate before the next visit.
- ✓ Lab: Hematocrit or hemoglobin is required for menstruating females and any at-risk child
- ✓ Lab for at-risk child: Urinalysis, tuberculin test, cholesterol screening and SDT screening are required; and pelvic exam for at-risk females.
- ✓ Dental reminder: Yearly dental reminder to take child to a qualified dental provider for a dental examination.
- ✓ Immunizations: Tdap, MCV4 (Meningococcal), HPV (Papilloma) and Influenza yearly.
- ✓ Catch-up Immunizations: MMR, HepB, Varicella, HepA, IPV and PPV (Pneumonia).
- ✓ Immunizations for High-Risk: PPV (Pneumonia)

16-YEAR-OLD VISIT

- ✓ Health history: At a minimum, an initial/interval history and a family social history (FSH). Also a history of occurrence since the last screen visit.
- ✓ Age-appropriate developmental and a behavioral surveillance screening (HEADDSS):
 - Home
 - Activities
 - Suicide/Depression
 - Parent/Teen Interaction
 - Education
 - Danger/Drugs
 - Sexuality
- ✓ Vision: Objective visual acuity testing is to be provided once during ages 11 through 18. The screening consists of a visual acuity test e.g., Allen Cards, Snellen chart or HOTV Test in each eye.
- ✓ Hearing: Subjective by history to include concerns regarding school, home and communicative performance.
- ✓ Exam: The provider also conducts a physical examination of all body systems to include measurements of height and weight, temperature, pulse, checking blood pressure, and determining a Body Mass Index (BMI).
- ✓ Anticipatory Guidance: Age-appropriate anticipatory guidance is required to be given to parents in the areas of injury prevention, violence prevention, family interaction/communication, nutritional counseling and what to anticipate before the next visit.
- ✓ Lab: Hematocrit or hemoglobin is required for menstruating females and any at-risk child
- ✓ Lab for at-risk child: Urinalysis, tuberculin test, cholesterol screening and SDT screening are required; and pelvic exam for at-risk females.
- ✓ Dental reminder: Yearly dental reminder to take child to a qualified dental provider for a dental examination.
- ✓ Immunizations: Tdap, MCV4 (Meningococcal), HPV (Papilloma) and Influenza yearly.
- ✓ Catch-up Immunizations: MMR, HepB, Varicella, HepA, IPV and PPV (Pneumonia).
- ✓ Immunizations for High-Risk: PPV (Pneumonia)

17-YEAR-OLD VISIT- Optional

- ✓ Health history: At a minimum, an initial/interval history and a family social history (FSH). Also a history of occurrence since the last screen visit.
- ✓ Age-appropriate developmental and a behavioral surveillance screening (HEADDSS):
 - Home
 - Activities
 - Suicide/Depression
 - Parent/Teen Interaction
 - Education
 - Danger/Drugs
 - Sexuality
- ✓ Vision: Objective visual acuity testing is to be provided once during ages 11 through 18. The screening consists of a visual acuity test e.g., Allen Cards, Snellen chart or HOTV Test in each eye.
- ✓ Hearing: Subjective by history to include concerns regarding school, home and communicative performance.
- ✓ Exam: The provider also conducts a physical examination of all body systems to include measurements of height and weight, temperature, pulse, checking blood pressure, and determining a Body Mass Index (BMI).
- ✓ Anticipatory Guidance: Age-appropriate anticipatory guidance is required to be given to parents in the areas of injury prevention, violence prevention, family interaction/communication, nutritional counseling and what to anticipate before the next visit.
- ✓ Lab: Hematocrit or hemoglobin is required for menstruating females and any at-risk child
- ✓ Lab for at-risk child: Urinalysis, tuberculin test, cholesterol screening and SDT screening are required; and pelvic exam for at-risk females.
- ✓ Dental reminder: Yearly dental reminder to take child to a qualified dental provider for a dental examination.
- ✓ Immunizations: Tdap, MCV4 (Meningococcal), HPV (Papilloma) and Influenza yearly.
- ✓ Catch-up Immunizations: MMR, HepB, Varicella, HepA, IPV and PPV (Pneumonia).
- ✓ Immunizations for High-Risk: PPV (Pneumonia)

18-YEAR-OLD VISIT

- ✓ Health history: At a minimum, an initial/interval history and a family social history (FSH). Also a history of occurrence since the last screen visit.
- ✓ Age-appropriate developmental and a behavioral surveillance screening (HEADDS):
 - Home
 - Activities
 - Suicide/Depression
 - Parent/Teen Interaction
 - Education
 - Danger/Drugs
 - Sexuality
- ✓ Vision: Objective visual acuity testing is to be provided once during ages 11 through 18. The screening consists of a visual acuity test e.g., Allen Cards, Snellen chart or HOTV Test in each eye.
- ✓ Hearing: Subjective by history to include concerns regarding school, home and communicative performance.
- ✓ Exam: The provider also conducts a physical examination of all body systems to include measurements of height and weight, temperature, pulse, checking blood pressure, and determining a Body Mass Index (BMI).
- ✓ Anticipatory Guidance: Age-appropriate anticipatory guidance is required to be given to parents in the areas of injury prevention, violence prevention, family interaction/communication, nutritional counseling and what to anticipate before the next visit.
- ✓ Lab: Hematocrit or hemoglobin is required for menstruating females and any at-risk child
- ✓ Lab for at-risk child: Urinalysis, tuberculin test, cholesterol screening and STD screening are required; and pelvic exam for at-risk females.
- ✓ Dental reminder Yearly dental reminder to take child to a qualified dental provider for a dental examination.
- ✓ Immunizations: Tdap, MCV4 (Meningococcal), HPV (Papilloma) and Influenza yearly.
- ✓ Catch-up Immunizations: MMR, HepB, Varicella, HepA, IPV and PPV (Pneumonia).
- ✓ Immunizations for High-Risk: PPV (Pneumonia)

19-YEAR-OLD VISIT - Optional

- ✓ Health history: At a minimum, an initial/interval history and a family social history (FSH). Also a history of occurrence since the last screen visit.
- ✓ Age-appropriate developmental and a behavioral surveillance screening (HEADDSS):
 - Home
 - Activities
 - Suicide/Depression
 - Parent/Teen Interaction
 - Education
 - Danger/Drugs
 - Sexuality
- ✓ Vision: Objective visual acuity testing is to be provided once during ages 11 through 18. The screening consists of a visual acuity test e.g., Allen Cards, Snellen chart or HOTV Test in each eye.
- ✓ Hearing: Subjective by history to include concerns regarding school, home and communicative performance.
- ✓ Exam: The provider also conducts a physical examination of all body systems to include measurements of height and weight, temperature, pulse, checking blood pressure, and determining a Body Mass Index (BMI).
- ✓ Anticipatory Guidance: Age-appropriate anticipatory guidance is required to be given to parents in the areas of injury prevention, violence prevention, family interaction/communication, nutritional counseling and what to anticipate before the next visit.
- ✓ Lab: Hematocrit or hemoglobin is required for menstruating females and any at-risk child
- ✓ Lab for at-risk child: Urinalysis, tuberculin test, cholesterol screening and STD screening are required; and pelvic exam for at-risk females.
- ✓ Dental reminder Yearly dental reminder to take child to a qualified dental provider for a dental examination.
- ✓ Immunizations: Tdap, MCV4 (Meningococcal), HPV (Papilloma) and Influenza yearly.
- ✓ Catch-up Immunizations: MMR, HepB, Varicella, HepA, IPV and PPV (Pneumonia).
- ✓ Immunizations for High-Risk: PPV (Pneumonia)

20-YEAR-OLD VISIT

- ✓ Health history: At a minimum, an initial/interval history and a family social history (FSH). Also a history of occurrence since the last screen visit.
- ✓ Age-appropriate developmental and a behavioral surveillance screening (HEADDSS):
 - Home
 - Activities
 - Suicide/Depression
 - Parent/Teen Interaction
 - Education
 - Danger/Drugs
 - Sexuality
- ✓ Vision: Objective visual acuity testing is to be provided once during ages 11 through 18. The screening consists of a visual acuity test e.g., Allen Cards, Snellen chart or HOTV Test in each eye.
- ✓ Hearing: Subjective by history to include concerns regarding school, home and communicative performance.
- ✓ Exam: The provider also conducts a physical examination of all body systems to include measurements of height and weight, temperature, pulse, checking blood pressure, and determining a Body Mass Index (BMI).
- ✓ Anticipatory Guidance: Age-appropriate anticipatory guidance is required to be given to parents in the areas of injury prevention, violence prevention, family interaction/communication, nutritional counseling and what to anticipate before the next visit.
- ✓ Lab: Hematocrit or hemoglobin is required for menstruating females and any at-risk child
- ✓ Lab for any at-risk child: Urinalysis, tuberculin test, cholesterol screening and STD screening are required; and pelvic exam for at-risk females.
- ✓ Dental reminder Yearly dental reminder to take child to a qualified dental provider for a dental examination.
- ✓ Immunizations: Tdap, MCV4 (Meningococcal), HPV (Papilloma) and Influenza yearly.
- ✓ Catch-up Immunizations: MMR, HepB, Varicella, HepA, IPV and PPV (Pneumonia).
- ✓ Immunizations for High-Risk: PPV (Pneumonia)

DIAGNOSIS AND TREATMENT

OAC 317:30-3-65.5

When a screening indicates the need for further evaluation of an individual's health, a referral for appropriate diagnostic studies or treatment services must be provided without delay. Diagnostic services are defined as those services necessary to fully evaluate defects, physical or behavioral health illnesses, or conditions.

Health care that is medically necessary to correct or ameliorate defects, physical or mental illnesses, or conditions must also be provided and will be under the Child Health/EPSDT benefits package. The defects, illnesses and conditions must have been discovered or shown to have increased in severity during a covered screening.

Federal Medicaid regulations also require the state to determine whether the service is medically necessary, and does not require the provision of any items or services that the state determines is not safe and effective, or that are considered experimental.

CHILD ABUSE

Instances of child abuse and/or neglect discovered through screenings and regular examinations are to be reported in accordance with State Law. Title 21, Oklahoma Statutes, Section 846, as amended, states in part: "Every physician or surgeon, including doctors of medicine and dentistry, licensed osteopathic providers, residents, and interns, examining, attending, or treating a child under the age of 18 years and every registered nurse examining, attending or treating such a child in the absence of a physician or surgeon, and every other person having reason to believe that a child under the age of 18 years has had physical injury or injuries inflicted upon him or her by other than accidental means where the injury appears to have been caused as a result of physical abuse or neglect, shall report the matter promptly to the county office of the Department of Human Services in the county wherein the suspected injury occurred. Providing it shall be a misdemeanor for any person to knowingly and willfully fail to promptly report an incident as provided above." Persons reporting such incidents of abuse and/or neglect in accordance with the law are exempt from prosecution in civil or criminal suits that might be brought solely as a result of the filing of the report.

PRIOR AUTHORIZATION

Selected services for children covered under *SoonerCare* funding may require prior authorization. This will be determined by medical necessity. The OHCA's Medical Authorization Unit in coordination with the physician of the Medical Review Unit makes the determination.

When submitting a request for a prior authorization the following process should be followed:

- Occupational, Physical, and Speech Therapy- Complete the HCA-12A Form (must be completed by qualified provider), along with appropriate prescription (Rx) and/or evaluation for services needed.
- Requests for appliances, prostheses, and/or medical equipment, and medical supplies (e.g., hearing aids, eyeglasses, etc.) are submitted using the HCA-12A Form.

The HCA-12A Form can be accessed at the following link:

<http://okhca.org/WorkArea/showcontent.aspx?id=4601>

Submit to: Oklahoma Health Care Authority
Attn: Medical Authorization Unit
4545 N. Lincoln Blvd., Suite 124
Oklahoma City, OK 73105

- Dental services requiring a prior authorization will be submitted to the OHCA's Dental Services Unit using the HCA-12A Form (see sample form on the OHCA website).
- Medical Authorization Unit receives the request, confirms member eligibility and checks for duplication of services.
- An internal process determines medical necessity. Upon approval, the Medicaid Management Information Systems (MMIS) generates a prior authorization notification to the vendor and member.
- Upon receipt of prior authorization, the provider may render services and bill for these services as outlined in the notification letter; if *SoonerCare* eligibility is maintained.
- Children in the *SoonerCare* program require a referral from his/her PCP in addition to a prior authorization for services to be reimbursed.

Questions regarding prior authorization may be directed to the OHCA Medical Authorization Unit at 1-800-522-0114 or 405-522-6205 (option #9).

REFERRAL PROCEDURES

SoonerCare Choice members' PCPs may give referrals for medically necessary specialty and follow-up services identified through Child Health/EPSDT screens. **Referrals do not replace the OHCA prior authorization process.** Services that require a prior authorization from OHCA will need both a referral and a prior authorization.

- A PCP referral must be obtained prior to the member's visit for the referred services.
- OHCA will not reimburse the specialty provider without a referral.
- The referral number must be in box 17a on the HCFA 1500 form and box 83 on the UB 92 form.
- With the PCP's approval, the referral may be copied to other specialists and ancillary service provider with instructions considered necessary for proper treatment.
- Documentation in the medical record includes a medical report from the provider to whom the referral was made. The referred provider reports his/her findings to the referring provider within two weeks of the member's appointment. In the event a medical report is not received within a reasonable amount of time, the PCP contacts the health care provider to whom the referral was made to ensure receipt.

Self-referred services that do not require a referral from the PCP are:

- **Emergency care**
- **Dental services**
- **Vision services**
- **Hearing services**
- **Family planning services.**
- **Mental health services**
- **OB care**
- **Indian health benefits**
- **Child abuse exams.**

Unauthorized use of a *SoonerCare Choice* provider's number will result in official action to recover unauthorized reimbursements from the billing provider.

Physicians/Practitioners may contact the *SoonerCare* Administrative office at 877-823-4529, option 1, for additional assistance with referrals.

RESOURCES

OHCA staff and contractors are available to assist providers and *SoonerCare* members in accessing services by utilizing the most appropriate resources available to them. In addition, there are many community resources that may be helpful in the provision of follow-up assessments and treatments. Below is a list of both OHCA and community resources and contacts to assist providers in accessing appropriate services for *SoonerCare* members.

OHCA RESOURCES/CONTACTS

BEHAVIORAL HEALTH SERVICES - The OHCA Behavioral Health Services staff provides care management services to *SoonerCare* members in need of ongoing mental health care and treatment. Additionally, staff helps practitioners and others in the community who need assistance on behalf of *SoonerCare* members in locating and accessing appropriate behavioral health treatment services. For assistance with behavioral health issues call: 800-652-2010.

CARE MANAGEMENT - The OHCA Care Management team facilitates and coordinates the delivery of health care to *SoonerCare* members, by utilizing the most appropriate physicians/practitioners, resources and facilities within the scope of the Oklahoma *SoonerCare* program.

Care Management Department Structure:

- Geographical Region coverage
 - Director, Supervisors, Senior Exceptional Needs Coordinators
 - Exceptional Needs Coordinators (RNs); Exceptional Needs Associates (LPNs)

Services Performed:

- Coordinate care for members with complex medical needs and/or exceptional health care costs.
- Facilitate and coordinate discharge planning with physicians/practitioners, facilities and members. Includes reviewing and negotiating member's out-of-state care when comparable in-state services are not available.
- Case management of children receiving skilled nursing services. Includes periodic home visits to certify skilled nursing hours.
- Case Management of members in Breast and Cervical Cancer Program.
- Transplant Case Management
- Focused outreach to identified populations (Frequent ER Utilization, large transitional events)
- Specialty referral assistance for Primary Care Providers.
- Legislative inquiries.
- Evaluation for:
 - Drug-seeking behavior / poly-pharmacy / lock-in
 - Multiple providers
 - High-service utilization

Access to Care Management Department

- Toll-Free Care Mgt Dedicated Referral line 1-877-252-6002

CHILD HEALTH SERVICES/EPSDT UNIT

The OHCA Child Health Services unit coordinates and monitors the Child Health/EPSDT program. Additionally, staff provides education for parents and providers regarding Child Health/EPSDT services and performs provider outreach.

Access to Child Health Unit: (405)522-7188 or childhealthunit@okhca.org

Additional OHCA Contacts: 1-800-522-0114 or 405-522-6205

- **Behavioral Health Authorizations** **Option 6, 2**
- **Dental Authorizations** **Option 6, 5**
- **Pharmacy Authorizations** **Option 6, 1**
- **Pharmacy Issues** **Option 4**
- **Provider Contracts** **Option 5**
- **OHCA Call Center** **Option 1**
 - Claim status, eligibility inquiries, or policy questions
 - Status of medical authorizations

COMMUNITY RESOURCES

Child Health staff works with school districts, the Oklahoma State Department of Education and the Oklahoma State Department of Health in maximizing Child Health/EPSTD and Early Intervention (EI)/SoonerStart services to *SoonerCare* members through school-based and early intervention services.

EPSTD SCHOOL-BASED SERVICES - School districts may contract with OHCA to seek reimbursement for medically necessary Child Health/EPSTD covered services provided to *SoonerCare* members while attending school. Some services include:

- Speech therapy/evaluation
- Occupational therapy/evaluation
- Physical therapy/evaluation
- Assistive technology
- Hearing and Vision services
- Nursing services
- Psychological services
- Personal Care services

For questions regarding school-based services please contact OHCA Child Health Unit at (405) 522-7188.

EARLY INTERVENTION (E.I.) SERVICES

SoonerStart is Oklahoma's Early Intervention Program serving infants and toddlers with developmental delays from birth to 36 months. It is a joint effort of the Oklahoma Department of Education, Oklahoma State Department of Health, Oklahoma Department of Human Services, Oklahoma Department of Mental Health and Substance Abuse Services and the Oklahoma Health Care Authority.

Coordinating their efforts is the Oklahoma Commission on Children and Youth. There is no direct cost to families for services regardless of their income. This program is mandated by federal and state law and is funded through various state and federal resources.

SoonerStart recognizes the vital role of the family, and uses a family-centered approach when planning and providing services for a child.

The program can assist parents in understanding their child's developmental delays and the many services and resources available to them.

These services include:

- Parent Education and Counseling
- Nutritional, Social Work, Nursing
- Occupational and Physical Therapy
- Speech-language Therapy
- Special Instruction

CHILDREN FIRST (C1)

The Children First program is a community-based voluntary family resource program which offers home visitation to families expecting to deliver and/or parent their first child. The program encourages early and continuous prenatal care, personal development, and the involvement of fathers, grandparents and other supporting persons in parenting.

Public Health Nurses provide home visitation services during pregnancy and the first two years of the child's life. Activities are designed to be responsive to the developmental needs of mothers, children, and families during pregnancy and early parenthood.

Women meeting the following enrollment criteria:

- Pregnant woman less than 28 weeks gestation;
- Families expecting to deliver and/or parent their first child; and
- Families with little financial or social support.

The following services are provided at no cost to participating families:

- Brief Health Assessments of Mother and Child;
- Child Development Assessments;
- Parenting Education;
- Nutritional Education;
- Health and Safety Information;
- Linking families with services for health care, child care, mental health and job training; and
- Referrals to appropriate community service agencies.

For questions regarding EI and C1 Services, contact the Oklahoma State Department of Health at 405-271-9444.

CHILD GUIDANCE

Child Guidance is a public health program operating through county health departments. Its purpose is to promote optimal development, health behavior, and effective interaction for families with children under the age of 14.

Child Guidance services are based on the belief that all families can benefit from information and resources to assist them in guiding and nurturing their children. Services vary by county, but most often include child development, psychosocial, speech-language and hearing assessments and services.

Examples of typical concerns are:

- Parent-Child Relationships
- Guidance and Discipline
- Children's Behavior
- Communication Skills
- Child Development
- Speech and Language

For questions regarding Child Guidance services, contact your local county health department or the State Department of Health/Maternal and Child Health Services at 405-271-4477.

Additional Resources

- *SoonerCare* eligibility guidelines—contact local OKDHS county office
- Assistive Technology consultation and assistance:
 - Oklahoma ABLE Tech(800) 257-1705 (V/TDD) or (405) 744-9748
 - Oklahoma Assistive Technology Center (800) 700-OATC or (405) 271-1705 (TDD)
- Oklahoma Area wide Services Information System (OASIS) 1-800-42-OASIS
- SoonerRide 1-877-404-4500
- Behavioral Health:
 - Child Study Center.....(405) 271-6824
 - Children's Mental Health Coalition

HEARING, VISION AND DENTAL SERVICES

Hearing, vision and dental services are subject to their own periodicity schedules. However, age-appropriate hearing, vision and dental cursory screens must be performed as a part of the Child Health/EPSTDT screening. Additionally, it is recommended that all children receive further screening and/or treatments.

HEARING SERVICES

At a minimum, hearing services include hearing evaluations once every 12 months, hearing aid evaluation if indicated and purchase of a hearing aid when prescribed by a state licensed audiologist who meets the criteria listed in OAC 317-30-3-65.9. Interperiodic hearing examinations are allowed at intervals outside the periodicity schedule when a hearing condition is suspected (refer to OAC 317:30-5-676 for amount, duration and scope).

AUDIOMETRY TEST and EAR IMPRESSION (FOR EARMOLD)

Audiometric test (Immittance [Impedance] audiometry or tympanometry) includes bilateral assessment of middle ear status and reflex studies (when appropriate) provided by a state licensed speech pathologist or audiologist.

Ear impression includes taking impression of a member's ear and providing a finished ear mold which is used with the member's hearing aid provided by a state-licensed speech pathologist or audiologist.

VISION SERVICES

At a minimum, vision services include diagnosis and treatment for defects in vision; including eyeglasses once each 12 months. In addition, payment is made for glasses for children with congenital aphakia or following cataract removal (refer to OAC 317:30-3-65.7 for amount, duration and scope).

DENTAL SCREENING-SERVICES

An oral dental examination may be included in the screening and as a part of the nutritional status assessment. Federal regulations require provisions for dental services in accordance with the state's dental periodicity schedule and at other intervals as medically necessary. Therefore, when an oral examination is done at the time of the screening, the child may be referred directly to a dentist for further screening and/or treatment. Specific dental services are outlined in OAC 317:30-3-65.8.

BILLING

All comprehensive screenings provided to members under age 21 must be filed on a HCFA-1500 using the appropriate preventive medicine procedure code or an appropriate Evaluation and Management code from the Current Procedural Terminology Manual (CPT). The codes listed below are the only codes identified for use in claiming and reporting of EPSDT screens. In addition, these are the only codes that will be counted toward the Child Health/EPSDT bonus payment.

EPSDT SCREENING CODES:

- 99381-** Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new member; infant (age under 1 year)
- 99382** – Early childhood (age 1 through 4 years)
- 99383** - Late childhood (age 5 through 11 years)
- 99384** - Adolescent (age 12 through 17 years)
- 99385** - 18-39 years
- 99391-** Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunizations, laboratory/diagnostic procedures, established member; infant (age under 1 year)
- 99392** - Early childhood (age 1 through 4 years)
- 99393** - Late childhood (age 5 through 11 years)
- 99394** - Adolescent (age 12 through 17 years)
- 99395** - 18-39 years
- 99431** - History and examination for the normal newborn infant, initiation of diagnostic and treatment programs and preparation of hospital records. (This code should also be used for birthing room deliveries.)
- 99432** - Normal newborn care in other than hospital or birthing room setting, including physical examination of baby and conferences with parents

NOTE: A partial screening may be paid if the provider cannot provide all of the minimum components of the screening. A partial screen should not be billed as a Child Health/EPSDT screen, instead, should be billed using the appropriate CPT code.

Additionally, the following procedure codes may be used to indicate an EPSDT screen when accompanied by one of the V diagnosis codes: V20 - V20.2, and/or V70.0, and V70.3 - V70.9

- 99201** - Office or other outpatient visit for the evaluation and management of a new member, which requires these three key components:
- A problem focused history;
 - A problem focused examination; and
 - Straightforward medical decision making
- Usually, the presenting problems are self limited or minor. Physicians/Practitioners typically spend 10 minutes face-to-face with the member and/or family.
- 99202** - Office or other outpatient visit for the evaluation and management of a new member, which requires these three key components:
- An expanded problem focused history;
 - An expanded problem focused examination; and
 - Straightforward medical decision making
- Usually, the presenting problem(s) are of low to moderate severity. Physicians/Practitioners typically spend 20 minutes face-to-face with the member and/or family.
- 99203** - Office or other outpatient visit for the evaluation and management of a new member, which requires these three key components:
- A detailed history;
 - A detailed examination; and
 - Medical decision making of low complexity
- Usually, the presenting problem(s) are of moderate severity. Physicians/Practitioners typically spend 30 minutes face-to-face with the member and/or family.
- 99204** - Office or other outpatient visit for the evaluation and management of a new member, which requires these three:
- A comprehensive history;
 - A comprehensive examination; and
 - Medical decision making of moderate complexity
- Usually, the presenting problem(s) are of moderate to high severity. Physicians/Practitioners typically spend 45 minutes face-to-face with the member and/or family.
- 99205** - Office or other outpatient visit for the evaluation and management of a new member, which requires these three key components:
- A comprehensive history;
 - A comprehensive examination; and
 - Medical decision making of high complexity
- Usually, the presenting problem(s) are of moderate to high severity. Physicians/Practitioners typically spend 60 minutes face-to-face with the member and/or family.
- 99211**- For the evaluation and management of an established member, that may not require the presence of a physician. Usually, the presenting problems are minimal. Typically, five minutes are spent performing or supervising these services.

- 99212** - Office or other outpatient visit for the evaluation and management of an established member, which requires at least two of these three key components:
- A problem focused history;
 - A problem focused examination; and
 - Straightforward medical decision making
- Usually, the presenting problem(s) are self limited or minor. Physicians/Practitioners typically spend 10 minutes face-to-face with the member and/or family.
- 99213** - Office or other outpatient visit for the evaluation and management of an established member, which requires at least two of these three key components:
- An expanded problem focused history;
 - An expanded problem focused examination; and
 - Medical decision making of low complexity.
- Usually, the presenting problem(s) are of low to moderate severity. Physicians/Practitioners typically spend 15 minutes face-to-face with the member and/or family.
- 99214** - Office or other outpatient visit for the evaluation and management of an established member, which requires at least two of these three key components:
- A detailed history;
 - A detailed examination; and
 - Medical decision making of moderate complexity.
- Usually, the presenting problem(s) are of moderate to high severity. Physicians/Practitioners typically spend 25 minutes face-to-face with the member and/or family.
- 99215** - Office or other outpatient visit for the evaluation and management of an established member, which requires at least two of these three key components:
- A comprehensive history;
 - A comprehensive examination; and
 - Medical decision making of high complexity.
- Usually, the presenting problem(s) are of moderate to high severity. Physicians/Practitioners typically spend 40 minutes face-to-face with the member and/or family.

The following values are used to track treatment and referral of EPSDT services. A new drop down box has been added to the professional Internet claim form, the change affects both electronic and Internet claims. Please select the appropriate value when billing an EPSDT screen.

NU = Not used. This should be used when there was no identified problem found during the screening and the provider is not treating or referring the child for treatment.

AV = Available but not used. This should be used when a referral for diagnostic or corrective treatment was refused for all health problems identified.

S2 = Under treatment. This should be used when the patient is already under diagnostic or corrective treatment for all health problems identified.

ST = New Services Required. This should be used when referral for corrective treatment as a result of at least one health problem identified during an individual or periodic EPSDT screening service and were scheduled for another appointment with the screening provider or referred to another provider for further needed diagnostic or treatment services. (Do not include dental referrals).

EPSDT BONUS PAYMENT

OHCA has a total of \$1 million budgeted annually for the purpose of EPSDT bonus payments to be paid to *SoonerCare Choice* physicians/practitioners. If the total amount of bonus payments is \$1 million or less, each contractor that achieves an appropriate compliance rate will be paid accordingly; however should the total bonus payments exceed \$1 million the bonuses will be pro-rated and paid accordingly.

- Encounter claims shall be submitted within 60 days of the date of service.
- Denied claims shall be corrected and resubmitted within 60 days of adjudication.
- Compliance rate will be based on systems verification of encounter data submitted to OHCA no later than March 1st and corrected no later than May 1st of each year; **payment is based on “paid” encounter status (claims that resulted in actual payments will not be counted).**
- Annual bonus payment will not exceed 20 percent of the Contractor’s annual capitation payment for *SoonerCare*.
- Bonus payments are calculated according to specific age categories and expected number of screenings for age category. Contractor must achieve the threshold established in the contract or better compliance for EPSDT screenings for any of the five age categories listed below.

Age Categories

< 1
1
2-5
6-14
15-20

Refer to Attachment I of the *SoonerCare Choice* contract for number of expected screenings per age category.

Criteria for Calculating Bonus Payment

- Based on calendar year (Jan 1 – Dec 31);
- Contractor must maintain active contract status for full 12 months of calendar year;
- Actual age of child on date of service (DOS) screening was performed;
- # of screenings child should receive according to child’s age, during calendar year;
- # of member months in each age category;
- Prorated according to how long member on panel.

For further explanation of Compliance Rate and Bonus Payment Methodology and Example refer to Attachment I of the *SoonerCare* contract.

Avoiding Common Errors

- Verify member is assigned to PCP panel by checking eligibility prior to providing service (if enrolled with a different PCP or FFS, an EPSDT screen will not count toward bonus);
- Use the appropriate age category CPT codes (ex: 99391; established pt. under one year);
- Use appropriate V-diagnosis codes with E & M codes (ex: 99201 w/V20.2);
- Verify accuracy of claim before submitting (i.e., is the name correct as it appears on ID card; also do not use the SS# in place of Member ID); and
- Reconcile/resubmit denied encounters to get to “paid” status.

APPENDIX A

1905A Services

1905(a) services, deemed medically necessary and allowable under federal and Medicaid regulations, must be covered by the OHCA Child Health/EPSDT program even though those services may not be part of the Medicaid State Plan. However, such services may require a prior authorization and must be allowable under federal or Medicaid regulations.

- inpatient hospital services;
- outpatient hospital services;
- rural health clinic services, any other ambulatory services which are offered by a rural health clinic;
- Federally-qualified health center services, any other ambulatory services which are offered by a Federally-qualified health center;
- other laboratory and X-ray services;
- nursing facility services (other than services in an institution for mental diseases);
- early and periodic screening, diagnosis and treatment services;
- family planning services and supplies;
- physician services;
- physical therapy and related services;
- prescribed drugs, dentures and prosthetic devices, and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;
- services in an intermediate care facility for the mentally retarded;
- inpatient psychiatric hospital services for individuals under 21;
- services furnished by a nurse-midwife;
- hospice care;
- case management services and TB-related services;
- respiratory care services;
- services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner;
- personal care services;
- primary care case management;
- services furnished under a PACE program; and
- any other medical care, and any other type of remedial (counter act, repair or cure) care recognized under State law.

APPENDIX B

Joint Committee on Infant Hearing Risk Factors

Indicators of Infants at Risk of Late Onset or Progressive Hearing Loss

An infant with any of these risk factors for hearing loss and who has passed the birth screen should have audiological monitoring every six months until age three years. From Joint Committee on Infant Hearing (JCIH) 2000 position statement on the Web at: <http://www.jcih.org/jcih2000.pdf>

JCIH risk indicators, birth through age 28 days

- An illness or condition requiring admission of 48 hours or greater to a NICU;
- Stigmata or other findings associated with a syndrome known to include a sensorineural and or conductive hearing loss;
- Family history of permanent childhood sensorineural hearing loss;
- Craniofacial anomalies, including those with morphological abnormalities of the pinna and ear canal and;
- In-utero infection such as cytomegalovirus, herpes, toxoplasmosis, syphilis or rubella.

JCIH risk indicators, 29 days through 2 years

- Parental or caregiver concern regarding hearing, speech, language, and or developmental delay;
- Family history of permanent childhood hearing loss;
- Stigmata or other findings associated with a syndrome known to include a sensorineural or conductive hearing loss or eustachian tube dysfunction;
- Postnatal infections associated with sensorineural hearing loss including bacterial meningitis;
- In-utero infections such as cytomegalovirus, herpes, rubella, syphilis, and toxoplasmosis;
- Neonatal indicators—specifically hyperbilirubinemia at a serum level requiring exchange transfusion, persistent pulmonary hypertension of the newborn associated with mechanical ventilation, and conditions requiring the use of extracorporeal membrane oxygenation (ECMO);
- Syndromes associated with progressive hearing loss such as neurofibromatosis, osteopetrosis, and Usher's syndrome;
- Neurodegenerative disorders, such as Hunter syndrome, or sensory motor neuropathies, such as Friedreich's ataxia and Charcot-Marie-Tooth syndrome;
- Head trauma and;
- Recurrent or persistent otitis media with effusion for at least 3 months.

During the well baby visits in the medical home, all late-onset indicators should be determined and monitored for normal communication development during their routine medical care. The JCIH recommends ongoing audiologic and medical monitoring of infants with unilateral, mild or chronic conductive hearing loss. These infants may have speech, language and communication delays. Infants with unilateral loss are at risk for bilateral hearing loss. Fluctuating conductive hearing loss may occur with recurrent or persistent otitis media with effusion.

APPENDIX C

Developmental Surveillance and Screening

What are the goals of developmental surveillance and developmental screening and how are they different?

The goals of developmental surveillance and screening are to identify children who may need more comprehensive evaluation. The American Academy of Pediatrics defines developmental surveillance and developmental screening as different but complementary processes.¹

Developmental surveillance is a longitudinal, flexible, and cumulative process in which the health professional elicits any concerns that the parent might have, asks about developmental history, and observes the infant or child. Surveillance occurs at every EPSDT well-child visit (as well as every acute visit when possible).

Developmental screening, on the other hand, requires the use of a **standardized validated instrument** with all children at specific ages. Developmental surveillance using clinical judgment alone (without intermittent supplementation of a standardized screening tool) detects only 30 percent of children with delays.²⁻⁶ However, when surveillance is performed in combination with intermittent use of a standardized screening tool, detection rates have been shown to increase as much as threefold.^{7,8}

Why are developmental surveillance and screening important?

Surveillance and screening communicate the primary care provider's interest in the child's development, not just his or her physical health. These processes also assist in identifying children, especially those with less obvious delays or risk factors, who may benefit from more comprehensive evaluation. Improving earlier detection increases the number of children who can obtain maximal benefit from interventions known to optimize their health and well-being.

Scientific support for early identification and intervention: A recent explosion of evidence from neuroscience and developmental research validates the long-held belief that early life experience has a profound impact on the structure and function of the brain and ultimately, on a child's functional capacity in adulthood.⁹⁻¹¹ Because primary care providers are often the only professionals with whom children have contact prior to school age, medical providers have a vital role in identifying children who could potentially benefit from referral to early intervention. This importance is reflected in mandates regarding early intervention and identification and demonstrated in surveys indicating parents' interest in receiving guidance regarding their children's development and behavior.

Federal mandates require early identification and intervention: [The Individuals with Disabilities Education Act \(IDEA\) Amendments of 1990 to 1997](#) require states to provide early identification and provision of services to infants and toddlers with 1) developmental delays, 2) established conditions that are associated with developmental delays, and 3) at the state's option, children at risk for developmental delays. States that do not serve the at-risk population are encouraged to track and

monitor these children's development, so that they may be referred in the future if needed. IDEA also mandates that states refer children, free of charge, for a comprehensive, multidisciplinary evaluation by a team who, with the family, decides on which services are needed for the child. The [National Early Childhood Technical Assistance Center](#) lists early intervention programs by state and provides their contact information for interested parents and professionals.

In Oklahoma, medical providers needing to refer a child from 0-3 years of age for a free developmental assessment should contact [Sooner Start](#), the state Early Intervention program, with offices in counties throughout the state.

Parents are interested in knowing more about their child's development and behavior but primary care providers face significant barriers to providing this aspect of care. Surveys of parents indicate that they desire information and guidance from their health care provider about their child's development and behavior.^{12, 13} Other studies show that a majority of primary care providers feel inadequately trained or too time-pressured to accurately assess children's developmental or behavioral status or to provide related guidance in these areas.^{14, 15}

Current rates of identification and referral: In the US, prevalence rates vary between studies but it is commonly held that 12-17% of children have a developmental and/or behavioral disability, such as language/learning disabilities, [autism](#), [mental retardation](#), and [Attention-Deficit/Hyperactivity Disorder](#), among others.^{16, 17} However, less than half of all children with these conditions are identified before starting school, by which time opportunities for early intervention have been missed and significant delays (or preventable secondary morbidity) may have already occurred.^{4, 16, 17}

What are the OHCA's requirements for developmental surveillance and screening within EPSDT?

OHCA recommends physicians/practitioners follow the American Academy of Pediatrics most recent practice guidelines regarding surveillance and screening for children aged 0-3.¹ These guidelines contain an algorithm to guide these processes.

Summary of surveillance and screening steps in the algorithm:

1. Developmental surveillance should occur at **every** EPSDT well-child visit. Recommended surveillance activities include
 - Directly asking parents about their child's progress, for example: "Do you have any concerns about your child's behavior, development, or learning?"
 - Promptly addressing any concerns raised during surveillance with a standardized developmental screening test (at that visit or at a follow-up visit scheduled in the near future).

2. Regardless of concerns, physicians/practitioners should supplement surveillance by using a standardized, validated screening tool **for every child between the ages of 0-3 years**, at the following ages:
 - **9, 18, (24)*, 30 months**
 - **Note 1:** this means physicians/practitioners are **NOT REQUIRED** to use a screening instrument at **EVERY EPSDT visit**.
 - ***Note 2:** 30 months is the preferred age for administering a validated screening tool but if physicians/practitioners prefer to see children at 24 months instead of 30 months, a standard screen should be used at the 24-month visit.
 - **Note 3:** The algorithm does not recommend a specific tool for use, nor does OHCA, however, many physicians/practitioners report that the **Pediatric Evaluation of Developmental Status (PEDS)** or the **Ages and Stages Questionnaire (ASQ)** are their tools of choice for general screening because they can be completed by most parents and take minimal time for the provider. These brief instruments cover all areas of development and guide whether a child should be referred for further assessment. For concerns about autism spectrum disorders, many providers use the **Modified Checklist for Autism in Toddlers (M-CHAT)**.
 - Websites for these tools
 - **PEDS** - www.pedstest.com
 - **ASQ** - www.brookespublishing.com
 - **M-CHAT** - www.firstsigns.org (available for free)
3. If a screen indicates a risk for delay, the child should have appropriate medical and subspecialty evaluations. For example, a physician/practitioner might want to initiate or refer the child for a genetic and other lab and imaging work up. The algorithm also recommends referral for further developmental evaluation.
 - Every child age 0-3 years suspected of or at risk for delays can receive a free evaluation from [SoonerStart](#), the state Early Intervention program, with offices in counties throughout the state. Providers can make referrals to this system (but parents must make referrals to the public school system-see below).
 - Other referrals may be given to a developmental pediatrician, child psychiatrist, pediatric neurologist, and/or geneticist as appropriate.
 - For children older than 3, providers should provide information to parents on how to contact the public school system to request an evaluation for their child. Most children aged 3-5 years who have developmental issues are usually eligible to receive services in the public school system prior to starting kindergarten.

REFERENCES

1. American Academy of Pediatrics. Identifying Infants and Young Children with Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening. *Pediatrics*. 2006; 118(1):405-420. Available at: <http://aappolicy.aappublications.org>.
2. Bierman JM, Connor A, Vaage M, Honzik MP. Pediatrician's assessments of the intelligence of 2 year olds and their mental scores. *Pediatrics* 1964;34(5):680-690.
3. Korsch B, Cobb K, Ashe B. Pediatricians' appraisals of patient's intelligence. *Pediatrics*. 1967;27:990-1003.
4. First LR, Palfrey JS. The infant or young child with developmental delay. *New England Journal of Medicine*. 1994;330(7):478-483.
5. Lavigne JV, Binns HJ, Christoffel KK, et al. Behavioral and emotional problems among preschool children in pediatric primary care: prevalence and pediatricians' recognition. Pediatric Practice Research Group. *Pediatrics*. 1993;91(3):649-655.
6. Glascoe FP, Dworkin PH. Obstacles to effective developmental surveillance: Errors in clinical reasoning *Developmental and Behavioral Pediatrics*. 1993;14(5):344-349.
7. Squires J, Nickel RE, Eisert D. Early detection of developmental problems: strategies for monitoring young children in the practice setting. *Journal of Developmental and Behavioral Pediatrics*. 1996;17(6):420-427.
8. Sturner RA. Parent questionnaires: basic office equipment? *Journal of Developmental and Behavioral Pediatrics*. 1991;12(1):51-54.
9. National Research Council, Institute of Medicine. *From Neurons to Neighborhoods: The Science of Early Childhood Development*. Washington, DC: National Academies Press; 2000.
10. Kessler RC, Davis CG, Kendler KS. Childhood Adversity and Adult Psychiatric Disorder in the U.S. National Comorbidity Study. *Psychological Medicine*. 1997;27(5):1101-1119.
11. Forrest CB, Riley AW. Childhood Origins Of Adult Health: A Basis For Life-Course Health Policy. *Health Affairs*. 2004;23(5):155-164.
12. Young KT, Davis K, Schoen C. *The Commonwealth Fund Survey of Parents with Young Children*. New York, NY: Commonwealth Fund; August 1996. Available at: http://www.cmwf.org/usr_doc/172_parentssurvey.pdf
13. Halfon N, Inkelas M, Abrams M, Stevens G. *Quality of Preventive Health Care for Young Children: Strategies for Improvement*. New York, NY: The Commonwealth Fund; May 2005.
14. Sand N, Silverstein M, Glascoe FP, Gupta VB, Tonniges TP, O'Connor KG. Pediatricians' Reported Practices Regarding Developmental Screening: Do Guidelines Work? Do They Help? *Pediatrics*. 2005;116(1):174-179.
15. Sices L, Feudtner C, McLaughlin J, Drotar D, Williams M. How Do Primary Care Physicians Identify Young Children with Developmental Delays? A National Survey. *Journal of Developmental and Behavioral Pediatrics*. 2003;24(6).
16. Boyle CA, Decoufle P, Yeargin-Allsopp M. Prevalence and Health Impact of Developmental Disabilities in US Children. *Pediatrics*. 1994;93(3):399-403.
17. van Dyck PC, Kogan MD, McPherson MG, et al. Prevalence and characteristics of children with special health care needs. *Archives of Pediatrics and Adolescent Medicine*. 2004;158(9):884-890.

APPENDIX D

OHCA CHILD HEALTH SCREENING
PERIODICITY SCHEDULES

OK PERIODICITY SCHEDULE

	INFANCY							EARLY CHILDHOOD							
	NEW BORN INPT	1 WEEK Optional	By 1 MONTH	2 MONTH	4 MONTH	6 MONTH	9 MONTH	12 MONTH	15 MONTH Optional	18 MONTH	24 MONTH	3 YRS	4 YRS	5 YRS	
● - To be performed S - Subjective by history O - Objective by testing A - At risk Δ - If not performed at school															
HISTORY															
Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
MEASUREMENTS															
Height and Weight	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
Head Circumference	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
Blood Pressure												●	●	●	
BMI													●	●	
SENSORY SCREENING															
Vision	●	S	●	●	●	O	<-O----->		S	S	S	<-----O----->			
Hearing	●	S	S	S	S	S	S	S	S	S	S	S	O	Δ	
DEVELOPMENTAL / BEHAVIORAL ASSESSMENT	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
PHYSICAL EXAMINATION	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
PROCEDURES - GENERAL															
Hereditary / Metabolic Screening	●	Test if not previously tested													
Immunization	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
Hematocrit or Hemoglobin							<-●----->		A	A	A	A	A		
Urinalysis															
PROCEDURES - MEMBERS AT RISK															
Lead Screening						S	<-----●-->		S	S	●	Test if not previously tested			
Tuberculin Test								A	A	A	A	A	A	A	
Cholesterol Screening											A	A	A	A	
STD Screening															
Pelvic Exam															
ANTICIPATORY GUIDANCE															
Injury Prevention	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
Violence Prevention	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
Sleep Positioning Counseling	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
Nutritional Counseling	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
DENTAL REMINDER								<-----●-->					S	S	

Keys:

- = Indicates this element is to be performed
- S = Subjective; perform if indicated by history
- 0 = Objective; to be performed utilizing an approved standard testing method
- A = to be performed for members at risk
- Δ = to be performed, if not performed at school
- <-•-> = the range during which a service may be provided, with the • symbol indicating the preferred age

	MIDDLE CHILDHOOD					ADOLESCENCE							
<ul style="list-style-type: none"> ●- To be performed S- Subjective by history O- Objective by history A- At risk Δ- If not performed at school 	6 YRS	8 YRS	10 YRS	11 YRS Optional	12 YRS	13 YRS Optional	14 YRS	15 YRS Optional	16 YRS	17 YRS Optional	18 YRS	19 YRS Optional	20 YRS
HISTORY													
Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS													
Height and Weight	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference													
Blood Pressure	●	●	●	●	●	●	●	●	●	●	●	●	●
BMI	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING													
Vision	O	O	O	←-----O-----→								S	S
Hearing	Δ	Δ	Δ	S	S	S	S	S	S	S	S	S	S
DEVELOPMENTAL/ BEHAVIORAL ASSESSMENT	●	●	●	●	●	●	●	●	●	●	●	●	●
PHYSICAL EXAMINATION	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES - GENERAL													
Hereditary / Metabolic Screening													
Immunization	●	●	●	●	●	●	●	●	●	●	●	●	●
Hematocrit or Hemoglobin				A	A	A	A	A	A	A	A	A	A
Menstruating Females				A	A	A	A	A	A	A	A	A	A
Urinalysis				A	A	A	A	A	A	A	A	A	A
PROCEDURES-MEMBERS AT RISK													
Lead Screening													
Tuberculin Test	A	A	A	A	A	A	A	A	A	A	A	A	A
Cholesterol Screening	A	A	A	A	A	A	A	A	A	A	A	A	A
STD Screening				A	A	A	A	A	A	A	A	A	A
Pelvic Exam				A	A	A	A	A	A	A	A	A	A
ANTICIPATORY GUIDANCE													
Injury Prevention	●	●	●	●	●	●	●	●	●	●	●	●	●
Violence Prevention	●	●	●	●	●	●	●	●	●	●	●	●	●
Sleep Positioning Counseling													
Nutritional Counseling	●	●	●	●	●	●	●	●	●	●	●	●	●
DENTAL REMINDER	S	S	S	S	S	S	S	S	S	S	S	S	S

Keys:

- = Indicates this element is to be performed
- S = Subjective; perform if indicated by history
- 0 = Objective; to be performed utilizing an approved standard testing method
- A = to be performed for members at risk
- Δ = to be performed, if not performed at school
- <-•-> = the range during which a service may be provided, with the • symbol indicating the preferred age

APPENDIX E

✓ IMMUNIZATION SCHEDULES

Recommended Immunization Schedule for Persons Aged 0–6 Years—UNITED STATES • 2007

Vaccine ▼	Age ►	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19–23 months	2–3 years	4–6 years
Hepatitis B ¹	HepB	HepB	HepB	see footnote 1	HepB	HepB	HepB	HepB	HepB	HepB Series		
Rotavirus ²				Rota	Rota	Rota						
Diphtheria, Tetanus, Pertussis ³			DTaP	DTaP	DTaP	DTaP	DTaP	DTaP	DTaP			DTaP
<i>Haemophilus influenzae</i> type b ⁴			Hib	Hib	Hib ⁴	Hib	Hib	Hib	Hib	Hib		
Pneumococcal ⁵			PCV	PCV	PCV	PCV	PCV	PCV	PCV	PCV	PPV	
Inactivated Poliovirus			IPV	IPV	IPV	IPV	IPV	IPV	IPV	IPV		
Influenza ⁶							Influenza (Yearly)					
Measles, Mumps, Rubella ⁷							MMR	MMR	MMR	MMR		MMR
Varicella ⁸							Varicella	Varicella	Varicella	Varicella		Varicella
Hepatitis A ⁹							HepA (2 doses)			HepA Series		
Meningococcal ¹⁰												MPSV4

Range of recommended ages

Catch-up immunization

Certain high-risk groups

This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2006, for children aged 0–6 years. Additional information is available at <http://www.cdc.gov/nip/recs/child-schedule.htm>. Any dose not administered at the recommended age should be administered at any subsequent visit, when indicated and feasible. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and

other components of the vaccine are not contraindicated and if approved by the Food and Drug Administration for that dose of the series. Providers should consult the respective Advisory Committee on Immunization Practices statement for detailed recommendations. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at <http://www.vaers.hhs.gov> or by telephone, **800-822-7967**.

1. Hepatitis B vaccine (HepB). (Minimum age: birth)

At birth:

- Administer monovalent HepB to all newborns before hospital discharge.
- If mother is hepatitis surface antigen (HBsAg)-positive, administer HepB and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth.
- If mother's HBsAg status is unknown, administer HepB within 12 hours of birth. Determine the HBsAg status as soon as possible and if HBsAg-positive, administer HBIG (no later than age 1 week).
- If mother is HBsAg-negative, the birth dose can only be delayed with physician's order and mother's negative HBsAg laboratory report documented in the infant's medical record.

After the birth dose:

- The HepB series should be completed with either monovalent HepB or a combination vaccine containing HepB. The second dose should be administered at age 1–2 months. The final dose should be administered at age ≥24 weeks. Infants born to HBsAg-positive mothers should be tested for HBsAg and antibody to HBsAg after completion of ≥3 doses of a licensed HepB series, at age 9–18 months (generally at the next well-child visit).

4-month dose:

- It is permissible to administer 4 doses of HepB when combination vaccines are administered after the birth dose. If monovalent HepB is used for doses after the birth dose, a dose at age 4 months is not needed.

2. Rotavirus vaccine (Rota). (Minimum age: 6 weeks)

- Administer the first dose at age 6–12 weeks. Do not start the series later than age 12 weeks.
- Administer the final dose in the series by age 32 weeks. Do not administer a dose later than age 32 weeks.
- Data on safety and efficacy outside of these age ranges are insufficient.

3. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP). (Minimum age: 6 weeks)

- The fourth dose of DTaP may be administered as early as age 12 months, provided 6 months have elapsed since the third dose.
- Administer the final dose in the series at age 4–6 years.

4. *Haemophilus influenzae* type b conjugate vaccine (Hib). (Minimum age: 6 weeks)

- If PRP-OMP (PedvaxHIB[®] or ComVax[®] [Merck]) is administered at ages 2 and 4 months, a dose at age 6 months is not required.
- TriHiBit[®] (DTaP/Hib) combination products should not be used for primary immunization but can be used as boosters following any Hib vaccine in children aged ≥12 months.

5. Pneumococcal vaccine. (Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPV])

- Administer PCV at ages 24–59 months in certain high-risk groups. Administer PPV to children aged ≥2 years in certain high-risk groups. See *MMWR* 2000;49(No. RR-9):1–35.

6. Influenza vaccine. (Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 5 years for live, attenuated influenza vaccine [LAIV])

- All children aged 6–59 months and close contacts of all children aged 0–59 months are recommended to receive influenza vaccine.
- Influenza vaccine is recommended annually for children aged ≥59 months with certain risk factors, health-care workers, and other persons (including household members) in close contact with persons in groups at high risk. See *MMWR* 2006;55(No. RR-10):1–41.
- For healthy persons aged 5–49 years, LAIV may be used as an alternative to TIV.
- Children receiving TIV should receive 0.25 mL if aged 6–35 months or 0.5 mL if aged ≥3 years.
- Children aged <9 years who are receiving influenza vaccine for the first time should receive 2 doses (separated by ≥4 weeks for TIV and ≥6 weeks for LAIV).

7. Measles, mumps, and rubella vaccine (MMR). (Minimum age: 12 months)

- Administer the second dose of MMR at age 4–6 years. MMR may be administered before age 4–6 years, provided ≥4 weeks have elapsed since the first dose and both doses are administered at age ≥12 months.

8. Varicella vaccine. (Minimum age: 12 months)

- Administer the second dose of varicella vaccine at age 4–6 years. Varicella vaccine may be administered before age 4–6 years, provided that ≥3 months have elapsed since the first dose and both doses are administered at age ≥12 months. If second dose was administered ≥28 days following the first dose, the second dose does not need to be repeated.

9. Hepatitis A vaccine (HepA). (Minimum age: 12 months)

- HepA is recommended for all children aged 1 year (i.e., aged 12–23 months). The 2 doses in the series should be administered at least 6 months apart.
- Children not fully vaccinated by age 2 years can be vaccinated at subsequent visits.
- HepA is recommended for certain other groups of children, including in areas where vaccination programs target older children. See *MMWR* 2006;55(No. RR-7):1–23.

10. Meningococcal polysaccharide vaccine (MPSV4). (Minimum age: 2 years)

- Administer MPSV4 to children aged 2–10 years with terminal complement deficiencies or anatomic or functional asplenia and certain other high-risk groups. See *MMWR* 2005;54(No. RR-7):1–21.

Recommended Immunization Schedule for Persons Aged 7–18 Years—UNITED STATES • 2007

Vaccine ▼	Age ▶	7–10 years	11–12 YEARS	13–14 years	15 years	16–18 years
Tetanus, Diphtheria, Pertussis ¹	see footnote 1		Tdap		Tdap	
Human Papillomavirus ²	see footnote 2		HPV (3 doses)		HPV Series	
Meningococcal ³		MPSV4	MCV4		MCV4³ MCV4	
Pneumococcal ⁴			PPV			
Influenza ⁵			Influenza (Yearly)			
Hepatitis A ⁶			HepA Series			
Hepatitis B ⁷			HepB Series			
Inactivated Poliovirus ⁸			IPV Series			
Measles, Mumps, Rubella ⁹			MMR Series			
Varicella ¹⁰			Varicella Series			



Range of recommended ages



Catch-up immunization



Certain high-risk groups

This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2006, for children aged 7–18 years. Additional information is available at <http://www.cdc.gov/nip/recs/child-schedule.htm>. Any dose not administered at the recommended age should be administered at any subsequent visit, when indicated and feasible. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and other components

of the vaccine are not contraindicated and if approved by the Food and Drug Administration for that dose of the series. Providers should consult the respective Advisory Committee on Immunization Practices statement for detailed recommendations. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at <http://www.vaers.hhs.gov> or by telephone, 800-822-7967.

1. Tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap).

(Minimum age: 10 years for BOOSTRIX® and 11 years for ADACEL™)

- Administer at age 11–12 years for those who have completed the recommended childhood DTP/DaP vaccination series and have not received a tetanus and diphtheria toxoids vaccine (Td) booster dose.
- Adolescents aged 13–18 years who missed the 11–12 year Td/Tdap booster dose should also receive a single dose of Tdap if they have completed the recommended childhood DTP/DaP vaccination series.

2. Human papillomavirus vaccine (HPV). (Minimum age: 9 years)

- Administer the first dose of the HPV vaccine series to females at age 11–12 years.
- Administer the second dose 2 months after the first dose and the third dose 6 months after the first dose.
- Administer the HPV vaccine series to females at age 13–18 years if not previously vaccinated.

3. Meningococcal vaccine. (Minimum age: 11 years for meningococcal conjugate vaccine [MCV4]; 2 years for meningococcal polysaccharide vaccine [MPSV4])

- Administer MCV4 at age 11–12 years and to previously unvaccinated adolescents at high school entry (at approximately age 15 years).
- Administer MCV4 to previously unvaccinated college freshmen living in dormitories; MPSV4 is an acceptable alternative.
- Vaccination against invasive meningococcal disease is recommended for children and adolescents aged ≥2 years with terminal complement deficiencies or anatomic or functional asplenia and certain other high-risk groups. See *MMWR* 2005;54(No. RR-7):1–21. Use MPSV4 for children aged 2–10 years and MCV4 or MPSV4 for older children.

4. Pneumococcal polysaccharide vaccine (PPV). (Minimum age: 2 years)

- Administer for certain high-risk groups. See *MMWR* 1997;46(No. RR-8):1–24, and *MMWR* 2000;49(No. RR-9):1–35.

5. Influenza vaccine. (Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 5 years for live, attenuated influenza vaccine [LAIV])

- Influenza vaccine is recommended annually for persons with certain risk factors, health-care workers, and other persons (including household members) in close contact with persons in groups at high risk. See *MMWR* 2006;55 (No. RR-10):1–41.
- For healthy persons aged 5–49 years, LAIV may be used as an alternative to TIV.
- Children aged <9 years who are receiving influenza vaccine for the first time should receive 2 doses (separated by ≥4 weeks for TIV and ≥6 weeks for LAIV).

6. Hepatitis A vaccine (HepA). (Minimum age: 12 months)

- The 2 doses in the series should be administered at least 6 months apart.
- HepA is recommended for certain other groups of children, including in areas where vaccination programs target older children. See *MMWR* 2006;55 (No. RR-7):1–23.

7. Hepatitis B vaccine (HepB). (Minimum age: birth)

- Administer the 3-dose series to those who were not previously vaccinated.
- A 2-dose series of Recombivax HB® is licensed for children aged 11–15 years.

8. Inactivated poliovirus vaccine (IPV). (Minimum age: 6 weeks)

- For children who received an all-IPV or all-oral poliovirus (OPV) series, a fourth dose is not necessary if the third dose was administered at age ≥4 years.
- If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.

9. Measles, mumps, and rubella vaccine (MMR). (Minimum age: 12 months)

- If not previously vaccinated, administer 2 doses of MMR during any visit, with ≥4 weeks between the doses.

10. Varicella vaccine. (Minimum age: 12 months)

- Administer 2 doses of varicella vaccine to persons without evidence of immunity.
- Administer 2 doses of varicella vaccine to persons aged <13 years at least 3 months apart. Do not repeat the second dose, if administered ≥28 days after the first dose.
- Administer 2 doses of varicella vaccine to persons aged ≥13 years at least 4 weeks apart.

Catch-up Immunization Schedule

UNITED STATES • 2007

for Persons Aged 4 Months–18 Years Who Start Late or Who Are More Than 1 Month Behind

The table below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age.

CATCH-UP SCHEDULE FOR PERSONS AGED 4 MONTHS–6 YEARS					
Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
Hepatitis B ¹	Birth	4 weeks	8 weeks (and 16 weeks after first dose)		
Rotavirus ²	6 wks	4 weeks	4 weeks		
Diphtheria, Tetanus, Pertussis ³	6 wks	4 weeks	4 weeks	6 months	6 months ³
<i>Haemophilus influenzae</i> type b ⁴	6 wks	4 weeks if first dose administered at age <12 months 8 weeks (as final dose) if first dose administered at age 12–14 months No further doses needed if first dose administered at age ≥15 months	4 weeks ⁴ if current age <12 months 8 weeks (as final dose) ⁴ if current age ≥12 months and second dose administered at age <15 months No further doses needed if previous dose administered at age ≥15 months	8 weeks (as final dose) This dose only necessary for children aged 12 months–5 years who received 3 doses before age 12 months	
Pneumococcal ⁵	6 wks	4 weeks if first dose administered at age <12 months and current age <24 months 8 weeks (as final dose) if first dose administered at age ≥12 months or current age 24–59 months No further doses needed for healthy children if first dose administered at age ≥24 months	4 weeks if current age <12 months 8 weeks (as final dose) if current age ≥12 months No further doses needed for healthy children if previous dose administered at age ≥24 months	8 weeks (as final dose) This dose only necessary for children aged 12 months–5 years who received 3 doses before age 12 months	
Inactivated Poliovirus ⁶	6 wks	4 weeks	4 weeks	4 weeks ⁶	
Measles, Mumps, Rubella ⁷	12 mos	4 weeks			
Varicella ⁸	12 mos	3 months			
Hepatitis A ⁹	12 mos	6 months			
CATCH-UP SCHEDULE FOR PERSONS AGED 7–18 YEARS					
Tetanus, Diphtheria/ Tetanus, Diphtheria, Pertussis ¹⁰	7 yrs ¹⁰	4 weeks	8 weeks if first dose administered at age <12 months 6 months if first dose administered at age ≥12 months	6 months if first dose administered at age <12 months	
Human Papillomavirus ¹¹	9 yrs	4 weeks	12 weeks		
Hepatitis A ⁹	12 mos	6 months			
Hepatitis B ¹	Birth	4 weeks	8 weeks (and 16 weeks after first dose)		
Inactivated Poliovirus ⁶	6 wks	4 weeks	4 weeks	4 weeks ⁶	
Measles, Mumps, Rubella ⁷	12 mos	4 weeks			
Varicella ⁸	12 mos	4 weeks if first dose administered at age ≥13 years 3 months if first dose administered at age <13 years			

1. Hepatitis B vaccine (HepB). (Minimum age: birth)

- Administer the 3-dose series to those who were not previously vaccinated.
- A 2-dose series of Recombivax HB[®] is licensed for children aged 11–15 years.

2. Rotavirus vaccine (Rota). (Minimum age: 6 weeks)

- Do not start the series later than age 12 weeks.
- Administer the final dose in the series by age 32 weeks. Do not administer a dose later than age 32 weeks.
- Data on safety and efficacy outside of these age ranges are insufficient.

3. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP). (Minimum age: 6 weeks)

- The fifth dose is not necessary if the fourth dose was administered at age ≥4 years.
- DTaP is not indicated for persons aged ≥7 years.

4. *Haemophilus influenzae* type b conjugate vaccine (Hib). (Minimum age: 6 weeks)

- Vaccine is not generally recommended for children aged ≥5 years.
- If current age <12 months and the first 2 doses were PRP-OMP (PedvaxHIB[®] or ComVax[®] [Merck]), the third (and final) dose should be administered at age 12–15 months and at least 8 weeks after the second dose.
- If first dose was administered at age 7–11 months, administer 2 doses separated by 4 weeks plus a booster at age 12–15 months.

5. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)

- Vaccine is not generally recommended for children aged ≥5 years.

6. Inactivated poliovirus vaccine (IPV). (Minimum age: 6 weeks)

- For children who received an all-IPV or all-oral poliovirus (OPV) series, a fourth dose is not necessary if third dose was administered at age ≥4 years.
- If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.

7. Measles, mumps, and rubella vaccine (MMR). (Minimum age: 12 months)

- The second dose of MMR is recommended routinely at age 4–6 years but may be administered earlier if desired.
- If not previously vaccinated, administer 2 doses of MMR during any visit with ≥4 weeks between the doses.

8. Varicella vaccine. (Minimum age: 12 months)

- The second dose of varicella vaccine is recommended routinely at age 4–6 years but may be administered earlier if desired.
- Do not repeat the second dose in persons aged <13 years if administered ≥28 days after the first dose.

9. Hepatitis A vaccine (HepA). (Minimum age: 12 months)

- HepA is recommended for certain groups of children, including in areas where vaccination programs target older children. See *MMWR* 2006;55(No. RR-7):1–23.

10. Tetanus and diphtheria toxoids vaccine (Td) and tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap). (Minimum ages: 7 years for Td, 10 years for BOOSTRIX[®], and 11 years for ADACEL[™])

- Tdap should be substituted for a single dose of Td in the primary catch-up series or as a booster if age appropriate; use Td for other doses.
- A 5-year interval from the last Td dose is encouraged when Tdap is used as a booster dose. A booster (fourth) dose is needed if any of the previous doses were administered at age <12 months. Refer to ACIP recommendations for further information. See *MMWR* 2006;55(No. RR-3).

11. Human papillomavirus vaccine (HPV). (Minimum age: 9 years)

- Administer the HPV vaccine series to females at age 13–18 years if not previously vaccinated.

Information about reporting reactions after immunization is available online at <http://www.vaers.hhs.gov> or by telephone via the 24-hour national toll-free information line 800-822-7967. Suspected cases of vaccine-preventable diseases should be reported to the state or local health department. Additional information, including precautions and contraindications for immunization, is available from the National Center for Immunization and Respiratory Diseases at <http://www.cdc.gov/nip/default.htm> or telephone, 800-CDC-INFO (800-232-4636).