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# Title: *Preventive Services for Children and Adolescents Enrolled in Medica Choice Care℠, Medical AccessAbility Solution®,and Medica MinnesotaCare*

*This guideline was developed with input from specialists in family practice and pediatrics, and endorsed by the Medical Policy Committee and is consistent with the Minnesota Child and Teen Checkups (C&TC) Periodicity Schedule.*

This guideline was created for children and adolescents enrolled in Medica's Minnesota Health Care Program products, Medica Choice Care (Medical Assistance), Medica AccessAbility Solution (SNBC), and Medica MinnesotaCare (MinnesotaCare). It is a supplement to Medica's health promotion and disease prevention guidelines developed by the Institute for Clinical Systems Improvement, including *Preventive Services for Children and Adolescents* and *Immunizations* (available at www.medica.com in the "Providers," "Medical Policies" section).

## *Child and Teen Checkups (C&TC) Periodic Screening Schedule**

Child and Teen Checkups (C&TC) is the State of Minnesota's program name for Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. These programs are commonly referred to as "well child checkups." **The C&TC schedule of age-related screening recommendations is found on pages 4 and 5 of this guideline. The C&TC schedule of age-related dental standards is found on page 6 of this guideline.**

This screening schedule is a recommended **minimum** for children and adolescents ages birth through 20 years of age who are Medica Choice Care Medica AccessAbility Solution, and Medica MinnesotaCare members; additional visits may be provided to meet individual needs.

## *Key Points to Remember about the C&TC*

1. **ALL components of a Child and Teen Checkups visit must be completed and documented per Minnesota Department of Human Services and Federal Regulations, even when specific risk factors are not present.** (If unable to complete a component of the checkup, the reason for the failed attempt should be documented.)
2. **2013 changes to the C&TC periodicity schedule included the:**
   a. Addition of body mass index (BMI) measurement every C&TC visit beginning at 24 months of age
   b. Addition of *recommendation* of the maternal depression screening (see below for details)
   c. Elimination of the urinalysis requirement
   d. Addition of risk assessment for sexually transmitted infections (STI) and lab tests as indicated for sexually active youth.

3. **Blood lead screening tests** should be provided:
   a. At age 12 months (one test from 9 months through 15 months)
   b. At age 24 months (one test from 16 months through 30 months)
   c. At least once for children up to 6 years of age who have not been previously screened.
   d. To children 3 to 6 years of age whose parents answered "yes" or "don't know" to any question on the blood lead risk questionnaire. In order to monitor a change in the child's status, administer the blood lead risk questionnaire to all children 3 to 6 years of age whose previous test results were less than 10 µg/dL. The risk questionnaire can be reached by clicking on the following link: http://www.health.state.mn.us/divs/eh/lead/reports/screening/blsg4mn.pdf
   e. At any age, if the parent expresses concern about or requests testing and/or if the child moved from a major metropolitan area or another country, within the last 12 months and there is no documentation of a previous test within normal limits.

   There are Case Management Guidelines for children with diagnostic BLLs of >5 µg/dL. Please see the Child and Teen Checkups page at:

   http://www.health.state.mn.us/divs/fh/mch/ctc/index.html



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Documentation must include the lab tests ordered, date, and results of testing.

4. **Vision screening** *(refer to pages 3 and 4 for additional information)*
   a. Under age 3 years – subjective monitoring; and until visual acuity can be obtained and documented, observe child's eyes for ability to track, pupillary responses to light, and retinal reflex symmetry.
   b. Age 3 years and older – obtain and document objective measure of visual acuity (e.g., HOTV or LH Symbol [Lea] Chart for children between the ages of 3 and 6 years; Snellen or Sloan chart for children ages 6 years or older) in addition to subjective monitoring.
   c. Age 16 and 20 years: acuity testing is not required; however subjective screening should be done.

5. **Hemoglobin/Hematocrit**
   a. Use a micro hematocrit(Hct) determination or hemoglobin (Hb) concentration test for iron deficiency and iron deficiency anemia.
   b. One baseline Hb or Hct is required between 9 months and 15 months of age.
   c. One Hb or Hct is required between 12 years and 20 years of age for all menstruating females.

**6. Tuberculosis screening**
   a. All children/adolescents should be evaluated for their risk of exposure to TB. High-risk children include:
      - Recent close contacts of persons with infectious TB disease
      - Foreign-born children and children with foreign-born parents from high prevalence areas
      - Foreign travel to areas with endemic TB
      - Children with (or those children in households with) socioeconomic risk factors such as homelessness, living in shelters, or incarceration
   b. Any high-risk individual who has not received TB testing previously should be screened
   c. TB testing is recommended for high-risk children/adolescents only, either by tuberculin skin test (TST) or TB blood test.

7. **Hearing screening** *(refer to pages 3 and 4 for additional information)*
   a. Newborns – use Automated Auditory Brainstem Response (AABR) or Oto-Acoustic Emission (OAE) tests which are performed at the hospital
   b. If no results are on file for the Newborn Hearing Screening, or the child did not pass, refer to audiology at the birth-1 month C & TC for an objective screening.
   c. **Subjective monitoring at every C & TC visit** should occur – birth through 20 years of age
   d. Age 3 years – it is recommended that an objective screening with puretone audiometry is performed along with subjective monitoring and attempt objective screening with puretone audiometry, particularly if newborn hearing screening was not done or if the child is at-risk for hearing loss
   e. Age 4 years and older – perform objective screening with puretone audiometry (in addition to subjective monitoring).
   f. Age 16 and 20 year– subjective screening may be performed; however if no objective screening occurred at previous checkup, an objective screening with puretone audiometry should be performed.

8. **Dental referrals**
   a. Provide an oral health exam and anticipatory guidance and education for children and their families at every C&TC screening
   b. Begin verbal referrals for regular preventive dental checkups at the time of the eruption of the first tooth or no later than 12 months of age and at every subsequent C&TC visit, more if indicated by the child's history, clinical findings, and susceptibility to oral disease.
   c. It is recommended that high-risk infants and young children receive fluoride varnish applications every three to six months beginning at 12 months of age or when the first tooth erupts, and continuing until the child has established regular visits with a dental provider.

9. **Developmental Health**
   a. Surveillance is required at each C&TC screening.
   b. It is strongly recommended as best practice that a standardized developmental screening instrument be used at 9, 18 and 24 months and at 3 years of age.
   c. If a standardized screening instrument was not used at the 3 year C&TC visit, it is recommended that one be performed before the child turns 6 years of age, preferably at the 4 year C&TC visit.

10. **Social-Emotional/Mental Health**
   a. Surveillance is required at each C&TC screening.
   b. It is strongly recommended as best practice that a standardized social-emotional/mental health screening instrument is used beginning at 6 months of age.

**Additional information on developmental and social-emotional/mental health screenings**

Surveillance is the ongoing process of using professional judgment to identify potential problems. Surveillance includes eliciting parents'/guardians' concerns; collecting a developmental, social-emotional and mental health history; observations of child's behavior; identifying risk and protective factors (including exposure to trauma); and ongoing documentation of this surveillance (adapted from American Academy of Pediatrics [AAP]). Surveillance is part of the E&M code billed for the C&TC screening.

a. Currently, no standardized instrument covers both developmental and mental health screening domains. Therefore, two separate screening instruments are required to adequately screen for potential concerns, and a qualified provider's interpretation must be documented in the medical record to receive reimbursement for either or both. Use instruments recommended by the Minnesota Interagency Developmental Screening Task Force or the Minnesota Department of Human Services Division of Children's Mental Health.
b. General developmental and social-emotional screening instruments should be used first, and more focused or condition-specific instruments may be used if indicated.
c. Providers who meet the instrument-specific criteria, as outlined by the publisher, may perform screenings. This may include physicians, nurse practitioners, physician assistants, nurses, medical assistants or other appropriately trained staff.

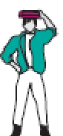
8. **Maternal Depression Screening**

As a risk assessment for the child, providers are encouraged to screen mothers who have children less than one year of age for maternal depression. Suggested screening times are at the 1-month visit, and either the 4-month or one other subsequent visit before the child's first birthday. MCHP allow up to three maternal depression screenings to be billed as a risk assessment for a child under one year of age. One of the following standardized screening tools should be used:

   a. Edinburgh Postnatal Depression Scale (EPDS)
   b. Patient Health Questionnaire – 9 (PHQ-9) Screener
   c. Beck Depression Inventory (BDI).

9. **Additional components of the C&TC are listed on pages 3-5 of this guideline.**

* **For additional information on Child and Teen Checkups provider requirements and documentation forms,** refer to the MN Department of Human Services, and the MHCP Provider Manual - Child and Teen Checkups page..



# Minnesota Child and Teen Checkups (C&TC)
## Schedule of Age-Related Screening Standards
## Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

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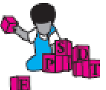

| C&TC Screening Components by Age | Infancy | | | | | Early Childhood | | | | | | Middle Childhood | | | | Adolescence | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Additional screening services/components may be provided as medically indicated. | 0 -1 mo | 2 mo | 4 mo | 6 mo | 9 mo | 12 mo | 15 mo | 18 mo | 24 mo | 3 yrs | 4 yrs | 5 yrs | 6 yrs | 8 yrs | 10 yrs | 12 yrs | 14 yrs | 16 yrs | 18 yrs | 20 yrs |
| **Anticipatory guidance & health education** | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| **Measurements:** • Head circumference | ● | ● | ● | ● | ● | ● | ● | ● | ● | | | | | | | | | | | |
| • Height and weight | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| • Body mass index (BMI) | | | | | | | | | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| • Blood pressure | | | | | | | | | | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| **Health history** - including nutrition, chemical use | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| **Developmental/social-emotional/mental health:** • Surveillance | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| • Developmental screening | | | | | R | | | R | R | R → | → | → | | | | | | | | |
| • Social-emotional/mental health screening | | | | R | | R | | R | R | R | R | R | R | R | R | R | R | R | R | R |
| • Maternal depression screening | R | R | R | R | R | | | | | | | | | | | | | | | |
| **Physical exam** - head to toe, including sexual development and oral exam | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| **Immunizations/review** | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| **Laboratory tests:** • Blood lead | | | | | ← | ● | → | ← | ● | if not done at 24 mo ← | → | → | | | | | | | | |
| • Hemoglobin/hematocrit | | | | | ← | ● | → | | | | | | | | | menstruating adolescents ← | ↔ | ↔ | ↔ | → |
| • Tuberculosis | ✖ | ✖ | ✖ | ✖ | ✖ | ✖ | ✖ | ✖ | ✖ | ✖ | ✖ | ✖ | ✖ | ✖ | ✖ | ✖ | ✖ | ✖ | ✖ | ✖ |
| • Sexually transmitted infection (STI) risk assessment - and lab testing for sexually active youth | | | | | | | | | | | | | | | | ✖ | ✖ | ✖ | ✖ | ✖ |
| • Other labs as medically indicated including newborn metabolic screen, cholesterol | | | | | | | | | | | | | | | | | | | | |
| **Vision** | ✖ | ✖ | ✖ | ✖ | ✖ | ✖ | ✖ | ✖ | ✖ | ● | ● | ● | ● | ● | ● | ● | ● | ✖ | ● | ✖ |
| **Hearing** | ‡ | ✖ | ✖ | ✖ | ✖ | ✖ | ✖ | ✖ | ✖ | R | ● | ● | ● | ● | ● | ● | ● | ✖ | ● | ✖ |
| **Dental checkups** - verbal referral starting at the eruption of the first tooth and no later than 12 months of age | | | | | | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| Use a **C&TC HIPAA compliant referral (condition) code:** NU, ST, AV or S2 | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● |

**Key**

● Required component for the visit

**R** Recommended screening with standardized instrument

✖ Risk assessment followed by appropriate action

‡ If no results for Newborn Hearing Screening on file, or did not pass, refer to audiology for objective screening

←→ Indicates range to provide component at least one time

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**Screening schedule:** Interperiodic or interim screens may be done as medically indicated and are reimbursable by Minnesota Health Care Programs (MHCP). For example, an adolescent with issues such as obesity, drug use, etc., may need more frequent screening.

For more information about each screening component, refer to the C&TC FACT Sheets and the MHCP Provider Manual C&TC Section.

Screening (MN Rule 9505.1696): "Screening" means the use of quick, simple procedures to separate apparently well children from those who need further examination for possible physical, developmental, or psychological problems.

**Developmental, social-emotional and mental health:** Surveillance is the ongoing process of using professional judgment to identify potential problems. Surveillance includes eliciting parents' concerns; collecting a developmental, social-emotional and mental health history; observations of child's behavior; identifying risk and protective factors (including exposure to trauma); and ongoing documentation of this surveillance (adapted from American Academy of Pediatrics [AAP]). Surveillance is part of the E&M code billed for the C&TC screening.

Screening with a standardized instrument at C&TC visits is recommended. Providers may bill for developmental, social-emotional, and mental health screening when a standardized instrument(s) is used to identify children who may need further evaluation, diagnosis and treatment. Use instruments recommended by the Minnesota Interagency Developmental Screening Task Force or the Minnesota Department of Human Services Division of Children's Mental Health. Refer to the MHCP Provider Manual C&TC Section for more coding and billing information.

**Hearing risk assessment:** should be performed on all infants, children and adolescents, even when pure tone audiometry is performed. A hearing screening questionnaire based on risk factors identified by the Joint Committee on Infant Hearing (2007) should be utilized to identify a child's risk-factors for hearing loss. Hearing screening documentation should include the child's risk factors for hearing loss. Additional hearing surveillance may include response to noise, tracking speech and language milestones, history of high fevers, chronic otitis media, serious illness necessitating ototoxic antibiotics, family history of early hearing loss, etc.

**Hearing screening:** Verify that newborn hearing screening results are in your medical files. If an infant did not receive or did not pass their newborn hearing screen in the hospital, an AABR or OAE should be performed on an outpatient basis. For age 3 years and older, pure tone audiometry is the standard for hearing screening. Refer to the MHCP Provider Manual C&TC Section for guidance regarding screenings that cannot be completed due to inadequate cooperation from the child or contraindication to screening at the time of the visit, e.g., due to infection. For 16 and 20 year-olds, perform pure tone audiometry if no objective screening occurred at previous checkup.

**Vision risk assessment:** (e.g., history of squinting, eyes that cross, abnormal head posture, family history of strabismus or amblyopia) should be performed on all infants and children even when visual acuity (at recommended ages) and muscle balance testing (children 6 months through 3rd grade) is performed.

**Vision acuity screening:** should be done starting at 3 years of age. For 16 and 20 year olds, perform acuity screening if no standardized screening occurred at previous checkup.

**STI screening:** Is recommended for adolescents that are sexually active.

**Dental checkups:** A verbal referral for regular preventive dental checkups should be provided at every C&TC visit. In keeping with the American Academy of Pediatric Dentistry (AAPD) recommendations, a child's first dental examination should be completed at the eruption of the first tooth and no later than 12 months. After this initial dental checkup, a child/youth should have a dental checkup every 6 months or as indicated by the child's risk status/susceptibility to disease. For more information about C&TC dental checkups refer to the C&TC Schedule of Age-Related Dental Standards.

**A C&TC HIPAA compliant referral (condition) code:** must be included in billing documentation to identify that a C&TC screening has been provided. Refer to the MHCP Provider Manual C&TC Section for more information.

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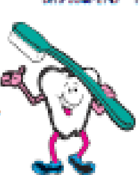
Minnesota Child and Teen Checkups (C&TC) Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

# Schedule of Age-Related Dental Standards



In keeping with the American Academy of Pediatric Dentistry recommendations, a child's first examination should be completed at the eruption of the first tooth in the mouth or no later than 12 months of age. Repeat every 6 months or as indicated by the child's risk status/susceptibility to disease. http://www.aapd.org/media/policies_guidelines/p_cariesriskassess.pdf *

See FACT Sheets in C&TC Provider Guide

| Components / Age | 6 – 12 mo | 12 – 24 mo | 2 – 6 yrs | 6 – 12 yrs | 12 – 20 yrs |
|---|---|---|---|---|---|
| Oral health history | ✔ | ✔ | ✔ | ✔ | ✔ |
| Clinical oral examination | ✔ | ✔ | ✔ | ✔ | ✔ |
| Assessments/screening | | | | | |
| ■ Oral growth and development | ✔ | ✔ | ✔ | ✔ | ✔ |
| ■ Caries risk* | ✔ | ✔ | ✔ | ✔ | ✔ |
| ■ Radiographic | ✔ | ✔ | ✔ | ✔ | ✔ |
| Prophylaxis and topical fluoride[1] | ✔ | ✔ | ✔ | ✔ | ✔ |
| Fluoride supplementation[2] | ✔ | ✔ | ✔ | ✔ | ✔ |
| Anticipatory guidance/counseling[3] | ✔ | ✔ | ✔ | ✔ | ✔ |
| Counseling | Parent | Parent | Patient/parent | Patient/parent | Patient |
| ■ Oral hygiene | ✔ | ✔ | ✔ | ✔ | ✔ |
| ■ Dietary[4] | ✔ | ✔ | ✔ | ✔ | ✔ |
| ■ Injury prevention[5] | ✔ | ✔ | ✔ | ✔ | ✔ |
| ■ Nonnutritive habits[6] | ✔ | ✔ | ✔ | ✔ | ✔ |
| ■ Speech/language development | ✔ | ✔ | ✔ | | |
| ■ Substance abuse | | | | ✔ | ✔ |
| ■ Intraoral/perioral piercing | | | | ✔ | ✔ |
| Assessment and treatment of developing malocclusion | | | ✔ | ✔ | ✔ |
| Assessment for sealants[7] | | | ✔ | ✔ | ✔ |
| Assessment and/or removal of third molars | | | | | ✔ |
| Transition to adult care | | | | | ✔ |

1. The child's history, clinical findings and susceptibility to oral disease should determine the timing, selection and frequency.
2. When systemic fluoride exposure is suboptimal; up to at least 16 years of age.
3. Appropriate discussion and counseling should be an integral component of each visit.
4. At every visit; initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and obesity.
5. Should include counseling on toys, pacifiers, car seat use and passenger restraints, routine playing, sports and mouthguards.
6. Should include counseling on the additional need for sucking fingers vs pacifiers, then the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescents, counsel regarding habits such as nail biting, clenching and grinding.
7. For caries susceptible posterior teeth with deep pits and fissures; placed as soon as possible after eruption. Coverage for sealants is limited to recipients through age 18 on first and second permanent molars.

Developed jointly by the Minnesota Departments of Human Services and Health

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## References:

**Pre-09/2015 MPC:**

1. Minnesota Department of Health. Child and Teen Checkups FACT Sheets. Minnesota Department of Human Services. Child and Teen Checkups (C&TC). Minnesota's Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.
2. Minnesota Department of Human Services and Minnesota Department of Health.
3. Minnesota Department of Human Services and Minnesota Department of Health. Minnesota Child and Teen Checkups (C&TC) Early and Periodic Screening, Diagnosis and Treatment (EPSDT): Schedule of Age-Related Dental Standards. Document
4. Minnesota Department of Human Services and Minnesota Department of Health. Minnesota Child and Teen Checkups Early and Periodic Screening, Diagnosis and Treatment (EPSDT): Schedule of Age-Related Screening Standards.

**09/2015 MPC:**

No new references

*Clinical guidelines are intended to be used to encourage quality patient care, but cannot guarantee specific patient outcome, and should be used only as a reference guide. The guidelines are not intended to replace a clinician's own judgment with regard to the care needed by individual members or to establish protocols for the care of all members. Coverage of specific services may vary based on the terms of specific member/enrollee contracts (including state and federal government program contracts), administrative policies, and state/federal mandates.*

DOCUMENT HISTORY

| Original MPC Endorsement Date | September 2002 |
|---|---|
| Subsequent MPC Endorsement Date(s) | 09/2004, 09/2005, 09/2007, 09/2009, 09/2013, 09/2015 |