EPSDT: Information for Providers

2024

PASSPORT
BY MOLINA HEALTHCARE

Agenda

1. What is EPSDT?
2. EPSDT Benefit
3. EPSDT Providers
4. CMS Guidance Unique to EPSDT Members

EPSDT: “A Program within a program”

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What is EPSDT?

EPSDT stands for **Early Periodic Screening, Diagnosis and Treatment**. EPSDT benefit provides comprehensive screening, diagnostic, treatment and preventative health care services for children under the age of 21 who are enrolled in Medicaid. EPSDT is key to ensuring children receive appropriate preventative, dental, mental health, developmental and specialty services.

EPSDT checkups are free for any child who is a Passport member.

- **Early:** Identifying problems early, starting at birth.
- **Periodic:** Checking children's health at periodic, age-appropriate intervals.
- **Screening**: Doing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems.
- **Diagnosis:** Performing diagnostic tests to follow up when a risk is identified.
- **Treatment:** Treating the problems found.

EPSDT Definitions

- **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services:** comprehensive and preventive health care services for children who are enrolled in Medicaid.

- **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Special Services:** medically necessary health care, diagnostic services, treatment, and other measures described in Section 1905(a) of the Social Security Act to correct or improve defects and physical and mental illnesses and conditions identified by EPSDT screening services for children who are enrolled in Medicaid, whether or not such services are covered under the State Plan.

- **EPSDT Eligible Member:** any member under the age of 21. EPSDT services are provided through the last day of the month in which the member turns 21.

Why is EPSDT Important?

- Periodic preventive care helps ensure the best outcomes for a child's long-term health and overall well-being in both childhood and as an adult.

- Ensures our members receive the most comprehensive, evidence-based well child exam that meets the full standard for EPSDT at the appropriate intervals.

- EPSDT special services helps eliminate potential barriers to additional diagnostic testing/screening and treatment to ensure they receive the medically necessary services they need.

EPSDT is the cornerstone of social policy to optimize child development for millions of qualifying children in the U.S.

EPSDT Benefit

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Passport by Molina Healthcare's Engagement Process

Passport's goal is to work with our member and provider community to ensure those who qualify for EPSDT services receive the proper preventive care and additional medically necessary health care needs are met.

Passport contacts members by phone, through mail, and in person to educate them on the importance of preventive care. In addition, we engage in outreach to remind members to schedule preventive care such as well-child visits and dental screenings.

For members who are approved for EPSDT Special Services, Passport automatically offers Care Management to address any additional needs and ensure they receive the services for which they were approved. Care Management services are available for all EPSDT eligible members; anyone can refer a member for Care Management outreach and assessment.

Passport works collaboratively with providers to optimize the health and wellbeing of our EPSDT eligible members. This includes alerting providers to member care gaps and working in tandem to ensure members receive all age-appropriate preventive care.

Passport Coverage

Eligible Members

- Any Passport member under the age of 21 child can receive EPSDT screenings. Additionally, any Medicaid eligible Passport member under 21 may receive EPSDT special services if the services are medically necessary and not covered in another Medicaid program area.

Passport Services

- Passport ensures EPSDT members' parents or guardians know what services are available and have access to the health care resources they need.
- Passport provides health education, including anticipatory guidance, to enrollees under age 21 and to their parents or guardians in order to effectively use those resources, including screenings and treatment.

Passport Coverage

EPSDT screenings have many age-related components that must be documented in the member's medical record by the provider. These include:

- A comprehensive health and developmental history, unclothed physical exam, appropriate immunizations, laboratory tests, and health education,
- Screenings and assessments, including lead exposure, autism, tobacco/alcohol/drug-use assessment and developmental/behavioral/psychosocial assessments,
- Measurements, including but not limited to length/height, weight, head, circumference, body mass index (BMI) and blood pressure,
- Vision and hearing screenings, including diagnosis and treatment for defects in vision and/or hearing, including eyeglasses and/or hearing aids,
- Dental services, including treatment for relief of pain and infections, restoration of teeth, and maintenance of dental health,
- Other medically necessary health care, diagnostic services, treatment, and measures to correct or improve defects and physical and mental illnesses and conditions discovered by screening services

Passport Coverage

Examples of additional covered services:

- Nutritional screening
- Newborn Metabolic/hemoglobin screening
- Anemia testing
- Hematocrit and/or Hemoglobin
- Lead screening and testing
- Tuberculin test, if indicated
- Sexually transmitted infection, including HIV testing
- Mental health, substance abuse assessments and other age-appropriate counseling
- Dental assessment, referrals and counseling
- Anticipatory guidance, including but not limited to safety, risk reduction, nutritional assessment, and Supplemental Nutrition Assistant Program (SNAP) and Women, Infants and Children (WIC) status
- Special Services – all medically necessary services that are not otherwise covered in the Passport plan benefit package or under the State Medicaid Plan or under EPSDT Special Services as specified by the State Plan, including those provided out of network. EPSDT Special Services require prior authorization.

EPSDT Special Services Limitations

Kentucky DMS specifies the following services are not available through EPSDT Special Services:

- Respite care
- Environmental services
- Educational services
- Vocational services
- Cosmetic services (unless deemed medically necessary to correct psychological distress for the member)
- Convenience services
- Experimental services/clinical trials or trial components that fall outside the routine KYDMS benefit
- Over-the-counter items

EPSDT Examination Schedule

Screening Visits	Age of Child
1st Screening*	3-5 Days
2nd Screening	By One Month
3rd Screening	Two Months
4th Screening	Four Months
5th Screening	Six Months
6th Screening	Nine Months
7th Screening	12 Months
8th Screening	15 Months
9th Screening	18 Months
10th Screening	24 Months
11th Screening	30 Months
Once a year for ages 3-21	

FAQ Call Out:

Providers should use best clinical judgement when a member misses an early childhood well child exam with the goal of matching developmental assessment as closely to chronical age as possible when scheduling.

When attempting to "catch up" members, it may not always be best practice to bring a child for multiple visits close together.

It may be better to schedule one visit based on current age with age focused developmental assessment and exam, developmentally appropriate anticipatory guidance, and provide missed immunizations.

For missed immunizations, providers would be expected to appropriate space between subsequent visits and refer to CDC schedule to determine best practice for make up doses.

EPSDT Preventive Examinations

EPSDT examinations can be performed by any of the licensed and/or certified settings below:

- Comprehensive health clinics
- Physician offices/primary care practices
- Federally Qualified Health Centers (FQHC)
- Rural Health Clinics (RHC)
- Public Health Departments
- Public schools/school districts certified by KDE.
    - Note: if you practice in a school district that has decided to adopt the “free care rule” within the public school system you may want to reach out to the school and coordinate preventive care visits. Under the free care rule, school districts can hire providers and provide health care services to Medicaid members for reimbursement by the State.

Immunization of EPSDT Patients

- Providers are required to follow CDC guidelines for vaccinations in conjunction with well child exams when possible. Members who have missed vaccinations may need to be brought in for additional visits.
- https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html
- If a provider or practice has opted not to provide vaccinations to Medicaid members, they are expected to help coordinate member care for those vaccines.
- It is important for opt-out providers to be aware of where members can be vaccinated in their community and be aware of any limits (e.g.: Local health department vaccination days/hours or requirements to schedule appointments) in order to better coordinate care.

Adolescent Immunizations

Passport has aligned with the AAP and ACS National HPV Vaccination Roundtable (CDC funded) recommendation for proactive HPV vaccination at 9 years of age.

- CDC immunizations schedule notes that HPV can start at 9 years.
- Evidence shows starting the 2-dose series at 9 years increases likelihood of completion by age 13 and provides better immune response.
- A recent study shows initiation at 9 and 10 years of age significantly increased (74% vs 31.1%) completion rates by age 13 which improves provider HEDIS rates and meets recommendation for “on time” vaccination*.
- HPV vaccination protects against 6 types of HPV related cancer.
- In 2021, Kentucky ranked 45th in new incidence of Cervical Cancer.
- Passport tracks HPV vaccinations for our EPSDT members beginning at age 9. Tracking denotes 0, 1, or 2 doses for all members ages 9-12 years. We identify care gaps based on a first dose expected by age 10.

Because one case of preventable cancer is one case too many.

* https://www.publications.aap.org/pediatrics/article/151/3/e2022058794/190722/Early-Initiation-of-HPV-Vaccination-and-Series?autologincheck=redirecteda

HPV Start at 9! What the research shows:

Challenges with bundling with Tdap and Meningococcal:

- Caregivers of children these ages do not want more than 1 shot per arm per visit.
- When presented with 3 shots, caregivers are more likely to request only the "vaccines they need for school" and skip HPV at the 11-year visit.
- Kentucky schools do not require HPV for admission currently, but that does not mean that HPV is any less important than Tdap and Meningococcal for the child.

Caregiver Education on the Benefits of Start at 9!

- Addresses potential caregiver reluctance to give more than 2 shots/visit.
- Kids don't like multiple shots either. Discussing this at 9 in front of the patient engages them in decision making. Start the conversation early enough with parent and child to complete by age 13.
- There is no evidence to date that protection wanes over time, there is no harm starting younger.
- Research shows discussion of stronger immune response with earlier vaccination resonates with caregivers.

Things to avoid when discussing with patient and caregiver:

- Do not focus on HPV exposure risk the older the child becomes. Caregivers become anxious thinking about exposure risk in younger children.

Effectiveness of HPV vaccination against cervical cancer and grade 3 intraepithelial neoplasia incidence drops significantly when vaccination occurs after age 13. - Lancet. 2021 Dec 4;398(10316):2084-2092

Ages 9-16 Years Optimal Vaccination Schedule

Vaccine	Optimal Age	Comments
HPV 1st Dose	9 years	CDC/ACIP, AAP and ACS agree HPV vaccination can start at age 9. National HPV Roundtable strongly recommends starting at age 9.
HPV 2nd Dose	6-12 months after first dose	HEDIS IMA Combo 2: criteria met when Combo 1 criteria met AND both HPV doses given between 9th and 13th birthdays.
Tdap: ≥ 7yrs	11 years	Standard recommended age by CDC/ACIP. HEDIS IMA Combo 1: criteria met when given between 10th and 13th birthday.
Meningococcal 1st Dose: • MenACWY-D ≥9 mos • MenACWY-CRM ≥2 mos • MenACWY-TT ≥2years	11 years	Standard recommended age by CDC/ACIP. HEDIS IMA Combo 1: criteria met when given between 11th and 13th birthdays
Meningococcal 2nd Dose	16 years	Standard recommended age by CDC/ACIP.

For more information about Start at 9 initiatives and resources for your practice visit: National HPV Roundtable – The official website of the National HPV Vaccination Roundtable. For additional articles related to HPV vaccination and evidence for starting at age 9 visit: Article collection: HPV Vaccination Starting at Age 9 (tandfonline.com)

Vaccines for Children (VFC)

VFC is a nationally sponsored program that provides vaccines at no cost to participating health care providers, thus allowing for eligible children aged eighteen (18) and under to receive free vaccines. Eligible children include children who are enrolled in Medicaid, children without health insurance, and Native American and Alaskan Native children.

Children who have health insurance that does not cover immunizations (underinsured) are also eligible if they obtain their vaccines from a Federally Qualified Health Center (FQHC) or Rural Health Center (RHC).

Providers may receive VFC vaccine and administer this vaccine at no charge if they are enrolled in the program and agree to follow the most current recommended childhood immunization schedule. Providers participating in the VFC program will be reimbursed an administrative fee for recommended childhood and adolescent immunizations. *Providers must submit claims using the SL modifier when billing for administration of vaccines provided through the VFC.*

For children enrolled in Medicaid, Passport covers the administration of each vaccine dose at a reimbursement rate set by the Department for Medicaid Services. When multiple vaccines are given on the same visit, Passport will reimburse for the administration of each vaccine.

When vaccines are given in conjunction with an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) visit or a physician office visit, Passport will reimburse for the administration of the vaccine in addition to the reimbursement for the visit.

Note: Providers are expected to follow VFC rules outlined in 907 KAR 1:680

Bright Futures Periodicity Schedule

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 nurturing parenting, have no manifestations of any important health problems, and are growing and developing in a satisfactory fashion. Developmental, psychosocial, and chronic disease issues for children and adolescents may require more frequent counseling and treatment visits separate from preventive care visits. Additional visits also may become necessary if circumstances suggest concerns.

These recommendations 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.

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*. 4th ed. American Academy of Pediatrics; 2017).

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

The Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care are updated annually.

	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 mo	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[5]												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[6]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																																
Vision[7]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	★	●	★	●	★	●	★	★	●	★	★	★	★	★	★
Hearing		●[8]	●[9]	→	★	★	★	★	★	★	★	★	★	★	●	●	●	★	●	★	●	←	←	●[10]	→	←	●	→	←	●	→		
DEVELOPMENTAL/SOCIAL/BEHAVIORAL/MENTAL HEALTH																																
Maternal Depression Screening[11]				●	●	●	●																									
Developmental Screening[12]								●			●		●																			
Autism Spectrum Disorder Screening[13]											●	●																				
Developmental Surveillance		●	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Behavioral/Social/Emotional Screening[14]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Tobacco, Alcohol, or Drug Use Assessment[15]																						★	★	★	★	★	★	★	★	★	★	★
Depression and Suicide Risk Screening[16]																							●	●	●	●	●	●	●	●	●	●
PHYSICAL EXAMINATION[17]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[18]																																
Newborn Blood		●[19]	●[20]	→																												
Newborn Bilirubin[21]		●																														
Critical Congenital Heart Defect[22]		●																														
Immunization[23]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Anemia[24]						★			●	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead[25]							★	★	● or ★[26]		★	● or ★[26]		★	★	★	★																
Tuberculosis[27]				★			★		★			★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia[28]												★			★		★		★	←	●	→	★	★	★	★	★	←			●	→	
Sexually Transmitted Infections[29]																						★	★	★	★	★	★	★	★	★	★	★
HIV[30]																						★	★	★	★	←	●	→	★	★	★	★
Hepatitis B Virus Infection[31]		★	→																													→
Hepatitis C Virus Infection[32]																													●	→		→
Sudden Cardiac Arrest/Death[33]																						★	→									→
Cervical Dysplasia[34]																																●
ORAL HEALTH[35]							●[36]	●[36]	★		★	★	★	★	★	★	★															
Fluoride Varnish[37]							←				●				→																	
Fluoride Supplementation[38]							★	★	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★				
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

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 conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per "The Prenatal Visit" (https://doi.org/10.1542/peds.2018-1218).
3. Newborns should have an evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).
4. Newborns 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 newborns should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in "Breastfeeding and the Use of Human Milk" (https://doi.org/10.1542/peds.2011-3552). Newborns discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per "Hospital Stay for Healthy Term Newborn Infants" (https://doi.org/10.1542/peds.2015-0699).
5. Screen, per "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" (https://doi.org/10.1542/peds.2007-2329C).
6. Screening should occur per "Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents" (https://doi.org/10.1542/peds.2017-1904). Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
7. A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3-year-olds. Instrument-based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" (https://doi.org/10.1542/peds.2015-3596) and "Procedures for the Evaluation of the Visual System by Pediatricians" (https://doi.org/10.1542/peds.2015-3597).
8. Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (https://doi.org/10.1542/peds.2007-2333).
9. Verify results as soon as possible, and follow up, as appropriate.
10. Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See "The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies" (https://www.sciencedirect.com/science/article/abs/pii/S1054139X16000483).
11. Screening should occur per "Incorporating Recognition and Management of Perinatal Depression Into Pediatric Practice" (https://doi.org/10.1542/peds.2018-3259).
12. Screening should occur per "Promoting Optimal Development: Identifying Infants and Young Children With Developmental Disorders Through Developmental Surveillance and Screening" (https://doi.org/10.1542/peds.2019-3449).
13. Screening should occur per "Identification, Evaluation, and Management of Children With Autism Spectrum Disorder" (https://doi.org/10.1542/peds.2019-3447).

(continued)

KEY: ● = to be performed ★ = risk assessment to be performed with appropriate action to follow, if positive ←——★ or ●——→ = range during which a service may be provided

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Bright Futures Periodicity Schedule Continued

(continued)

14. Screen for behavioral and social-emotional problems per "Promoting Optimal Development: Screening for Behavioral and Emotional Problems" (https://doi.org/10.1542/peds.2014-3716), "Mental Health Competencies for Pediatric Practice" (https://doi.org/10.1542/peds.2019-2757), "Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents With Anxiety Disorders" (https://pubmed.ncbi.nlm.nih.gov/32439401), and "Screening for Anxiety in Adolescent and Adult Women: A Recommendation From the Women's Preventive Services Initiative" (https://pubmed.ncbi.nlm.nih.gov/32510990). The screening should be family centered and may include asking about caregiver emotional and mental health concerns and social determinants of health, racism, poverty, and relational health. See "Poverty and Child Health in the United States" (https://doi.org/10.1542/peds.2016-0339), "The Impact of Racism on Child and Adolescent Health" (https://doi.org/10.1542/peds.2019-1765), and "Preventing Childhood Toxic Stress: Partnering With Families and Communities to Promote Relational Health" (https://doi.org/10.1542/peds.2021-052582).
15. A recommended assessment tool is available at http://crafft.org.
16. Screen adolescents for depression and suicide risk, making every effort to preserve confidentiality of the adolescent. See "Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I. Practice Preparation, Identification, Assessment, and Initial Management" (https://doi.org/10.1542/peds.2017-4081), "Mental Health Competencies for Pediatric Practice" (https://doi.org/10.1542/peds.2019-2757), "Suicide and Suicide Attempts in Adolescents" (https://doi.org/10.1542/peds.2016-1420), and "The 21st Century Cures Act & Adolescent Confidentiality" (https://www.adolescenthealth.org/Advocacy/Advocacy-Activities/2019-(1)/NASPAG-SAHM-Statement.aspx).
17. At each visit, age-appropriate physical examination is essential, with infant totally unclothed and older children undressed and suitably draped. See "Use of Chaperones During the Physical Examination of the Pediatric Patient" (https://doi.org/10.1542/peds.2011-0322).
18. These may be modified, depending on entry point into schedule and individual need.
19. Confirm initial screen was accomplished, verify results, and follow up, as appropriate. The Recommended Uniform Screening Panel (https://www.hrsa.gov/advisory-committees/heritable-disorders/rusp/index.html), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (https://www.babysfirsttest.org/) establish the criteria for and coverage of newborn screening procedures and programs.
20. Verify results as soon as possible, and follow up, as appropriate.
21. Confirm initial screening was accomplished, verify results, and follow up, as appropriate. See "Hyperbilirubinemia in the Newborn Infant ≥35 Weeks' Gestation: An Update With Clarifications" (https://doi.org/10.1542/peds.2009-0329).
22. Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per "Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease" (https://doi.org/10.1542/peds.2011-3211).
23. Schedules, per the AAP Committee on Infectious Diseases, are available at https://publications.aap.org/redbook/pages/immunization-schedules. Every visit should be an opportunity to update and complete a child's immunizations.
24. Perform risk assessment or screening, as appropriate, per recommendations in the current edition of the AAP *Pediatric Nutrition: Policy of the American Academy of Pediatrics* (Iron chapter).
25. For children at risk of lead exposure, see "Prevention of Childhood Lead Toxicity" (https://doi.org/10.1542/peds.2016-1493) and "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention" (https://www.cdc.gov/nceh/lead/docs/final_document_030712.pdf).
26. Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence areas.
27. Tuberculosis testing per recommendations of the AAP Committee on Infectious Diseases, published in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*. Testing should be performed on recognition of high-risk factors.
28. See "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).
29. Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*.
30. Adolescents should be screened for HIV according to the US Preventive Services Task Force (USPSTF) recommendations (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening) once between the ages of 15 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.
31. Perform a risk assessment for hepatitis B virus (HBV) infection according to recommendations per the USPSTF (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-b-virus-infection-screening) and in the 2021–2024 edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*, making every effort to preserve confidentiality of the patient.
32. All individuals should be screened for hepatitis C virus (HCV) infection according to the USPSTF (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-c-screening) and Centers for Disease Control and Prevention (CDC) recommendations (https://www.cdc.gov/mmwr/volumes/69/rr/rr6902a1.htm) at least once between the ages of 18 and 79. Those at increased risk of HCV infection, including those who are persons with past or current injection drug use, should be tested for HCV infection and reassessed annually.
33. Perform a risk assessment, as appropriate, per "Sudden Death in the Young: Information for the Primary Care Provider" (https://doi.org/10.1542/peds.2021-052044).
34. See USPSTF recommendations (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/cervical-cancer-screening). Indications for pelvic examinations prior to age 21 are noted in "Gynecologic Examination for Adolescents in the Pediatric Office Setting" (https://doi.org/10.1542/peds.2010-1564).
35. Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment (https://www.aap.org/en/patient-care/oral-health/oral-health-practice-tools/) and refer to a dental home. Recommend brushing with fluoride toothpaste in the proper dosage for age. See "Maintaining and Improving the Oral Health of Young Children" (https://doi.org/10.1542/peds.2014-2984).
36. Perform a risk assessment (https://www.aap.org/en/patient-care/oral-health/oral-health-practice-tools/). See "Maintaining and Improving the Oral Health of Young Children" (https://doi.org/10.1542/peds.2014-2984).
37. The USPSTF recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-dental-caries-in-children-younger-than-age-5-years-screening-and-interventions1). Once teeth are present, apply fluoride varnish to all children every 3 to 6 months in the primary care or dental office based on caries risk. Indications for fluoride use are noted in "Fluoride Use in Caries Prevention in the Primary Care Setting" (https://doi.org/10.1542/peds.2020-034637).
38. If primary water source is deficient in fluoride, consider oral fluoride supplementation. See "Fluoride Use in Caries Prevention in the Primary Care Setting" (https://doi.org/10.1542/peds.2020-034637).

Note: Periodicity Schedule reference #26 is specific to Medicaid recipients and requires lead blood testing at 12 and 24 months secondary to increased population risk. Verbal lead risk assessment does not meet Medicaid requirement.

Summary of Changes Made to the Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule)

This schedule reflects changes approved in November 2021 and published in July 2022. For updates and a list of previous changes made, visit www.aap.org/periodicityschedule.

CHANGES MADE IN NOVEMBER 2021

HEPATITIS B VIRUS INFECTION

Assessing risk for HBV infection has been added to occur from newborn to 21 years (to account for the range in which the risk assessment can take place) to be consistent with recommendations of the USPSTF and the 2021–2024 edition of the AAP *Red Book: Report of the Committee on Infectious Diseases.*

- Footnote 31 has been added to read as follows: "Perform a risk assessment for hepatitis B virus (HBV) infection according to recommendations per the USPSTF (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-b-virus-infection-screening) and in the 2021–2024 edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*, making every effort to preserve confidentiality of the patient."

SUDDEN CARDIAC ARREST AND SUDDEN CARDIAC DEATH

Assessing risk for sudden cardiac arrest and sudden cardiac death has been added to occur from 11 to 21 years (to account for the range in which the risk assessment can take place) to be consistent with AAP policy ("Sudden Death in the Young: Information for the Primary Care Provider").

- Footnote 33 has been added to read as follows: "Perform a risk assessment, as appropriate, per 'Sudden Death in the Young: Information for the Primary Care Provider' (https://doi.org/10.1542/peds.2021-052044)."

DEPRESSION AND SUICIDE RISK

Screening for suicide risk has been added to the existing depression screening recommendation to be consistent with the GLAD-PC and AAP policy.

- Footnote 16 has been updated to read as follows: "Screen adolescents for depression and suicide risk, making every effort to preserve confidentiality of the adolescent. See 'Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I. Practice Preparation, Identification, Assessment, and Initial Management' (https://doi.org/10.1542/peds.2017-4081), 'Mental Health Competencies for Pediatric Practice' (https://doi.org/10.1542/peds.2019-2757), 'Suicide and Suicide Attempts in Adolescents' (https://doi.org/10.1542/peds.2016-1420), and 'The 21st Century Cures Act & Adolescent Confidentiality' (https://www.adolescenthealth.org/Advocacy/Advocacy-Activities/2019-(1)/NASPAG-SAHM-Statement.aspx)."

BEHAVIORAL/SOCIAL/EMOTIONAL

The Psychosocial/Behavioral Assessment recommendation has been updated to Behavioral/Social/Emotional Screening (annually from newborn to 21 years) to align with AAP policy, the American College of Obstetricians and Gynecologists (Women's Preventive Services Initiative) recommendations, and the American Academy of Child & Adolescent Psychiatry guidelines.

- Footnote 14 has been updated to read as follows: "Screen for behavioral and social-emotional problems per 'Promoting Optimal Development: Screening for Behavioral and Emotional Problems' (https://doi.org/10.1542/peds.2014-3716), 'Mental Health Competencies for Pediatric Practice' (https://doi.org/10.1542/peds.2019-2757), 'Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents With Anxiety Disorders' (https://pubmed.ncbi.nlm.nih.gov/32439401), and 'Screening for Anxiety in Adolescent and Adult Women: A Recommendation From the Women's Preventive Services Initiative' (https://pubmed.ncbi.nlm.nih.gov/32510990/). The screening should be family centered and may include asking about caregiver emotional and mental health concerns and social determinants of health, racism, poverty, and relational health. See 'Poverty and Child Health in the United States' (https://doi.org/10.1542/peds.2016-0339), 'The Impact of Racism on Child and Adolescent Health' (https://doi.org/10.1542/peds.2019-1765), and 'Preventing Childhood Toxic Stress: Partnering With Families and Communities to Promote Relational Health' (https://doi.org/10.1542/peds.2021-052582)."

FLUORIDE VARNISH

- Footnote 37 has been updated to read as follows: "The USPSTF recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-dental-caries-in-children-younger-than-age-5-years-screening-and-interventions1). Once teeth are present, apply fluoride varnish to all children every 3 to 6 months in the primary care or dental office based on caries risk. Indications for fluoride use are noted in 'Fluoride Use in Caries Prevention in the Primary Care Setting' (https://doi.org/10.1542/peds.2020-034637)."

FLUORIDE SUPPLEMENTATION

- Footnote 38 has been updated to read as follows: "If primary water source is deficient in fluoride, consider oral fluoride supplementation. See 'Fluoride Use in Caries Prevention in the Primary Care Setting' (https://doi.org/10.1542/peds.2020_034637)."

CHANGES MADE IN NOVEMBER 2020

DEVELOPMENTAL

- Footnote 12 has been updated to read as follows: "Screening should occur per 'Promoting Optimal Development: Identifying Infant and Young Children With Developmental Disorders Through Developmental Surveillance and Screening' (https://doi.org/10.1542/peds.2019-3449)."

AUTISM SPECTRUM DISORDER

- Footnote 13 has been updated to read as follows: "Screening should occur per 'Identification, Evaluation, and Management of Children With Autism Spectrum Disorder' (https://doi.org/10.1542/peds.2019-3447)."

HEPATITIS C VIRUS INFECTION

- Screening for HCV infection has been added to occur at least once between the ages of 18 and 79 years (to be consistent with recommendations of the USPSTF and CDC).
- Footnote 32 has been added to read as follows: "All individuals should be screened for hepatitis C virus (HCV) infection according to the USPSTF (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-c-screening) and Centers for Disease Control and Prevention (CDC) recommendations (https://www.cdc.gov/mmwr/volumes/69/rr/rr6902a1.htm) at least once between the ages of 18 and 79. Those at increased risk of HCV infection, including those who are persons with past or current injection drug use, should be tested for HCV infection and reassessed annually."

HRSA
Health Resources & Services Administration
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EPSDT Periodic Examination Coding

CPT Code New/Existing	Description	Standard ICD-10 Codes	Description	"EP" Modifier
99381/91	Preventive visit, Age <1 year	**Z00.110** **Z00.111**	Health supervision for newborn under 8 days old, **or** Health supervision for newborn 8-28 days old	Use only when all components of the appropriate EPSDT screening interval have been completed and documented in the member's medical record.
		Z00.121 **Z00.129**	(see Below)	
99382/92	Preventive visit, Age 1-4	**Z00.121**	Routine child health exam with abnormal findings	
99383/93	Preventive visit, Age 5-11	**Z00.129**	Routine child health exam without abnormal findings	
99384/94	Preventive visit, Age 12-17			
99385/95	Preventive visit, Age 18-20	**Z00.00**	General adult medical exam without abnormal findings	
		Z00.01	General adult medical exam with abnormal findings	
Additional ICD-10 Codes: Z00.2, Z00.3, Z02.0, Z02.5, Z76.1, Z76.2				
Related Codes		**Description**		
83655		Blood test - lead		
Z71.3		Dietary counseling and surveillance		
Z68.51 – Z68.54		BMI percentile (use for 2-20 years of age)		
Z71.82		Exercise counseling		
Z02.5		Encounter for examination for participation in sport (Note: a sports physical does not count as a comprehensive EPSDT preventive exam but can be completed in conjunction with a preventive visit)		

Note: Use of Category II codes are preferred but not required. Examples: 3008F to confirm BMI performed and documented or 2014F to confirm mental status has been assessed and documented for members ≥ 9 years.

EPSDT Providers

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Who are EPSDT Providers?

Any practitioner, including a physician, clinic, home health agency, medical equipment supplier, psychologist, speech therapist or audiologist, may provide EPSDT and/or EPSDT Special Services. This includes out-of-network providers if there are no in-network providers available to provide a medically necessary EPSDT Special Service.
Reminder: All EPSDT Special Services require prior authorization.

Passport-contracted network providers are required to ensure the provision of screening, preventive, and medically necessary diagnostic and treatment services for individuals under the age of 21.

EPSDT Provider Responsibilities (1/4)

- EPSDT providers must maintain a screening periodicity tracking system for members seen for initial screenings and any subsequent screenings to ensure they are performed timely and in accordance with the periodicity schedule.
  - Screening and preventive care includes but is not limited to well child exams including immunizations, oral health, vision and hearing

- Providers should inform members, guardians and/or their legal representatives of the periodicity schedule at each visit. Scheduling of initial and periodic screening of EPSDT-eligible Medicaid members is the responsibility of the EPSDT screening providers, as well as overall care coordination between other treating providers.

- EPSDT providers must track and report when members, guardians and/or their legal representative accepts and/or refuses EPSDT and EPSDT Special Services.

EPSDT Provider Responsibilities (2/4)

Providers must give written notification to families with eligible children when well-child visits, screenings, and immunizations are due.

For each scheduled appointment, EPSDT providers must:

1. Provide written notice to the member of the appointment dates.
2. Attempt to notify the member of the appointment dates by telephone.

Providers must contact the parents and/or guardians of members younger than 18 years needing follow-up treatments. Members who are of legal age to consent for care should be contacted for follow-ups as needed.

Providers must contact pregnant or postpartum woman younger than 18 years who need prenatal or postpartum care.

EPSDT Provider Responsibilities (3/4)

Primary Care Providers (PCP) must:

- Follow the **Patient Protection and Affordable Care Act** (ACA) mandated use of the current American Academy of Pediatrics periodicity schedule and Bright Futures guidelines and anticipatory guidance when delivering the EPSDT benefit, including but not limited to screening, vision and hearing services.

- Provide all age-specific assessments and services including immunizations and labs.

- Provide screening, preventive, and medically necessary diagnostic and treatment services. When outside the scope of the provider, the PCP should refer for diagnostic and treatment service and appropriately coordinate care. Members who fail to follow up with or refuse diagnostic/treatment service referral can be referred to Passport for additional outreach follow same procedure as missed well child exam appointments.

- Request Prior Authorization for EPSDT Special Services through the Passport Prior Authorization process.

EPSDT Provider Responsibilities (4/4)

Missed/Failed Member Appointments

EPSDT providers must follow up on missed appointments. If the member fails to keep the scheduled appointment and the member, guardian and/or legal representative fails to contact the provider to reschedule, the provider must send an appointment letter or make a telephone call and provide the member another opportunity to be screened within thirty (30) days of the initial/previous missed appointment.

Two (2) good faith efforts to contact the member, guardian and/or legal representative are required to reschedule a screening appointment. EPSDT providers must document any missed appointments and the two (2) good faith efforts in the medical record.

Failure of a member, guardian and/or legal representative to keep the second and/or subsequent appointment and the member, guardian and/or legal representative responds to the provider's follow-up contact after 30 days from last contact, a declination is considered for the missed screening/appointment only.

The provider must continue to maintain periodicity and schedule the member for the next screening due following the same process.

EPSDT Provider Responsibilities

Missed/Failed Member Appointments

After a provider makes two (2) attempts to reschedule and is unable to bring the member into care within thirty (30) days from the first missed appointment, the provider can refer the member to Passport using the Health Education Referral Form at www.passporthealthplan.com > Health Care Providers > Forms

Upon referral, Passport and the provider will work collaboratively to try to bring the member into care and back in compliance with the AAP periodicity schedule.

Passport will attempt to contact the member's parent and/or guardian with written correspondence, telephone contacts and/or face-to-face contacts informing them of:

1. The importance of well child visits,
2. That the well child visit is due,
3. How and where to access these services, including transportation and scheduling services, and
4. Informing the parent and/or guardian that the services are provided without cost.

EPSDT Provider Responsibility: Care Coordination

Screening during well child exams for EPSDT eligible members may lead to a referral for additional diagnostic assessment or treatment that is outside the scope of the primary care provider.

- Passport does not require a formal referral for this type of care, but some specialists may request it in order to see a member.
- When the member does not follow up with the specialists or diagnostic service, the PCP should attempt to re-coordinate care.
- If re-coordination attempts fail, the provider can refer the member to Passport using the Health Education Referral Form at www.passporthealthplan.com > Health Care Providers > Forms
- *After referral to Passport, we will attempt to outreach the member and connect them to the additional services needed including addressing any barriers to care required.*

All Providers Responsibility: WIC Coordination

Who Qualifies for WIC? Women, Infants and Children (WIC) is income based but Medicaid and TANF are considered automatic income eligibility qualifiers! The member must demonstrate that they are at "nutritional risk." The following populations are categorically eligible for WIC:

- Women who are pregnant, up to 6 months postpartum (post delivery or end of pregnancy), or breastfeeding (up to infant's first birthday).
- Infants until their 1st birthday
- Children until their 5th birthday

What steps are needed?

- Application and evaluation for "nutritional risk." Nutritional risk means that an individual has a medical-based or dietary-based condition, including but not limited to the following:
  - nutrition-related metabolic disease, diabetes, low birth weight, failure to thrive, prematurity, infants of mothers with a substance use disorder, developmental disabilities or intellectual disabilities, AIDS, allergy or intolerance that affects nutritional status, and anemia
- Nutritional risk evaluation is often completed in the member's local WIC clinic/agency. However, another health professional (examples: physician, nurse practitioner, nurse, nutritionist) can also provide information needed to verify the member meets criteria for nutritional risk.
- If, as the provider, you have made the referral to WIC, and within the confines of applicable PHI/HIPAA laws:
  - It can speed up the process to provide the patient's diagnosis associated with nutritional risk.
  - Alternatively, WIC may reach back to you to request medical information to confirm nutritional risk.

WIC Coordination of care by providers is an adjunct of Section 1902(a)(11)(C) of the Social Security Act and the state's related expectation that MCO's and providers within MCO's collaborate with WIC to improve patient nutritional health.

Passport EPSDT Provider Monitoring

Reporting

Includes encounters submissions on:

- EPSDT Screenings
- Basic Case Management Services
- Member/Guardian acceptance, refusal of and/or missed EPSDT services
- Medically necessary diagnostic and preventive services and referrals for treatment and Specialty Services

Auditing

- Includes review of member medical records/charts as evidence of service provision
- Chart audits conducted by DMS
- Random audits conducted by Passport

HEDIS® & Performance Measures

HEDIS® includes performance measures related to dozens of important health care issue. Examples of measures applicable to care delivered to children and adolescents include but are not limited to:

- Child and adolescent well child exams (W30 and WCV)
- Child and adolescent immunization status (CIS Combo 10 and IMA Combo 2)
- Weight assessment and counseling for nutrition and physical activity for children and adolescents (WCC)
- Lead screening in children (LSC)
- Chlamydia screening for sexually active adolescents and young adults (CHL)
- Annual dental visits for children and adolescents (ADV)
- Appropriate monitoring and follow up for children prescribed medication to treat ADHD (ADD)
- Ensuring children and adolescents first use psychosocial interventions (therapy) prior to trial of antipsychotic medication (APP)
- Metabolic monitoring for children and adolescents prescribed antipsychotic medications (AMP)

HEDIS® Tip Sheets are available for providers under the "Resources" tab of Passport's Payer Spaces in the Availity Essentials Portal at www.Availity.com.

CMS Guidance Unique to EPSDT Members

Blood Lead Screening Reminders

Medicaid Recipients

- Universal screening blood test at 12 and 24 months old
- Screening blood test for any child between the ages of 36 and 72 months with no record of a previous lead blood test

Any child

- Capillary blood lead test result ≥ 3.5 µg/dL must be confirmed by venous sample
- Ongoing monitoring by PCP including follow up blood lead testing, developmental surveillance, and appropriate referrals to specialists following CDC guidelines: https://www.cdc.gov/nceh/lead/advisory/acclpp/actions-blls.htm

KY Department of Public Health Reporting

- Report elevated blood lead levels to both the KY DPH and the local health department in which the child resides
- Inform patient's caregiver that the Health Department will contact them to provide education and assess for environmental lead risk

Links:
KYDPH CLPPP: https://chfs.ky.gov/agencies/dph/dmch/cfhib/Pages/clppp.aspx
Local Health Departments: https://chfs.ky.gov/agencies/dph/dafm/LHDInfo/HealthDepartmenthoursofoperation.pdf

Questions?

Contact your Provider Service Representative or email our EPSDT Program Director, Jessica Beal, Psy.D. at Jessica.Beal@MolinaHealthCare.com

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