Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Medical Protocol and Periodicity Schedule (the Medical Schedule) and EPSDT Dental Protocol and Periodicity Schedule (the Dental Schedule)

The Medical Schedule

The EPSDT Medical Protocol and Periodicity Schedule (the Medical Schedule) consists of screening procedures arranged according to the intervals or age levels at which each procedure should be provided. See 130 CMR 450.140 through 450.150 for more information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services and Preventive Pediatric Health-Care Screening and Diagnosis (PPHSD) services.

Pediatric Preventive Health-Care Visits – Pediatric preventive health-care visits must

- contain the components explained in the descriptions in the EPSDT Medical Protocol and Periodicity Schedule; and
- occur at the following ages, at a minimum: one to two weeks, one month, two months, four months, six months, nine months, 12 months, 15 months, 18 months, two years, and then every year until the member's 21st birthday.

Each EPSDT or PPHSD visit must include the following components.

Initial or Interval Health History

- **Initial** – an initial history must be taken at the first member visit with a provider. The initial health history includes the family health history and baseline data on the member, including but not limited to
  (a) growth and developmental history;
  (b) immunization history;
  (c) medications, herbal remedies, and known reactions to medications and allergies; and
  (d) pertinent information about previous illnesses and hospitalizations, risk-taking behaviors, such as drug, alcohol, and tobacco use, sexual activity, and other medical, psychosocial, and behavioral health concerns.
- **Interval** – an interval history must be taken at each periodic visit. The interval history includes an update of the member's medical history, including but not limited to
  (a) a review of all systems and any illnesses, diseases, medications, or medical problems experienced by the member since the last visit; and
  (b) an updated assessment of lifestyle, risk behavior, sexual activity, psychosocial and behavioral health concerns.

Unclothed Comprehensive Physical Examination

- **Growth Assessment** – assessment of growth parameters using height and weight. Measurements must be plotted on appropriate growth charts. Screen for healthy weight using the Centers for Disease Control and Prevention (CDC) body mass index (BMI) charts for members aged two through 20 years of age. Include head-circumference measurements until the age of two years.
- **Blood Pressure** – selective screening for high blood pressure at every well visit starting at three years of age.

Nutritional Assessment

- Ask about dietary habits.
- Promote breastfeeding as the best form of infant nutrition. Assess breastfed infants between two and five days of age.
- Starting in middle childhood, screen annually for eating disorders and ask about body image and dieting patterns.
- Providers must make every effort to inform a potentially eligible member or his or her parent or guardian about the Women, Infants, and Children (WIC) nutrition program. A referral to WIC should be made using the WIC Medical Referral Form (MRF) from the Massachusetts WIC Program.
- The member, parent, or guardian may also be referred to the Supplemental Nutrition Assistance Program (SNAP), which is administered by the Department of Transitional Assistance.

Developmental Screening

- The provider must screen the member for delays or differences in functioning in the following areas, as appropriate to the member's age.
  (a) physical development, including gross motor development (strength, balance, and locomotion), fine motor development (hand-eye coordination), and sexual development;
  (b) cognitive development, including self-help and self-care skills, and problem-solving and reasoning abilities;
  (c) language development, including expression, comprehension, and articulation;
  (d) social integration and peer relations, including school performance and family issues;
  (e) socialization and infant attachment indicators;
  (f) psychosocial and behavioral development, behavioral difficulties, such as sleep disturbances and aggression, psychological problems, such as depression, and risk-taking behavior; and
  (g) signs of family violence and physical or sexual abuse.
- Essential components of the screening process include, but are not limited to
  (a) sensitive attention to member, parent, or guardian concerns about the member;
  (b) thoughtful inquiry about parent or guardian observations;
  (c) observation by the provider and the member’s parent or guardian about the member’s behaviors;
  (d) examination of specific developmental attainments; and
  (e) observation of member, parent, or guardian interaction.
- Providers must inform the parent or guardian about the benefits of developmental intervention and special education services if a concern is identified. To access these services for any member who is between birth and two years six months, providers should refer the member to the local Early Intervention Program of the Massachusetts Department of Public Health. If the child is older than two years six months, providers should refer the parent or guardian to the local public school system. Early Intervention and/or the local public school will conduct assessments to determine eligibility and service needs.

Behavioral Health Screening

- In performing the behavioral health screening, providers must utilize a clinically appropriate tool from the following list of approved, standardized behavioral health screening tools.
  (a) Ages and Stages Questionnaires (ASQ: SE);
  (b) Brief Infant-Toddler Social and Emotional Assessment (BITSEA);
  (c) Car, Relax, Alone, Forget, Friends, Trouble, (CRAFFT);
  (d) Early Childhood Screening Assessment (ECSA);
  (e) Modified Checklist for Autism in Toddlers (M-CHAT);

(f) Modified Checklist for Autism in Toddlers Revised with Follow-up (M-CHAT-R/F);
(g) Parents' Evaluation of Developmental Status (PEDS);
(h) Patient Health Questionnaire-9 (PHQ-9);
(i) Pediatric Symptom Checklist (PSC) and Pediatric Symptom Checklist-Youth Report (PSC-Y);
(j) Strengths and Difficulties Questionnaire (SDQ); and
(k) Survey of Wellbeing of Young Children (SWYC).

- If there is evidence of a behavioral health concern, or need for further assessment, providers must offer the necessary behavioral health services or make a referral to another provider who can provide the appropriate services. Providers can seek assistance from MassHealth or a member's health plan to determine which providers may be available to provide these services and how to use out-of-network providers, if necessary.

Hearing Screening – an objective hearing screening must be performed using an audiometer or otoacoustic emissions at the following ages: four years, five years, six years, eight years, and 10 years.

- If the objective hearing screen is performed in another setting, such as a school, the screening does not need to be repeated by the provider, but he or she must document the results. Conduct a subjective hearing assessment at all other routine visits. Conduct audiologic monitoring every six months until the age of three years if there is a language delay or risk of hearing loss.
- If the provider receives notification of a missed or failed newborn hearing screen, then the provider must ensure that a new screening or diagnostic follow-up takes place. Providers may contact the Massachusetts Department of Public Health's Universal Newborn Hearing Screening Program for additional information about the newborn hearing screening.

Vision Screening

- Assess newborns before discharge or at least by the age of two weeks, including corneal light reflex and red reflex.
- Evaluate fixation preference, alignment, and eye disease by the age of six months and at each subsequent visit until 12 months of age. Screen for strabismus between the ages of three years and five years. An objective visual acuity screening must be performed at the following ages: three years, four years, five years, six years, eight years, 10 years, 12 years, 15 years, 17 years, and 18 years.
- Screen children at entry to kindergarten if they have not been screened during the previous 12-month period using the Massachusetts Preschool Vision Screening Protocol. Children who fail to pass the vision screening and children with neurodevelopmental delay must be referred to a licensed optometrist or ophthalmologist.
- If the objective vision screen is performed in another setting, such as a school, the screen does not need to be repeated by the provider, but he or she must document the results in the member's medical record.

Newborn Metabolic Screening – Verify that newborn has received all required newborn metabolic screenings, especially if newborn was not born in a hospital setting or was born outside Massachusetts.

Dental Assessment and Referral

- Assess oral health at each visit. Intraoral assessments should identify obvious dental problems and ensure that regular visits to a dental provider are occurring.
- The screening provider must encourage members to seek regular dental care from a dental provider, at the eruption of the first tooth and no later than 12 months of age, including examinations once every six months, preventive services, and treatment, as necessary.

- Assess the need for fluoride supplementation starting at the age of six months continuing until 14 years of age, based on availability in water supply and dietary source of fluoride. Counsel on good dental-hygiene habits, and prevention of infant caries, including avoidance of bottle-propping, weaning from bottle, and drinking from a cup by one year of age.

Cancer Screening and Examination

- Initiate pelvic exam and Pap test at 21 years of age or earlier at the discretion of clinician or patient.
- Perform a clinical breast exam and counsel about the benefits and limitations of breast self-exam instruction starting at 20 years of age for females.
- Perform a clinical testicular exam and counsel about the benefits and limitations of self-exam instruction annually beginning at the age of 15 years, for males.
- Screen all members for the presence of other cancers as indicated by member or family history.

Immunization Assessment and Administration – Assess the member's immunization status and administer all immunizations for which the member is due in accordance with the recommendations of the Department of Public Health's Immunization Program.

Lead Toxicity Screening – Perform initial screening between nine and 12 months and again at two and three years of age. Screen at four years of age if a child lives in a city or town with a high risk for childhood lead poisoning. Screen at entry to kindergarten if not screened before. Children should be screened for lead poisoning more than once a year when they meet one of the high-risk criteria set forth by the Massachusetts Childhood Lead Poisoning Prevention Program (MCLPPP) or whenever in the sound medical judgment of the health care provider, they are at high risk of lead poisoning. A list of high-risk communities and additional information about screening can be found at www.mass.gov/dph/clppp. Pursuant to M.G.L. c. 111, § 191, physicians, other health care providers, and private laboratories must report all cases of childhood lead poisoning known to them to the Director within three working days of identification, unless previously reported. If a child suffers multiple episodes of lead poisoning, the provider must report each episode.

Tuberculin Skin Test – Test all members at high risk. Determine the need for repeat skin testing by the likelihood of continued exposure to infectious TB.

Hemoglobin/Hematocrit Test

- Test once between nine months and 12 months of age; and
- at clinician discretion, conduct detailed assessment of infants at high risk for iron deficiency.
- Conduct assessment, including dietary iron sufficiency, at the clinician's discretion for children aged one year through 10 years; and
- screen all non-pregnant adolescents for anemia every 5-10 years starting at 12 years of age and screen members 11 through 21 years of age annually, if at high risk.

Cholesterol Screening – Screen children aged two years through 17 years at least once if they have a family history of premature cardiovascular disease or a parent with known lipid disorder or who is overweight or obese. Screen once between the ages of 18 years and 21 years, if not screened previously.

Hepatitis C – Obtain anti-hepatitis C virus test after the age of 12 months in children with mothers infected with hepatitis C virus and periodically test all children if at high risk. Periodically test all high-risk members 11 through 20 years of age.

Sexually Transmitted Infections – Screen all sexually active adolescents and young adults annually for gonorrhea and chlamydia. Initiate female pelvic exam and Pap test at 21 years of age or earlier, based on risk factors at clinician discretion. Consider urine-based screening for females when a pelvic exam is not performed. Advise about the schedule of HPV vaccines. Screen for syphilis if at risk.

HIV – Annual testing for those at increased risk and routine screening at 13 years of age and older. Advise about risk factors for HIV infection.

Other Laboratory Testing – Obtain other laboratory tests according to the member's risk, the provider's professional judgment, and applicable state requirements for newborn screening tests.

Health Education and Anticipatory Guidance

- Age-specific and appropriate counseling, considering the privacy concerns of the member, must be delivered to parents, guardians, or members about common and expected developmental advancements and common physical and behavioral concerns.
- Effective discussion includes assessment and teaching based on a family-centered, culturally competent approach, addressing the concerns of the members, parent(s), and guardian(s). Discussion topics should include, but not be limited to
  (a) developmental expectations and sound parenting practices;
  (b) behavioral risks, such as avoidance of the use of alcohol, drugs, tobacco, and other substances with the potential for abuse; violence, bullying; and depression;
  (c) safe and healthy sexual behaviors, including abstinence and contraception, with sensitivity to sexual orientation;
  (d) benefits and components of a healthy diet, and safe weight management; ways to maintain adequate calcium and vitamin D and advise against sugar-sweetened and caffeinated drinks;
  (e) benefits of daily physical activity, opportunities for daily physical activity, parents as role models;
  (f) asking about sleep habits and encourage proper sleep amounts. Advise that infants be placed on their backs when putting them to sleep until at least sx months of age;
  (g) impact of electronic media as a risk factor for being overweight, low school performance, and violent behavior. Encourage limiting of screen time. Discourage placement of computers and TVs in bedrooms;
  (h) chronic and communicable disease prevention;
  (i) safety measures and injury prevention, including childproofing, car seats and seat belts, bike and motorcycle helmets, poison prevention, gun safety, and other age-appropriate counseling;
  (j) use of sunscreen, minimizing exposure to the sun, and discouraging the use of indoor tanning; and
  (k) potential risks of body piercing or tattooing.
- Educational activities and resources (such as printed brochures, audiovisual materials, class instruction, and health-risk questionnaires) can enhance comprehensive child and adolescent health supervision, but should not replace interaction between the provider and the member.
- Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents—Third Edition and the American Medical Association's (AMA) Guidelines for Adolescent Preventive Services (GAPS) provide lists of topics that may be discussed, and resources for providers, parents, guardians, and members.

The Dental Schedule

The EPSDT Dental Protocol and Periodicity Schedule (the Dental Schedule) consists of procedures arranged according to the intervals or age levels at which each procedure is to be provided. The Dental Schedule is based

on the Preventive Pediatric Oral Health Care recommendations from the American Academy of Pediatric Dentistry (AAPD) Reference Manual 2007-2008. See 130 CMR 450.140 through 450.150 for more information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services and Preventive Pediatric Health-Care Screening and Diagnosis (PPHSD) services.

Recommendations for Preventive Pediatric Oral Health Care (AAPD Reference Manual 2007-2008)

	6 - 12 Months	12 - 24 Months	2 - 6 Years	6 - 12 Years	12 -20 Years
Clinical oral examination (1,2)	x	x	x	x	x
Assess oral growth and development (3)	x	x	x	x	x
Caries-risk assessment (4)	x	x	x	x	x
Radiographic assessment (5)	x	x	x	x	x
Prophylaxis and topical fluoride (4,5)	x	x	x	x	x
Fluoride supplementation (6,7)	x	x	x	x	x
Anticipatory guidance/counseling (8)	x	x	x	x	x
Oral hygiene counseling (9)	Parent	Parent	Patient/parent	Patient/parent	Patient
Dietary counseling (10)	x	x	x	x	x
Injury prevention counseling (11)	x	x	x	x	x
Counseling for nonnutritive habits (12)	x	x	x	x	x
Counseling for speech/language development	x	x	x		
Substance use disorder screening				x	x
Screening for intraoral/perioral piercing				x	x
Assessment and treatment of developing malocclusion			x	x	x
Assessment for pit and fissure sealants (13)			x	x	x
Assessment and/or removal of third molars					x
Transition to adult dental care					x

1. First examination at the eruption of the first tooth and no later than 12 months. Repeat every six months or as indicated by child's risk status/susceptibility to disease.
2. Includes assessment of pathology and injuries.
3. By clinical examination.
4. Must be repeated regularly and frequently to maximize effectiveness.
5. Timing, selection, and frequency determined by child's history, clinical findings, and susceptibility to

oral disease.

6. Consider when systematic fluoride exposure is suboptimal.
7. Up to at least 16 years.
8. Appropriate discussion and counseling should be an integral part of each visit for care.
9. Initially, responsibility of parent or guardian; as child develops, jointly with parent or guardian; then, when indicated, only child.
10. At every appointment, initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity.
11. Initially play objects, pacifiers, car seats; then when learning to walk, sports and routine playing, including the importance of mouthguards.
12. At first, discuss the need for additional sucking; digits vs. pacifiers; then the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.
13. For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption.

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