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SECTION 94 Early and Periodic Screening, Diagnosis and Treatment Services 05/01/10

94.01 INTRODUCTION

Members under the age of twenty-one (21) may get medically necessary MaineCare Benefits Manual, Chapter II services for which they qualify. In addition, Federal Medicaid regulations require that MaineCare provide Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) to members under the age of 21 in accordance with 42 U.S.C. §1396d(a).

94.02 ELIGIBILITY FOR SERVICES

MaineCare members under the age of 21 are eligible for services described in this Section.

94.03 PREVENTION SERVICES

94.03-1 Bright Futures Health Assessment Visits

Effective 05/01/10

A. **Bright Futures Guidelines**

In Appendix 1, MaineCare has adopted the most recent version of the Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents of the American Academy of Pediatrics (http://brightfutures.aap.org) (hereinafter "Bright Futures") as the standard of care expected at health assessment visits for MaineCare members under the age of 21. There are nineteen (19) separate age appropriate MaineCare Bright Futures health assessment forms that delineate the age-specific guidelines for each required visit.

See Appendix 1 for the MaineCare Bright Futures periodic health assessment schedule that begins with a neonatal examination and continues up to the age of 21.

B. **Provider Requirements**

In order to do health assessments under the Bright Futures guidelines, a provider must:

1. be a physician, a physician's assistant, an advanced practice registered nurse in private practice, or those staff employed in a Rural Health Clinic, an ambulatory care clinic, a hospital based practice, or a Federally Qualified Health Center;

2. be a MaineCare provider, i.e. have signed a MaineCare Provider/Supplier Agreement;

3. sign a Supplemental Provider Agreement;

4. follow the MaineCare Bright Futures periodic health assessment schedule (Appendix 1);

5. document health assessment visits on the appropriate MaineCare Bright Futures health assessment form. If the health assessment exam using the Bright Futures guidelines differs from the reminders on the MaineCare

health assessment form, please note it in the comment section of the form.

If one or more components of a health assessment visit are performed elsewhere (e.g. by another provider because of a referral, by a Head Start agency or by a school), the results of the procedure(s) done by others must be recorded on the MaineCare Bright Futures health assessment form before a provider may request payment for the health assessment visit. In all cases, each component of the health assessment must be addressed.

6. establish and maintain a consolidated health record for each member that includes, but is not limited to, the following:

   a. identifying information (e.g. member's name, address, birth date, MaineCare ID number, and the name of the caretaker, if applicable);

   b. comprehensive health history including information from health assessment visits and/or from other providers;

   c. documentation of comprehensive, unclothed and age-appropriate physical examinations;

   d. documentation of the diagnosis and treatment of problems discovered or suspected as a result of a health assessment visit; and

   e. treatment plan as necessary for problems discovered. A provider of treatment may modify his or her treatment plan at any time. Also, a parent or other qualified provider may request modification of the treatment plan.

Effective 05/01/10

Providers may meet these documentation requirements by retaining completed copies of the MaineCare Bright Futures health assessment forms in each child's consolidated health record; and

7. comply with Chapter I, Administrative Policies and Procedures, of the MaineCare Benefits Manual and any other Sections of the MaineCare Benefits Manual that apply to the services they provide.

C. **Lead**

1. **Blood Lead Testing**

MaineCare children are at significantly higher risk for lead exposure than other children and have higher lead levels according to MaineCare data.

As part of the Bright Futures health assessment visit done at one and two years of age, providers must test the blood for lead levels. MaineCare will pay MaineCare physicians, physician's assistants, and advanced practice

registered nurses who are in private practice an enhanced reimbursement for venous and capillary blood draws when they are done for blood lead testing.

2. **Environmental Investigations**

Effective 05/01/10

MaineCare will reimburse the Maine Department of Health and Human Services, Centers for Disease Control and Prevention for environmental investigations of a child's home or primary residence when the child has been diagnosed as having an elevated blood lead level. MaineCare will not pay for testing of substances such as soil, dust, paint or water which are sent to a laboratory for analysis.

D. **Immunizations**

As part of the Bright Futures health assessment visit, providers must evaluate the member's immunization history and bring him or her up to date on all required immunizations. If immunizations are needed but cannot be administered at the time of a health assessment visit, the provider should recall the member to give the immunizations at a more appropriate time.

Effective 05/01/10

MaineCare recommends that providers use the Maine Department of Health and Human Services, Centers for Disease Control and Prevention, guidelines for provision of age appropriate immunizations. The Centers for Disease Control and Prevention uses the Federal Centers for Disease Control and Prevention guidelines. These guidelines may be obtained by contacting the Centers for Disease Control and Prevention Immunization Program.

E. **Health Assessments Done Outside of the Normal Schedule**

When children need health assessments outside of the normal schedule, providers must use the age appropriate MaineCare Bright Futures health assessment form for the age closest to the child's chronological age to document the visit.

When children have behavioral health issues, any treatment provider or individuals outside of the health care system can request an examination off the periodic health assessment schedule with the consent of the child and/or the child's parent(s) or guardian(s). Individuals outside of the health care system include, but are not limited to, teachers, school nurses, and day care providers.

F. **Follow-up Treatment**

Effective 05/01/10

The provider must initiate medically necessary follow-up treatment identified as needed during a health assessment visit, including but not limited to treatment for defects in vision, hearing and dental care, at the earliest practical date commensurate with the needs of the child. Generally, this should happen within six months from the date of the health assessment visit.

Billing for follow-up treatment for health care needs identified during the health assessment visit must be done using the appropriate Evaluation and Management Current Procedural Terminology (CPT) codes. Do not use the MaineCare Bright Futures health assessment form when billing for follow-up treatment services.

Members enrolled in MaineCare managed care may need a referral from their primary care provider if the needed follow-up treatment is a "managed service."

G. **Omission of Health Assessment Components**

One or more components of a health assessment visit may be omitted if any of the following circumstances exist. If any of the following circumstances exist and a component of the health assessment visit is not performed, the provider must record the appropriate reason on the MaineCare Bright Futures health assessment form.

1. **Procedure Impossible to Perform**

In some circumstances the member's behavior may be such that a procedure is impossible to perform. In the interest of providing comprehensive health assessments for all children, the provider should arrange another appointment with the member and attempt the procedure(s) again before submitting a claim for the health assessment visit.

2. **Religious Exemption**

Some procedures, especially immunizations, are contrary to the religious beliefs of some members/caretakers and may be refused on that basis.

3. **Member/Caretaker Does Not Want Procedure Done**

Members/caretakers occasionally may ask that specific procedures not be done. These personal requests may be granted, but should be distinguished from religious exemptions when possible.

4. **Procedure Not Medically Necessary or Medically Contraindicated**

The provider may omit a procedure if, in his/her professional judgment, the procedure is not medically necessary or is medically contraindicated.

94.04 HEALTH PROMOTION

Effective 05/01/10

94.04-1 **Informing and Periodicity**

MaineCare will inform all members about the availability of Early and Periodic Screening, Diagnosis and Treatment within sixty (60) calendar days of their enrollment in MaineCare and in the case of families that have not utilized such services, annually thereafter.

MaineCare will notify members that a health assessment visit is due by the first of the month in which visits are due according to the MaineCare Bright Futures periodic health assessment schedule (Appendix 1).

94.04-2 **Special Assistance for Members under Age 21**

MaineCare will provide the following assistance to members.

A. Arrange or schedule appointments for services or treatment for problems found as a result of a health assessment visit.

B. Find a MaineCare provider.

C. Arrange transportation.

Effective 05/01/10

D. Make referrals for follow-up by the Maine Department of Health and Human Services, Centers for Disease Control and Prevention, Public Health Nursing (PHN) staff or nursing staff under contract with the Centers for Disease Control and Prevention to perform PHN functions for, but not limited to, the following reasons. The child:

1. does not have a primary care provider;

2. is significantly behind in his/her immunizations;

3. is missing appointments with his or her provider(s); or

4. needs a repeat blood lead test.

Effective 05/01/10

Providers may use the MaineCare Bright Futures health assessment form to request a referral to the Centers for Disease Control and Prevention or may call or fax the Health Care Management Unit of MaineCare Services.

E. Help with issues identified as a result of a health assessment visit when requested by the provider.

F. Provide information in alternative formats such as Braille or provide interpreter services for members who are deaf/hard of hearing or who are non-English or limited English speaking.

94.04-3 **Home Visits for Children Age Two and Under**

A. MaineCare will pay for home visits for families with a child age two and under who is enrolled in MaineCare when one or more of the following risk criteria exist:

1. The infant or child:
   a. had a birth weight under 2500 grams;
   b. was born pre-term, i.e. under 37 weeks; and/or
   c. has a chronic illness or disability.

2. The infant or child's:
   a. mother is single and was under 20 years of age at the time of birth; or
   b. parents have been diagnosed with mental retardation.

3. There is a history of substance abuse in the household, excluding nicotine use or abuse.

Home visit services are direct services provided by a registered nurse or other trained professional in accordance with a plan of care approved by the child's physician, physician's assistant or advanced practice registered nurse. Home visit services are not case management. MaineCare will pay for up to 2.5 hours of direct services provided in the home per family per month.

Effective 05/01/10

B. Staff at the following clinics, agencies, and centers may provide services through home visits, ambulatory care clinics, home health agencies, Federally Qualified Health Centers and Rural Health Clinics. Staff providing services through home visits must work within the scope of their licenses and any additional restrictions of the agencies employing them. Prior to doing a home visit, these staff members must:

1. develop a plan of care based on the risk criterion being addressed,

2. make sure the plan is approved by the child's physician, physician's assistant, or advanced practice registered nurse, and

Effective 05/01/10

3. request and receive prior authorization from the MaineCare Prior Authorization (PA) Unit of MaineCare Service.

94.05 TREATMENT SERVICES

94.05-1 Providers

Effective 05/01/10

Providers of treatment services must:

A. be appropriately credentialed or licensed individuals or entities and be working within the scope of their licensure. For example: All durable medical equipment (DME) must be supplied through a DME provider,

B. sign a MaineCare Provider/Supplier Agreement,

C. comply with Chapter I, Administrative Policies and Procedures, of the MaineCare Benefits Manual, and

D. comply with all MaineCare policies found in those sections of the MaineCare Benefits Manual applicable to the service provided, including but not limited to provider qualification requirements.

94.05-2 Covered Services

Treatment services covered under the EPSDT Program consist of all medically necessary services listed in §1905(a) of the Social Security Act (42 U.S.C. §1396(a) and (r)) that are needed to correct or ameliorate defects and physical or mental conditions detected through the EPSDT screening process. The program covers only those treatment services that are not specifically included under any other MaineCare regulation, because:

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A. They are of a type not described in any other regulation.

B. The frequency exceeds that covered by the regulation.

C. The duration exceeds that covered by the regulation.

To receive payment for services under the EPSDT program, the member or provider must:

A. obtain prior authorization;

B. demonstrate that the service is medically necessary, as the term is defined in Chapter I, §1.02 (D) of the MaineCare Benefits Manual; and

C. show that the service is not covered by another MaineCare regulation.

Treatment Services must:

A. be documented scientifically with valid clinical evidence of effectiveness. (The Department may request additional information to support the assertion that there is scientifically valid evidence of the efficacy of the proposed treatment or service. The Department will request this information if it determines that the service requested is outside the scope of standard medical practice.);

B. not be considered investigational or experimental;

C. be the most cost effective service that would provide the member with the same medically necessary outcome and intended purpose;

D. be prior authorized by the Authorization Unit of MaineCare Services. Requests for prior authorization of Durable Medical Equipment will be reviewed by an authorized agent of the Department.

E. be medically necessary as defined in Chapter I, Section 1.02 (D);

F. not be custodial, academic, educational, vocational, recreational or social in nature as described in Chapter I, Section 1.02 (D), General Administrative Policies and Procedures, of this Manual;

G. not be respite care, which is defined as services given to individuals unable to care for themselves that are provided on a short-term basis because of the absence or need for relief of those persons normally providing the care.

94.05-3 **Prior Authorization**

A. **Written Requests**

The MaineCare provider who is prescribing the treatment service must request and receive prior authorization from the Authorization Unit of MaineCare

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Services or the Departments' Authorized Agent before the service is referred and/or provided.

To obtain prior authorization, the prescribing provider must complete the appropriate prior authorization request form available from the MaineCare Authorization Unit or on the Department's website at: http://www.maine.gov/dhhs/oms/providerfiles/pa_inst_sheets_forms.html.

To obtain prior authorization for durable medical equipment (DME), the request must be submitted on the MA-56R form. Any request for DME that is denied under Chapter II, Section 60, Medical Supplies and Durable Medical Equipment will be considered and reviewed under EPSDT criteria.

In addition, the MaineCare Authorization Unit may request the following additional information:

1. A plan of care that:

   a. describes the problem(s) or conditions(s) the plan addresses;

   b. identifies the service(s) needed to address the problem(s) or condition(s) and why they will meet the medical needs;

   c. describes the frequency, duration, and goal of each needed service;

   d. identifies the provider(s) who will provide each needed service; and

   e. includes the prescribing provider's signature.

   The prescribing provider must review and revise the plan at least annually. If a change in the child's health status requires a plan modification, the prescribing provider must revise and sign the plan within one week of the health status change.

2. Documentation of medical necessity of the services identified in the plan of care that, at a minimum, includes:

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   a. Supporting medical records;

   b. What other service(s)/equipment has been tried, if any, and why it was unsuccessful;

   c. Explains clearly why the services are of a type, frequency or duration not otherwise covered by MaineCare regulations;

   d. Clearly addresses why services covered elsewhere in the MaineCare Benefits Manual are inappropriate or insufficient to meet the member's needs;

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e. Any supporting medical literature which demonstrates that the proposed service/equipment will be effective in addressing the member's need.

The MaineCare Authorization Unit will notify providers of its decision regarding the request for prior authorization in accordance with Chapter I, Administrative Policies and Procedures, of the MaineCare Benefits Manual.

B. **Emergency Requests**

In an emergency where the member's condition does not allow time for the prescribing provider to submit a written request, he/she may phone or fax the MaineCare Authorization Unit requesting prior authorization of the service.

Effective 05/01/10

In an emergency where the prescribing provider is unable to contact the MaineCare Authorization Unit (e.g. evenings, weekends, holidays, mandatory shut-down days) and has documented the reasons why contact could not be made, MaineCare after receipt and review of such stated documentation may at the discretion of the Department authorize services retroactively to the start of the medical emergency. The prescribing provider must contact the MaineCare Authorization Unit the next business day. In these cases, the prescribing provider must submit all necessary written documentation within seven (7) business days of the phone or fax contact.

94.06 BILLING AND REIMBURSEMENT

94.06-1 Bright Futures Health Assessment Visits

MaineCare will reimburse providers for one health assessment visit per member for each age shown on the MaineCare Bright Futures periodic health assessment schedule (Appendix 1).

A. **Physicians, Physician's Assistants, Advanced Practice Registered Nurses in Private Practice**

Effective 05/01/10

Use the Evaluation and Management Preventive Medicine Services and Newborn Care codes set forth in the Early and Periodic Screening, Diagnosis and Treatment Services Appendix to the Billing Instructions. Contact MaineCare Services, Provider Relations Unit to get a copy of the Appendix to the Billing Instructions.

Bill in accordance with the Billing Instructions of the Department for the CMS 1500.

B. **Federally Qualified Health Centers (FQHC)/Rural Health Clinics (RHC)**

Use core visit code established in the MaineCare Benefits Manual, Chapter III, Section 31 (FQHCs) or Section 103 (RHCs).

Effective 05/01/10

Bill in accordance with the Billing Instructions of the Department for the CMS 1500.

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C. **Hospital Based/Owned Physician Practices**

Bill in accordance with the Department's Billing Instructions for the CMS 1500 or the UB 04 as appropriate.

D. **Ambulatory Care Clinics**

Use codes established in the MaineCare Benefits Manual, Chapter III, Ambulatory Care Clinics Section 3.

Bill in accordance with the Billing Instructions of the Department for the CMS 1500.

E. **Durable Medical Equipment providers**

Use codes established in the MaineCare Benefits Manual, Chapter III, Section 60, Medical Supplies and Durable Medical Equipment.

Bill in accordance with the Billing Instructions of the Department for the CMS 1500.

94.06-2. **Lead Testing**

A. **Blood Lead Testing**

MaineCare will pay physicians, physicians' assistants, advanced practice registered nurses and other appropriately licensed providers rendering services within the scope of their practice an enhanced reimbursement for blood draws performed for the purpose of testing blood lead levels in MaineCare members at ages one (1) and two (2). Newly MaineCare eligible children between the ages of three (3) and five (5) years of age may also receive a screening blood lead test if they have not been previously screened for lead poisoning

Use codes/modifiers in the Early and Periodic Screening, Diagnosis and Treatment Appendix to the Billing Instructions.

Bill in accordance with the Billing Instructions of the Department for the CMS 1500.

B. **Environmental Investigations**

MaineCare will pay the Maine Department of Health and Human Services, Maine Disease Control and Prevention, for professional staff time and activities during an on-site investigation of a member's home (or primary residence) when the child has been diagnosed as having an elevated blood lead level. MaineCare will not reimburse for any testing of substances (e.g. soil, dust, water, paint) that are sent to a laboratory for analysis.

Effective 05/01/10

Use the code in the Early and Periodic Screening, Diagnosis and Treatment Appendix to the Billing Instructions.

Bill in accordance with the Billing Instructions of the Department for the CMS 1500.

Effective 05/01/10

94.06-3. **Home Visits for Children Age Two (2) and Under**

MaineCare will pay for direct services provided in the child's home that are part of a plan of care approved by the member's physician, physician's assistant, or advanced practice registered nurse. MaineCare will pay for up to two point five (2.5) hours of direct service per family per month provided by a registered nurse or other specially trained professional employed either by a home health agency; a Federally Qualified Health Center; a Rural Health Clinic; or an Ambulatory Care Clinic.

Use the code in the Early and Periodic Screening, Diagnosis and Treatment Appendix to the Billing Instructions.

Bill in accordance with the Billing Instructions of the Department for the CMS 1500.

94.06-4. **Treatment Services**

MaineCare will pay the lower of:

A. The provider's usual and customary charge as evidenced by a written fee schedule in accordance with Medicare guidelines; or

B. The reimbursement rate established by MaineCare for treatment services in accordance with the guidelines of the originating section of MaineCare policy; or

C. The lowest published Durable Medical Equipment fee schedule, when applicable.

Bill using the Billing Instructions of the Department for the CMS 1500, UB 04 or ADA claim form, as appropriate.

NOTE: Billing instructions are included in the provider enrollment packet or are available by contacting the MaineCare Services Billing and Information Unit at 1-800-321-5557 Option 8.

Effective
05/01/10

Recommendations for Preventive Pediatric Health Care Committee on Practice and Ambulatory Medicine
Appendix 1

Each child and family is unique; therefore, these **Recommendations for Preventive Pediatric Health Care** are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in satisfactory fashion. Additional visits may become necessary if circumstances suggest variations from normal.

These guidelines represent a consensus by the Committee on Practice and Ambulatory Medicine in consultation with national committees and sections of the American Academy of Pediatrics. The Committee emphasizes the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

The following Bright Futures/AAP Periodicity Schedule with corresponding footnotes 1-23 is for visual reference only. Refer to Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents of the American Academy of Pediatrics at **http://brightfutures.aap.org/clinical_practice.html** for complete details.

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

Bright Futures.
prevention and health promotion for infants, children, adolescents, and their families™

Each child and family is unique; therefore, these **Recommendations for Preventive Pediatric Health Care** are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in satisfactory fashion. **Additional visits may become necessary** if circumstances suggest variations from normal.

Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.

These guidelines represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of **continuity of care** in comprehensive health supervision and the need to avoid **fragmentation of care.**

	INFANCY								EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE										
AGE[1]	PRENATAL[2]	NEWBORN[3]	3–5 d[4]	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 m	15 mo	18 mo	24 mo	30 mo	3 y	4 y	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y	21 y
HISTORY Initial/Interval	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
MEASUREMENTS																																
Length/Height and Weight		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Head Circumference		•	•	•	•	•	•	•	•	•	•	•																				
Weight for Length		•	•	•	•	•	•	•	•	•	•																					
Body Mass Index												•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Blood Pressure[5]		★	★	★	★	★	★	★	★	★	★	★	★	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
SENSORY SCREENING																																
Vision		★	★	★	★	★	★	★	★	★	★	★	★	•[6]	•	•	•	★	•	★	•	★	•	★	★	★	★	★	★	★	★	★
Hearing		•[7]	★	★	★	★	★	★	★	★	★	★	★	★	•	•	•	★	•	★	•	★	★	★	★	★	★	★	★	★	★	★
DEVELOPMENTAL/BEHAVIORAL ASSESSMENT																																
Developmental Screening[8]								•			•		•																			
Autism Screening[9]											•	•																				
Developmental Surveillance[8]		•	•	•	•	•	•		•	•		•		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Psychosocial/Behavioral Assessment		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Alcohol and Drug Use Assessment																						★	★	★	★	★	★	★	★	★	★	★
PHYSICAL EXAMINATION[10]		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
PROCEDURES[11]																																
Newborn Metabolic/Hemoglobin Screening[12]	◄	◄	•	►	►	►																										
Immunization[13]		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Hematocrit or Hemoglobin[14]						★			•		★	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead Screening[15]							★	★	•or★[16]		★	•or★[16]		★	★	★	★															
Tuberculin Test[17]				★			★		★		★	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia Screening[18]												★			★		★		★		★	★	★	★	★	★	★	★	◄	►		
STI Screening[19]																						★	★	★	★	★	★	★	★	★	★	★
Cervical Dyslasia Screening[20]																						★	★	★	★	★	★	★	★	★	★	★
ORAL HEALTH[21]							★	★	•or★[22]		•or★[22]	•or★[22]	•or★[22]	•[22]			•[22]															
ANTICIPATORY GUIDANCE[23]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a consultation. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding per AAP statement "The Prenatal Visit" (2001) [URL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;107/6/1454].
3. Every infant should have a newborn evaluation after birth; breastfeeding encouraged; and instruction and support offered. Every infant should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding infants should receive formal breastfeeding evaluation, encouragement, and instruction as recommended in AAP statement "Breastfeeding and the Use of Human Milk" (2005) [URL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;115/5/496]. For newborns discharged in less than 48 hours after delivery, the infant must be examined within 48 hours of discharge per AAP statement "Hospital Stay for Healthy Term Newborns" (2004) [URL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;113/5/1434].
4. If bilirubin measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
5. If the patient is uncooperative, reassess within 6 months per the AAP statement "Eye Examination in Infants, Children, and Young Adults by Pediatricians" (2007) [URL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;111/5/902].
6. All newborns should be screened per AAP statement "Year 2000 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (2000) [URL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;106/4/798]; Joint Committee on Infant Hearing, Year 2007 position statement: principles and guidelines for early hearing detection and intervention programs. Pediatrics. 2007;120:898–921.
8. AAP Council on Children With Disabilities, AAP Section on Developmental/Behavioral Pediatrics, AAP Bright Futures Steering Committee, AAP Medical Home Initiatives for Children With Special Needs Project Advisory Committee. Identifying infants and young children with developmental disorders in the medical home: an algorithm for developmental surveillance and screening. Pediatrics. 2006;118:405–420 [URL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;118/1/405].
9. Gupta VB, Hyman SL, Johnson CP, et al. Identifying children with autism early. Pediatrics. 2007;119:152–153 [URL: http://pediatrics.aappublications.org/cgi/content/full/119/1/152].
10. At each visit, age-appropriate physical examination is essential, with infant fully undressed, older child undressed and safely draped.
11. These may be modified, depending on entry point into schedule and individual need.
12. Newborn metabolic and hemoglobinopathy screening should be done according to state law. Results should be reviewed at visits and appropriate retesting or referral done as needed.
13. Schedules per the Committee on Infectious Diseases, published annually in the January issue of Pediatrics. Every visit should be an opportunity to update and complete a child's immunizations.
14. See AAP Pediatric Nutrition Handbook, 5th Edition (2003) for a discussion of universal and selective screening options. See also Recommendations to prevent and control iron deficiency in the United States. MMWR. 1998;47(RR-3):1–36.
15. For children at risk of lead exposure, consult the AAP statement "Lead Exposure in Children: Prevention, Detection, and Management" (2005) [URL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;116/4/1036]. Additional screening should be done in accordance with state law where applicable.
16. Perform risk assessments or screens as appropriate, based on universal screening requirements for patients with Medicaid or high prevalence areas.
17. Tuberculosis testing per recommendations of the Committee on Infectious Diseases, published in the current edition of *Red Book: Report of the Committee on Infectious Diseases*. Testing should be done on recognition of high-risk factors.
18. "Third Report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III) Final Report" (2002) [URL: http://www.nhlbi.nih.gov/guidelines/cholesterol/atp3_rpt.htm] and "The Expert Committee Recommendations on the Assessment, Prevention, and Treatment of Child and Adolescent Overweight and Obesity." Supplement to Pediatrics. In press.
19. All sexually active patients should be screened for sexually transmitted infections (STIs).
20. All sexually active girls should have screening for cervical dysplasia as part of a pelvic examination beginning within 3 years of onset of sexual activity or age 21 (whichever comes first).
21. Referral to dentist home, if available. Otherwise, administer oral health risk assessment. If the primary water source is deficient in fluoride, consider oral fluoride supplementation.
22. At the visits for 5 years and 6 years of age. It should be determined whether the patient has a dental home. If the patient does not have a dental home, a referral should be made to one. If the primary water source is deficient in fluoride, consider oral fluoride supplementation.
23. Refer to the specific guidance by age as listed in Bright Futures Guidelines. (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008.)

KEY

• = to be performed ★ = risk assessment to be performed, with appropriate action to follow, if positive ◄—•—► = range during which a service may be provided, with the symbol indicating the preferred age

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1. If a child comes under care the first time at any point on the schedule, or if any of the items are not accomplished at the suggested age, the schedule should be brought up to day at the earliest possible time.

2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding per AAP statement. "The Prenatal Visit (2001) [URL: http://aapolicy.aappublications.org/cgi.content/full/pediatrics;107/6/1456].

3. Every infant should have a newborn evaluation after birth, breastfeeding encouraged, and instruction and support offered.

4. Every infant should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding infants should receive formal breastfeeding evaluation, encouragement, and instruction as recommended in AAP statement "Breastfeeding and the Use of Human Milk" (2005) [URL: http://aappolicy.aappublications.org/content.full/pediatrics;113/5/1434].

5. Blood pressure measurement in infants and children with certain risk conditions should be performed at visits before age 3 years.

6. If the patient is uncooperative, rescreen within 6 months per the AAP statement "Eye Examinations in Infants, Children, and Young Adults by Pediatricians" (2007) [URL: http://aappolicy.aappublications.org/cgi.content/full/pediatrics;111/4/902].

7. All newborns should be screened per AAP statement "Year 2000 Positions Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (2000) [URL: http://aappolicy.aappublications.org.cgi/content/full/pediatrics;106/4/798], Joint Committee on Infant Hearing. Year 2007 position statement principles and guidelines for early hearing detection and intervention programs. *Pediatrics*. 2007;120:898-921.

8. AAP Council on Children With Disabilities, AAP Section on Developmental Behaviors Pediatrics, AAP Bright Futures Steering Committee, AAP Medical Home Initiatives for Children With Special Needs Project Advisory Committee. Identifying infants and young children with developmental disorders in the medical home: an algorithm for developmental surveillance and screening. *Pediatrics*. 2006; 118:405-420 {URL: http://aappolicy.aappublications.org/cgi/content/full/119/1/152].

9. Gupta VB, Hyman SL, Johnson CP, et al. Identifying children with autism early? *Pediatrics*. 2007; 119:152-153 (URL: http://pediatrics.aappublications.org/cgi.content/full/119/1/152].

10. At each visit age-appropriate physical examination is essential, with infant totally unclothed, older child undressed and suitably draped.

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11. These may be modified, depending on entry point into schedule and individual need.

12. Newborn metabolic and hemoglobinopathy screening should be done according to state law. Results should be reviewed at visits and appropriate retesting or referral done as needed.

13. Schedules per the Committee on Infection Diseases, published annually in the January issue of *Pediatrics*. Every visit should be an opportunity to update and complete a child's immunizations.

14. See AAP Pediatric Nutrition Handbook, 5th Edition (2003) for a discussion of universal and selective screening options. See also Recommendations to prevent and control iron deficiency in the United States, *MMWR*. 1998; 47{RR-3):1-36.

15. For children at this of lead exposure, consult the AAP statement "Lead Exposure in Children: Prevention, Detection, and Management" (2005) [URL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;116/4/1036]. Additionally, screening should be done in accordance with state law where applicable.

16. Perform risk assessments or screens as appropriate, based on universal screening requirements for patients with Medicaid or high prevalence.

17. Tuberculosis testing per recommendations of the Committee on infectious Diseases, published in the current edition of *Red Book*: *Report of the Committee on Infectious Diseases*. Testing should be done on recognition of high-risk factors.

18. "Third Report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III) Final Report" (2002) [URL: http://circ.ahajournals.org/cgi/content/full/106/25/3143] and "The Expert Committee Recommendations on the Assessment, Prevention and Treatment of Child and Adolescent Overweight and Obesity." Supplement to *Pediatrics*. In press.

19. All sexually active patients should be screened for sexually transmitted infections (STIs).

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22. At the visits for 3 years and 6 years of age, it should be determined whether the patient has a dental home. If the patient does not have a dental home, a referral should be made to one. If the primary water source is deficient in fluoride, consider oral fluoride supplementation.

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23. Refer to the specific guidance by age as listed in the Bright Futures Guidelines. (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 3rd Ed. Elk Grove Village, IL: American Academy of Pediatrics: 2008.)