DC Medicaid HealthCheck Periodicity Schedule

Based on Recommendations from Preventive Pediatric Health Care
from Bright Futures/American Academy of Pediatrics (AAP)

The DC HealthCheck Periodicity Schedule follows AAP health recommendations in consultation with the local medical community. The recommendations are for the care of children who have no manifestations of any important health problems. Additional visits or interperiodic screens may become necessary if circumstances suggest the need for more screens, i.e., medical conditions, referral by parent, Head Start, DC Public Schools, early intervention services and programs. Developmental, psychosocial, and chronic disease issues may require frequent counseling and treatment visits separate from preventive care visits. Additional visits also may become necessary if circumstances suggest variations from normal. If a child comes under care for the first time, or if any items are not done at the suggested age, the schedule should be brought up to date as soon as possible. The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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

	CPT CODE	INFANCY								EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLSECENCE										
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	99381-5; or 99391-5	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
PHYSICAL EXAMINATION[5]			•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
MEASUREMENTS																																	
Length/Height and Weight	Included as part of preventive medicine visit CPT codes		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Head Circumference			•	•	•	•	•	•	•	•	•	•	•																				
Weight for Length			•	•	•	•	•	•	•	•	•	•																					
Body Mass Index[6]													•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Blood Pressure[7]															•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
ANTICIPATORY GUIDANCE		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
ORAL HEALTH																																	
Oral Health Assessment[8]	D0191							•[9]	•[9]																								
Fluoride Varnish[10]	99188							←•	→•			←•	→•																				
SENSORY SCREENINGS																																	
Vision[11]	99173, 99174														•	•	•	•		•		•		•			•						
Hearing	92551-2, 92587		•[12]	•[13]	→•											•	•	•		•		•	←•	→•	←•	→•	←•	→•	←•	→•	←•	→•	←•	→•
DEVELOPMENTAL/BEHAVIORAL HEALTH																																	
Developmental Surveillance	Included as part of History		•	•	•	•	•	•		•	•		•		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Developmental Screening[15]	96110								•			•		•																			
Autism Spectrum Disorder Screening[16]	96110											•	•																				
Psychosocial/Behavioral Surveillance	Included as part of History		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Psychosocial/Behavioral Screening[17]	96127		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Tobacco, Alcohol, or Drug Use Screening[18]	99420																																
Behavioral Health Screening[19]	96127																							•	•	•	•	•	•	•	•	•	•
Maternal Depression Screening[20]	96161				•	•	•	•																									
PROCEDURES[21]																																	
Immunization[22]	90460-1; 90471-4		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Newborn Screening[23]	Bill as applicable depending on provider capacity		•	→•																													
Lead[24]	88655									•or [25]			•or [25]																				
Anemia[26]	Include all applicable CPT codes									•																							
Dyslipidemia[27]																					←•	→•							←•	→•			
Tuberculosis[28]																																	
Cervical Dysplasia[29]																																	•
Sexually Transmitted Infections[30]																																	
HIV[31]																										←•	→•						
Hepatitis C Virus Infection[32]																														•→			

NOTES

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 AAP statement "The Prenatal Visit" (2009).
3. Every infant should have a newborn evaluation after birth, breastfeeding encouraged, and instruction and support offered.
4. Every infant should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital, to include evaluation for feeding and jaundice. Breastfeeding infants should receive formal breastfeeding evaluation, encouragement, and instruction as recommended in AAP statement "Breastfeeding and the Use of Human Milk" (2012).
   For newborns discharged in less than 48 hours after delivery, the infant must be examined within 48 hours of discharge per AAP statement "Hospital Stay for Healthy Term Newborns" (2010).
5. At each visit, age-appropriate physical examination is essential, with infant totally unclothed, older child undressed and suitably draped. See "Use of Chaperones During the Physical Examination of the Pediatric Patient" (2011).
6. Screen per "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" (2007).
7. Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
8. Oral Health Services by the primary care provider include oral health assessments, fluoride varnish applications, and referral to a Dental Home. An oral health assessment (Risk Assessment Tool) is a required component of a preventive health visit to a primary care provider for children prior to the establishment of a Dental Home. Fluoride varnish should be applied to teeth in a primary care setting by trained primary care providers from the eruption of the first tooth up to age 3 years. Fluoride varnish should be applied 2 times per year and up to 4 times per year, depending on patient risk for caries. To bill for fluoride varnish application for children under 3 years old use CPT code 99188. Children should be referred to a Dental Home beginning within 6 months of the eruption of the first tooth and should have an established dental home by no later than age 3 years. A Dental Home is where all aspects of a child's oral health care is delivered in a comprehensive, continuously accessible, and coordinated way by a single dental practice.
9. Perform a risk assessment. See "Maintaining and Improving the Oral Health of Young Children" (2014).
10. See USPSTF recommendations (2014). Once teeth are present, fluoride varnish may be applied to all children every 3–6 months in the primary care or dental office. Indications for fluoride use are noted in "Fluoride Use in Caries Prevention in the Primary Care Setting" (2014).
11. 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" (2016) and "Procedures for the Evaluation of the Visual System by Pediatricians" (2016).
12. 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" (2007).
13. Verify results as soon as possible, and follow up, as appropriate.
14. 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" (2016).
15. Screening should occur per "Promoting Optimal Development: Identifying Infant and Young Children with Developmental Disorders Through Developmental Surveillance and Screening" (2020). Developmental surveillance is the process of recognizing children who may be at risk of developmental delays and should be performed at every well-child visit. Developmental screening is the administration of a brief standardized tool aiding the identification of children at risk of a developmental disorder, and is required at 9, 18, and 30 months. To bill for a developmental screening using a structured validated tool as a part of the preventive care visit, use CPT code 96110.
16. Screening should occur per "Identification, Evaluation, and Management of Children with Autism Spectrum Disorder" (2020).
17. Psychosocial/behavioral screening and depression screening are a key part of monitoring mental health in children and youth, and allow for early identification of and intervention of mental health problems. If a child is identified as requiring further mental health services or treatment, please refer to "The DC Collaborative for Mental Health in Pediatric Primary Care's Child and Adolescent Mental Health Resource Guide" (2017). The psychosocial/ behavioral assessment should be family-centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health. See "Promoting Optimal Development: Screening for Behavioral and Emotional Problems" (2015) and "Poverty and Child Health in the United States" (2016). For depression screening, recommended screening using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit.
18. A recommended screening tool is the CRAFFT Screening Tool.
19. Recommended screening using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit.
20. Screening should occur per "Incorporating Recognition and Management of Perinatal and Postpartum Depression into Pediatric Practice" (2010).
21. These may be modified, depending on entry point into schedule and individual need.
22. Immunization Schedules, per the AAP Committee on Infectious Diseases, are available at. Every visit should be an opportunity to update and complete a child's immunizations.
23. District of Columbia law requires all newborns to have a blood test for all conditions defined in the District of Columbia Newborn Screening Act. For a full list of conditions that should be tested for go to Chapter 4: Newborn Screening. *Understanding Genetics: A District of Columbia Guide for Patients and Health Professionals*: Results should be reviewed at visits and appropriate retesting or referral done as needed. In addition to District-required Newborn blood lead tests, the newborn bilirubin and critical congenital heart defect tests should be completed.
24. For children at risk of lead exposure, see "Prevention of Childhood Lead Toxicity" (2020) and "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention" (2012). District law (2012) requires that all children receive two blood lead screening tests between ages 6–14 months and 22–26 months; and providers must report lead-poisoned children to DOEE's Childhood Lead Poisoning Prevention Program within 72 hours by faxing (202) 535-2607.
25. Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence areas.
26. 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).
27. See the AAP-endorsed guidelines from the National Heart Blood and Lung Institute, "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" (2012).
28. Tuberculosis testing per recommendations of the Committee on Infectious Diseases, published in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases* (2012). Testing should be done on recognition of high-risk factors.
29. All sexually active girls should have screening for cervical dysplasia as part of a pelvic examination beginning within 3 years of onset of sexual activity or age 21 (whichever comes first). See USPSTF Cervical Cancer Screening recommendations (2012). Indications for pelvic examinations prior to age 21 are noted in "Gynecologic Examination for Adolescents in the Pediatric Office Setting" (2010).
30. 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* (2012).
31. Adolescents should be screened for HIV according to the USPSTF HIV Infection Screening recommendations (2013) 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.
32. All individuals should be screened for hepatitis C virus (HCV) infection according to the USPSTF recommendations and Centers for Disease Control and Prevention (CDC) recommendations 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.