Carta Trámite

20 de diciembre de 2021

A: Todos los Proveedores Contratados por First Medical Health Plan, Inc. para el Plan Vital, Región Única y Población Vital X (Virtual)

Re: ***Carta Normativa 21-1214-03 relacionada a la Enmienda de la Política 16-1102 del Programa Early and Periodic Screening Diagnosis and Treatment (EPSDT) - Detección, Diagnóstico y Tratamiento Periódico.***

Estimado(a) Proveedor(a):

Reciba un cordial saludo de parte de First Medical Health Plan, Inc.

Adjunto a este comunicado encontrará la Carta Normativa 21-1214-03 de la Administración de Seguros de Salud de Puerto Rico (ASES).

A través de esta Carta Normativa, la ASES informa que, se revisó la Política 16-011 del ***Programa Early and Periodic Screening Diagnosis and Treatment (EPSDT).*** Esta Política será efectiva a partir del 1 de enero de 2021. El propósito de revisión de la Política fue para integrar las recomendaciones de la Asociación Americana de Pediatría, *Bright Futures* y el Departamento de Salud de Puerto Rico.

Para referencia se incluyen los siguientes anejos:

- Política 16-1102 *Amended* 12142021
- *Recommendations for Preventive Pediatric Health Care*
- *Birth to 36 months: Boys L Weight-for-age percentiles*
- *Birth to 36 months: Girls L Weight-for-age percentiles*
- *Birth to 36 months: Boys Head circumference-for-age and Weight-for-length percentiles*
- *Birth to 36 months: Girls Head circumference-for-age and Weight-for-length percentiles*
- *2 to 20 years: Boys Stature Weight-for-age percentiles*
- *2 to 20 years: Boys Body mass index-for-age percentiles*
- *2 to 20 years: Girls Stature Weight-for-age percentiles*
- *2 to 20 years: Girls Body mass index-for-age percentiles*
- *Itinerario de vacunación para niños y adolescentes 2021, edades 0 a 18 años*
- *Recommended Dental Periodicity Schedule for Pediatric Oral Health assessment, Preventive Services, and Anticipatory Guidance/ Counseling*
- *Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents*
- *Form CMS-416 Annual EPSDT Participation Report*

- Guías de Servicios Pediátricos Preventivos Rev. 2021

Le exhortamos a leer detenidamente la Carta Normativa 21-1214-03, la Política 16-1102 enmendada y los anejos que se incluyen para que se familiarice con los datos e instrucciones impartidas por la ASES.

De usted tener alguna pregunta relacionada a este comunicado y/o necesita información adicional, siéntase en la libertad de comunicarse con nuestro Centro de Servicio al Proveedor al número libre de cargos 1-844-347-7802 de lunes a viernes de 7:00 a.m. a 7:00 p.m. También, puede acceder a nuestra página electrónica www.firstmedicalvital.com

Cordialmente,

Departamento de Cumplimiento
First Medical Health Plan, Inc.

GOBIERNO DE PUERTO RICO
ADMINISTRACIÓN DE SEGUROS DE SALUD
Director Ejecutivo I Jorge E. Galva, JD, MHA I jgalva@asespr.org

14 de diciembre de 2021

Carta Normativa 2021-1214-03

A: **Organizaciones de Manejo Coordinado de Salud (MCOs) y Proveedores Participantes del Plan de Salud del Gobierno - Plan Vital**

ASUNTO: **Programa Early and Periodic Screening Diagnosis and Treatment (EPSDT) del Plan Vital**

Se incluye la política de la ASES para el Programa de Detección, Diagnóstico y Tratamiento Temprano, EPSDT, por sus siglas en inglés, la cual fue revisada recientemente. La implantación de esta política revisada es efectiva a partir del **1ero de enero de 2022.**

El propósito de revisar esta política fue para integrar las recomendaciones más recientes de Asociación Americana de Pediatría, *Bright Futures*, y el Departamento de Salud de Puerto Rico. Todas las entidades contratadas deberán armonizar los accesos a los servicios concernientes a esta población mediante sus respectivas políticas y procedimientos para cumplir con la Política de ASES sobre el Programa EPSDT. Se le requiere a cada aseguradora contratada bajo Plan Vital enviar a la ASES sus políticas EPSDT revisadas, depositándolas en el share file de Planificación (en el archivo Ad-hoc), no más tarde del próximo **20 de diciembre de 2021**.

Entre los anejos incluimos para su referencia las hojas para gráficas de crecimiento (Growth Charts), itinerario de vacunación, recomendaciones de periodicidad para servicios preventivos pediátricos en salud general y en salud oral. Se incluye, además, la Guía de Servicios Pediátricos Preventivos, emitida por el Departamento de Salud el 10 de agosto de 2021.

Es posible que esta política requiera modificarse en cualquier momento ya que está supeditada a cambios en regulaciones federales y locales. Le recordamos a todas las aseguradoras bajo Plan Vital que deben mantener orientados a sus proveedores contratados en cuanto a lo que incluye el programa EPSDT y la política de ASES.

Esperamos su cooperación y cabal cumplimiento con lo aquí expuesto.

Cordialmente,

Jorge E. Galva, JD, MHA
Director Ejecutivo

Anejos (15)

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ADMINISTRACIÓN DE SEGUROS DE SALUD
Director Ejecutivo I Jorge E. Galva, JD, MHA I jgalva@asespr.org

Planning, Quality and Clinical Affairs			
Government Health Plan (GHP) -Plan Vital Early and Periodic Screening, Diagnostic and Treatment Program (EPSDT) Policy			
Number: 16-1102 *Amended*	**Review Date:** **December 10, 2021**	**Effective Date:** January 1st, 2022	**Number of Pages:** 11
Approved By: **Jorge E. Galva Rodriguez, JD, MHA** **Signature:** Executive Director			**Date:** 12/14/2021
Reference: Contract Section 7.9, 42 CFR 441 Subpart B			

PURPOSE:

The purpose of this policy is to clearly establish and define the requirements to be delegated to all MCOS participating in the GHP- Salud Vital as it is related to the compliance with the EPSDT Programs requirements for needed services as well as member's identification, notification, education, outreach, tracking and reporting. The scope also includes the provision for providers EPSDT education with service requirements, compliance, and surveillance of quality measures.

PROGRAM DESCRIPTION:

EPSDT is a comprehensive child health care program of primary prevention, early diagnosis, treatment, correction, and improvement (amelioration) of physical and mental health problems for GHP- Salud Vital members under the age of 21. The purpose of EPSDT is to ensure the availability and accessibility of health care resources as well as to assist the government health plan recipients in effectively utilizing these resources. All services must be directed to prevent, treat, or ameliorate physical, mental, or developmental problems or conditions by certified providers, in sufficient amount, duration and scope on basis of medical necessity. **EPSDT services end on the last day of the beneficiary's twenty-first (21st) birthday month.**

EPSDT focuses on continuum of care by assessing health needs, providing preventive screening, initiating needed referrals, and completing recommended medical treatment and appropriate follow up. Its services include screening, vision, dental and hearing services as well as all other medically necessary mandatory and optional services listed in the government health plan contract requirements to correct or ameliorate defects and physical and mental illness and conditions identified in an EPSDT screening.

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SCOPE:
EPSDT consist of screening services in accordance with the periodicity requirements of Title 42 of the Code of Federal Regulations (42 CFR 441.58), preventive, diagnostic, treatment and rehabilitative services. The Program include, but is not limited to, coverage of inpatient and outpatient services, laboratory and x-ray, physician services, medications, dental, rehabilitative therapy, behavioral health, medical supplies and prosthetic devices as defined below in accordance to the Government Health Plan (GHP-Salud Vital) contract with MCOs. However, EPSDT services do not include services that are experimental, that are solely for cosmetic purposes or that are not cost effective when compared to other interventions.

A well child visit is synonymous with an EPSDT visit and includes all screenings and services described in the ESPDT Schedules *(*Appendix 1*)*. The EPSDT Periodicity Schedule is based on recommendations by the guidelines of the American Academy of Pediatrics and are intended to meet reasonable and prevailing standards of medical practice and specifies screening services at each stage of the child's life. This schedule is offered to all PCP providers to document all age specific, required information related to EPSDT screenings and visits. PCP providers must ensure that members receive required health screenings in compliance with this schedule. The service intervals represent minimum requirements, and any services determined by a primary care provider to be medically necessary must be provided, regardless of the interval. The requirements and reporting forms for an EPSDT screening service are described in another section of this Policy.

DEFINITIONS:

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

1. **Early** is assessing health care in early life so that potential disease and disabilities can be prevented or detected in their preliminary states when they are most effectively treated. In the case of a child already enrolled in the GHP, it means assessing as early as possible in the child's life, or as soon after the member's eligibility for the services has been established.

2. **Periodic** is assessing a child's health at regular, recommended intervals in the child's life to assure continued healthy development.

3. **Screening** is the use of tests and procedures to determine if children being examined have conditions warranting closer medical or dental attention. As such, prior authorization (PA) may not be required for any EPSDT screening services. When a screening examination indicates the need for further evaluation of a child's health, the child should be referred for diagnosis without delay. **For the EPSDT program, screening and diagnosis are not synonymous.**

4. **Diagnostic** means the determination of the nature or cause of a condition, illness, or injury through the combined use of health history, physical, developmental, and psychological examination, laboratory, test, X-rays, when appropriate.

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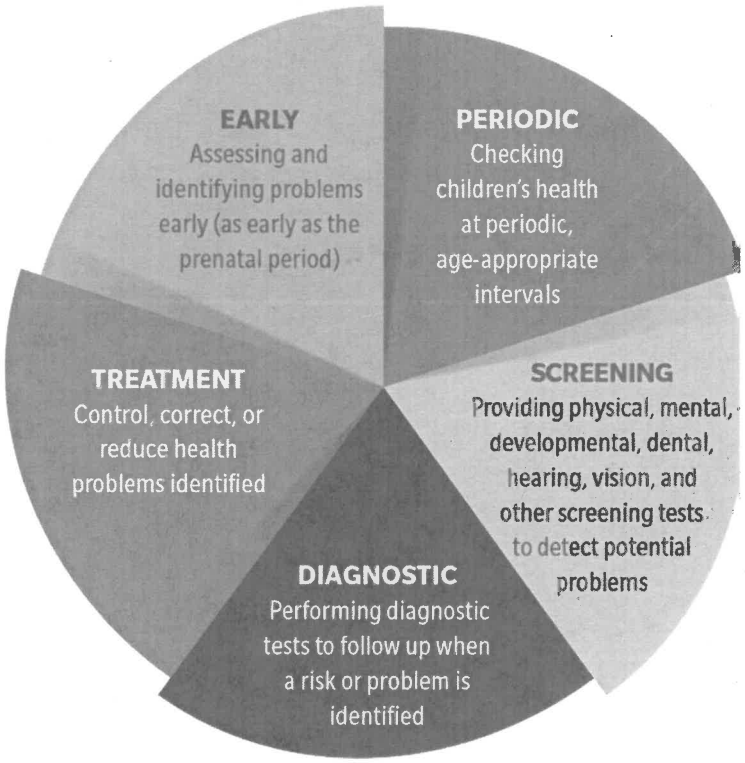
5. **Treatment** is the provision of services needed to control, correct or lessen health problems.

   The affirmative obligation to connect children with necessary treatment makes EPSDT different from Medicaid for adults. As described by CMS, EPSDT's goal is to assure that individual children get the health care they need when they need it – the right care to the right child at the right time in the right setting.



REQUIREMENTS:

Comprehensive periodic screenings must be performed by a clinician according to the time frames identified in the EPSDT (Early and Periodic Screening, Diagnostic and Treatment) Periodicity Schedule (Appendix 1) and inter periodic screenings as appropriate for each member age group.

PMG's and PCP's must implement processes to ensure age-appropriate screening and care coordination when member needs are identified. Providers are encouraged to utilize the GHP-Salud Vital approved standard developmental screening tools and charts, and complete training in the use of those tools. MCOs are required by ASES to establish monitoring processes for PMG's and PCP's providers and implement interventions for those not on-compliance.

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[1] California Children's Trust , http://cachildrenstrust.org/National Health Law Program; http://www.healthlaw.org/ National Center for Youth Law http://www.youthlaw.org/: Meeting The Moment 2020

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EPSDT screenings and services must include the following:

1. A comprehensive health and developmental history including assessment of both physical and mental development, including substance abuse disorders.
2. Growth and development screening which includes physical, nutritional and behavioral health assessments (See Appendix 2A - 2D, Body Mass lndex Charts).
3. Measurements (height, weight, body mass index; including head circumference for infants).
4. A comprehensive unclothed physical examination.
5. Appropriate immunizations according to age, health history and the guidance issued by the Advisory Committee on Immunization Practices (ACIP).
6. Laboratory testing, including blood lead screening assessment and serum blood lead testing, appropriate to age and identified risk factors. Anemia testing and diagnostic testing for sickle cell trait if a child has not been previously tested with sickle cell preparation or a hemoglobin solubility test.
7. Health education according to age group will be provided including the anticipatory guidance for the child and caregiver.
8. Periodical Vision screening with diagnosis and treatment services for visual defects, including eyeglasses.
9. Tuberculosis testing; as applicable.
10. Periodical Hearing screening including diagnostics and treatment services including devices for communication augmentation and cochlear implants.
11. Appropriate oral health screening, intended to maintain oral health and to identify oral pathology, including tooth decay and/or oral lesions, conducted by the primary care physician and dental specialists. Services will also include dental emergency services for pain relief, infection treatment, and tooth restoration.

EPSDT SERVICE DESCRIPTION:

EPSDT services must be provided according to community standards of practice and the EPSDT Periodicity Schedule (See Appendix 1). The Contractors (MCOs), through its subcontracted healthcare providers, are responsible for delivering the services as described in this policy. The healthcare providers must also adhere to the following specific standards and requirements:

1. **Preventive visit-** A periodic preventive comprehensive health and developmental history including assessment of both physical and mental development. All elements of medical history, physical exam, developmental measurements, preventive laboratories, autism, and depression screening needs to be done according to member age and risk factors. Appointments according to schedule (Appendix 1) should be done and tracking system to assure compliance must be in place. However, newly enrollees under CHIP eligible children should be seen within the first 90 days in the ambulatory setting and within the first 24 hours in the hospital setting.

2- **Immunization** – Includes all child and adolescent immunizations as specified in the PR Department of Health Immunization Schedule. All appropriate immunizations must be provided to establish and maintain up-to-date immunization for each EPSDT member (See Appendix 3 for schedule). PMG's and PCP must coordinate with the PR Department of Health Services Vaccines

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for Children program in the delivery of immunization services. Immunizations must be provided according to the Advisory Committee on immunization Practices (ACIP).

The vaccines themselves are provided for by the Department of Health Immunization Program throughout their recognized and certified vaccination centers. MCOs will cover the cost related to vaccine administration, under the fee schedule established by the ASES contract to all MCOs. Vaccine for Non-Federal Medicaid member will be covered by the MCOs.

3. **Vision Screening** - Eye examinations as appropriate to age according to the EPSDT Periodicity Schedule and medically necessary diagnosis and treatment for defects in vision including one pair of eyeglasses every 24 month (two years). In special circumstances replacement of eyeglasses could be approved with preauthorization before the two-year benefit limit.

4. **Blood Lead Screening** - A blood lead screening risk assessment must be completed at each EPSDT visit at twelve (12) and twenty-four (24) age. Children between twenty-four (24) and seventy-two (72) months of age (up to 6 years of age) should receive a blood lead screening test if there is no record of a previous blood test.

PMG's and PCP's must implement protocols for:

a. Care coordination for members with elevated blood lead levels to ensure timely follow-up and retesting.
b. Coordination and transitioning of a child who has an elevated blood level to another specialist provider, as necessary.

5. **Tuberculosis Screening** - PMG's and PCP's must implement protocols for care and coordination of members who received TB testing to ensure timely reading of the TB skin test and treatment if medically necessary. Children at increased risk of tuberculosis (TB) include those who have contact with persons:

a. Confirmed or suspected as having TB
b. ln jail or prison during the last five years.
c. Living in a household with an H|V-infected person or the child is infected with HIV.
d. Traveling/emigrating from or having significant contact with persons indigenous to endemic countries.

6. **Hearing Screening** – Including:

a. Each hospital or birthing center screens all newborns using a physiological hearing screening method as early as clinically possible prior to initial discharge. When there is an indication that a newborn or infant may have a hearing loss or congenital disorder, the family is referred to the Pediatric Health provider/ center for appropriate assessment and early intervention.
b. Hearing screening evaluation according to age with appropriate referral to establish a diagnosis and necessary treatment to improve any auditory deficit that can interfere with appropriate communication with normal language development or delays in learning and social development. Hearing aids will be covered by the PSG, cochlear

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implants will be coordinated through the Puerto Rico Health Department Catastrophic Funds

7- **Nutritional Assessment** - Nutritional assessment is conducted to assist EPSDT members whose health status may improve with nutrition intervention. The MCOs coordinate with the WIC Program, available to all federally qualified Medicaid participants, to get an initial comprehensive nutritional evaluation, as well as a nutritional follow-up and assistance until a child reaches 5 years of age. PMG's and PCPs are required to provide the required formulary and assessments necessary for initiation in the WIC Program to those children that requires special nutrition and supplements assistance. Also, assessment of nutritional status will be provided by the primary care provider (PCP) as part of the EPSDT screenings specified in the Periodicity Schedule (Appendix 1) and on an inter-periodic basis, as determined necessary by the member's PCP. It also covers nutritional assessments provided by a registered dietitian when ordered by the member's PCP and contracted by the MCOs. This includes EPSDT eligible members who are under or overweight. Prior authorization (PA) is not required when the assessment is ordered by the PCP.

8- **Dental and Oral Health Services** – As soon as the eruption of the first tooth and no later than 12 months of age, a dental evaluation must be done by a certified dentist or dental hygienist, working under the supervision of a certified dentist. The screening is intended to prevent dental problems or to identify gross dental or oral lesions. Providers must comply with the Preventive Dental Periodicity Schedule (Appendix 4A – 4B). Other dental services may be covered in accordance to plan benefits and medical necessity.

For best practices recommendations we shall follow American Academy of Pediatric Dentistry: Periodicity of examination, preventive dental services, anticipatory guidance/ counseling, and oral treatment for infants, children, and adolescents. *The Reference Manual of Pediatric Dentistry. Chicago, Ill.: American Academy of Pediatric Dentistry; 2020:232-42.*

9. **Health Education and Anticipatory Guidance** – MCOs, the PMG's, contracted PCP's, and other health providers must offer anticipatory guidance and health education for both the children and the caregivers in the following topics:

- Breast feeding
- Car Seat Safety
- Smoke free environment
- Accidents and injuries preventions
- UV protection
- Physical Activity
- Healthy Diet
- Prevention of STDs and HIV
- Clinical oral examination
- Caries risk assessment
- Dental radiographic assessment
- Prophylaxis and topical fluoride

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- Fluoride supplementation

10. **Mental Health and Substance Use Services** – Treatment for mental health and substance use are available for early detection, and to provide early referral for diagnosis and treatment. Screening tools are used to detected autism, substance and alcohol abuse on adolescents and caregivers. Psychiatric and psychological treatment will be provided according to medical needs, in individualized or family therapies interventions. Inpatient mental health and substance abuse, mental health partial ambulatory, and counseling services will be available as medically necessary.

    The recommended timing is:
    - Developmental screening at 9 months, 18 months, and 30 months of age
    - Autism spectrum disorder screening at 18 months and 24 months of age
    - Developmental surveillance at nearly every interval from newborn to age 21
    - Psychosocial/behavioral assessment at every interval from newborn to age 21
    - Tobacco, alcohol, or drug use assessment at every interval from age 12 to 21
    - Depression screening at every interval from age 12 to 21
    - Maternal depression screening at several points during the infancy stage42

11. **Medically Necessary Therapies** - Medically necessary therapies are covered and includes physical therapy, occupational therapy, speech therapy necessary to correct or ameliorate physical defects, mental illnesses and other conditions discovered during the screening services.

12. **Coordination with other State Agencies** – Coordinations with other state agencies are done to assure adequate referral and service feedback. Service referral are done to WIC program for nutritional evaluations and provision of special nutritional requirement according to established diagnosis. Referrals to Early Head Start programs, are coordinated to assure that children with special needs or developmental gaps could receive the appropriate early intervention services for the identified problem. In Puerto Rico, the community agency "Fondos Unidos" aid children with developmental and special needs. Appropriate referral for such services is coordinated with the GHP- Salud Vital medical providers or MCOs case managers. The Puerto Rico Department of Health also provide services through the Early Interventions Programs available throughout the island.

[2] While federal law does not prescribe a specific periodicity schedule, CMS has highlighted, and most states have adopted, the American Academy of Pediatrics Bright Future Schedule (AAP/Bright Futures). The schedule (AAP/Bright Futures) provides recommendations for a series of screenings, assessments, and procedures at various stages of childhood (prenatal, infancy, early childhood, middle childhood, and adolescence through age 21) across several domains. In the "developmental/behavioral health" domain, AAP/Bright Futures recommends what is described above.

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13- **Transportation Services** – None-emergency transportation to promote access to needed preventive, diagnosis and treatment services are provided by the Medicaid office under the Puerto Rico Health department. The MCOs' Case Managers also identify other community resources, such as municipal government offices, to provide non-emergency transportation to EPSDT population to access medical or preventive services.

14- La**nguage Access and Culturally Appropriate Services** – In most instances, GHP-Salud Vital population receives services with health professionals that are fully bilingual, Spanish and English. All participants enrolled, and caregivers should be able to choose a provider that fully understands and communicates the medically necessary instructions, education, and orientation effectively on both languages, English and Spanish. Physicians need to be trained to provide culturally and linguistically appropriate services, taking in account cultural beliefs, languages barriers or limitations and ethnic diversity.

15- **Family Planning Services-** Family planning services will be provided to sexually active adolescents on childbearing age. Those services include orientation and education on pregnancy and sexually transmitted diseases prevention. Access to contraceptive methods is available under the Family Planning Program established in all MCOs.

16. **Other services** - Case management service is available through the MCOs' Case Management Programs, where all children with special needs undergo a special registration according to the identified medical diagnosis. The registry will provide access to necessary care, without the need of a PCP's referral, from specialized providers, clinics, surgical and medical procedure, laboratories, and all necessary tests as well as medication treatment.

17. **Medical Supplies**, including diabetes test strips, when medically necessary, for children and youth under age 21.

18. **Organ transplants** are not covered by the current benefits for the GHP- Salud Vital enrollees, except for corneal, bone and skin transplants. When such services are necessary, the MCO case management team coordinates with the Puerto Rico Health Department to access services through the Catastrophic Funds. Those catastrophic Funds are identified to cover services not currently under the scope of benefits of the GHP- Salud Vital but that could be clinically necessary, such as organ transplants, services out of Puerto Rico including any United State territory, medical equipment such as adapted car seats and nutritional supplements to compliment dietary restrictions for special conditions.

19. **Services Provided on Schools, Community base care** – MCOs are required to identify and develop necessary services coordination with all regional Community Base and School Services available to assist, complement or to provide clinical services to the EPSDT population. Current Community Base Primary Centers, or federally qualify and sponsor centers such as 330 - 329 and HIV treatment Center are required to be part of the contracted MCOS provider network.

20.– **Member Education, Identification and Tracking** - All MCOS will provide EPSDT members education on preventive periodicity schedules including immunization,

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preventive tests, members benefit, preventive services access and referrals, transportations services when needed, appointment system with outreach, tracking activities and policies.

21. **Providers Education, Compliance and Quality Measures** – All MCOS will educate the PCPs providers on EPSDT policies and procedures, periodicity schedules, EPSDT benefits, preventive and evidence base practices and services guidelines, EPSDT member identification, outreach and tracking activities and policies. Quality measures and understanding and tracking of HEDIS applicable parameters should also be provided.

22. **Reporting system** – On a quarterly basis, MCOs should report to ASES all activities done to comply with the EPSDT members; at least meeting the requirements on EPSDT report to CMS (Appendix 5). MCOs should perform random audits of EPSDT on PCPs' medical records and should report in terms of compliance percentage on such required elements. Those quality elements should be part of the physicians' incentive programs. The reports should include results of outreach and tracking activities designed to comply with the adequate standards of ESPDT member's access to care.

23. **Telemedicine** - the Centers for Medicare & Medicaid Services (CMS) has broadened access to Medicare telehealth services so that beneficiaries can receive a wider range of services from their doctors without having to travel to a healthcare facility. These policy changes build on the regulatory flexibilities granted under the President's emergency declaration. CMS is expanding this benefit on a temporary and emergency basis under the 1135 waiver authority and Coronavirus Preparedness and Response Supplemental Appropriations Act. The benefits are part of the broader effort by CMS and the White House Task Force to ensure that all Americans – particularly those at high-risk of complications from the virus that causes the disease COVID-19 – are aware of easy-to-use, accessible benefits that can help keep them healthy while helping to contain the community spread of this virus.

    - During the Public health emergency, recognize Preventive Medicine Services (PMS) CPT codes (99381- 99385, 99391-99395) as eligible for telemedicine and pay with parity to in-person visits, keeping with current PMS payment policies.
    - As all children should ideally receive all comprehensive components of the PMS visit, the American Academy of Pediatrics strongly recommends a second (in-person) visit, wherever and whenever feasible, to complete components that were not able to be accomplished during the telemedicine PMS visit. Payment for this second visit will be included (bundled) in the initial full PMS payment.
    - These visits are considered the same as in-person visits and are paid at the same rate as regular, in-person visits.
    - 99421: Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes

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- 99422: Online digital evaluation and management service, for an established patient, for up to 7 days cumulative time during the 7 days; 11– 20 minutes
- 99423: Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes.
- The provider must use an interactive audio and video telecommunications system that permits real-time communication between the distant site and the patient at home.
- 99423: Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes.
- The provider must use an interactive audio and video telecommunications system that permits real-time communication between the distant site and the patient at home.

Reviews and Approvals

Up Date	Section Review	Modification and Reason
April 7, 2016	EPSDT SERVICES DESCRIPTION *Vision Screening (Item 3)*	Periodicity for eyeglasses coverage is corrected from "one year" to "every 24 months" in accordance to the State Plan (SPA)
May 8, 2019	HEADER *Page 1*	Substituted Compliance and Clinical Affairs with "Planning, Quality, and Clinical Affairs" Substituted Government Health Plan –*(GHP)* with "Government Health Plan (GHP) – Salud Vital" to bring document up to date with current Puerto Rico Government's Health Plan name: *Salud Vital.* Included current ASES approver, *Angela Avila Marrero, Executive Director*
	OVERALL DOCUMENT	Substitute *GHP* with *GHP-Salud Vital* to bring document up to date with current Puerto Rico Government's Health Plan name: Salud Vital and page numbering was added.
May 14, 2019	EPSDT SERVICES DESCRIPTION *Nutritional Assessment (Item 7)* *Dental and Oral Health Services (Item 8)* *Health Education and Anticipatory Guidance (Item 9)* *Mental Health and Substance Use Services (Item 10)* *Coordination with other State Agencies (Item 12)* *Transportation Services (Item 13)* *Language Access and Culturally (Item 14)* *Appropriate Services (Item 15)* *Family Planning Services (Item 16)* *Organ transplants (Item 17)* *Reporting system (Item 18)*	Various corrections and reviews performed on spelling, punctuation, and grammar for clarity.

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May 14, 2019	APPENDIX-1 *Periodicity Schedule Bright Future_2019* APPENDIX-3 *Vaccination Schedule_PRDOH.2018*	Updated to most recent guidelines.
Sept 7,2021	PROGRAM DESCRIPTION	Added for clarity: *EPSDT services end on the last day of the beneficiary's twenty-first (21st) birthday month.*
Sept 7,2021	DEFINITIONS *Early* *Periodic* *Screening* *Diagnostic* *Treatment* *-Diagram*	Review and edited for clarity and alignment with CMS. Also, a diagram was included with shortened definitions.
Dec 10,2021	EPSDT SERVICE DESCRIPTION	
	Dental and Oral Health Services	AAP best practices reference was included.
	Mental Health and Substance Use Services	Recommended screening timings recommended by AAP/Bright Futures was included.
	Telemedicine	Policy changes on services based on regulatory flexibilities granted under the President's emergency declaration due COVID-19 pandemic was added.
	APPENDIX-1 *Periodicity Schedule Bright Future_2021* APPENDIX-3 *Vaccination Schedule_PRDOH.2021*	Updated to most recent guidelines.
	APPENDIX 4A *bp_dental_period_schedule* APPENDIX 4B *Examination_Prevention_ Guidance_Counseling_Treatment*	Added to reflect most recent guidelines.

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DEPARTAMENTO DE SALUD

Guías de Servicios Pediátricos Preventivos

Revisada 2021

Aprobada por

Carlos R. Mellado López, MD
Secretario
Departamento de Salud

10 de agosto de 2021

El Departamento de Salud establece las Guías de Servicios Pediátricos Preventivos con el propósito de promover las mejores prácticas al brindar servicios médicos a la población pediátrica. Las guías proveen recomendaciones para que toda persona de 21 años o menos reciba evaluaciones médicas que provean la oportunidad para identificar y diagnosticar tempranamente aquellas condiciones físicas, mentales y conductuales que requieren una pronta atención y en cumplimiento con los requisitos de EPSDT del Centro de Servicios para Medicaid. El contenido de las guías se desarrolló con recomendaciones por un panel de expertos, recomendaciones actualizadas de *Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents*, publicado por la Academia Americana de Pediatría (versión marzo 2021), y de *United States Preventive Task Force*.

Interpretación de Guías de Servicios Pediátricos Preventivos

Las Guías de Servicios Pediátricos Preventivos están divididas en cuatro etapas:

- Infancia de 0 a 9 meses
- Niñez Temprana de 12 a 48 meses
- Niñez de 5 a 10 años
- Jóvenes de 11 a 21 años

En cada etapa el esquema incluye las edades a las cuales se debe ofrecer una visita preventiva, y un listado de evaluaciones, cernimientos y/o **pruebas de laboratorios universales, las cuales se recomiendan se administren a toda la población pediátrica en las edades indicadas por el símbolo** ✓. En el listado se enfatizan áreas específicas a explorar en el historial y examen físico, temas a enfatizar durante la orientación anticipatoria, cernimientos recomendados a utilizar para completar la evaluación y acciones a tomar relevantes a los resultados, durante la visita médica.

Cada etapa presenta un listado de evaluaciones, cernimientos y/o pruebas de laboratorios selectivas**, pruebas o acciones a tomar por el profesional de la salud justificado por el juicio clínico y los hallazgos de riesgo en las evaluaciones (historial, examen físico y/o cernimientos) indicando las edades correspondientes por el símbolo** ☑

Universal Infancia	Acción	Visita Prenatal	Recién Nacido	3 a 5 días	1 mes	2 m	4 m	6 m	9 m
Historial y examen físico	En visita prenatal historial familiar y de embarazo		✓	✓	✓	✓	✓	✓	✓
Medidas: peso (kg), largo (cm), Circunferencia de cabeza (cm)	Clasificar y evaluar percentil en gráfica		✓	✓	✓	✓	✓	✓	✓
Vigilancia, desarrollo y evaluación de conducta y condición psicosocial	Observación clínica e historial, atención a los determinantes sociales, trauma, seguridad alimentaria		✓	✓	✓	✓	✓	✓	✓
Inmunizaciones	Evaluar cumplimiento con esquema vigente y administrar vacunas necesarias para su cumplimiento		✓	✓	✓	✓	✓	✓	✓
Evaluación y apoyo de lactancia/ orientación alimentación en 1er año	Vigilar aumento de peso en primera semana y referir a grupos de apoyo en la comunidad cuando sea indicado, orientar introducción de sólidos y alimentos	✓	✓	✓	✓	✓	✓	✓	✓
Cernimiento de Depresión Materna	Cernimiento Edinburgh/ Referir para apoyo y ayuda si resulta positivo				✓			✓	
Guía Anticipatoria	Enfatizar prácticas de dormir seguro y prevención de lesiones no intencionales	✓	✓	✓	✓	✓	✓	✓	✓
Cernimiento Auditivo Ley 311, 2003	A infantes con pruebas positivas deben realizárseles la prueba confirmatoria antes de los 3 meses de edad y recibir tratamiento definitivo antes de cumplir 6 meses de edad		✓						
Cernimiento Metabólico y Hemoglobinopatía	Ley 84, 1987		✓						
Cernimiento Defecto Cardíaco Congénito Crítico	Oximetría de pulso luego de las 24 horas de nacido, antes de la alta		✓						
Cernimiento Hiperbilirubinemia	Prueba de bilirrubina antes de la alta de hospital, a las 48 horas nacidos en el hogar		✓						
Cernimiento del Desarrollo	Administrar instrumento de cernimiento validado. *Ages and Stages* (ASQ) última edición o *Survey Wellbeing Young Children* (SWYC)								✓
Evaluación y Cernimiento de riesgo de caries	Cernimiento de riesgo para caries (*Caries-risk Assessment Questionnaire*), resultado de alto riesgo, referir inmediatamente con el primer diente al dentista							✓	✓
Cernimiento Riesgo Tuberculosis	Cuestionario de riesgos, historial de exposición			✓				✓	
Cernimiento riesgo de exposición a plomo	Cuestionario de riesgos con resultado positivo, ordenar muestra de plomo en sangre							✓	✓

Infancia (continuación)

Selectivo Infancia	Evaluación	Acción	Visita Prenatal	Recién Nacido	3 a 5 días	1 mes	2 m	4 m	6 m	9 m
Presión	Historial positivo de riesgo	Presión arterial		☑	☑	☑	☑	☑	☑	☑
Visión	Historial y/o físico positivo	Oftalmólogo		☑	☑	☑	☑	☑	☑	☑
Madre Prueba Zika Positivo durante embarazo	Sonograma de cabeza Evaluación por Oftalmólogo Pediátrico, Seguir protocolo de cernimientos recomendado para estos infantes, cernimiento auditivo debe hacerse por "*Auditory Brainstem Response*" (ABR)	Referir a Servicios de Niños con Necesidades Médicas Especiales (Centros Pediátricos)		☑						
Anemia	Historial de prematuro	Hematocrito o Hgb						☑		

Universal Niñez Temprana	Acción	12 m	15 m	18 m	24 m	30 m	36 m	48 m
Historial y examen físico	Historial de actividad física y alimentación	✓	✓	✓	✓	✓	✓	✓
Medida peso/estatura	Clasificar percentil en gráfica	✓	✓	✓	✓	✓	✓	✓
Circunferencia de cabeza	Clasificar percentil en gráfica	✓	✓	✓	✓			
Guía Anticipatoria	Controlar tiempo exposición a consolas digitales y tv	✓	✓	✓	✓	✓	✓	✓
Vigilancia desarrollo y evaluación de conducta y condición psicosocial	Observación clínica e historial	✓	✓	✓	✓	✓	✓	✓
IMC / BMI	Clasificar percentil en gráfica				✓	✓	✓	✓
Presión Arterial							✓	✓
Inmunizaciones	Evaluar cumplimiento con esquema vigente y administrar vacunas necesarias para su cumplimiento	✓	✓	✓	✓	✓	✓	✓
Agudeza Visual	Evaluar objetivamente agudeza visual (ej.: cartilla Snellen)						✓	✓
Cernimiento auditivo	Audiometría							✓
Anemia	Hematocrito o Hgb	✓						
Autismo	Administrar instrumento *Modified Checklist for Autism in Toddlers*, (M-CHAT) o versión revisada (M-CHAT-R/F), seguir protocolo para autismo			✓	✓	✓		
Cernimiento en el Desarrollo	Administrar instrumento de cernimiento validado. *Ages and Stages* (ASQ) última edición o *Survey Wellbeing Young Children* (SWYC)			✓		✓		
Evaluación de Salud Oral	Referir al dentista para: limpieza cada 6 meses y barniz de Fluoruro	✓		✓	✓	✓	✓	✓
Cernimiento Riesgo Tuberculosis	Cuestionario de riesgos, historial positivo de exposición ordenar PPD	✓			✓		✓	✓
Plomo	Nivel de plomo en sangre	✓			✓			

Selectivo Niñez Temprana	Evaluación	Acción	12 m	15 m	18 m	24 m	30 m	36 m	48 m
Presión Sanguínea	Historial positivo de riesgos	BP	☑	☑	☑	☑	☑		
Visión	Historial y/o físico positivo	Oftalmólogo	☑	☑	☑	☑	☑		
Audición	Historial y/o físico positivo	Audiólogo	☑	☑	☑	☑	☑	☑	
Anemia	Historial y/o físico positivo	Hematocrito		☑	☑		☑	☑	☑
Dislipidemia	Historial familiar de riesgo enfermedades cardiovasculares y físico positivo (obeso)	Panel lípidos en ayuna				☑			☑
Plomo**	Cernimiento de riesgo (Cuestionario de riesgo)	Niveles plomo en sangre, cuando cuestionario es positivo para riesgo de exposición						☑	☑

Universal Niñez	**Acción**		**5 años**	**6 años**	**7 años**	**8 años**	**9 años**	**10 años**
Historial y examen físico	Historial de actividad física y bienestar emocional		✓	✓	✓	✓	✓	✓
Peso, estatura, IMC/BMI	Clasificar percentil en gráfica		✓	✓	✓	✓	✓	✓
Presión arterial			✓	✓	✓	✓	✓	✓
Guía anticipatoria	Promover actividad física más de1 hora diaria / disminuir tiempo en consolas a menos de 2 horas diarias		✓	✓	✓	✓	✓	✓
Vigilancia desarrollo	Observación clínica e historial		✓	✓	✓	✓	✓	✓
Vigilancia conducta	Observación clínica e historial		✓	✓	✓	✓	✓	✓
Inmunizaciones	Evaluar cumplimiento con esquema vigente Administrar vacunas necesarias para cumplir con esquema		✓	✓	✓	✓	✓	✓
Agudeza visual	Evaluar objetivamente agudeza visual (ej.: cartilla Snellen)		✓	✓		✓		✓
Cernimiento auditivos	Audiometría		✓	✓		✓		✓
Dislipidemia	Cernimiento: panel lípidos en ayuna						Una vez entre 9 a 10 años	
Salud oral	Visita al dentista para limpieza y evaluación 2 veces al año		✓	✓	✓	✓	✓	✓
Cernimiento riesgo tuberculosis	Cuestionario de riesgos, historial de exposición positiva ordenar PPD o prueba IGRA en sangre (solo a mayores de 4 años)		✓	✓	✓	✓	✓	✓
Selectivo	**Evaluación**	**Acción**	**5 años**	**6 años**	**7 años**	**8 años**	**9 años**	**10 años**
Visión	Historial y/o físico positivo	Referido oftalmólogo	☑	☑	☑	☑	☑	☑
Audición	Historial positivo	Referido Audiólogo	☑	☑	☑	☑	☑	☑
Anemia	Historial y/o físico positivo	Hematocrito o Hgb	☑	☑	☑	☑	☑	☑
Plomo	Historial de riesgo a exposición a plomo	Niveles plomo en sangre	☑	☑				
Dislipidemia	Historial familiar de riesgo enfermedades cardiovasculares y físico positivo (obeso)	Panel lípidos en ayuna	☑	☑	☑			

Universal Jóvenes	Acción	11-14 años	15-17 años	18-21 años
Historial detallado y examen físico	Historial de actividad física y bienestar emocional. Desarrollo características sexuales secundarias, menarquia, sueños mojados, historial actividad sexual, hábitos de dormir, acoso (*bullying)*	Anual	Anual	Anual
Peso, estatura, IMC/BMI	Clasificar percentil en gráfica	Anual	Anual	Anual
Presión arterial		Anual	Anual	Anual
Vigilancia desarrollo	Observación clínica e historial	Anual	Anual	Anual
Evaluación conducta	Cernimiento conducta de riesgo, conocida como CRAFFT versión 2.1+N en inglés o en español	Anual	Anual	Anual
Evaluación presencia de Violencia y/o Depresión	Cernimiento de depresión, "*Patient Health Questionnaire 9*" (PHQ9), historial de violencia o agresión	Anual	Anual	Anual
Promoción estilos de vida saludables	(Alimentación, Actividad Física, actividad sexual responsable y saludable, prevención del uso de alcohol y sustancias controladas, prevención de fumar y cigarrillos electrónicos)	Anual	Anual	Anual
Guía anticipatoria	Anticipar cambios fisiológicos y emocionales típicos para cada etapa	Anual	Anual	Anual
Inmunizaciones	Evaluar cumplimiento con esquema vigente. Administrar vacunas necesarias para cumplir con esquema	Anual	Anual	Anual
Visión	Evaluación objetiva utilizando tabla optométrica (ej.: cartilla Snellen)	Una vez entre los 11 a 14 años	Una vez entre los 15 a 17 años	Una vez entre los 18 a 21 años
Cernimiento auditivo	Cernimiento por audiometría que incluya alta frecuencia entre 6,000 a 8,000 hz	Una vez entre 11 a 14 años	Una vez entre los 15 a 17 años	Una vez entre los 18 a 21 años
Dislipidemia	Panel lípidos en ayuna	una vez entre los 9 a 11 años		Una vez entre los 17 a 21 años
Salud Oral	Visita al dentista para evaluación y limpieza profesional 2 veces al año	Anual	Anual	Anual
VIH, Ley 45 de 2016	Prueba de laboratorio con consentimiento previo e información del significado de los resultados positivo o negativo / a partir de los 13 años, repetir prueba cada 5 años	13 años	Una vez entre los 15 a 17 años	
Prueba en orina para Clamidia, Gonorrea	Universal NAAT en orina		Una vez entre los 15 a 17 años	
Sífilis (VDRL)	Laboratorio			Una vez entre los 18 a 21 años
Displasia cervical	Pap smear			A los 21 años

Universal Jóvenes	Acción	11-14 años	15-17 años	18-21 años
Tuberculosis	PPD o IGRA en sangre			Una vez entre los 18 a 21 años
Hepatitis C	Muestra de sangre para presencia de anticuerpos a Hepatitis C			Una vez en después de los 17 años

Selectivo	Evaluación	Acción	Temprana: 11-14 años	Media: 15-17 años	Tardía: 18-21 años
Visión	Historial, físico, cernimiento positivo	Referir al Oftalmólogo	☑	☑	☑
Audición	Historial, físico, cernimiento positivo	Referir al Audiólogo	☑	☑	☑
Anemia	Historial y/o físico positivo	Hematocrito o Hgb	☑	☑	☑
Embarazo	Sospecha embarazo	Prueba serológica	☑	☑	☑
Tuberculosis	Exposición casos TB positivo	PPD o IGRA en sangre	☑	☑	
Prueba en orina para Clamidia, Gonorrea	Historial y/o físico positivo	Laboratorios NAATS	☑		☑
Sífilis (VDRL)	Historial y físico positivo	Laboratorio VDRL	☑	☑	

Enlaces de Referencia:

Enlaces para pruebas de cernimiento recomendadas

MCHAT y MCHAT-R/F https://mchatscreen.com/

Ages and Stages (ASQ) http://agesandstages.com/

SWYC https://www.floatinghospital.org/The-Survey-of-Wellbeing-of-Young-Children/Age-Specific-Forms

CRAFFT o Carlos https://crafft.org/get-the-crafft/

Cuestionario para Evaluar Riesgo de Tuberculosis en Poblaciones Pediátricas
http://www.salud.gov.pr/Dept-de-Salud/Documents/Cuestionario%20para%20Evaluar%20Riesgo%20de%20Tuberculosis%20en%20Poblaciones%20Pedi%C3%A1tricas.pdf

Cuestionario para evaluar riesgo de plomo

Cernimiento de depresión PHQ-9 para adolescentes
https://aidsetc.org/sites/default/files/resources_files/PHQ-A%20Spanish_II%20.pdf

Otros cernimientos para desórdenes de salud mental
https://www.hiv.uw.edu/page/mental-health-screening/ihds

Herramienta para identificar otros cernimientos
https://screeningtime.org/star-center/#/screening-tools

Enlaces para herramientas en las visitas preventivas

Manual de AAP, Códigos para facturar visitas pediátricas
https://downloads.aap.org/AAP/PDF/Coding%20Preventive%20Care.pdf

Bright Futures AAP
https://brightfutures.aap.org/Pages/default.aspx

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Departamento de Salud

Preguntas sobre evaluación de riesgos

Cuestionario sobre evaluación de riesgos		
Pregunta	**Respuesta**	
	Sí	**No**
1. ¿Vive su hijo en una casa o en un edificio construido antes de 1978 que presente pintura descascarada o agrietada o en el cual se haya realizado recientemente, se esté realizando o se planee realizar una restauración o remodelación, o visita habitualmente su hijo una casa o un edificio con las características mencionadas? **Nota**: Este lugar puede incluir una guardería infantil, el preescolar y el hogar de su niñera o de algún pariente.		
2. ¿Alguna vez han vivido su hijo o su familia fuera de los Estados Unidos o han llegado recientemente de algún viaje en el extranjero?		
3. ¿Tiene su hijo hermanos, amigos o vive con alguna persona que está recibiendo tratamiento por intoxicación con plomo?		
4. ¿Se lleva su hijo a la boca objetos como juguetes, joyas o llaves frecuentemente? ¿Ingiere su hijo sustancias no comestibles (pica)? **Nota**: Se debe destacar la posibilidad del hábito de llevarse juguetes a la boca debido a las retiradas recientes.		
5. ¿Está su hijo en contacto frecuente con algún adulto cuyo trabajo o hobby implique la exposición al plomo? **Nota**: Trabajos como pintar viviendas, renovar, construir, soldar o la alfarería. Ejemplos de hobbies: realizar tareas de alfarería o fabricación de vidrios, pescar, fabricar armas de fuego y coleccionar figuritas de plomo.		
6. ¿Vive su hijo cerca de alguna fundidora de plomo, planta de reciclado de baterías u		

otra industria activa donde probablemente se libere plomo o vive su hijo cerca de alguna autopista principal con mucho tráfico donde el suelo y el polvo puedan estar contaminados con plomo? **Nota:** En caso de que dicha industria sea local, puede resultar necesario alertar a los padres o cuidadores. Haga toda pregunta adicional que pueda resultar específica a una comunidad en particular.		

En caso de que la respuesta a cualquiera de las preguntas anteriores sea afirmativa, se considerará que el niño presenta riesgo de exposición a altos niveles de plomo y se le deberá realizar un análisis de plomo en sangre.

Questions or comments: dohweb@health.state.ny.us

Revisado: December 2007

ESCALA DE EDINBURGO (Spanish Version)

Como usted hace poco tuvo un bebé, nos gustaría saber como se ha estado sintiendo. Por favor SUBRAYE la respuesta que más se acerca a como se ha sentido en los últimos 7 días.
Or
Por favor haga un círculo alrededor de la respuesta que más se acerca a como se ha sentido en los últimos 7 días.

Éste es un ejemplo ya completo:

Me he sentido contenta:

0 Sí, siempre
1 Sí, casi siempre
2 No muy a menudo
3 No, nunca

En los últimos 7 días:

1. He podido reír y ver el lado bueno de las cosas:
   0 Tanto como siempre
   1 No tanto ahora
   2 Mucho menos
   3 No, no he podido

2. He mirado al futuro con placer:
   0 Tanto como siempre
   1 Algo menos de lo que solía hacer
   2 Definitivamente menos
   3 No, nada

3. Me he culpado sin necesidad cuando las cosas marchaban mal:
   3 Sí, casi siempre
   2 Sí, algunas veces
   1 No muy a menudo
   0 No, nunca

4. He estado ansiosa y preocupada sin motivo:
   0 No, nada
   1 Casi nada
   2 Sí, a veces
   3 Sí, a menudo

5. He sentido miedo o pánico sin motivo alguno:
   3 Sí, bastante
   2 Sí, a veces
   1 No, no mucho
   0 No, nada

En los últimos 7 días:

6. Las cosas me oprimen o agobian:
   3 Sí, casi siempre
   2 Sí, a veces
   1 No, casi nunca
   0 No, nada

7. Me he sentido tan infeliz, que he tenido dificultad para dormir:
   3 Sí, casi siempre
   2 Sí, a menudo
   1 No muy a menudo
   0 No, nada

8. Me he sentido triste y desgraciada:
   3 Sí, casi siempre
   2 Sí, bastante a menudo
   1 No muy a menudo
   0 No, nada

9. He estado tan infeliz que he estado llorando:
   3 Sí, casi siempre
   2 Sí, bastante a menudo
   1 Sólo ocasionalmente
   0 No, nunca

10. He pensado en hacerme daño a mí misma:
    3 Sí, bastante a menudo
    2 Sí, a menudo
    1 Casi nunca
    0 No, nunca

Scoring and Other Information

Response categories are scored 0, 1, 2, and 3 according to increased severity of the symptom. Items 3, 5-10 are reverse scored (i.e., 3, 2, 1, and 0). The total score is calculated by adding together the scores for each of the ten items. Users may reproduce the scale without further permission providing they respect copyright (which remains with the *British Journal of Psychiatry*) quoting the names of the authors, the title and the source of the paper in all reproduced copies.

The Edinburgh Postnatal Depression Scale (EPDS) has been developed to assist primary care health professionals to detect mothers suffering from postnatal depression; a distressing disorder more prolonged than the "blues" (which occur in the first week after delivery) but less severe than puerperal psychosis.

Previous studies have shown that postnatal depression affects at least 10% of women and that many depressed mothers remain untreated. These mothers may cope with their baby and with household tasks, but their enjoyment of life is seriously affected and it is possible that there are long-term effects on the family.

The EPDS was developed at health centres in Livingston and Edinburgh. It consists of ten short statements. The mother underlines which of the four possible responses is closest to how she has been feeling during the past week. Most mothers complete the scale without difficulty in less than 5 minutes.

The validation study showed that mothers who scored above a threshold 12/13 were likely to be suffering from a depressive illness of varying severity. Nevertheless the EPDS score should not override clinical judgement. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt during the previous week, and in doubtful cases it may be usefully repeated after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Instructions for users

1. The mother is asked to underline the response which comes closest to how she has been feeling in the previous 7 days.
2. All ten items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others.
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.
5. The EPDS may be used at 6-8 weeks to screen postnatal women or during pregnancy. The child health clinic, postnatal check-up or a home visit may provide suitable opportunities for its completion.

Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry*, *150*, 782-786.

This Spanish version was developed at the University of Iowa based on earlier Spanish versions of the instrument. For further information, please contact Michael W. O'Hara, Department of Psychology, University of Iowa, Iowa City, IA 52245. mike-ohara@uiowa.edu.

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

Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

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

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in a satisfactory fashion. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits. Additional visits also may become necessary if circumstances suggest variations from normal.

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/BEHAVIORAL HEALTH																															
Developmental Screening[11]								●			●		●																		
Autism Spectrum Disorder Screening[12]											●	●																			
Developmental Surveillance		●	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Psychosocial/Behavioral Assessment[13]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Tobacco, Alcohol, or Drug Use Assessment[14]																						★	★	★	★	★	★	★	★	★	★
Depression Screening[15]																							●	●	●	●	●	●	●	●	●
Maternal Depression 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 C Virus Infection[31]																													●	→	
Cervical Dysplasia[32]																															●
ORAL HEALTH[33]							●[34]	●[34]	★		★	★	★	★	★	★	★														
Fluoride Varnish[35]							←				●		→																		
Fluoride Supplementation[36]							★	★	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★				
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://pediatrics.aappublications.org/content/142/1/e20181218).
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" (http://pediatrics.aappublications.org/content/129/3/e827.full). Newborns discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per "Hospital Stay for Healthy Term Newborns" (http://pediatrics.aappublications.org/content/125/2/405.full).
5. Screen, per "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" (http://pediatrics.aappublications.org/content/120/Supplement_4/S164.full)
6. Screening should occur per "Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents" (http://pediatrics.aappublications.org/content/140/3/e20171904). 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" (http://pediatrics.aappublications.org/content/137/1/e20153596) and "Procedures for the Evaluation of the Visual System by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/e20153597).
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" (http://pediatrics.aappublications.org/content/120/4/898.full).
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 "Promoting Optimal Development: Identifying Infants and Young Children With Developmental Disorders Through Developmental Surveillance and Screening" (https://pediatrics.aappublications.org/content/145/1/e20193449).
12. Screening should occur per "Identification, Evaluation, and Management of Children With Autism Spectrum Disorder" (https://pediatrics.aappublications.org/content/145/1/e20193447).
13. This 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" (http://pediatrics.aappublications.org/content/135/2/384) and "Poverty and Child Health in the United States" (http://pediatrics.aappublications.org/content/137/4/e20160339).
14. A recommended assessment tool is available at http://crafft.org.
15. Recommended screening using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit and at https://downloads.aap.org/AAP/PDF/Mental_Health_Tools_for_Pediatrics.pdf.
16. Screening should occur per "Incorporating Recognition and Management of Perinatal Depression Into Pediatric Practice" (https://pediatrics.aappublications.org/content/143/1/e20183259).
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" (http://pediatrics.aappublications.org/content/127/5/991.full).
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/newborn-screening/states) establish the criteria for and coverage of newborn screening procedures and programs.

(continued)

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

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(continued)

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" (http://pediatrics.aappublications.org/content/124/4/1193).
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" (http://pediatrics.aappublications.org/content/129/1/190.full).
23. Schedules, per the AAP Committee on Infectious Diseases, are available at https://redbook.solutions.aap.org/SS/immunization_Schedules.aspx. 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" (http://pediatrics.aappublications.org/content/138/1/e20161493) and "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention" (http://www.cdc.gov/nceh/lead/ACCLPP/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. 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.
32. 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" (http://pediatrics.aappublications.org/content/126/3/583.full).
33. Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment (https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Oral-Health/Pages/Oral-Health-Practice-Tools.aspx) 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" (http://pediatrics.aappublications.org/content/134/6/1224).
34. Perform a risk assessment (https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Oral-Health/Pages/Oral-Health-Practice-Tools.aspx). See "Maintaining and Improving the Oral Health of Young Children" (http://pediatrics.aappublications.org/content/134/6/1224).
35. See USPSTF recommendations (https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/dental-caries-in-children-from-birth-through-age-5-years-screening). Once teeth are present, fluoride varnish may be applied to all children every 3 to 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" (http://pediatrics.aappublications.org/content/134/3/626).
36. If primary water source is deficient in fluoride, consider oral fluoride supplementation. See "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626).

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

This schedule reflects changes approved in November 2020 and published in March 2021. For updates and a list of previous changes made, visit www.aap.org/periodicityschedule.

CHANGES MADE IN NOVEMBER 2020

DEVELOPMENTAL

- Footnote 11 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://pediatrics.aappublications.org/content/145/1/e20193449)."

AUTISM SPECTRUM DISORDER

- Footnote 12 has been updated to read as follows: "Screening should occur per 'Identification, Evaluation, and Management of Children With Autism Spectrum Disorder' (https://pediatrics.aappublications.org/content/145/1/e20193447)."

HEPATITIS C VIRUS INFECTION

- Screening for hepatitis C virus 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 31 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."
- Footnotes 31 through 35 have been renumbered as footnotes 32 through 36.

CHANGES MADE IN OCTOBER 2019

MATERNAL DEPRESSION

- Footnote 16 has been updated to read as follows: "Screening should occur per 'Incorporating Recognition and Management of Perinatal Depression Into Pediatric Practice' (https://pediatrics.aappublications.org/content/143/1/e20183259)."

CHANGES MADE IN DECEMBER 2018

BLOOD PRESSURE

- Footnote 6 has been updated to read as follows: "Screening should occur per 'Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents' (http://pediatrics.aappublications.org/content/140/3/e20171904). Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years."

ANEMIA

- Footnote 24 has been updated to read as follows: "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)."

LEAD

- Footnote 25 has been updated to read as follows: "For children at risk of lead exposure, see 'Prevention of Childhood Lead Toxicity' (http://pediatrics.aappublications.org/content /138/1/e20161493) and 'Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention' (https://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf)."

HRSA
Health Resources & Services Administration
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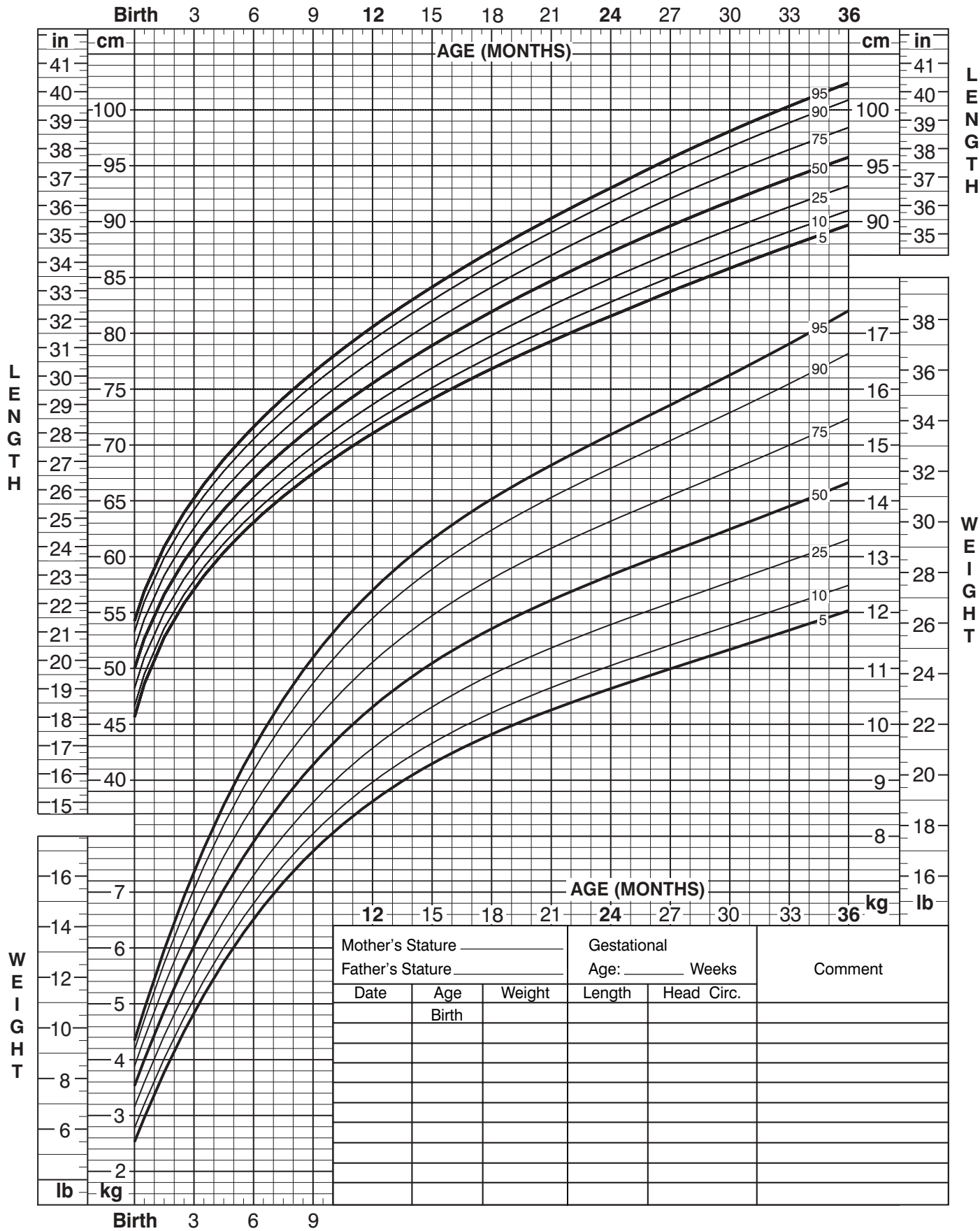
Birth to 36 months: Boys
Length-for-age and Weight-for-age percentiles

NAME _____

RECORD # _____



Mother's Stature _____ Father's Stature _____			Gestational Age: _____ Weeks		Comment
Date	Age	Weight	Length	Head Circ.	
	Birth				

Published May 30, 2000 (modified 4/20/01).

SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
http://www.cdc.gov/growthcharts

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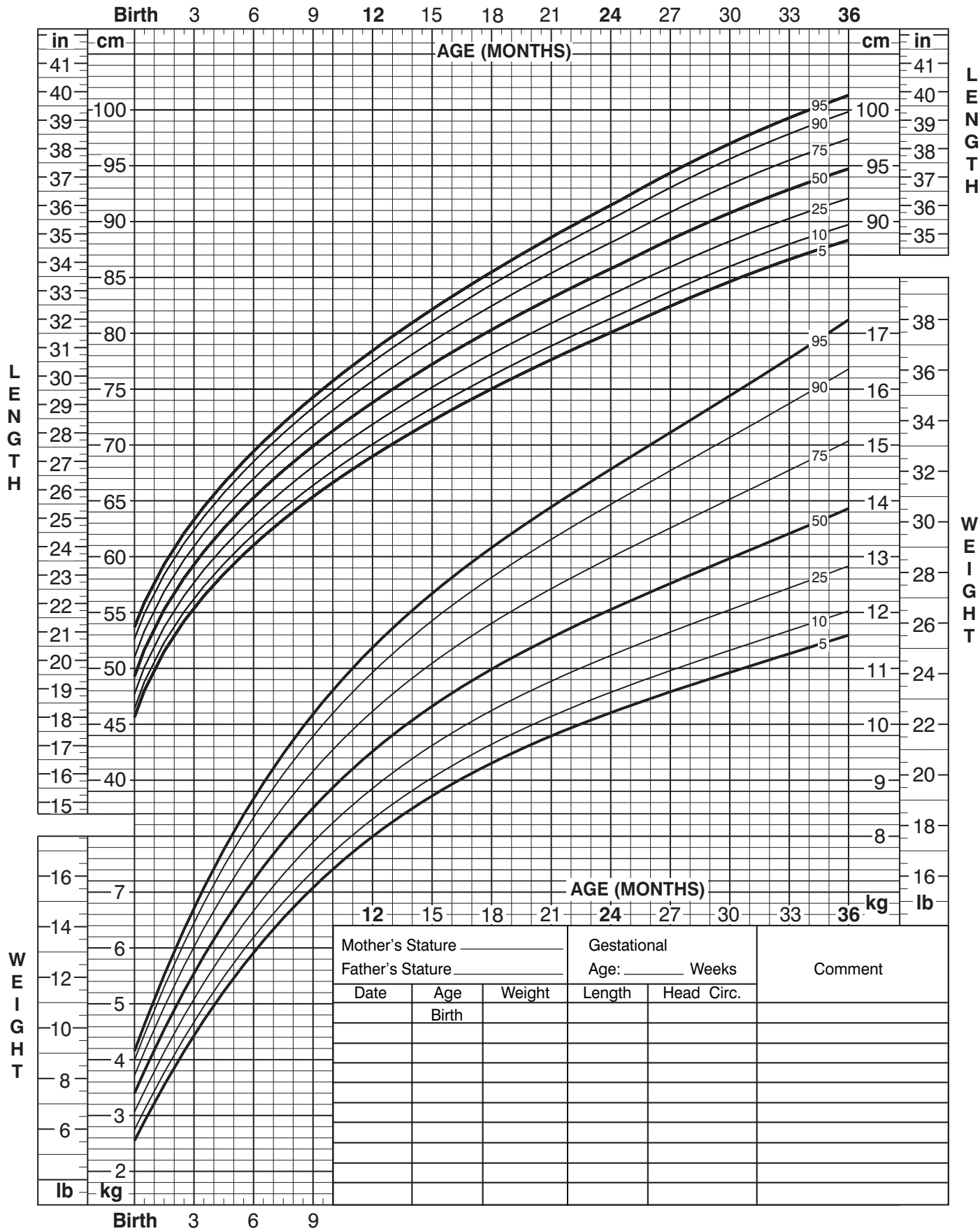
Birth to 36 months: Girls
Length-for-age and Weight-for-age percentiles

NAME _____

RECORD # _____



Published May 30, 2000 (modified 4/20/01).

SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
http://www.cdc.gov/growthcharts

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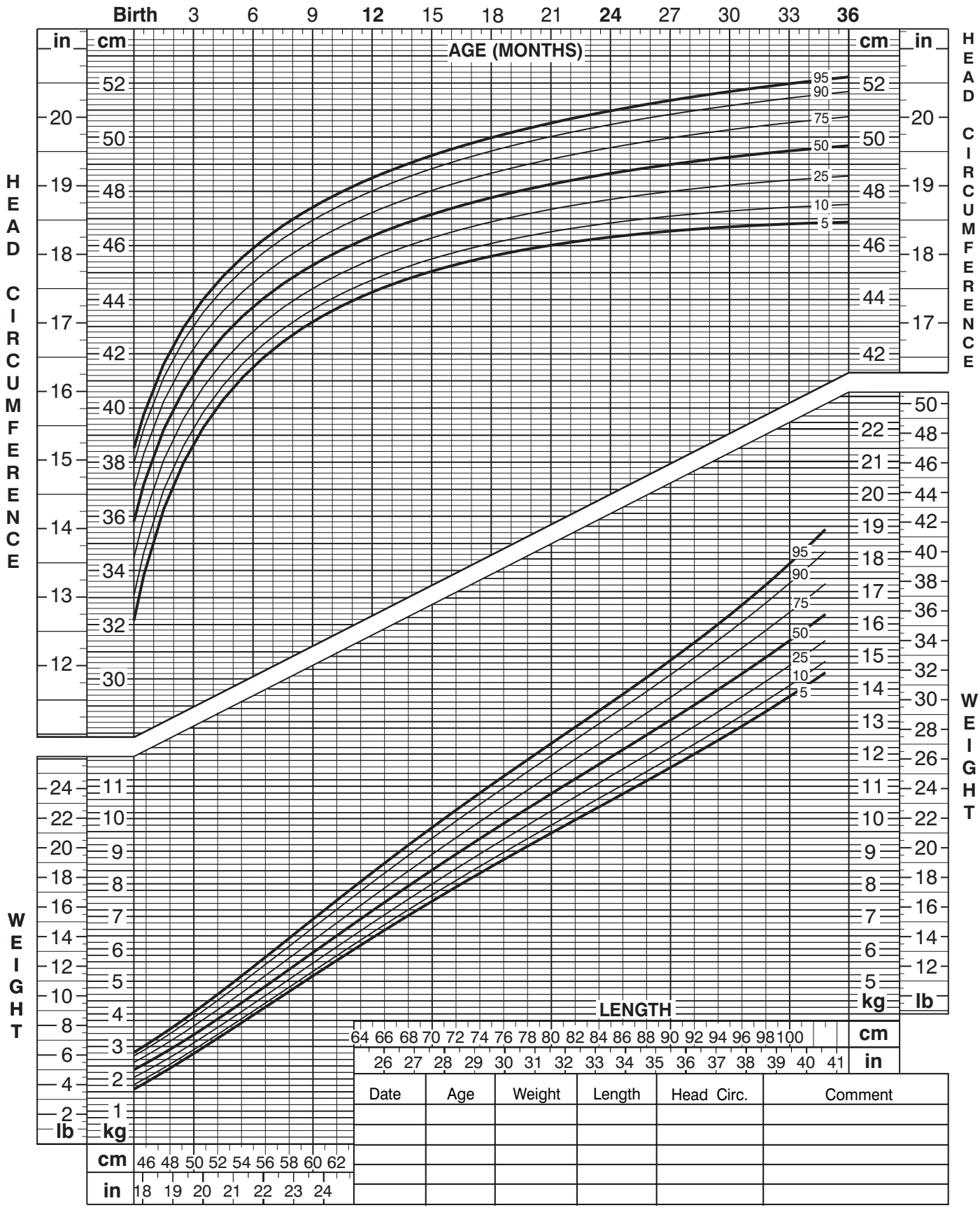
Birth to 36 months: Boys
Head circumference-for-age and Weight-for-length percentiles

NAME _____

RECORD # _____



Published May 30, 2000 (modified 10/16/00).

SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
http://www.cdc.gov/growthcharts

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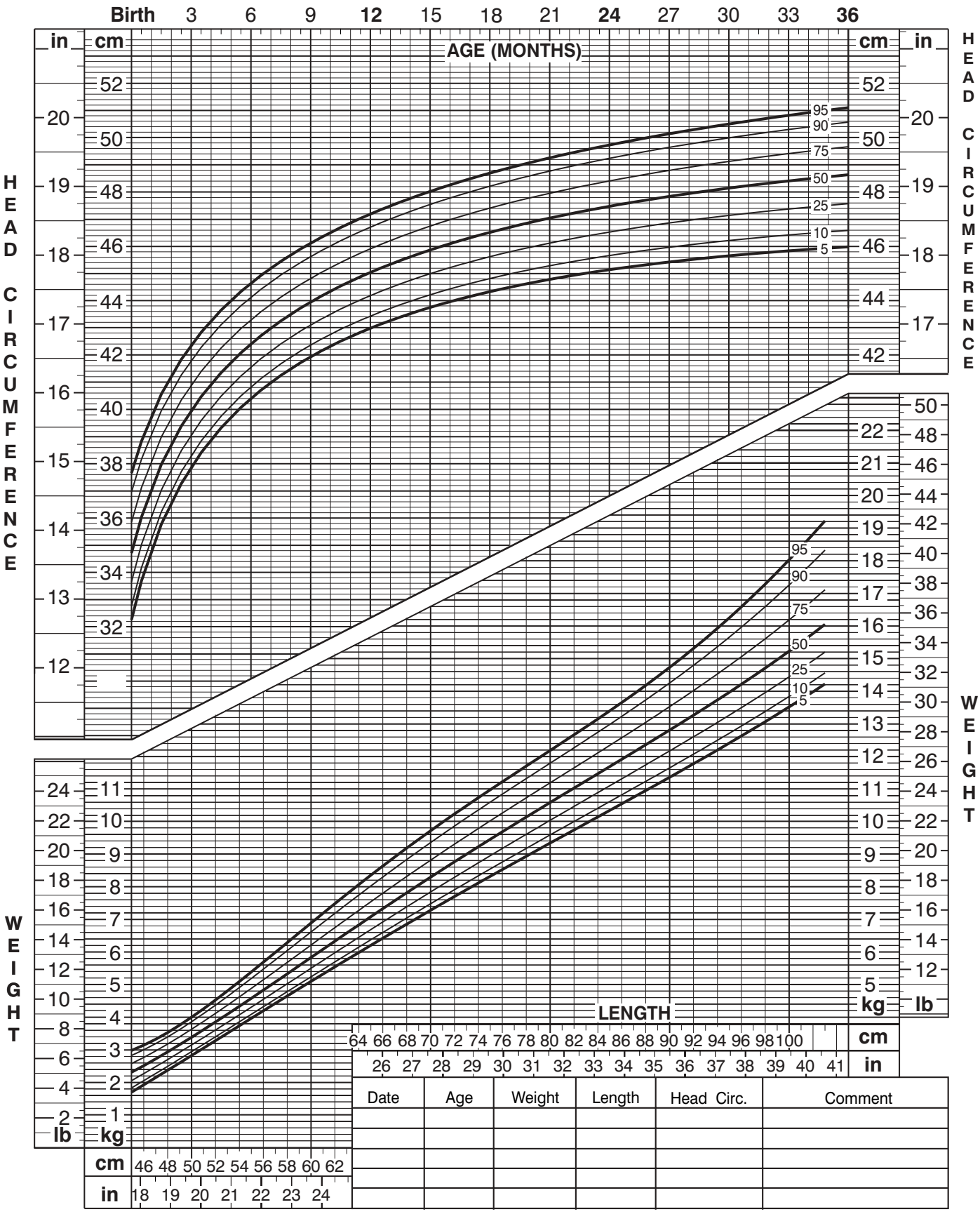
Birth to 36 months: Girls
Head circumference-for-age and
Weight-for-length percentiles

NAME _____

RECORD # _____



Published May 30, 2000 (modified 10/16/00).

SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).

http://www.cdc.gov/growthcharts

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2 to 20 years: Boys
Stature-for-age and Weight-for-age percentiles

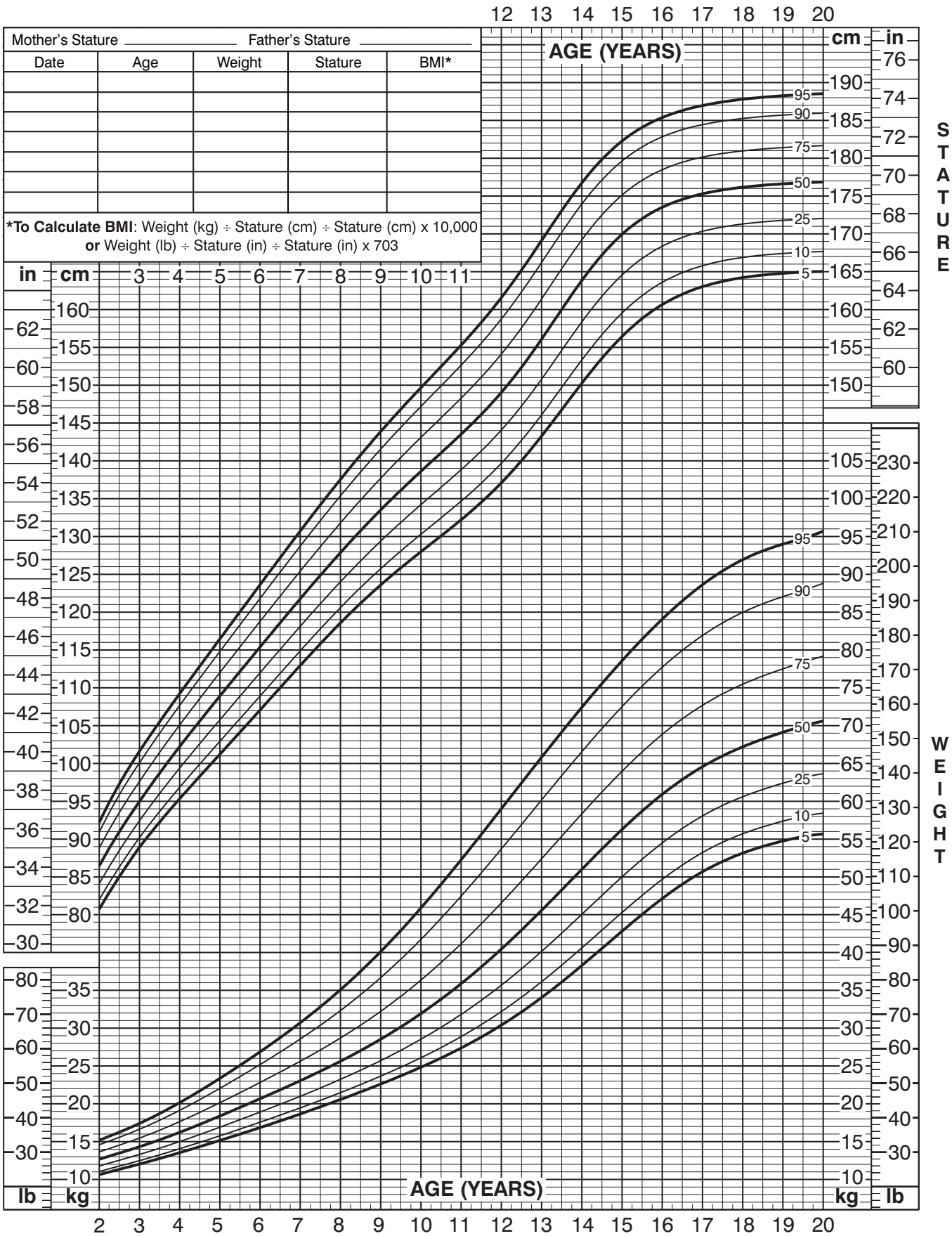
NAME _____

RECORD # _____

Mother's Stature _____ Father's Stature _____

Date	Age	Weight	Stature	BMI*

***To Calculate BMI**: Weight (kg) ÷ Stature (cm) ÷ Stature (cm) x 10,000
or Weight (lb) ÷ Stature (in) ÷ Stature (in) x 703



Published May 30, 2000 (modified 11/21/00).
SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
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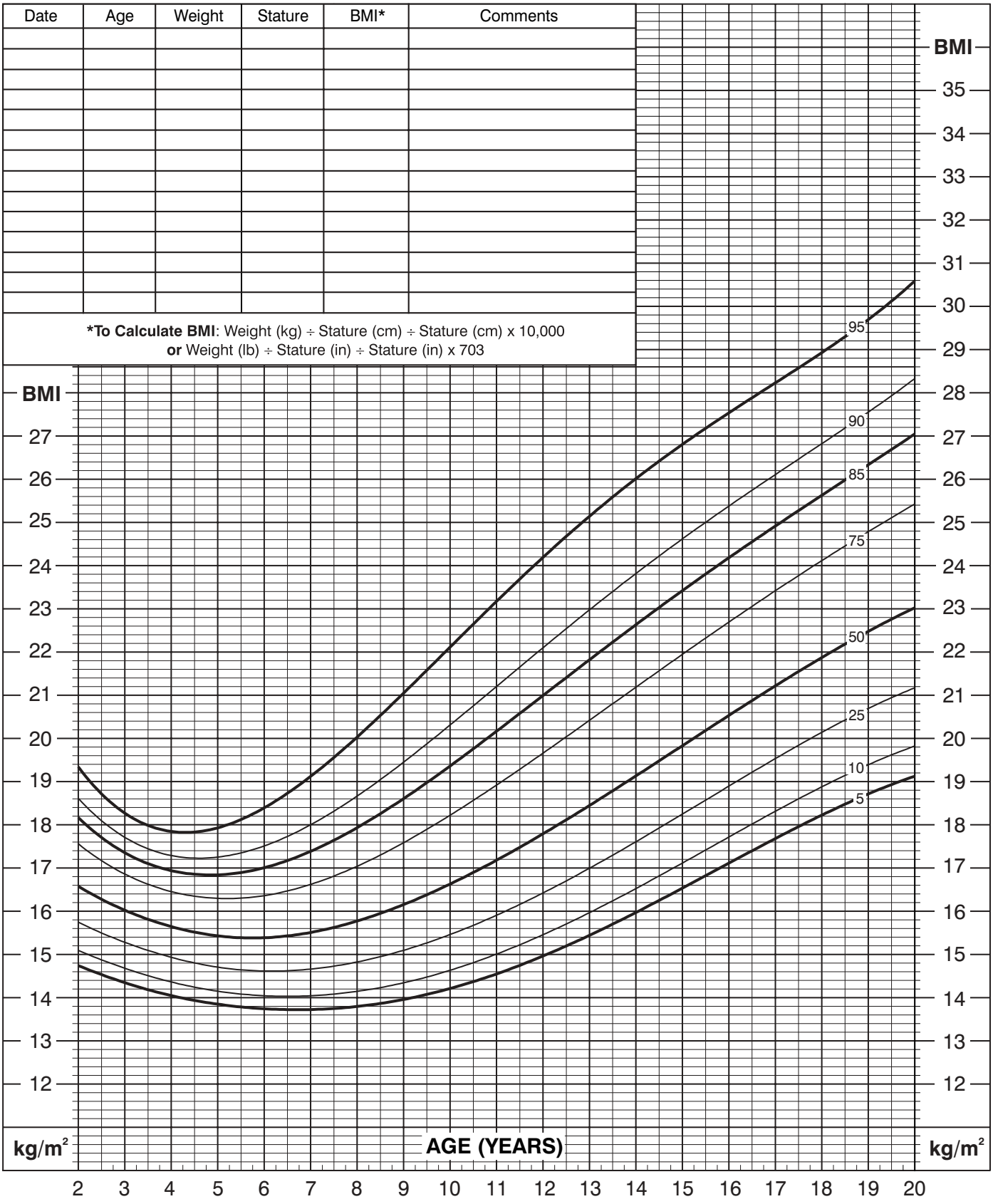
2 to 20 years: Boys
Body mass index-for-age percentiles

NAME _____

RECORD # _____

Date	Age	Weight	Stature	BMI*	Comments

***To Calculate BMI**: Weight (kg) ÷ Stature (cm) ÷ Stature (cm) x 10,000
or Weight (lb) ÷ Stature (in) ÷ Stature (in) x 703



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2 to 20 years: Girls
Stature-for-age and Weight-for-age percentiles

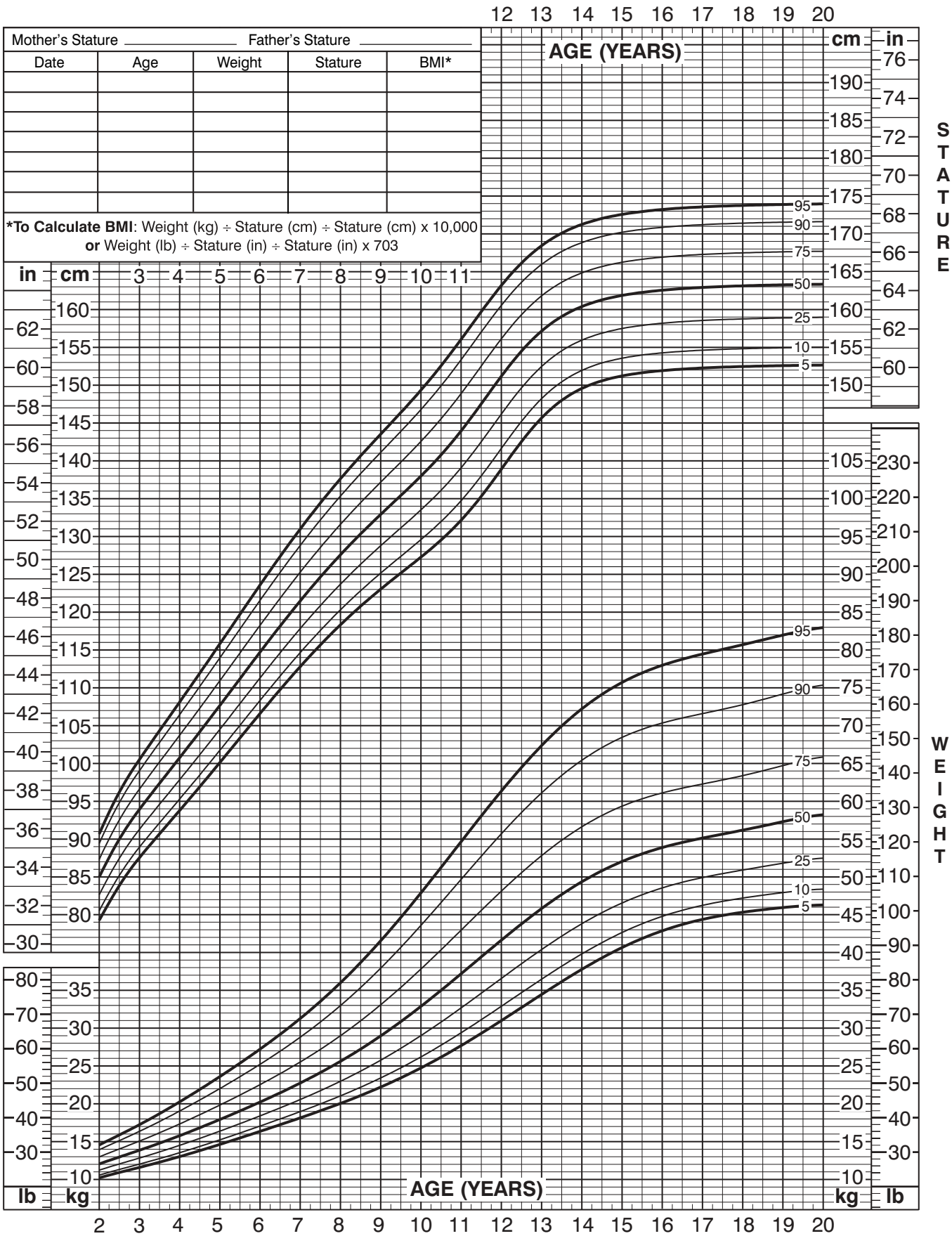
NAME _____

RECORD # _____

Mother's Stature _____ Father's Stature _____

Date	Age	Weight	Stature	BMI*

***To Calculate BMI**: Weight (kg) ÷ Stature (cm) ÷ Stature (cm) x 10,000
or Weight (lb) ÷ Stature (in) ÷ Stature (in) x 703



Published May 30, 2000 (modified 11/21/00).

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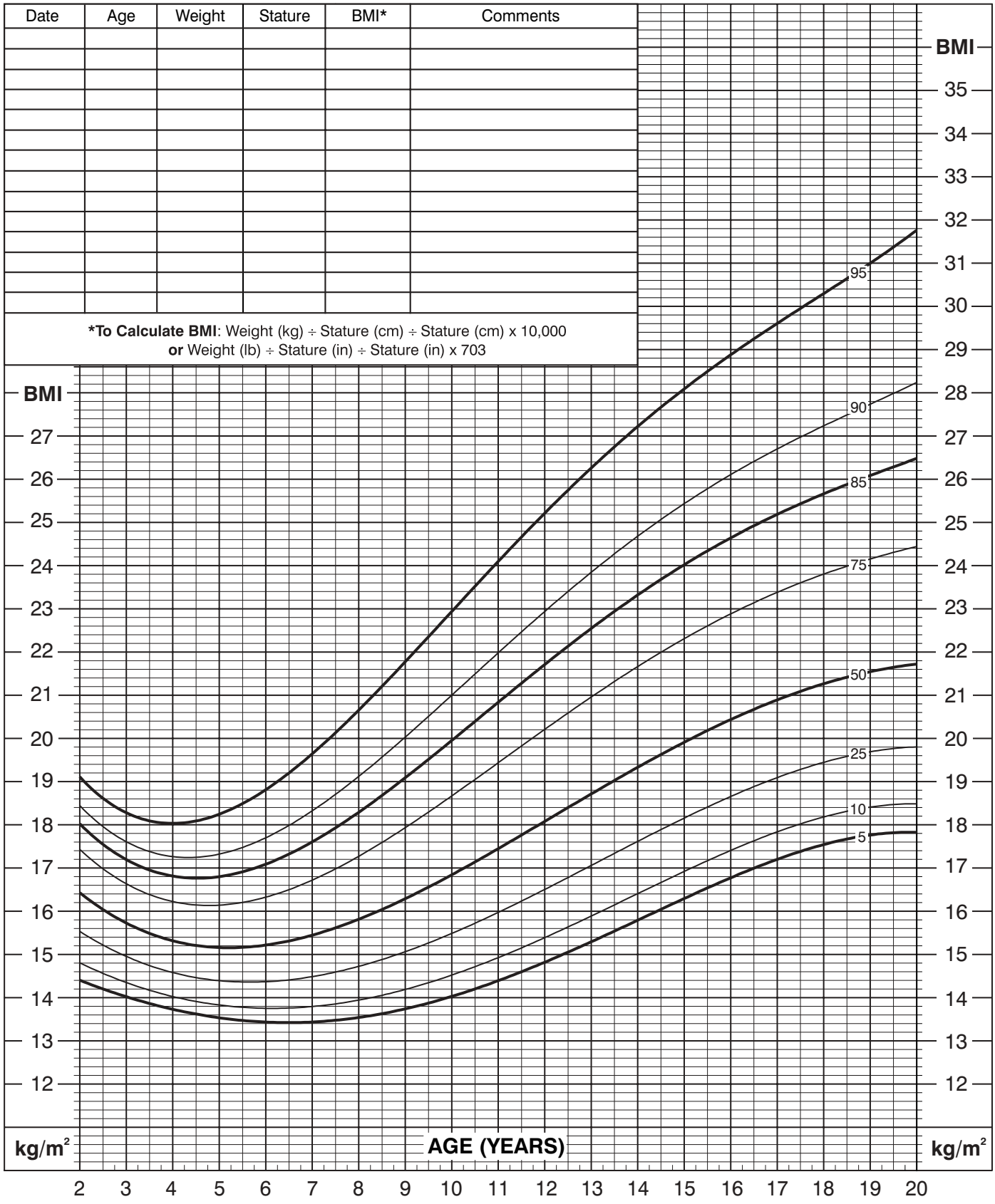
2 to 20 years: Girls
Body mass index-for-age percentiles

NAME _____

RECORD # _____

Date	Age	Weight	Stature	BMI*	Comments

***To Calculate BMI**: Weight (kg) ÷ Stature (cm) ÷ Stature (cm) x 10,000
or Weight (lb) ÷ Stature (in) ÷ Stature (in) x 703



Published May 30, 2000 (modified 10/16/00).
SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
http://www.cdc.gov/growthcharts

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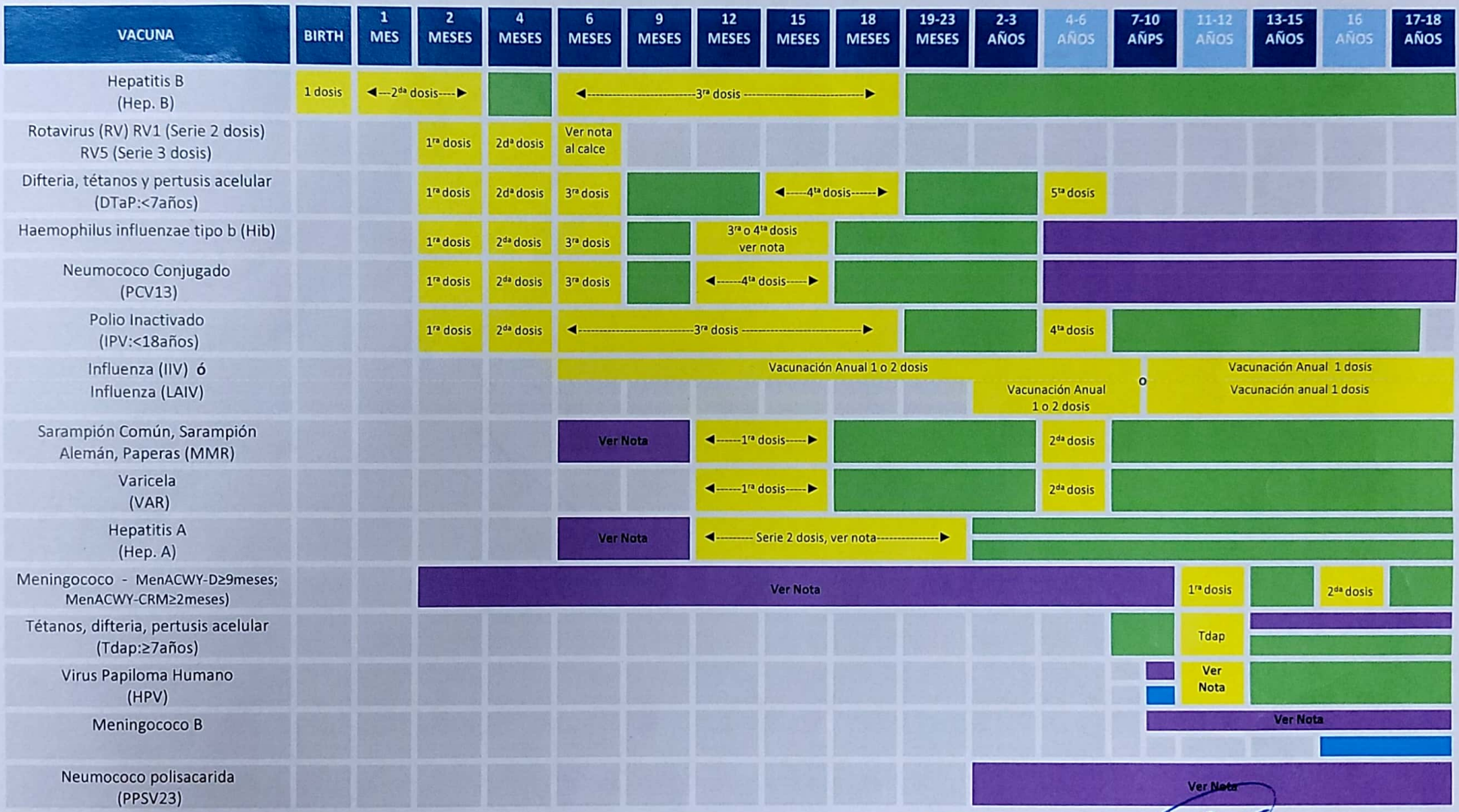
Departamento de Salud

ITINERARIO DE VACUNACION PARA NIÑOS Y ADOLESCENTES 2021
EDADES O A 18 AÑOS



11 de agosto de 2021

Carlos Mellado López, MD
Secretario, Departamento de Salud

Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents

Latest Revision

2018

How to Cite: American Academy of Pediatric Dentistry. Periodicity of examination, preventive dental services, anticipatory guidance/counseling, and oral treatment for infants, children, and adolescents. The Reference Manual of Pediatric Dentistry. Chicago, Ill.: American Academy of Pediatric Dentistry; 2020:232-42.

Purpose

The American Academy of Pediatric Dentistry (**AAPD**) intends these recommendations to help practitioners make clinical decisions concerning preventive oral health interventions, including anticipatory guidance and preventive counseling, for infants, children, and adolescents.

Methods

This document was developed by the Clinical Affairs Committee and adopted in 1991. This document is a revision of the previous version, last revised in 2013. The update used electronic database and hand searches of articles in the medical and dental literature using the terms: periodicity of dental examinations, dental recall intervals, preventive dental services, anticipatory guidance and dentistry, caries risk assessment, early childhood caries, dental caries prediction, dental care cost effectiveness and children, periodontal disease and children and adolescents U.S., pit and fissure sealants, dental sealants, fluoride supplementation and topical fluoride, dental trauma, dental fracture and tooth, non-nutritive oral habits, treatment of developing malocclusion, removal of wisdom teeth, removal of third molars; fields: all; limits: within the last 10 years, humans, English, and clinical trials; birth through age 18. From this search, 1,884 articles matched these criteria and were evaluated by title and/or abstract. Information from 49 articles was chosen for review to update this document. When data did not appear sufficient or were inconclusive, recommendations were based upon expert and/or consensus opinion by experienced researchers and clinicians.

Background

Professional dental care is necessary to maintain oral health.[1] The AAPD emphasizes the importance of initiating professional oral health intervention in infancy and continuing through adolescence and beyond.[2] The periodicity of professional oral health intervention and services is based on a patient's individual needs and risk indicators.[3-8] Each age group, as well as each individual child, has distinct developmental needs to be addressed at specific intervals as part of a comprehensive evaluation.[2,9-11] Continuity of care is based on the assessed needs of the individual patient and assures appropriate management of all oral conditions, dental disease, and injuries.[12-18] The early dental visit to establish a dental home provides a foundation upon which a lifetime of preventive education and oral health care can be built. The early establishment of a dental home has the potential to provide more effective and less costly dental care when compared to dental care provided in emergency care facilities or hospitals.[19-23] Anticipatory guidance and counseling are essential components of the dental visit.[2,9,10,19,20,22,24-37]

Collaborative efforts and effective communication between medical and dental homes are essential to prevent oral disease and promote oral and overall health among children. Medical professionals can play an important role in children's oral health by providing primary prevention and coordinated care. Equally, dentists can improve the overall health of children not only by treating dental disease, but also by proactively recognizing child abuse, preventing traumatic injuries through anticipatory guidance, preventing obesity by longitudinal dietary counseling, and monitoring of weight status.[28] In addition, dentists can have an important role in assessing immunization status and developmental milestones for potential delays, as well as making appropriate referral for further neurodevelopmental evaluations and therapeutic services.[29] The unique opportunity that dentists have to help address overall health issues strengthens as children get older since frecuency of well child medical visits decreases at the same time the frecuency of dental recall visits increases. Research shows that children aged six- to 12-years are, on average, four times more likely to visit a dentist than a pediatrician.[30,31]

Recommendations

This document addresses periodicity and general principles of examination, preventive dental services, anticipatory guidance/counseling, and oral treatment for children who have no contributory medical conditions and are developing normally. Accurate, comprehensive, and up-to-date medical, dental, and

ABBREVIATIONS

AAPD: American Academy Pediatric Dentistry. **ECC:** Early childhood caries. **SHCN:** Special health care needs.

social histories are necessary for correct diagnosis and effective treatment planning. Recommendations may be modified to meet the unique requirements of patients with special health care needs (**SHCN**).[32]

Clinical oral examination

The first examination is recommended at the time of the eruption of the first tooth and no later than 12 months of age.[2,19,20,22] The developing dentition and occlusion should be monitored throughout eruption at regular clinical examinations.[27] Evidence-based prevention and early detection and management of caries/oral conditions can improve a child's oral and general health, well-being, and school readiness.[5,24,33-36] It has been reported that the number and cost of dental procedures among high-risk children is less for those seen at an earlier age versus later, confirming the fact that the sooner a child is seen by a dentist, the less treatment needs they are likely to have in the future.[37] On the other hand, delayed diagnosis of dental disease can result in exacerbated problems which lead to more extensive and costly care.[8,33,38-41] Early diagnosis of developing malocclusions may allow for timely therapeutic intervention.[9,27]

Components of a comprehensive oral examination include assessment of:

- general health/growth.
- pain.
- extraoral soft tissues.
- temporomandibular joints.
- intraoral soft tissues.
- oral hygiene and periodontal health.
- intraoral hard tissues.
- developing occlusion.
- caries risk.
- behavior of child.

Based upon the visual examination, the dentist may employ additional diagnostic aids (e.g., radiographs, photographs, pulp vitality testing, laboratory tests, study casts).[8,13,42-44]

The interval of examination should be based on the child's individual needs or risk status/susceptibility to disease; some patients may require examination and preventive services at more or less frequent intervals, based upon historical, clinical, and radiographic findings.[4,7,8,16,18,25,45-48] Caries and its sequelae are among the most prevalent health problems facing infants, children, and adolescents in America.[49] Caries lesions are cumulative and progressive and, in the primary dentition, are highly predictive of caries occurring in the permanent dentition.[6,50] Reevaluation and reinforcement of preventive activities contribute to improved instruction for the caregiver of the child or adolescent, continuity of evaluation of the patient's health status, and repetitive exposure to dental procedures, potentially allaying anxiety and fear for the apprehensive child or adolescent.[51] Individuals with SHCN may require individualized preventive and treatment strategies that take into consideration the unique needs and disabilities of the patient.[32]

Caries-risk assessment

Risk assessment is a key element of contemporary preventive care for infants, children, adolescents, and persons with SHCN. It should be carried out as soon as the first primary teeth erupt and be reassessed periodically by dental and medical providers.[6,25] Its goal is to prevent disease by (1) identifying children at high risk for caries, (2) developing individualized preventive measures and caries management, as well as (3) aiding the practitioner in determining appropriate periodicity of services.[25,52,53] Given that the etiology of dental caries is multifactorial and complex, current caries-risk assessment models entail a combination of factors including diet, fluoride exposure, host susceptibility, and microflora analysis and consideration of how these factors interact with social, cultural, and behavioral factors. More comprehensive models that include social, political, psychological, and environmental determinants of health also are available.[54-57] Caries risk assessment forms and caries management protocols are available and aim to simplify and clarify the process.[25,58,59]

Sufficient evidence demonstrates certain groups of children at greater risk for development of early childhood caries (**ECC**) would benefit from infant oral health care.[24,33,60-64] Infants and young children have unique caries-risk factors such as ongoing establishment of oral flora and host defense systems, susceptibility of newly erupted teeth, and development of dietary habits. Because the etiology of ECC is multifactorial and significantly influenced by health behaviors,[65] preventive messages for expectant parents and parents of very young children should target factors known to place children at a higher risk for developing caries (e.g., early Mutans streptococci transmssion, poor oral hygiene habits, nighttime feeding, high sugar consumption frequency).[24,33,57,66] Motivational problems may develop when parents/patients are not interested in changing behaviors or feel that the changes require excessive effort. Therefore, it is important that health care professionals utilize preventive approaches based on psychological and behavioral strategies. Moreover, they should be sensitive to how they can effectively communicate their recommendations so that parents/patients can perceive their recommendations as behaviors worth pursuing. Two examples of effective motivational approaches used for caries prevention that share similar psychological philosophies are motivational interviewing and self-determination theory.[67-73]

Studies consistently have reported caries experience in the primary dentition as a predictor of future caries.[74] Early school-aged children are at a transitional phase from primary to mixed dentition. These children face challenges such as unsupervised toothbrushing and increased consumption of cariogenic foods and beverages while at school, placing them at a higher risk for developing caries.[75-77] Therefore, special attention should be given to school-aged children regarding their oral hygiene and dietary practices.

Adolescence can be a time of heightened caries activity due to an increased number of tooth surfaces in the permanent dentition and intake of cariogenic substances, as well as low

priority for oral hygiene procedures.[9,55,56] Risk assessment can assure preventive care (e.g., water fluoridation, professional and home-use fluoride and antimicrobial agents, frequency of dental visits) is tailored to each individual's needs and direct resources to those for whom preventive interventions provide the greatest benefit.[9] 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.[11,25]

Prophylaxis and professional topical fluoride treatment

The interval for frequency of professional preventive services is based upon assessed risk for caries and periodontal disease.[3,4,7,8,10,11,25,58,59,60] Prophylaxis aids in plaque, stain, and calculus removal, as well as in educating the patient on oral hygiene techniques and facilitating the clinical examination.[10] Gingivitis, which is nearly universal in children and adolescents, usually responds to thorough removal of bacterial deposits and improved oral hygiene.[47,79,80] Hormonal fluctuations, including those occurring during the onset of puberty, can modify the gingival inflammatory response to dental plaque.[47,48,81] Children can develop any of the several forms of periodontitis, with aggressive periodontitis occurring more commonly in children and adolescents than adults.[47,48,80]

Children who exhibit higher risk of developing caries and/or periodontal disease would benefit from recall appointments at greater frequency than every six months (e.g., every three months).[3,4,8,10,11,25,59] This allows increased professional fluoride therapy application and improvement of oral health by demonstrating proper oral hygiene techniques, in addition to microbial monitoring, antimicrobial therapy reapplication, and reevaluating behavioral changes for effectiveness.[3,10,48,59,82-84] An individualized preventive plan increases the probability of good oral health by demonstrating proper oral hygiene methods/techniques and removing plaque, stain, and calculus.[4,48,84]

Fluoride contributes to the prevention, inhibition, and reversal of caries.[85-87] Professional topical fluoride treatments should be based on caries risk assessment.[19,25,86,89] Plaque and pellicle are not a barrier to fluoride uptake in enamel.[10] Consequently, there is no evidence of a difference in caries rates or fluoride uptake in patients who receive rubber cup prophylaxis or a tooth-brush prophylaxis before fluoride treatment.[88,89] Precautionary measures should be taken to prevent swallowing of any professionally-applied topical fluoride. Children at high caries risk should receive greater frequency of professional fluoride applications (e.g., every three months).[85,89-92] Ideally, this would occur as part of a comprehensive preventive program in a dental home.[19]

Fluoride supplementation

The AAPD encourages optimal fluoride exposure for every child, recognizing fluoride in the community water supplies as the most beneficial and cost-effective preventive intervention.[85] Fluoride supplementation should be considered for children at moderate to high caries risk when fluoride exposure is not optimal.[85] Determination of dietary fluoride sources (e.g., drinking water, toothpaste, foods, beverages) before prescribing supplements is required and can help reduce intake of excess fluoride.[85] In addition, supplementation should be in accordance with the guidelines recommended by the AAPD[85] and the American Dental Association[93,94].

Radiographic assessment

Radiographs are a valuable adjunct in the oral health care of infants, children, and adolescents to diagnose and monitor oral diseases and evaluate dentoalveolar trauma, as well as monitor dentofacial development and the progress of therapy.[45] Timing of initial radiographic examination should not be based on the patient's age, but upon each child's individual circumstances.[45,46] The need for dental radiographs can be determined only after consideration of the patient's medical and dental histories, completion of a thorough clinical examination, and assessment of the patient's vulnerability to environmental factors that affect oral health.[45] Every effort must be made to minimize the patient's radiation exposure by applying good radiological practices (e.g., use of protective aprons and thyroid collars, when appropriate) and by following the as low as reasonably achievable (ALARA principle).[45]

Anticipatory guidance/counseling

Anticipatory guidance is the process of providing practical and developmentally-appropriate information about children's health to prepare parents for significant physical, emotional, and psychological milestones.[2,9,19,20,95,96] Individualized discussion and counseling should be an integral part of each visit. Topics to be included are oral/dental development and growth, speech/language development, nonnutritive habits, diet and nutrition, injury prevention, tobacco product use, substance use/abuse, intraoral/perioral piercing, and oral jewelry/accessories.[2,9,15,19,27,95-102,213,214]

Anticipatory guidance regarding the characteristics of a normal healthy oral cavity should occur during infant oral health visits and throughout follow-up dental visits. This allows parents to measure against any changes such as, but not limited to, growth delays, traumatic injuries, and poor oral hygiene or presence of caries lesions. Tooth development and chronology of eruption can help parents better understand the implications of delayed or accelerated tooth emergence and the role of fluorides in newly erupted teeth that may be at higher risk of developing caries, especially during the post-eruption maturation process.[95] Assessment of developmental milestones (e.g., fine/gross motor skills, language, social interactions) is crucial for early recognition of potential delays and appropriate referral to therapeutic services.[29] Speech and language are integral components of a child's early development.[101] Abnormal delays in speech and language production can be recognized early with referral made to address these concerns. Communication and coordination of appliance

therapy with a speech and language professional can assist in the timely treatment of speech disorders.[101]

Oral habits (e.g., nonnutritive sucking: digital and pacifier habits; bruxism; tongue thrust swallow and abnormal tongue position; self-injurious/self-mutilating behavior) may apply forces to teeth and dentoalveolar structures. Although early use of pacifiers and digit sucking are considered normal, habits of sufficient frequency, intensity, and duration can contribute to deleterious changes in occlusion and facial development.[27] It is important to discuss the need for early pacifier and digit sucking, then the need to wean from the habits before malocclusion or skeletal dysplasias occur.[27] Early dental visits provide an opportunity to encourage parents to help their children stop sucking habits by age three years or younger. For school-aged children and adolescent patients, counseling regarding any existing habits (e.g., fingernail biting, clenching, bruxism) is appropriate.[27] Parents should be provided with information regarding the potential immediate and long-term effects on the craniofacial complex and dentition from a habit. If treatment is indicated, it can include patient/parent counseling, behavior modification techniques, appliance therapy, or referral to other providers including, but not limited to, orthodontists, psychologists, or otolaryngologists.[27]

Oral hygiene counseling involves the parent and patient. Initially, oral hygiene is the responsibility of the parent. As the child develops, home care is performed jointly by parent and child. When a child demonstrates the understanding and ability to perform personal hygiene techniques, the health care professional should counsel the child. The effectiveness of home care should be monitored at every visit and includes a discussion on the consistency of daily oral hygiene preventive activities, including adequate fluoride exposure.[3,4,9,25,85,103]

The development of dietary habits and childhood food preferences appears to be established early and may affect the oral health as well as general health and well-being of a child.[104] The establishment of a dental home no later than 12 months of age allows dietary and nutrition counseling to occur early. This helps parents to develop proper oral health habits early in their child's life, rather than trying to change established unhealthy habits later. During infancy, counseling should focus on breastfeeding, bottle or no-spill cup usage, concerns with nighttime feedings, frequency of in-between meal consumption of sugar-sweetened beverages (e.g., sweetened milk, 100 percent juice, soft drinks, fruit drinks, sports drinks) and snacks, as well as special diets.[26] Excess consumption of carbohydrates, fats, and sodium contribute to poor systemic health.[105-107] Dietary analysis and the role of dietary choices on oral health, malnutrition, and obesity should be addressed through nutritional and preventive oral health counseling at periodic visits.[26,108] The U.S. Departments of Health and Human Services and Agriculture provide dietary guidelines every five years to help Americans two years of age and older make healthy choices to help prevent chronic diseases and guidance for parents and their children and promote a healthy diet.[109]

Traumatic dental injuries that occur in preschool, school-age children, and young adults comprise five percent of all injuries for which treatment is sought.[110] Facial trauma that results in fractured, displaced, or lost teeth can have significant negative functional, esthetic, and psychological effects on children.[111] Practitioners should provide age-appropriate injury prevention counseling for orofacial trauma.[15,96] Initially, discussions would include advice regarding play objects, pacifiers, car seats, and electrical cords. As motor coordination develops and the child grows older, the parent/patient should be counseled on additional safety and preventive measures, including use of athletic mouthguards for sporting activities. Dental injuries could have improved outcomes not only if the public were aware of first-aid measures and the need to seek immediate treatment, but also if the injured child had access to emergency care at all times. Caregivers report that, even though their children had a dental home, they have experienced barriers to care when referred outside of the dental home for emergency services.[112] Barriers faced by caregivers include availability of providers and clinics for delivery of emergency care and the distance one must travel for treatment. Therefore, it is important that all primary care providers inform parents about ways to access emergency care for dental injuries and provide telephone numbers to access a dentist, including for after-hours emergency care.[113]

Smoking and smokeless tobacco use almost always are initiated and established in adolescence.[114-116] In 2016, 7.2 percent of middle school students and 20.2 percent of high school students reported current tobacco product use.[117] The most common tobacco products used by middle school and high school students were reported to be e-cigarettes, cigarettes, cigars, smokeless tobacco, hookahs, pipe tobacco, and bidis (unfiltered cigarettes from India).[117] E-cigarette use rose from 1.5 percent to 16.0 percent among high school students and from 0.6 percent to 5.3 percent among middle school students from 2011 to 2015.[117] During this time period, children may be exposed to opportunities to experiment with other substances that negatively impact their health and well-being. Practitioners should provide education regarding the serious health consequences of tobacco use and exposure to second hand smoke.[97,117] The practitioner may need to obtain information regarding tobacco use and alcohol/drug abuse confidentially from an adolescent patient.[9,100] When tobacco or substance abuse has been identified, practitioners should provide brief interventions for encouragement, support, and positive reinforcement for avoiding substance use.[97,100] If indicated, dental practitioners should provide referral to primary care providers or behavioral-health/addiction specialists for assessment and/or treatment of substance use disorders.[100]

Complications from intraoral/perioral piercings can range from pain, infection, and tooth fracture to life-threatening conditions of bleeding, edema, and airway obstruction.[99] Education regarding pathologic conditions and sequelae associated with piercings should be initiated for the preteen

child/parent and reinforced during subsequent periodic visits.The AAPD strongly opposes the practice of piercing intraoral and perioral tissues and use of jewelry on intraoral and perioral tissues due to the potential for pathological conditions and sequelae associated with these practices.[99]

Treatment of dental disease/injury

Health care providers who diagnose oral disease or trauma should either provide therapy or refer the patient to an appropriately-trained individual for treatment.[118] Immediate intervention is necessary to prevent further dental destruction, as well as more widespread health problems. Postponed treatment can result in exacerbated problems that may lead to the need for more extensive care.[22,34,35,40] Early intervention could result in savings of health care dollars for individuals, community health care programs, and third-party payors.[21,29,30,34]

Treatment of developing malocclusion

Guidance of eruption and development of the primary, mixed, and permanent dentitions is an integral component of comprehensive oral health care for all pediatric dental patients.[27] Dentists have the responsibility to recognize, diagnose, and manage or refer abnormalities in the developing dentition as dictated by the complexity of the problem and the individual clinician's training, knowledge, and experience.[118] Early diagnosis and successful treatment of developing malocclusions can have both short-term and long-term benefits, while achieving the goals of occlusal harmony and function and dentofacial esthetics.[104-108] Early treatment is beneficial for many patients, but is not indicated for every patient. When there is a reasonable indication that an oral habit will result in unfavorable sequelae in the developing permanent dentition, any treatment must be appropriate for the child's development, comprehension, and ability to cooperate. Use of an appliance is indicated only when the child wants to stop the habit and would benefit from a reminder.[27] At each stage of occlusal development, the objectives of intervention/treatment include: (1) reversing adverse growth, (2) preventing dental and skeletal disharmonies, (3) improving esthetics of the smile, (4) improving self-image, and (5) improving the occlusion.[27]

Sealants

A 2016 systematic review concluded sealants are effective in preventing and arresting pit-and-fissure occlusal caries lesions of primary and permanent molars in children and adolescents and can minimize the progression of noncavitated occlusal caries lesions.[120] They are indicated for primary and permanent teeth with pits and fissures that are predisposed to plaque retention.[121] At-risk pits and fissures should be sealed as soon as possible. Because caries risk may increase at any time during a patient's life due to changes in habits (e.g., dietary, home care), oral microflora, or physical condition, unsealed teeth subsequently might benefit from sealant application.[122] The need for sealant placement should be reassessed at periodic preventive care appointments. Sealants should be monitored and repaired or replaced as needed.[121-123]

Third molars

Panoramic or periapical radiographic assessment is indicated during late adolescence to assess the presence, position, and development of third molars.[45,46] A decision to remove or retain third molars should be made before the middle of the third decade.[124,125] Impacted third molars are potentially pathologic. Pathologic conditions generally are more common with an increase in age. Evaluation and treatment may require removal, exposure, and/or repositioning. In selected cases, long-term clinical and radiographic monitoring may be needed. Treatment should be provided before pathologic conditions adversely affect the patient's oral and/or systemic health.[119,124,125] Consideration should be given to removal when there is a high probability of disease or pathology and/or the risks associated with early removal are less than the risks of later removal.[14,119,125] Postoperative complications for removal of impacted third molars are low when performed at an early age.[126] A Cochrane review in 2012 reported there was no difference in late lower incisor crowding with removal or retention of asymptomatic impacted third molars.[127]

Referral for regular and periodic dental care

As adolescent patients approach the age of majority, it is important to educate the patient and parent on the value of transitioning to a dentist who is knowledgeable in adult oral 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.[9,128] Until the new dental home is established, the patient should maintain a relationship with the current care provider and have access to emergency services. For the patient with SHCN, in cases where it is not possible or desired to transition to another practitioner, the dental home can remain with the pediatric dentist and appropriate referrals for specialized dental care should be recommended when needed.[128] Proper communication and records transfer allow for consistent and continuous care for the patient.[42]

Recommendations by age

Six to 12 months

1. Complete the clinical oral examination with adjunctive diagnostic tools (e.g., radiographs as determined by child's history, clinical findings, and susceptibility to oral disease) to assess oral growth and development, pathology, and/or injuries; provide diagnosis.
2. Complete a caries risk assessment.
3. Provide oral hygiene counseling for parents, including the implications of the oral health of the caregiver.
4. Clean teeth and remove supra- and sub-gingival stains or deposits as indicated.

5. Assess the child's systemic and topical fluoride status (including type of infant formula used, if any, and exposure to fluoridated toothpaste) and provide counseling regarding fluoride.
6. Assess appropriateness of feeding practices, including bottle and breast-feeding, and provide counseling as indicated; provide dietary counseling related to oral health.
7. Provide age-appropriate injury prevention counseling for orofacial trauma.
8. Provide counseling for nonnutritive oral habits (e.g., digit, pacifiers).
9. Provide required treatment and/or appropriate referral for any oral diseases or injuries.
10. Provide anticipatory guidance.
11. Assess overall growth and development, and make appropriate referral to therapeutic services if needed.
12. Consult with the child's physician as needed.
13. Determine the interval for periodic reevaluation.

12 to 24 months

1. Repeat the procedures for ages six to 12 months every six months or as indicated by the child's individual needs or risk status/susceptibility to disease.
2. Assess appropriateness of feeding practices (including bottle, breast-feeding, and no-spill training cups) and provide counseling as indicated.
3. Review patient's fluoride status and provide parental counseling.
4. Provide topical fluoride treatments every six months or as indicated by the child's individual needs or risk status/susceptibility to disease.

Two to six years

1. Repeat the procedures for 12 to 24 months every six months or as indicated by the child's individual needs or risk status/susceptibility to disease. Provide age-appropriate oral hygiene instructions.
2. Scale and clean the teeth every six months or as indicated by individual patient's needs.
3. Provide pit and fissure sealants for caries-susceptible anterior and posterior primary and permanent teeth.
4. Provide counseling and services (e.g., mouthguards) as needed for orofacial trauma prevention.
5. Provide assessment/treatment or referral of developing malocclusion as indicated by individual patient's needs.
6. Provide required treatment and/or appropriate referral for any oral diseases, habits, or injuries as indicated.
7. Assess speech and language development and provide appropriate referral as indicated.

Six to 12 years

1. Repeat the procedures for ages two to six years every six months or as indicated by child's individual needs.
2. Provide substance abuse counseling (e.g., smoking, smokeless tobacco) and/or referral to primary care providers or behavioral health/addiction specialists if indicated.
3. Provide counseling on intraoral/perioral piercing.

12 years and older

1. Repeat the procedures for ages six to 12 years every six months or as indicated by the child's individual needs or risk status/susceptibility to disease.
2. 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 and/or the risks associated with early removal are less than the risks of later removal.
3. At an age determined by patient, parent, and pediatric dentist, refer the patient to a general dentist for continuing oral care.

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FORM CMS-416: ANNUAL EPSDT PARTICIPATION REPORT

State Code | **Fiscal Year**

		Totals	Age Group <1	Age Group 1-2	Age Group 3-5	Age Group 6-9	Age Group 10-14	Age Group 15-18	Age Group 19-20
1a. Total individuals eligible for EPSDT	CN:	0							
	MN:	0							
	Total:	0	0	0	0	0	0	0	0
1b. Total Individuals eligible for EPSDT for 90 Continous Days	CN:	0							
	MN:	0							
	Total:	0	0	0	0	0	0	0	0
1c. Total Individuals Eligible under a CHIP Medicaid Expansion	CN:	0							
	MN:	0							
	Total:	0	0	0	0	0	0	0	0
2a. State Periodicity Schedule									
2b. Number of Years in Age Group			**1**	**2**	**3**	**4**	**5**	**4**	**2**
2c. Annualized State Periodicity Schedule			0.00	0.00	0.00	0.00	0.00	0.00	0.00
3a. Total Months of Eligibility	CN:	0							
	MN:	0							
	Total:	0	0	0	0	0	0	0	0
3b. Average Period of Eligibility	CN:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	MN:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
4. Expected Number of Screenings per Eligible	CN:		0.00	0.00	0.00	0.00	0.00	0.00	0.00
	MN:		0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total:		0.00	0.00	0.00	0.00	0.00	0.00	0.00
5. Expected Number of Screenings	CN:	0	0	0	0	0	0	0	0
	MN:	0	0	0	0	0	0	0	0
	Total:	0	0	0	0	0	0	0	0
6. Total Screens Received	CN:	0							
	MN:	0							
	Total:	0	0	0	0	0	0	0	0
7. SCREENING RATIO	CN:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	MN:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
8. Total Eligibles Who Should Receive at Least One Initial or Periodic Screen	CN:	0	0	0	0	0	0	0	0
	MN:	0	0	0	0	0	0	0	0
	Total:	0	0	0	0	0	0	0	0

* Includes 12-month visit
Note: "CN" = Categorically Needy, "MN"= Medically Needy

FORM CMS-416: ANNUAL EPSDT PARTICIPATION REPORT

State Code | **Fiscal Year**

		Totals	Age Group <1	Age Group 1-2	Age Group 3-5	Age Group 6-9	Age Group 10-14	Age Group 15-18	Age Group 19-20
9. Total Eligibles Receiving at least One Initial or Periodic Screen	CN:	0							
	MN:	0							
	Total:	0	0	0	0	0	0	0	0
10. PARTICIPANT RATIO	CN:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	MN:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
11. Total Eligibles Referred for Corrective Treatment	CN:	0							
	MN:	0							
	Total:	0	0	0	0	0	0	0	0
12a. Total Eligibles Receiving Any Dental Services	CN:	0							
	MN:	0							
	Total:	0	0	0	0	0	0	0	0
12b. Total Eligibles Receiving Preventive Dental Services	CN:	0							
	MN:	0							
	Total:	0	0	0	0	0	0	0	0
12c. Total Eligibles Receiving Dental Treatment Services	CN:	0							
	MN:	0							
	Total:	0	0	0	0	0	0	0	0
12d. Total Eligibles Receiving a Sealant on a Permanent Molar Tooth	CN:	0							
	MN:	0							
	Total:	0				0	0		
12e. Total Eligibles Reciving Dental Diagnostic Services	CN:	0							
	MN:	0							
	Total:	0	0	0	0	0	0	0	0
12f. Total Eligibles Receiving Oral Health Services provided by a Non-Dentist Provider	CN:	0							
	MN:	0							
	Total:	0	0	0	0	0	0	0	0
12g. Total Eligibles Reciving Any Dental Or Oral Health Service	CN:	0							
	MN:	0							
	Total:	0	0	0	0	0	0	0	0
13. Total Eligibles Enrolled in Managed Care	CN:	0							
	MN:	0							
	Total:	0	0	0	0	0	0	0	0
14. Total Number of Screening Blood Lead Tests	CN:	0							
	MN:	0							
	Total:	0	0	0	0				

* Includes 12-month visit
Note: "CN" = Categorically Needy, "MN"= Medically Needy

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

The EPSDT Program offers free comprehensive and preventive services to all Puerto Rico Government Health Plan beneficiaries under twenty-one (21) years old, enrolled in the Medicaid Program. This Program is designed to identify children with actual or potential health problems in order to screen, diagnose and treat the problem(s) before they become permanent, lifelong disabilities. Please talk to your provider to learn more about preventive services and to schedule an appointment. The EPSDT Program includes:

Screening Services

- Comprehensive Health and Developmental History
- Comprehensive Physical Exam
- Appropriate Immunizations (According to the Advisory Committee of Immunization Practices and the Puerto Rico Health Department)
- Laboratory Test, including lead toxicity screening
- Health Education (Anticipatory guidance that includes child development, healthy lifestyle and accident and disease prevention)

Vision Services

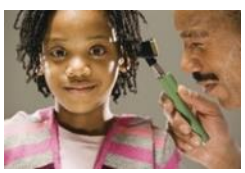
The purpose of vision test is to identify possible vision problems. Once a vision problem is identified, the child or adolescent should receive additional evaluations and the necessary treatment, including eyeglasses.

Dental Services

Oral health is important for your overall health. At minimum, dental services include relief of pain and infections, reconstruction and maintenance. Dental services should not be limited to emergency services.

Hearing Services

The purpose of hearing test is to identify possible hearing problems. If a hearing problem is identified the child or adolescent should receive additional evaluation and necessary treatment, including hearing aids.



Diagnostic

Diagnostic tests are essential test need to diagnose certain conditions. If during a screening test, further evaluation is needed the child or adolescent should receive a diagnostic test without delay, including referrals and follow-up appointments.

Treatment

Treatment for medically needed services will be provided to control, correct or reduce health problems identified in children or adolescents.

Periodicity Schedule

For detailed information related to periodic screening, vision and hearing services, please refer to the Preventive Services Guide available in the benefits section of our webpage at www.firstmedicalvital.com or visit one of our Service Offices to request a free copy.

Telemedicine

If you require the services remotely, you can validate with your Primary Medical Group or contact the Customer Service Department.

If you need information on how to access preventive services, please contact our Customer Service Department at 1-844-347-7800 or TTY at 1-844-347-7805.

Reference: www.medicaid.gov/medicaid/benefits/epsdt/index.html

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Detección Temprana y Periódica, Diagnóstico y Tratamiento (EPSDT)

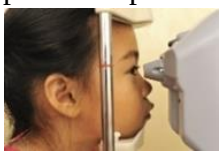
El Programa EPSDT ofrece servicios gratuitos de salud integral y servicios preventivos a todos los beneficiarios del Plan de Salud del Gobierno de Puerto Rico menores de veintiún (21) años, inscritos en el Programa de Medicaid. Este Programa está diseñado para identificar niños con problemas de salud actuales o potenciales, para detectar, diagnosticar y tratar los problemas antes de que se conviertan en discapacidades permanentes. Por favor, comuníquese con su proveedor para conocer más acerca de los servicios preventivos y programar una cita. El Programa de EPSDT incluye:

Servicios de Detección

- Salud Integral e Historial del Desarrollo
- Examen Físico
- Inmunizaciones Correspondientes (Acorde al Comité Asesor de Practicas de Inmunización y al Departamento de Salud de Puerto Rico)
- Exámenes de Laboratorio, incluyendo la detección de toxicidad de plomo
- Educación en Salud (Guía anticipada que incluye el desarrollo del niño, estilo de vida saludable y prevención de accidentes y enfermedades)

Servicios para la Visión

El propósito del examen de la vista es para identificar posibles problemas de visión. Una vez que se identifica un problema de la visión, el niño o adolescente debe recibir una evaluación adicional y el tratamiento necesario, incluyendo espejuelos.



Servicios Dentales

La salud oral es importante para la salud en general. Como mínimo, los servicios dentales incluyen manejo del dolor e infecciones, reconstrucción y mantenimiento. Los servicios dentales no deberán limitarse a servicios de emergencia.

Servicios de Audición

El propósito de una prueba de audición es para identificar posibles problemas de audición. Si un problema de audición es identificado, el niño o adolescente debe recibir una evaluación adicional y el tratamiento necesario, incluyendo audífonos.

Diagnósticos

Las pruebas de diagnóstico son pruebas esenciales para diagnosticar ciertas condiciones. Si durante una prueba de detección, se necesita una evaluación adicional, el niño o adolescente debe recibir una prueba de diagnóstico sin demora, incluyendo referidos y citas de seguimiento.

Tratamiento

Se proveerá tratamiento para los servicios médicamente necesarios, para controlar, corregir o reducir los problemas de salud identificados en niños o adolescentes.

Calendario de Periodicidad

Para información detallada relacionada a la detección periódica, servicios de visión y audición, por favor, refiérase a la Guía de Servicios Preventivos disponible en la sección de beneficios de nuestra página electrónica www.firstmedicalvital.com o visite una de nuestras Oficinas de Servicios para una copia gratis.

Telemedicina

De requerir los servicios de forma remota, puede validar con su Grupo Médico Primario o contactar el Departamento de Servicio al Cliente.

Si usted necesita información en cómo acceder a los servicios preventivos, por favor contacte nuestro Departamento de Servicios al Cliente al 1-844-347-7800 o TTY al 1-844-347-7805. Referencias: www.medicaid.gov/medicaid/benefits/epsdt/index.

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