



Transmittal Letter ALL-249

DATE: November 2024

TO: All Providers Participating in MassHealth

FROM: Mike Levine, Assistant Secretary for MassHealth

RE: **All Provider Manuals: Updates to Appendix W: EPSDT Services Medical and Dental Protocols and Periodicity Schedules and Appendix Z: EPSDT/PPHSD Screening Services Codes**

Summary

This letter transmits a revised Appendix W: EPSDT Services Medical and Dental Protocols and Periodicity Schedules and a revised Appendix Z: EPSDT/PPHSD Screening Services Codes for all provider manuals.

The updated Appendices W and Z are effective on November 21, 2024.

Please note that [All Provider Bulletin 348](#) (effective January 1, 2023), related to maternal and caregiver depression screening limitations and cadence, is hereby superseded by the transmittal of the revised Appendix W and Appendix Z. Screening the child's parent(s) or caregiver(s) for postpartum depression should now occur at every preventive pediatric visit from the one month visit to the twelve month visit.

The Medical and Dental Schedules

With this transmittal letter, MassHealth is highlighting changes to the Medical Schedule and the Dental Schedule in Appendix W. These revisions further align the Medical Schedule with the Bright Futures *Guidelines and Periodicity Schedule*, and the Massachusetts Health Quality Partners *Pediatric Preventive Care Guidelines*. The changes also update guidance regarding postpartum depression screening to be consistent with Chapter 186 of the Acts of 2024 and update the Dental Schedule to be consistent with the Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents from the American Academy of Pediatric Dentistry.

EPSDT/PPHSD Service Codes

This letter transmits revisions to the list of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) or Preventive Pediatric Health-care Screening and Diagnosis (PPHSD) service codes contained Appendix Z.

Effective for dates of service beginning January 1, 2023, providers must use the following codes and modifiers for developmental and behavioral health screening during preventive pediatric visits:

Add

-U1	-U3	-UD
-U2	-U4	96127

Modify

96110

MassHealth Website

This transmittal letter and attached pages are available on the MassHealth website at www.mass.gov/masshealth-transmittal-letters.

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Questions?

- Call MassHealth at (800) 841-2900, TDD/TTY: 711
- Email us at provider@masshealthquestions.com

New Material

The pages listed here contain new or revised language.

All Provider Manuals

Pages W-i through W-13

Pages Z-1 through Z-4

Obsolete Material

The pages listed here are no longer in effect.

All Provider Manuals

Pages W-1 through W-11 — transmitted by Transmittal Letter ALL-233

Pages Z-1 through Z-2 — transmitted by Transmittal Letter ALL-207

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Early and Periodic Screening, Diagnostic, 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, Diagnostic, and Treatment (EPSDT) services and Preventive Pediatric Healthcare Screening and Diagnosis (PPHSD) services. This schedule reflects recommended well and preventive child healthcare screening services. If the clinical needs of a child justify deviation from this schedule, the provider must document this fact in the member's medical record, including the provider's clinical judgment and justification for that deviation.

The Medical Schedule reflects guidance from several sources, including, but not limited to:

- The United States [Centers for Disease Control and Prevention \(CDC\)](#).
- The [Bright Futures Guidelines](#) and the [Bright Futures/American Academy of Pediatrics \(AAP\) Periodicity Schedule](#). The Periodicity Schedule presents recommendations for each age-related visit in the Bright Futures Guidelines, including recommendations for screenings, assessments, physical exams, and procedures. The Periodicity Schedule is updated between editions of the Bright Futures Guidelines.
- [The Massachusetts Health Quality Partners \(MHQP\) Pediatric Preventive Care Guidelines](#). MHQP is an independent, nonprofit organization that includes healthcare providers, payers, and patients in Massachusetts with the goal of improving patient care in the state of Massachusetts.

Frequency of Pediatric Preventive Healthcare Visits

Pediatric preventive healthcare visits should contain the parts explained in the descriptions in the Medical Schedule and, at a minimum, occur at the following ages:

- newborn;
- three to five days;
 - newborns sent home from the hospital **fewer than 48 hours after delivery** should be evaluated within 48 hours of discharge;
 - newborns sent home from the hospital **48 hours or more after delivery** should be evaluated within 48 to 72 hours after discharge;
- by one month;
- two, four, six, and nine months;
- 12, 15, 18, 24, and 30 months; and
- annually from three to 21 years.

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Components of Pediatric Preventive Healthcare Visits

History

Health histories should be taken at each preventive healthcare visit. Typically, an initial health history taken at a member's first visit with a provider is more comprehensive than health histories taken during later preventive healthcare visits.

Visit history may be obtained according to the concerns of the family and the health care professional's preference or style of practice. History that is relevant to the age-specific health supervision visit is gathered to assess strengths, accomplish surveillance, and enhance the health care professional's understanding of the child and family. Past medical history and pertinent family history are important elements of the initial and interval history. Some visits also include relevant social history questions.

Health histories should include age-appropriate history about the member, including but not limited to:

- family history;
- birth, growth, nutrition, and developmental history;
- immunization history;
- current and past medications, including any alternative or complementary medicine;
- medication allergies and other allergies;
- medical history, including previous diagnoses, surgeries, and hospitalizations;
- review of systems;
- risk-taking behaviors, including alcohol, marijuana, tobacco, opiate, and other substance use;
- sexual health and development, including sexual activity; and
- other medical, psychosocial, and behavioral health concerns.

Measurements

- a) **Length/Height and Weight** – Providers should get length/height and weight measurements for children ages birth to 21 years at every preventive healthcare visit and plot them using appropriate, standard growth charts such as those available [through the CDC](#).
- b) **Head Circumference** – providers should get head circumference measurements at every preventive healthcare visit from ages newborn to 24 months and plot them using appropriate, standard growth charts such as those available [through the CDC](#).
- c) **Weight for Length** – Provider should plot weight for length using appropriate, standard growth charts such as those available [through the CDC](#) at every preventive healthcare visit from ages newborn to 18 months.
- d) **Body Mass Index (BMI) Screen for Obesity** - BMI should be plotted using appropriate, standard growth charts such as those available [through the CDC](#) or calculated at every preventive healthcare visit from ages 24 months to 20 years. Use the [World Health Organization \(WHO\)](#) growth charts for monitoring weight in children ages one to two years.
- e) **Blood Pressure** - Blood pressure measurement should be done at every preventive visit

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starting at age three. For infants and children with certain chronic conditions (including obesity, sleep-disordered breathing, and those born preterm), blood pressure measurement should be done at preventive visits before age three.

Sensory Screening

a) Vision Screening

- **For ages 0 to one years old:**
 - Assess newborn before being sent home or at least by age two weeks using red reflex.
 - Evaluate fixation preference, alignment, and eye disease by age six months.
- **For ages one to 18 years old:**
 - Perform visual acuity test at ages 3, 4, 5, 6, 8, 10, 12, 15, and 18 years. Document in the medical record if the test is performed in another setting such as a school.
 - Screen for strabismus between ages three and five years.
 - Perform vision screening at entry to kindergarten if not screened during the prior year, as recommended by the [Massachusetts Preschool Vision Screening Protocol](#).

b) Hearing Screening

- **For newborns:** Confirm initial screen was completed, verify results, and follow up, as appropriate.
- **For ages three-to-five days to three months:** Verify results of newborn hearing screening, and follow up, as appropriate.
- **For ages four months to three years:** Perform risk assessment for hearing problems at each preventive visit.
- **For ages four to 10 years:** Perform hearing screening at ages 4, 5, 6, 8, and 10 years.
- **For ages 11 to 21 years:** 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.

Developmental/Behavioral Health

Psychosocial and Behavioral Assessment

Psychosocial and behavioral health assessment should occur at every preventive healthcare visit, including initial and periodic visits, from birth to 21 years old. In performing psychosocial and behavioral health screening, providers should use one of the clinically and age-appropriate screening tools listed in the Bright Futures Toolkit at <https://publications.aap.org/toolkits/resources/15625>.

Each preventive healthcare visit should include screening for health-related social needs such as food insecurity, exposure to intimate partner(s) or community violence, caregiver substance use, housing instability, and other matters that may impact child and family wellbeing.

If there is evidence of a psychosocial or behavioral health concern or need for further assessment, the provider should offer the necessary behavioral health services or make a referral to another provider who can provide them. Providers must refer the child to the local

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Early Intervention Program of the Massachusetts Department of Public Health if they are ages 0 to 30 months, and to the local public school system if they are older than 30 months. The Early Intervention Program, the local public school, or both will conduct assessments to determine eligibility and service needs. To determine which providers may be available to provide the needed behavioral health services and how to use out-of-network providers, if necessary, contact the MassHealth Customer Service Center at (800) 841-2900, TDD/TTY: 711 or the member’s health plan.

Providers may also contact the Massachusetts Child Psychiatry Access Program (www.mcpap.com) for pediatric psychiatric consultation and referral for ongoing behavioral health care.

Parent and Caregiver Postpartum Depression Screening and Referral

Screening the child’s parent(s) or caregiver(s) for postpartum depression should occur at every preventive pediatric visit from the one month visit to the twelve month visit. MassHealth will reimburse for every postpartum depression screening that occurs during this period without any limitations on frequency, as clinically appropriate. Providers should use a standardized screening tool such as the Edinburgh Postpartum Depression Scale (EPDS) or any of the recommended postpartum depression screening tools listed in the Bright Futures Toolkit at <https://publications.aap.org/toolkits/resources/15625>.

For those who have a positive screen for postpartum depression, providers should discuss available potential treatments for postpartum depression or major depressive disorder, including pharmacological treatments, and provide a referral to a mental health clinician, as clinically appropriate. Providers may contact MCPAP for Moms (www.mcpapformoms.org) for live consultation and referral to services or other supports. Other appropriate resources may include the Massachusetts Behavioral Health Help Line (www.masshelpline.com), a Community Behavioral Health Center (www.mass.gov/community-behavioral-health-centers), National Maternal Mental Health Hotline (<https://mchb.hrsa.gov/national-maternal-mental-health-hotline>), or Postpartum Support International of Massachusetts (<https://psichapters.com/ma>). Providers should help coordinate follow-up care as appropriate or encourage the parent or caregiver to follow up with their own health care provider.

Autism Spectrum Disorder Screening

Screening using an autism-specific tool should occur at the 18-month and 24-month preventive healthcare visits. Providers should choose one of the standardized Autism screening tools listed in the Bright Futures Toolkit at <https://publications.aap.org/toolkits/resources/15625>. In addition to the Autism screeners listed for the 18-month and 2-year-old (24-month) visit, additional Autism screeners can be found in the Child Development section within [AAP “Developmental Screening Tools” table](#) (found in Supplemental Information).

Developmental Screening

Ongoing surveillance is supplemented and strengthened by standardized developmental screening tests that are recommended to be used at 9, 18, and 30 months but may also be applied at any visit

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at which developmental surveillance elicits a concern. Providers should choose one of the age-appropriate standardized developmental screening tools in the Bright Futures Toolkit at <https://publications.aap.org/toolkits/resources/15625>.

If concerns are identified, refer the child to the local Early Intervention Program of the Massachusetts Department of Public Health if they are age 0 to 30 months, and to the local public school system if they are above age 30 months. The Early Intervention Program, the local public school, or both will conduct assessments to determine eligibility and service needs.

Developmental Surveillance

Developmental surveillance should occur at each preventive healthcare visit from newborn to age 21 except at visits when developmental screening is being done. Comprehensive child development surveillance may include:

- eliciting and attending to the parents' concerns;
- maintaining a developmental history;
- making accurate and informed observations of the child;
- identifying the presence of risk and protective factors;
- periodically using screening tests; and
- documenting the process and findings.

Depression Screening

Screening for depression should occur at every preventive healthcare visit from ages 12 to 21 years using a standardized depression screening tool such as the Patient Health Questionnaire Modified for Adolescents (PHQ-9 Modified), or other tools available in the Guidelines for Adolescent Depression in Primary Care (GLAD-PC) toolkit.

Providers who identify a concern may contact the Massachusetts Child Psychiatry Access Program (www.mcpap.com) for pediatric psychiatric consultation and referral for ongoing behavioral health care.

Tobacco, Alcohol, and Drug Use Assessment

Risk assessment for tobacco, alcohol, and drug use should be performed at every preventive healthcare visit from ages 11 to 21 years. It is recommended that providers use a standardized substance screening tool from among those listed in Bright Futures. SBIRT is a validated framework for screening and intervening upon substance use in routine clinical encounters. Validated substance-use screening tools that can be used as part of SBIRT include CRAFFT 2.1+N or S2BI. If concerns are identified, providers may contact the Massachusetts Child Psychiatry Access Program (www.mcpap.com) to be connected to the Adolescent Substance and Addiction Program (ASAP), a program of MCPAP that provides pediatric primary care providers with pediatric substance use disorder consultation.

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If a referral to treatment is needed, providers may contact the Massachusetts Substance Use Helpline (helplinema.org) or the Office of Youth & Young Adult Services at the Massachusetts Department of Public Health Bureau of Substance Addiction Services at (617) 624-5111.

Physical Exam

A developmentally appropriate physical exam should be performed at every preventive healthcare visit. Infants should be completely unclothed, and other children undressed, draped, and chaperoned, as indicated. The use of a chaperone should be a shared decision among the patient, the patient's parent or guardian, and physician.

Procedures

Newborn Blood Screening

Verify at the newborn or the three- to five-day preventive healthcare visit that all required newborn screenings were performed, especially if the newborn was not born in a hospital setting or was born outside Massachusetts. Verify results and follow up as appropriate. Additional information about the Massachusetts newborn screening program is available from the New England Newborn Screening Program (<https://nensp.umassmed.edu>).

Newborn Bilirubin Screening

Confirm at the newborn preventive healthcare visit that the initial screening was completed, verify results, and follow up as appropriate.

Critical Congenital Heart Defect Screening

Screening for critical congenital heart defect or disease using pulse oximetry should be performed in newborns, after 24 hours old, before being sent home from the hospital. Confirm at the newborn preventive healthcare visit that the screening has been done.

Immunization Assessment and Administration

Immunize according to the Massachusetts Department of Public Health's Immunization Program. Immunization status should be assessed at every preventive healthcare visit from newborn to 21 years old.

Anemia Screening

- **For ages 0 to one years old:** Screen once between ages nine and 12 months. At clinician discretion, conduct assessment of infants at high risk for iron deficiency. Consider screening at ages 15 and 30 months, based on risk factors.
- **For ages one to 10 years old:** Conduct risk assessment or screening, including dietary iron sufficiency, at clinician discretion. Screen those with risk factors annually from ages two to five.
- **For ages 11 to 21:** Conduct risk assessment or screening. Screen all non-pregnant female adolescents for anemia every five to 10 years during well visits starting at age 12. Screen

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- those with known risk factors (i.e., excessive menstrual blood loss, low iron intake, or previous diagnosis of iron deficiency anemia) annually.

Lead Exposure Screening

Screen for lead exposure according to the guidance set forth by the Massachusetts Childhood Lead Poisoning Prevention Program (MCLPPP). As described in the MCLPPP's *Changes to the Lead Regulation for Pediatric Healthcare Providers* updated in October 2017

(www.mass.gov/doc/lead-fact-sheet-for-providers-111417-0/download), initial screening is recommended between nine and 12 months and again at two and three years old. Screen at four years old if a child lives in a city or town with a high risk for childhood lead exposure. Screen at entry to daycare, preschool, or kindergarten if not screened before.

A list of high-risk communities can be found at www.mass.gov/lists/view-annual-screening-and-blood-lead-level-reports-and-high-risk-community-list. Additional information about screening may be found at www.mass.gov/dph/clppp.

Under M.G.L. c. 111, § 191

(<https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVI/Chapter111/Section191>), physicians, other healthcare providers, and private laboratories must report all known cases of childhood lead poisoning known to the agency 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.

Tuberculosis Assessment and Testing

Risk for tuberculosis should be assessed at the one-month and at the six-month, 12-month, and 24-month preventive healthcare visit and then annually from three to 21 years old. Testing should be performed as indicated by the results of the risk assessment.

Dyslipidemia Assessment and Testing

Assess for dyslipidemia risk factors every two years at ages two, four, six, and eight, and then annually from ages 12 to 16. Screen for dyslipidemia once between ages nine and 11, and once between ages 17 and 21.

Sexually Transmitted Infections (STIs) Assessment and Testing

Assess for risk of STIs annually starting at the 11-year preventive healthcare visit, with screening as indicated by the risk assessment.

Human Immunodeficiency Virus (HIV) Assessment and Testing

Assess for risk of HIV annually starting at the 11-year preventive healthcare visit, and test as indicated by the results of the risk assessment. Adolescents should be tested as least once between the ages of 15 and 18. 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.

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Cervical Dysplasia Screening

Cytology screening for cervical cancer should begin at the 21-year preventive healthcare visit. In compliance with guidance from the U.S. Preventive Services Task Force, human papillomavirus (HPV) testing is not recommended at age 21

(www.uspreventiveservicestaskforce.org/uspstf/recommendation/cervical-cancer-screening).

Oral Health

It is recommended that a dental home is established for a child by no later than 12 months of age. A dental home is the ongoing relationship between a dentist and a patient, including oral health care delivered in a safe, culturally sensitive, individualized, complete, continuous, accessible, compassionate, and patient and family-centered way, regardless of race, ethnicity, religion, sexual or gender identity, and family structure. A dental home addresses anticipatory guidance and preventive, acute, and comprehensive oral health care and includes referral to dental specialists when appropriate.

For further details regarding oral health, see the Dental Schedule below in Section II of this Appendix II. Basic oral health education (as described in the Anticipatory Guidance section below), fluoride varnish, and fluoride supplementation are three aspects of oral health that are addressed by both primary care providers and dental providers.

Fluoride Varnish

Assess the need for fluoride varnish at all preventive visits from 6 months to 5 years old. Once teeth are present, fluoride varnish may be applied to the child every 3 to 6 months in the primary care or dental office.

Fluoride Supplementation

Assess the need for dietary fluoride supplementation at 6 months, 9 months, 12 months, and then at all preventive visits from 18 months to 16 years old. Dietary fluoride supplements should be considered for children if their primary water source is lacking in fluoride.

Anticipatory Guidance

Age-appropriate anticipatory guidance should be provided at every preventive healthcare visit with discussion topics including, but not be limited to:

- developmental expectations and sound parenting practices;
- behavioral risks, such as avoidance of the use of alcohol, drugs, tobacco, e-cigarettes (also known as vaping), opiates, cannabis, and other substances;
- safe environments at home, in school, and in the community, which are free of violence, toxic stress, bullying, and ostracism;
- mental health, including depression and anxiety, based on risk factors and individual patient presentation in adolescence;
- academic or behavioral problems that may be signs of attention deficit hyperactivity disorder (ADHD);
- safe and healthy sexual behaviors, including family planning options, with sensitivity to sexual orientation and gender identity;

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- benefits and components of a healthy diet and safe weight management, ways to maintain adequate calcium and vitamin D, and counseling against sugar-sweetened and caffeinated drinks;
- benefits of daily physical activity, opportunities for daily physical activity, and parents as role models;
- healthy sleep habits and encouraging proper sleep amounts and safe sleep practices, including placing infants on their backs when putting them to sleep, avoiding co-sleeping, and use of a firm sleep surface without soft bedding or toys;
- 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;
- safety related to online activity, social networking, and use of smartphones and other handheld devices;
- chronic and communicable disease prevention;
- basic oral health education, including the benefits of daily oral hygiene, fluoride, and the benefits of establishing a dental home; safety measures and injury prevention, including childproofing, car seats and seat belts, bike and motorcycle helmets, poison prevention, firearm safety, and other age-appropriate counseling;
- skin protection, including using sunscreen, reducing exposure to the sun, and discouraging use of indoor tanning;
- potential risks of body piercing and tattooing;
- nutrition, which primary care providers may assess and promote by doing the following:
 - ask about dietary habits;
 - promote breastfeeding as the optimal form of infant nutrition and assess breastfed infants between two and five days old;
 - starting in middle childhood, screen annually for eating disorders and ask about body image and dieting patterns; and
 - make every effort to inform a possibly eligible member or the parent or guardian about the Women, Infants, and Children (WIC) nutrition program, including providing information on the pre-application, which can be found at www.mass.gov/forms/apply-for-wic-online. If eligible, a referral to WIC should be made using the [WIC Medical Referral Form \(MRF\)](#) from the Massachusetts WIC Program. In addition, if eligible, the member, parent, or guardian should also be referred to the [Supplemental Nutrition Assistance Program \(SNAP\)](#), which is administered by the Department of Transitional Assistance.

IC Medical Schedule Table

The Medical Schedule is included in this table at www.mass.gov/doc/epsdt-medical-periodicity-schedule-matrix2024-11-21-0/download.

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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 *Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents* from the [American Academy of Pediatric Dentistry \(AAPD\) Reference Manual 2023-2024](#). See [130 CMR 450.140 through 450.150](#) for more information about Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and Preventive Pediatric Healthcare Screening and Diagnosis (PPHSD) services. This schedule reflects recommended well and preventive child healthcare screening services. If the clinical needs of a child justify deviation from this schedule, the provider must document this fact in the member's dental record, including the provider's clinical judgment and justification for that deviation.

Dental Schedule Table

The Dental Schedule is included in the following table. Explanations of each part are included in next section.

Procedure	6 – 12 Months	12 -24 Months	2 - 6 Years	6 - 12 Years	12 - 20 Years
Clinical oral examination ⁽¹⁾	x	x	x	x	x
Assess oral growth and development ⁽²⁾	x	x	x	x	x
Caries-risk assessment ⁽³⁾	x	x	x	x	x
Radiographic assessment ⁽⁴⁾			x	x	x
Prophylaxis and topical fluoride ⁽⁵⁾	x	x	x	x	x
Fluoride supplementation ⁽⁶⁾	x	x	x	x	x
Anticipatory guidance/counseling ⁽⁷⁾	x	x	x	x	x
Oral hygiene counseling ⁽⁸⁾	Parent	Parent	Patient/parent	Patient/parent	Patient
Dietary counseling ⁽⁹⁾	x	x	x	x	x
Counseling for nonnutritive habits ⁽¹⁰⁾	x	x	x	x	x
Injury prevention and safety counseling ⁽¹¹⁾	x	x	x	x	x
Assess speech/language development ⁽¹²⁾	x	x	x		
Assessment developing occlusion ⁽¹³⁾			x	x	x
Assessment for pit and fissure sealants ⁽¹⁴⁾			x	x	x

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Procedure	6 – 12 Months	12 -24 Months	2 - 6 Years	6 - 12 Years	12 - 20 Years
Periodontal-risk assessment ⁽¹⁵⁾			x	x	x
Counseling for tobacco, vaping, and substance misuse ⁽¹⁶⁾				x	x
Counseling for human papilloma virus/vaccine ⁽¹⁷⁾				x	x
Counseling for intraoral/perioral piercing ⁽¹⁸⁾				x	x
Assess third molars ⁽¹⁹⁾					x
Transition to adult dental care ⁽²¹⁾					x

Explanations of the Dental Schedule Table

The explanations in this section are numbered and align with the numbers that appear in the Dental Schedule Table.

1. The first clinical oral exam should occur at the eruption of the first tooth and no later than 12 months old. Clinical exams should take place every six months or as indicated by the child’s risk status and susceptibility to disease. The clinical exam includes assessment of all hard and soft tissues, as well as pathology and injuries.
2. Oral growth and development are assessed by clinical exam.
3. Caries risk review should be performed as soon as the first primary tooth erupts to prevent disease by identifying patients at high risk for caries and developing individualized preventive measures and caries management, as well as determining appropriate periodicity of services. Because a child’s risk for developing dental disease can change over time due to changes in habits (e.g., diet, home care), oral microflora, or physical condition, risk assessment must be documented and repeated regularly and frequently to maximize effectiveness.
4. Radiographic reviews are an important component of the clinical assessment. Timing, selection, and frequency are determined by child’s history, clinical findings, and susceptibility to oral disease and in compliance with ADA/FDA guidelines (www.fda.gov/radiation-emitting-products/medical-x-ray-imaging/selection-patients-dental-radiographic-examinations). Every effort must be made to minimize the patient’s radiation exposure by applying best radiological practices and minimizing radiographs only to those necessary to obtain essential diagnostic information and achieve satisfactory diagnosis. Variations from the ADA/FDA clinical guidelines must be documented in the patient record.
5. Prophylaxis and topical fluoride treatments are important preventive measures that should be a regular part of the periodic exam and assessment process. The interval for frequency of professional preventive services is based upon assessed risk for caries and periodontal disease. Once teeth are present, fluoride varnish may be applied every three to six months in the dental

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office or primary care setting.

<https://publications.aap.org/pediatrics/article/146/6/e2020034637/33536/Fluoride-Use-in-Caries-Prevention-in-the-Primary>)

6. Consider fluoride supplementation for children up to at least 16 years of age when systemic fluoride exposure is suboptimal or as otherwise indicated by guidance of the American Academy of Pediatric Dentistry and the Bright Futures Periodicity schedule. See list of Massachusetts fluoridated communities at www.mass.gov/info-details/community-water-fluoridation-status.
7. Anticipatory guidance is the process of providing practical and developmentally appropriate information to prepare parents for significant milestones in oral development, teething and tooth eruption, oral hygiene, feeding and eating practices, fluoride, and injury prevention. Individualized discussion and counseling are integral components of each visit.
8. Oral hygiene counseling involves the parents and child. Initially, oral hygiene is the responsibility of the parent. As the child develops, home care can be performed jointly by the parent and child. When a child demonstrates the understanding and ability to perform personal hygiene techniques, age-appropriate instruction should be provided to the child. The effectiveness of home care should be monitored at every visit and includes a discussion on the consistency of daily oral hygiene preventative activities, including adequate fluoride exposure.
9. Dietary counseling is an integral part of every visit. For very young children, this should include a discussion of appropriate feeding practices and prevention of early childhood caries. By age one, the counseling should include the role of refined carbohydrates and frequency of snacking and sugar-sweetened beverages in caries development and childhood obesity.
10. Counseling related to non-nutritive sucking habits should include information about the need for additional sucking (e.g. digits vs. pacifiers). As the child grows, counseling should include the need to wean from the sucking habit before malocclusion or deleterious effect on the dentofacial complex occurs. For school-aged children and adolescent patients, counseling should include any existing habits such as fingernail biting, clenching, or bruxism.
11. Injury prevention counseling should initially include information about play objects, pacifiers, car seats, electrical cords, and secondhand smoke. As the child nears age one, counseling should include learning to walk and routine playing. As motor coordination develops and the child grows older, the parent/patient should be counseled on additional safety and preventive measures, including use of protective equipment (e.g., athletic mouthguards, helmets with face shields) for contact sports and high-speed activities.
12. Observation for age-appropriate speech articulation and fluency as well as receptive and expressive language milestones is crucial for early recognition of potential delays and appropriate referral to therapeutic services.
13. Assessment of developing occlusion should begin in the two- to six-year age range and include identification of: transverse, vertical, and sagittal growth patterns; asymmetry; occlusal disharmonies; functional status including temporomandibular joint dysfunction; and esthetic influences on self-image and emotional development. Abnormalities in occlusal development should be recognized, diagnosed, and managed or referred in a timely manner.
14. For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; dental sealants should be placed as soon as possible after eruption. Sealants are

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a crucial part of preventive dental care and can minimize the progression of non-cavitated occlusal caries lesions.

15. Periodontal risk assessment identifies individuals at increased risk of developing gingival and periodontal diseases and pathologies and should be repeated during each clinical examination to monitor changes in risk status and to maximize effectiveness. Periodontal probing should be added to the risk-assessment process after the eruption of the first permanent molars and incisors as tolerated by the child. Probing of primary teeth may be indicated when clinical and radiographic findings indicate the presence of periodontal pathology.
16. Education regarding prevention of tobacco use, vaping, and substance misuse should begin as early as age six according to the National Cancer Institute and American Dental Association. When tobacco or substance use has been identified, brief interventions should encourage, support, and positively reinforce avoiding substance use. If indicated, appropriate referrals should be made for assessment and/or treatment of substance use disorders.
17. Human papilloma virus (HPV) is associated with several types of cancers, including oral and oropharyngeal cancers. As adolescent patients tend to see the dentist twice yearly and more often than their medical care provider, this is a window of opportunity for the dental professional to counsel patients and parents about HPV's link to oral cancer and the potential benefits of receiving the HPV vaccine.
18. The oral health consequences of intraoral/perioral piercings should be initiated for the preteen child and parent and reinforced during subsequent periodic visits.
19. During late adolescence, assess the presence, position, and development of third molars, giving consideration to removal when there is a high probability of disease or pathology or the risks associated with early removal are less than the risks of later removal.
20. As adolescent patients approach 21 years of age, educating the patient and parent on the value of transitioning to a dentist who is experienced in adult oral health can help minimize disruption of high-quality, developmentally appropriate health care. At the time agreed upon by the patient, parent, and pediatric dentist, the patient should be referred to a specific practitioner in an environment sensitive to the adolescent's individual needs.

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EPDT/PPHSD Screening Services Codes

The following services are payable according to 130 CMR 450.146 through 450.150 in addition to the initial, periodic, or interperiodic, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) or Preventive Pediatric Health-care Screening and Diagnosis (PPHSD) visit when they are performed and interpreted in the office of the provider who furnished the visit.

Laboratory Services

<u>Service Code</u>	<u>Service Description</u>
81000	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy
81002	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy
84703	Gonadotropin, chorionic (hCG); qualitative
85013	Blood count; spun microhematocrit
85014	Blood count; hematocrit (Hct)
85018	Blood count; hemoglobin (Hgb)
86580	Skin test, tuberculosis, intradermal
87081	Culture, presumptive, pathogenic organisms, screening only
87210	Smear, primary source, with interpretation; wet mount for infectious agents (e.g., saline, India ink, KOH preps)

Audiometric Hearing Function Tests

92551	Screening test, pure tone, air only
92552	Pure tone audiometry (threshold); air only
92587	Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report

Parent and Caregiver Depression, Developmental, or Autism Spectrum Disorder Screening

96110	Developmental screening, with scoring and documentation, per standardized instrument
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(Parent and Caregiver Depression Screening, should occur at every preventive pediatric visit from the one month visit to the twelve month visit, may be billed up to the twelve month preventive pediatric visit for the administration and scoring of a recommended postpartum depression screening tool, and must be billed with the UD modifier used together with either modifier -U1 or U2.

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Service

Code Service Description

Developmental Screening, should occur at the 9-, 18-, and 30-month preventive pediatric visits and at any visit in which developmental surveillance elicits a concern, may be billed up to the age 8 preventative pediatric visit for administration and scoring of an age-appropriate standardized developmental screening tool per Appendix W and must be billed with modifier -U1 or -U2.

Autism Spectrum Disorder Screening, should occur at the 18- and 24-month preventive pediatric visits, may be billed up to the age 3 preventative pediatric visit for administration and scoring of a standardized autism screening tool per Appendix W and must be billed with modifier -U3 or -U4.

If multiple screenings are performed during a single visit, it is permitted to list 96110 along with the appropriate modifier multiple times on the claim so long as different screenings are performed for each listing of 96110 and the exact modifiers do not repeat.)

Behavioral Health Assessment and Depression Screening

96127 Brief emotional/behavioral assessments, with scoring and documentation, per standardized instrument (4 to 21 years of age. From 4 to 11 years of age, to be billed for the administration of a standardized behavioral health screening tool per Appendix W. From 12 to 21 years of age, to be billed for the administration of a standardized depression screening tool per Appendix W. Must be billed with either modifier -U1 or -U2. Code 96127 is not payable when code 90791 is billed for the same date of service for the same member. For such dates of service, the provider must bill only code 90791).

Vision Tests

99173 Screening test of visual acuity, quantitative, bilateral

Service Code Modifiers and Descriptions

Modifier Modifier Description

- U1 No developmental health or behavioral health need identified. (Used with codes 96110, 96127)
- U2 Developmental health or behavioral health need identified. (Used with codes 96110, 96127)
- U3 No follow-up needed (Used with code 96110)
- U4 Follow-up needed (Used with code 96110)
- UD Administration and scoring of a standardized screening tool for parent and caregiver postpartum depression. (Used with code 96110 in combination with U1 or U2)

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