EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)

Maryland Healthy Kids Medical Program

Clinical & Administrative Manual

MARYLAND DEPARTMENT OF HEALTH

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Maryland Healthy Kids/Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program

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Mission

The **Mission** of the Maryland Healthy Kids/EPSDT Program is to promote access to and assure availability of quality health care for Medical Assistance children, adolescents, and young adults under 21 years of age.

Goal

The **Goal** of the Program is to provide appropriate evidenced-based performance improvement assessments and targeted interventions to enhance the quality of health services delivered by Medicaid providers to eligible recipients under 21 years of age.

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Section 1: Introduction-Maryland Healthy Kids/Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program

A. OVERVIEW

Medicaid, or Medical Assistance (MA), is a joint federal and state program authorized under Title XIX of the Social Security Act to provide health and long-term care coverage to low-income people and others in certain categories. The State Medicaid Program is operated within the **Maryland Department of Health (MDH)**. Maryland Medicaid also operates similar programs for moderate to low-income children, who are not eligible for Medicaid. These are the *Maryland Children's Health Program (MCHP)* and MCHP Premium Programs. Since Medicaid, MCHP, and MCHP Premium provide children with the same comprehensive benefit package, this Manual will generally refer to the Programs as Medicaid/MCHP.

Most children in Medicaid/MCHP receive services through the *Maryland Health Choice Program*, a Statewide Medicaid managed care program. HealthChoice beneficiaries enroll in one of eight managed care organizations (MCO). MCOs that participate in the HealthChoice program are responsible for providing the full range of health care services covered by the Medicaid fee-for-service program, except for certain Medicaid-covered benefits that are "carved-out" and made available to enrollees outside the MCOs.

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program is a federal requirement that mandates that States cover certain benefits for Medicaid recipients from birth through 20 years of age that are not necessarily covered for individuals 21 years of age and older. The Program came into existence in 1967 after Congress passed the Section 1905(r) Amendment to the Social Security Act. States are allowed to develop their own EPSDT periodicity schedule with input from medical societies and organizations involved in child health.

In Maryland, the preventive care component of the EPSDT Program is known as the *Healthy Kids Program*. The preventive health care services allow for early identification and treatment of health problems before they become medically complex and costly to treat.

Standards for the Healthy Kids Program are developed through collaboration with key stakeholders such as the MDH, the Maryland Chapter of the American Academy of Pediatrics, the University of Maryland School of Dentistry, and the Maryland Department of the Environment.

The *Maryland Healthy Kids Preventive Health Schedule* (Refer to Section 2) closely correlates to the American Academy of Pediatrics periodicity schedule. The primary purpose of this manual is to provide clinical and administrative guidance in the implementation of the required preventive care standards of the Maryland Healthy Kids/EPSDT Program.

B. HEALTHY KIDS PROGRAM ADMINISTRATION

The Medical Benefits Management Administration (MBMA) administers the Maryland Healthy Kids Program. The Healthy Kids Program has a team of nurses who serve as regional consultants to MCOs and providers certified in the Program. This team performs a vital role by conducting performance improvement activities to assure that services rendered to Medicaid children and adolescents are meeting the Program standards.

The Medicaid Divisions which support the Healthy Kids/EPSDT Program are the Medical Benefits Management Administration, Quality Assurance, Customer Relations, Outreach and Care Coordination, and the Division of Children's Services. The Healthy Kids Program, which is part of the Division of Children's Services, is responsible for policies that relate to the treatment components of the EPSDT Program. These components include dental services, vision, audiology, therapies, and other services provided only for children and adolescents under 21 years of age who are enrolled in Medicaid.

The Healthy Kids/EPSDT Program responsibilities include:

- Informing eligible children under 21 years of age about the EPSDT/Healthy Kids Program;
- Assuring that EPSDT screening services are available from Program-certified primary care providers enrolled in Managed Care networks and the fee-for-service Medicaid Program;
- Assuring that medically necessary treatment services are available;
- Communicating and coordinating with agencies and programs such as local health departments (LHDs), Women Infants & Children's Services (WIC*)*, Head Start and foster care;
- Providing funds to LHDs to collaborate with the MCOs and provide support services such as outreach, appointment scheduling, transportation assistance, tracking, and case management services to assist with treatment for identified problems and assure continuity of care.

C. PROVIDER CERTIFICATION AND QUALIFICATIONS

In order to provide services to a Medicaid recipient, a provider must contract with the Maryland Medicaid Program and one or more of the MCOs. The Maryland Healthy Kids Program must certify all primary care providers who provide health care services to Medicaid/MCHP recipients under 21 years of age, even if the provider does not contract directly with Medicaid. The certification requirement applies to PCPs contracted with MCOs and PCPs providing care to recipients not enrolled with an MCO who have a red and white Medicaid card (commonly referred to as "fee-for-service MA"). Providers who need certification as primary care providers include, solo practices, group practices and rendering providers within group practices who are:

- Board certified providers in pediatrics, family medicine and internal medicine
- Licensed physicians and osteopaths, certified nurse practitioners and physician assistants
- Health care providers such as federally qualified health centers, hospital outpatient department clinics, and school-based health centers.

To participate in the Program, the provider must agree to adhere to the standards of preventive health care described in the Maryland Healthy Kids Program Manual. Providers are required to follow the *Maryland Healthy Kids Preventive Health Schedule* (Refer to Section 2). In addition**,** federal and state regulations stipulate that preventive care services are required for Medicaid enrolled recipients *under* 21 years of age. The *Provider Application for Certification and Participation* (Refer to Section 1, Addendum), outlines the conditions for participation. The Maryland Healthy Kids Program certification requires a face-to-face meeting with a Healthy Kids Program Nurse Consultant.

After the certification process is complete *a Provider Certification Letter* is sent to the PCP and MCO. The letter should be saved since it is required for MCO credentialing (Refer to Section 1, Addendum). The provider's Maryland Medicaid number becomes the EPSDT Certification number. When a **new** provider joins the practice, the provider should complete the following steps:

1. **Complete the online application for a MA number on the Electronic Provider Revalidation and Enrollment Portal *ePREP Provider Portal***
2. If the new provider already has an active MA number, the ePREP application process will serve to update the provider's current practice address and link the provider to the group practice number.
3. **Once the application has been submitted through ePREP please check the website or call Provider Enrollment at 1-844-463-7768 for application status.**
4. Contact the **Maryland Healthy Kids Program at 410-767-1836** to schedule a certification visit with the Program consultant for your area* *This step should be completed once the provider has a Medicaid number or has started the application process in ePREP.

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Once a provider is certified and he/she demonstrates compliance with the Healthy Kids Program, the certification stays with the provider **for 5 years** regardless of whether the provider changes practice sites or opens his or her own private practice. **Therefore, it is important to notify the** *Healthy Kids Program Nurse Consultant* **for your area of any changes to your practice** (Refer to Section 8). **MDH mails transmittals based on this information, so it is important to keep practice and provider information current.** *Providers who participate in the Healthy Kids Program receive specialized services offered by the state and local health departments*.

Healthy Kids Program Nurse Consultant Services

- Certification of new providers (Pediatric, Family Practice and Internal Medicine***)*** entering group practices or establishing new solo practices.
- Certification of new and established practices
- Notifying providers of updates and changes to the program as applicable.
- Maintenance of applicable clinical and Program manuals/materials online at: Maryland Healthy Kids Program
- Interpretation of Medicaid health policies and federal/state regulations
- Orientation and staff training in Program standards and procedures
- Monitoring of performance regarding program implementation through medical record reviews;
- Assistance with Medicaid billing and MCO encounter data reporting
- Education of providers about MCO and LHD referral process for outreach and health related services.

Additional Services from MDH

- Distribution of child health pamphlets and Program forms to aid Program implementation;
- Availability of resources and referrals for community services from the Maryland Children's Health Program Information Line at **1-855-642-8572**;
- Provision of free vaccines through the Vaccines for Children Program;
- Assistance in meeting the requirements of timely services to children with special needs;

D. LOCAL HEALTH DEPARTMENTS, HEALTHCHOICE AND HEALTHY KIDS PROGRAMS*

Each local health department receives direct funding from the Medical Assistance Program to perform a wide range of administrative functions for the Program such as:

- Conduct Medical Assistance eligibility determinations for children and pregnant women applying for the Maryland Children's Health Program.
- Provide assistance to families when children under 21 years of age need to access follow-up treatment services resulting from a Healthy Kids preventive care screen
- Assist high risk recipients to access necessary health care services
- Educate recipients about EPSDT, the health care delivery systems, including HealthChoice, and the Maryland Public Mental Health System
- Serve as ombudsman between recipients and MCOs
- Provide transportation assistance to medically necessary health care services covered by Medicaid

**Availability of these services varies according to program priorities established by individual local health departments.*

Eligibility Determination Units - Maryland Children's Health Program (MCHP)

Families with children can apply for MCHP through ***Maryland Health Connection***. They can apply:

- ➢ Online at Maryland Health Connection. To apply, customers must create a user account, then go to the "Start New Application" from the Quick Links on the Account Home page.
- ➢ By calling the **Maryland Health Connection Call Center** at **1-855-642-8572.**
- ➢ In-person at the ***recipient's*** Local Health Department*, or Local Department of Human Services*.

LHD Administrative Care Coordination Units (ACCUs)

The *Local Health Department Administrative Care Coordinators Unit* is the single point of entry for referrals to the local health department (Refer to Section 8). The ACCU coordinates efforts with the MCOs in providing outreach and education to Medicaid recipients (Refer to Section 5). The ACCU can be contacted by calling the *Local Health Department* where the child resides (Refer to Section 8). The ACCU accepts referrals from primary care providers and the MCOs for assistance with bringing non-compliant and high-risk recipients into care according to the following criteria:

- Children, 0-2 years of age, who have missed two consecutive Healthy Kids appointments
- Any child/adolescent under 21 years of age with an identified health problem who has missed two consecutive appointments for follow-up treatment
- Pregnant women who have missed two consecutive prenatal appointments

Refer to the Managed Care Organization's (MCO's) Provider Manual for specific instructions on how and when to make referrals to the ACCU or the MCO. Regarding pregnant women, contact the MCO outreach and/or case management department to initiate follow-up and outreach efforts after the recipient has missed two consecutive appointments within a 60-day period. Follow-up and outreach can be in the form of a letter, email, text, postcard or phone call to the recipient. The date and method should be documented in the child's record.

Ombudsman Program

The Health Choice Program is required to provide an Ombudsman to assist members who are experiencing a dispute or dissatisfaction with their MCO regarding medical services. The local health departments operate the local component of this Program under the direction of the Health Choice and Acute Care Administration's Complaint Resolution Unit (CRU) or LHD Ombudsman when contacted for specific information about a particular issue.
The **Medicaid Health Choice Help Line** at **1-800-284-4510** is available for members to call for education, inquiries, or to request assistance with resolving problems with their MCO. Providers may call this number to resolve problems related to access to care on behalf of enrollees. Providers with billing or claim issues please email **mdh.healthchoiceprovider@maryland.gov.**

Transportation Services

The Medicaid Program provides transportation grants to each local jurisdiction to assist clients with transportation to Medicaid covered services. Contact information can be found in the Local Transportation Contacts List (Refer to Section 8). The MCO may also provide limited transportation assistance.

E. MEDICAID MANAGED CARE ORGANIZATIONS (MCOs)

Contract Agreements between the MCO and the Primary Care Provider

Primary Care Providers (PCPs) establish individual contracts with one or more of the nine MCOs. PCPs are responsible for familiarizing themselves with the content of the MCO Provider Manuals. These manuals reinforce service delivery requirements for the Medicaid recipients according to MCO policy and State regulations. Minor differences from one MCO to another are provided in the manuals that include, but are not limited to, MCO encounter data reporting requirements or MCO pre-authorization processes. Providers who wish to enroll in one or more of the MCO's should contact the *Provider Relations Department* (Refer the Section 8). **Health Choice regulations require that MCOs assign recipients under 21 years of age to a Healthy Kids certified PCP**. Exceptions can be made if the parent specifically requests that their child be assigned to a non-certified PCP, e.g., when the child has a chronic condition and receives ongoing care from a specialist. Subcontracting components of Healthy Kids preventive care services is allowed but can lead to fragmentation of care for the recipient and difficulty in managing the recipient's care. However, where subcontracting agreements exist, the PCP is required to have a copy of the preventive care service rendered by the subcontracted provider in the child's medical record. The regulations that govern the Medicaid Health Choice Program are 10.09.62-74 and can be viewed at *Code of Maryland Regulations*. Specific information about each of the MCOs, including preauthorization phone numbers, customer service lines, 24 hour Nurse Help Lines, as well as pharmacy and vision services vendors, can be found in *Health Choice Managed Care Organization Resource List*.

MCO Newborn Coordinator Roles and Responsibilities

Infants born to mothers who are enrolled in an MCO are automatically enrolled in the mother's MCO. Each MCO has a designated MCO Newborn Coordinator (Refer to Section 8) who serves as a point of contact for providers with questions or concerns related to eligibility and provision of services to newborns within the first 60 days of life. The Newborn Coordinator (NC) will be available through a toll-free line, Monday through Friday, during normal working hours 9:00 a.m. to 5:00 p.m. Services provided by the newborn coordinator are outlined in the Provider Action Grid (Refer to Section 8.14).

The NC will be able to:

- Research the eligibility of a newborn whose MCO assignment is in question and confirm for the provider the MCO to which the newborn belongs.
- Interfacing with the Medicaid Enrollment Broker to resolve enrollment concerns,

- Making retroactive provider enrollment and capitation adjustments,
- Coordinating and authorizing both in-network and out-of-network care as appropriate
- Coordinating with MCO ancillary provider networks, pharmacy or durable medical equipment, to assure appropriate delivery of care,
- Requesting newborn ID card,
- Facilitating resolution of claims for services to newborns.

F. HEALTHY KIDS PROGRAM PERFORMANCE IMPROVEMENT STANDARDS

The Maryland Healthy Kids Program is committed to ensuring that children enrolled in Medicaid/MCHP receive quality health care services. Performance improvement activities performed by the Healthy Kids nurse consultants include practice based medical record reviews and office staff training. These activities assure continuous improvement in the delivery of preventive care services to children.

The Healthy Kids Program continues to conduct office based medical record reviews at participating practice sites. By signing the *Medicaid Provider Agreement in ePREP* and the *Healthy Kids Program Provider Application for Certification and Participation* (Refer to Section 1, Addendum), providers agree to these reviews as defined by the conditions for certification. Further, the recipient consents to having their records reviewed when they enroll in Medicaid and receive benefits.

G. HIPAA PRIVACY

Maintaining the confidentiality of medical information is of critical importance. Please review the *Health Insurance Portability and Accountability Act* passed by Congress in 1996. It provides information about patient privacy and the role of the Maryland Medicaid Program in assuring that Maryland services are delivered in accordance with *Maryland COMAR Regulations*.

SECTION 1 **ADDENDUM**

Provider Application for Certification and Participation

Updated 2020

THE MARYLAND HEALTHY KIDS/EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) PROGRAM PROVIDER APPLICATION FOR CERTIFICATION & PARTICIPATION

Provider Name: _____ **Group Name:** _____

Primary Address: _____ **Group# (MA number):** _____

City: _____ **State:** _____ **Zip:** _____ **County:** _____

Specialty: _____ **Ages Served:** _____ **Contact Person:** _____

Telephone: _____ **Fax:** _____ **E-mail:** _____

MCO Participation (specify each MCO): _____ /_____ /_____ /_____ /_____ /_____

I. *PROVIDER QUALIFICATIONS* (Check all that apply):

☐ National Provider Identifier (NPI): _____

☐ Currently participate in the Maryland Medical Assistance Program; provider number: _____

☐ Currently participate with one or more Medicaid MCOs; MCO number (if not MA #): _____

☐ License number(s): _____ Specify state(s): _____

Provider shall meet one of the following requirements: (specify)

☐ Be board-certified, (circle specialty) pediatrics, family practice, internal medicine;

☐ Be a licensed physician or osteopath, or certified nurse practitioner, or physician assistant delivering primary health care to children and adolescents;

☐ Be a local health department or free-standing clinic.

II. *CONDITIONS FOR PARTICIPATION*

All providers rendering preventive screening services to children must meet the following conditions, which are specified in the Maryland Healthy Kids/EPSDT Program regulations (COMAR 10.09.23) and Program policies:

(1) Provide or ensure the provision of the full set of screening procedures as outlined in the Healthy Kids Schedule of Preventive Health Care and in a manner prescribed by the Department in the Healthy Kids Provider Manual;

(2) Provide inter-periodic and full screening as deemed medically necessary;

(3) Provide or arrange for: a) referrals for diagnosis, treatment, and follow-up services if the screening indicates a need for additional services; b) acute and tertiary care; c) long-term and rehabilitative care; and d) referrals for specialty mental health care when appropriate;

(4) Inform the parent or guardian of the need for preventive health care visits at the time of enrollment or assignment, and schedule appointments to facilitate adherence to the periodicity schedule (Schedule of Preventive Health Care);

(5) Agree to cooperate with state and local health department efforts to assure that children receive needed follow-up and treatment services. This requires referrals to the local health departments when appropriate to track children for missed appointments and delays with immunizations and treatments.

(6) Maintain a physical location where the full array of EPSDT screening and preventive health services are delivered;

(7) Maintain a patient record system that is sufficiently detailed and current to allow another provider who is unfamiliar with the patient to properly continue treatment in the absence of the primary care provider. Additionally, the record must sufficiently document the preventive screening components in accordance with the Healthy Kids Schedule of Preventive Health Care;

(8) Agree to on-site visits by the State program staff that will:

- Verify provider qualifications
- Assess the need for provider/staff training, technical assistance, or in-service training,
- Determine if equipment necessary to perform required procedures is available, functioning, and being properly used,
- Review/audit Medical Assistance recipient charts to determine if the program standards are being met, if quality and quantity of child health services delivered is sufficient, and if appropriate referral and treatment services are adequately provided;

(9) Agree to participate in the Vaccines for Children (VFC) Program to assure that needed vaccines are readily available to the Medicaid enrollee according to the currently recommended Immunization Schedule, and

(10) Agree to cooperate with Department efforts to provide timely access for all child health services including services for children with special needs and children in state supervised care.

PROVIDER AGREEMENT

I _____ (print name) agree to comply with requirement listed in Section II Conditions for Participation and understand I may be granted a provisional certification upon review of my application. I also understand that I may receive full certification status only after the completion of an on-site review.

Signature: _____ Date: _____

DEPARTMENT CERTIFICATION

This provider meets the provider qualification requirements and conditions for participation listed in Sections I and II.

Nurse Consultant Signature: _____ Full Certification granted on (date): _____

Return to EPSDT Program by:

Mail: MDH – Unit 79
Healthy Kids Program
Division of Children's Service
201 W. Preston Street, Room 210 Baltimore, MD 21201

OR FAX: 410-333-5426

OR Scan/email to: Lesa.Watkins@maryland.gov

Section 2: Maryland EPSDT Preventive Health Care Schedule

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Section 2: Maryland EPSDT Preventive Health Care Schedule

The *Maryland Healthy Kids Preventive Health Schedule* adheres to standards established by state and federal regulations. The Schedule defines how often a child/adolescent should have a preventive care visit and closely correlates to the schedule recommended by the *American Academy of Pediatrics* (AAP) and *Bright Futures* (Refer to Section 2). Since children eligible for Medical Assistance (MA) may be at greater risk for ***health-related issues*** than the general population, elements such as lead testing are required. **The Schedule includes eight full preventive visits in the first year of life, three visits in the second year, two visits in the third year, and yearly visits three through 20 years of age.** Children should receive annual preventive well-child visits starting at age 3 years. However, the Schedule does not allow more frequent preventive care visits, if documented as medically necessary. *The Maryland Healthy Kids Encounter Forms* are available to facilitate documentation of the required components (Refer to Section 7, Appendix I). Preventive care services included under the Maryland Healthy Kids Program are as follows:

A. INITIAL SCREENING SERVICES

Initial screening services include the full scope of comprehensive services outlined in the *Maryland Healthy Kids Preventive Health Schedule*. These services should be provided to all children when being seen for the first time by a Maryland Healthy Kids Program certified PCP. MCOs are responsible for ensuring that enrolled children have an initial screen with the PCP according to the following guidelines:

➢ Within 90 days of the enrollment date for children 2-20 years of age

➢ Within 30 days of the enrollment date for children under 2 years of age

➢ Within 30 days of enrollment for children in need of an initial evaluation for a health condition identified on the *Preventive Screen Questionnaire* (Refer to Section 7, Appendix II)

➢ At an interval consistent with the *Maryland Healthy Kids Preventive Health Schedule,* if the child was established in the PCP's practice prior to the child's MCO enrollment.

Maryland Healthy Kids Preventive Health Schedule

Components		Infancy (months)							Early Childhood (months)							Late Childhood (yrs.)								Adolescence (yrs.)							
Health History and Development		**Birth**	**3-5 d**	**1**	**2**	**4**	**6**	**9**	**12**	**15**	**18**	**24**	**30**	**36**	**48**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**
Medical and family history/update		X	X	X	→	→	→	→	X	→	→	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Peri-natal history		X	X	X	→	→	→	→	→	→	→																				
Psycho-social/environmental assessment/update		X	X	X	→	→	→	→	X	→	→	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Developmental Surveillance (Subjective)			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Developmental Screening (Standard Tools)[1]								X	→	→	X	X	→																			
Autism Screening											X	X	→																			
Mental health/behavioral assessment														X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Substance use assessment																						X	X	X	X	X	X	X	X	X	X	X
Depression Screening																						X	X	X	X	X	X	X	X	X	X	X
Maternal Depression Screening				X	X	X	X																									
Physical Exam																																
Systems exam		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Vision/hearing assessments[2]		O[2]	S	S	S	S	S	S	S	S	S	S	S	O	O	O	O	S	O	S	O	S	O	S	S	O	S	S	O	S	S
Oral/dentition assessment		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Nutrition assessment		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Measurements and graphing:	Height and Weight	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X
	Head Circumference	X	X	X	X	X	X	X	X	X	X	X																			
	BMI											X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X
Blood Pressure[3]														X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Risk Assessments by Questionnaire																																
Lead assessment by questionnaire							X	X	X	X	X	X	X	X	X	X																
Tuberculosis *				X	→	→	X	→	X	→	→	X	→	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Heart disease/cholesterol *												X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Sexually transmitted infections (STI) *																						X	X	X	X	X	X	X	X	X	X	X
Anemia *																						X	X	X	X	X	X	X	X	X	X	X
Laboratory Tests																																
Newborn Metabolic Screening		X		X	→																											
Blood lead Test									X	→	→	X	→	→	→	→																
Anemia Hgb/Hct									X	→	→	X	→	→	→	→																
Dyslipidemia Test																				X	→	→							X	→	→
HIV Test																										X	→	→	→			
Immunizations																																
History of immunizations		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Vaccines given per schedule		X	→	→	X	X	X	→	X	X	X	→	→	→	→	→	→	→	→	→	→	→	X	X	→	→	→	→	→	→	→	→
Fluoride Varnish Program[4]								X	X	X	X	X	X	X	X	X																
Health Education																																
Age-appropriate education/guidance		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Counsel/referral for identified problems		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Dental education/referral									X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Scheduled return visit		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

Key : X Recommended; → Recommended if not previously done; S Subjective by history /observation; O Objective by standardized testing; * Counseling/testing recommended when positive

The Schedule reflects minimum standards required for all Maryland Medicaid recipients from birth to 21 years of age. The Maryland Healthy Kids Program requires yearly preventive care visits between ages 3 years through 20 years. [1]Refer to AAP 2006 Policy Statement referenced in the Healthy Kids Program Manual.-Screening required using standardized tools. [2]Newborn Hearing Screen follow-up recommended for abnormal results. [3]Blood Pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years. [4]The fluoride varnish may be administered by either a primary care provider or a dentist.

B. PERIODIC SCREENING SERVICES

Periodic screening services include the full scope of comprehensive services outlined in the *Maryland Healthy Kids Preventive Health Schedule*. These services should be provided during preventive care visits at the intervals specified in the Schedule. The full array of services should be provided whenever a child is due for a complete preventive care visit. This is crucial if the child has been seen for episodic care and has missed preventive care visits according to the Schedule.

The comprehensive periodic assessments of the child's physical, developmental, and mental health status are important aspects of preventive and primary care. These assessments are necessary to prevent, diagnose and treat childhood illness or disability before they become serious.

C. ADDITIONAL SCREENING SERVICES

Preventive care follow-up visits may be provided at intervals apart from the *Maryland Healthy Kids Preventive Health Schedule.* These interim visits allow reassessment of a previously diagnosed condition. These visits are limited to those which are medically necessary to provide confirmation of a diagnosis, follow-up of treatment or referral of the child for specialty services.

D. HEARING, VISION, AND DENTAL SCREENING SERVICES

Hearing, vision and dental screening are part of the full scope of services expected during preventive care visits. These screenings can be billed as a separate service. Qualified specialists may be needed when vision, hearing or dental issues are identified by the PCP. No referrals are needed for these services. Instrument based hearing and vision screenings are recommended beginning at age 3 (if cooperative). See the periodicity schedule and recommendations from Bright Futures for additional information. Hearing, vision and dental care screening results should be included in the child's medical record**.**

The Maryland Healthy Smiles Dental Program provides coverage for children under the age of 21, former foster care recipients under the age of 26, pregnant women 21 years of age and older, and adults enrolled in the Rare and Expensive Case Management (REM) program. SKYGEN USA, LLC (Formerly Scion Dental) administers the *Maryland Healthy Smiles Dental Program*.

Section 3: Healthy Kids/EPSDT Screening Components

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A. HEALTH AND DEVELOPMENTAL HISTORY

Comprehensive Health History

Comprehensive health and family histories are key components of effective screening for high risk factors, as well as important tools for obtaining relevant health information and identifying health conditions that have a genetic component. At the initial Healthy Kids visit, obtain a complete medical, family, psychosocial, perinatal, immunization and developmental history. At each subsequent well child visit, update and document the child/family's health history. A standardized set of questions can improve the provider's ability to identify children/teens at risk of having significant health problems. The Maryland Healthy Kids Program provides the *Medical/Family History Questionnaire* for this purpose available in both English and Spanish languages (Refer to Section 7, Appendix I, for the *English* and *Spanish* versions). The parent, guardian, or patient may complete this form prior to review by the provider. Update the medical, family, and psychosocial histories annually.

In general, a comprehensive health history includes:

- Personal medical and mental health history: chronic and acute illnesses, allergies, surgeries, injuries, and nutritional conditions and concerns, (i.e., failure to thrive, anorexia/bulimia, etc.),
- Perinatal history: prenatal care, birth history, conditions and concerns in the neonatal period, etc.,
- Developmental history: attainment of developmental milestones, learning disorders/educational concerns,
- Family medical and mental health history: health of the immediate and extended family (through the first generation of grandparents, aunts, uncles, etc.) including chronic and acute illnesses (physical and mental), hereditary disorders, disabilities, family violence and substance abuse,
- Psychosocial history: family constellation (number of members and who is living in household) and family relationships and functioning or dynamics (any boyfriend/girlfriend of single parent, parental separation/divorce, foster care or adoption), housing, financial needs, assessment of support systems, exposure to family and community violence,
- Immunization history: record of previous immunizations and assessment of current immunization status,
- Adolescent history: menarche, sexual activity, substance abuse, mental health problems and current status, social functioning and academic concerns.

Developmental Surveillance and Screening

Developmental surveillance is a longitudinal, continuous, and cumulative process of recognizing children who may be at risk of developmental delays. Developmental surveillance involves eliciting parents' concerns, obtaining a developmental history, making accurate and informed observations of the child, identifying the presence of risk and protective factors, and documenting the process and findings**. Developmental surveillance should be performed at all Healthy Kids preventive care visits.**

In contrast, *developmental screening* is the administration of a brief standardized, validated tool to aid the identification of children at risk of a developmental disorder. Periodic developmental screening of all children in addition to ongoing developmental surveillance can significantly increase the identification of children with developmental delays.

Based on the 2006 policy statement of the American Academy of Pediatrics (AAP), it is now **required** that general developmental screening be performed for all children at the 9-, 18-, and 24-30 month Healthy Kids preventive care visits, and whenever a concern is identified through developmental surveillance.[1] If the child is not seen at these recommended ages, screening should be conducted at the next preventive care visit. The AAP also **recommends** screening specifically for autism at the 18- and 24-month visits using a standardized tool.[2]

Both developmental surveillance and screening should address the following areas, as age-appropriate:

- speech and language development
- gross and fine motor development,
- self-help and self-care skills,
- social development,
- cognitive development,
- presence of learning disabilities

- [1]AAP. (2006). Identifying Infants and Young Children with Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening. *Pediatrics*, 118(1), 405 - 420 Retrieved on 08/08/14, from http://pediatrics.aappublications.org/content/118/1/405.full.

- [2]AAP. (2007). Identification and Evaluation of Children with Autism Spectrum Disorders. *Pediatrics*, 120 (5),1183-1215. Retrieved on 08/08/14 from http://pediatrics.aappublications.org/content/120/5/1183.

Developmental Screening Tools

- Healthy Kids recommends the following standardized, validated developmental screening tools for use in general developmental screening at the intervals noted above:
    - *The Ages and Stages Questionnaire* (ASQ) [3]
    - *Parents' Evaluation of Developmental Status* (PEDS) [4]

- An additional list of standardized, validated general *Developmental Screening Tool* https://health.maryland.gov/mmcp/epsdt/healthykids/Addendum3/Section-3-Addendum.pdf as been approved for use in the Healthy Kids Program to screen children through age of 5 (refer to Section 3, Addendum).

- Results of the developmental surveillance and screening, and the screening tool used, should be documented in the medical record. Children identified as being at risk for developmental delays should have documented counseling and referral for additional evaluation services. (Refer to Section 3 Addendum). https://health.maryland.gov/mmcp/epsdt/healthykids/Addendum3/Section-3-Addendum.pdf *Refer* to *Section 6* of this Manual for coding and documentation guidelines.

Screening for Autism Spectrum Disorders (ASDs)

- Autism Spectrum Disorders (ASDs) are neuro-developmental conditions characterized by:
    - Impairments in social interaction,
    - Impairments in communication,
    - Restricted repetitive and stereotyped patterns of behavior, interests, and activities.

  The Centers for Disease Control and Prevention (CDC) estimated that autism affects 1 in every 68 children aged 8 years old. The rates are higher among males, among families where another sibling has ASD, and among children with certain medical conditions (including Fragile X syndrome, fetal alcohol syndrome). The exact cause of ASDs is unknown.[5]

  Early identification and early intervention services are critical to optimizing educational and functional outcomes for children with ASDs. Since 2007, the AAP recommended that primary care providers (PCPs), in addition to conducting general developmental surveillance and screening, should perform autism-specific surveillance during all well child visits. [6]

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[3]See the ASQ website: *http://agesandstages.com/.*
[4]See the PEDS website: *http://www.pedstest.com/default.aspx.*
[5]CDC (2014). Prevalence of Autism Spectrum Disorder Among Children Aged 8 Years - Autism and Developmental Disabilities Monitoring Network, 11 Sites, United States, 2010. *CDC Surveillance Summaries.* 63(SS02), 1-21. Retrieved on 08/18/2014, from *http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6302a1.htm?s_cid=ss6302a1_w.*

Autism-specific surveillance includes:

- Ascertaining family history of ASDs, especially among older siblings,
- Eliciting parent concerns, particularly about communication, social reciprocity, and pretend play skills,
- Assessing the child's behavior and attainment of communication and social-emotional milestones.

- Red flags that warrant immediate referral include:
  - No babbling or pointing or other gesture by 12 months,
  - No single word by 16 months,
  - No 2-word spontaneous phrases (not echolalic) by 24 months,
  - Loss of language or social skills at any age,
  - Failed results of an autism-specific screen of any child using a structured, standardized instrument at 18 and 24 months of age.

- In addition to **requiring** general developmental screening, the MD Healthy Kids Program **recommends** autism-specific surveillance at all visits and requires structured autism-specific screening at 18 and 24-30 month well child visits. The MD Healthy Kids Program recommends the *Modified Checklist for Autism in Toddlers-Revised, with Follow up* https://mchatscreen.com/ (MCHAT-R/F) screening instrument (Refer to Section 3, Addendum).[7]

- As with general developmental surveillance and screening, children with findings of concern on autism-specific surveillance or screening should be simultaneously referred for medical evaluation and to the *Maryland Infants & Toddlers Program* *https://marylandpublicschools.org/programs/Pages/Special-Education/MITP/index.aspx* at 410-767-0238 which is a program of the Division of Early Intervention and Special Education Services.

- AAP. (2007). Identification and Evaluation of Children with Autism Spectrum Disorders. *Pediatrics*, 120 (5), 1183-1215. Retrieved on 08/08/14 *from* *http://pediatrics.aappublications.org/content/120/5/1183.*.
- The MCHAT-R/F screening instrument can be accessed and freely downloaded at
- https://cms.m-chat.org/LineagenMChat/media/Lineagen-M-Chat-Media/mchatDOTorg.pdf

- The following organizations provide resources for information about general developmental screening, autism-specific screening, and early intervention:

    - *AAP National Center for Medical Home Implementation*[8]
    - *CDC "Learn the Signs. Act Early" campaign*[9]

Mental Health Assessment

- The mental health assessment provides an overall view of the child's personality, behavior, social interactions, affect and temperament. It is the responsibility of the PCP to conduct a mental health assessment on each Healthy Kids visit, beginning at 3 years of age, to identify risks associated with behavioral or emotional problems.

- The Pediatric Symptom Checklist is a psychosocial screen designed to facilitate the recognition of cognitive, emotional, and behavioral problems so that appropriate interventions can be initiated as early as possible.

- https://www.massgeneral.org/assets/MGH/pdf/psychiatry/psc/psc-english.pdf

- https://www.massgeneral.org/assets/MGH/pdf/psychiatry/psc/psc-spanish.pdf

- **Maryland Behavioral Health Integration in Pediatric Primary Care** (B-HIPP) is a free service for PCPs caring for patients with mental health needs from infancy through the transition to young-adulthood. It provides support to PCP through four main components: telephone consultation, continuing education, resource and referral networking and social work co-location. For more information, refer to B-HIPP website at *www.mdbhipp.org* at or call **1-855-632-4477**.

- **Bright Futures in Practice**, a series of publications from the Maternal and Child Health Bureau and the National Center for Education in Maternal & Child Health, provides additional information regarding mental health assessment for children and adolescents. Information regarding mental health assessment can be found on the ***Bright Futures*** website at *http://brightfutures.aap.org*.

- Document the result of the mental health assessment in the medical record. In some cases, when a mental health problem is identified, the primary care provider can counsel the patient and note this in the record. However, when specialty mental health services are needed, refer directly to the **Maryland Public Behavioral System** by contacting **1-800-888-1965 (consumers and providers).** Access additional mental health information and resources on Optum Maryland's website at: *https://maryland.optum.com/.* Document the referral in the medical record.

- See -https://medicalhomeinfo.aap.org/Pages/default.aspx
- See *http://www.cdc.gov/ncbddd/actearly/hcp/index.html*.

Depression in Children

- Depression is often overlooked and considered to be "mood swings" that are a normal part of childhood. This is unfortunate, because the early diagnosis and treatment of depressive disorders is paramount in the healthy development of the child. Depression is occurring earlier on the developmental continuum than in the past. Children/adolescents and their parents are less likely to identify symptoms of depression. Often the PCP is in a better position to trend the behavior and suggest that the child/adolescent should see a mental health professional.

- Risk Factors for Depression:

    - A parent who experienced depression at an early age,
    - Family history of depression
    - Teen cigarette smoking,
    - Stress,
    - A loss of a parent or loved one by death or divorce or other loss,
    - Attention, conduct, or learning disorder,
    - Chronic illness, such as diabetes,
    - Abuse or neglect,
    - Other trauma, including natural disasters.

- Signs That May Be Associated with Depression in Children and Adolescents:

    - Frequent vague, non-specific physical complaints such as headaches, muscle aches, stomachaches, or tiredness,
    - Frequent absences from school or change in school performance,
    - Talk of or efforts to run away,
    - Outbursts of shouting, complaining, unexplained irritability or crying,
    - Being bored,
    - Lack of interest in playing with friends,
    - Alcohol or substance abuse,
    - Social isolation, poor communication,
    - Fear of death,
    - Extreme sensitivity to rejection or failure,
    - Increased irritability, anger, or hostility,
    - Reckless behavior,
    - Difficulty with relationships
    - Change in sleep patterns.

- Depressed children have an increased risk of suicidal ideation and gestures. Early diagnosis and treatment, accurate evaluation of suicidal ideation, and limiting access to lethal agents, including firearms and medications, may hold the greatest suicide prevention value.

Attention Deficit Hyperactivity Disorder (ADHD)

- ADHD is a disorder characterized by behavior and attention difficulties exhibited in multiple settings. It begins in childhood and is identified by specific attention, hyperactivity and impulsiveness criteria found in the *American Psychiatric Association's Diagnostic and Statistical Manual (DSM-5).*[10]

- A clinician with skills and knowledge in the area of mental health, developmental or behavioral pediatrics must perform the ADHD evaluation. A provider who specializes in developmental or behavioral pediatrics can become a specialty mental health provider through Maryland Medical Assistance by registering with the **Community Mental Health Unit** at the **MDH Office of Health Care Quality**. To print the *Community Mental Health Program Application,* follow the link *https://health.maryland.gov/ohcq/Pages/home.aspx. For* more information, contact the **Community Mental Health Unit** at **877-402-8220/410-402-8060** or visit their webpage at: https://health.maryland.gov/ohcq/Pages/Programs.aspx

- The overall approach to diagnosing a child with ADHD involves the following:

    - A comprehensive interview with the child's adult caregiver,
    - A mental status examination of the child,
    - A medical evaluation for general health and neurological status,
    - A cognitive assessment of ability and achievement,
    - Use of ADHD-focused parent and teacher rating scales,
    - School reports and other adjunctive evaluations separate from the school reports such as speech, language assessment, etc.

- A child diagnosed with ADHD without any accompanying emotional disorders can receive care from a PCP for management of medications. However, medication is only one component in the comprehensive treatment of ADHD. Adjunctive services can significantly improve a child's response. Teaching and reinforcing organizational skills and social skills are adjunctive interventions that can significantly improve outcomes. In addition, ongoing contact and follow-up with the parents of a child with ADHD on medication is a critical component of the medication management.

- [10]Diagnostic and Statistical Manual of Mental Disorders. (2013). 5th edition. Arlington, VA., *American Psychiatric Association.*

- Several psychiatric conditions frequently occur with ADHD, i.e., mood disorder, conduct disorder, oppositional defiant disorder, and bipolar disorder. ADHD is classified as a specialty mental health disorder, possibly requiring multiple therapeutic approaches (Refer to Section V, *Public Mental Health System*). If the child's behavior changes significantly, reevaluation is necessary through a mental health referral by contacting **Maryland Public Mental Health System** at **1-800-888-1965** (consumers and providers). Access additional mental health information and resources online on Optum Maryland's website at: *https://maryland.optum.com/*

- For more information about ADHD, refer to the *AAP Clinical Practices Guidelines for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents.*[11]

Child Abuse Assessment

- Provider awareness of the physical and behavioral indicators of child abuse, neglect or mental injury is critical to identification of mistreatment in children. Child abuse tends to be repetitive and usually escalates over time. In many cases, the abuse is the result of unrealistic caretaker expectations, and the abuser is not intending to hurt the child. This is particularly true with shaken baby syndrome. Multiple socioeconomic or physical factors may place children at greater risk for child abuse. It is important to be aware of the child and parent risk factors that predispose children to abuse and neglect.

- Child Risk Factors for Abuse:
    - Emotional/behavioral difficulties
    - Chronic illness
    - Physical disabilities
    - Developmental disabilities
    - Preterm birth
    - Unwanted child
    - Unplanned pregnancy
    - Younger than 3 years old.

[11] See AAP. (2011). ADHD: Clinical Practice Guidelines for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents. *Pediatrics*. 128(5), 1007-1022. Retrieved on 10/31/20014, from *http://pediatrics.aappublications.org/content/128/5/1007.full.pdf.*

- Parent Risk Factors for Child Abuse:
    - Low self-esteem
    - Poor impulse control
    - Substance use/alcohol use
    - Young maternal or paternal age
    - Parent abused as a child
    - Depression or other mental illness
    - Poor knowledge of child development or unrealistic expectations for child
    - Negative perception of normal child behavior.

- Environmental Risk Factors (Community and Society):
    - Social isolation
    - Poverty
    - Unemployment
    - Low educational achievement
    - Single parent
    - Non-biologically related male living in the home
    - Family or intimate partner violence.

- Behavioral Indicators for Possible Abuse:
    - Extremes in child behavior
    - Substance abuse by child
    - School problems
    - Depression
    - Frequent runaway activity
    - Suicide attempts
    - Poor social interactions,
    - Sudden changes in daily routines.

The *SEEK Questionnaire* (Refer to Section 7, Appendix II, for the *English* and *Spanish* versions) is designed to assist providers to identify and address potential risks for abuse and neglect for children younger than 3 years of age.

- Child abuse and neglect is a serious problem that requires the involvement of professionals in the community for the purpose of prevention, identification, and treatment. The medical history is integral to the evaluation. The provider should obtain sufficient information to complete the physical and decide if local protective services or police are needed. When suspicions of inflicted injury occur, interview the parent and child separately. Past medical history, the child's social situation and the parent's response to the event are necessary components of the history. Not all child abuse occurs in high-risk families. Although the incidence is higher in high-risk families, the provider should thoroughly evaluate every child with a suspicious injury. For more instructions on the role of the pediatrician in identifying abused children, refer to *2015 AAP Guidance on the Evaluation of Suspected Child Physical Abuse*.[12]

- Red Flags that Signal Possible Abuse:

    - Inconsistent history,
    - No explanation for injury/bruises,
    - Delay in seeking care,
    - Incident inconsistent with child's developmental level,
    - Severe injury not witnessed or corroborated,
    - Scene of injury not consistent with history,
    - High risk social situation,
    - Previous suspicious and/or multiple injuries,
    - Blaming of injury on siblings.

- In Maryland, Subtitle 7 of the Maryland Family Law Code Annotated requires professionals, including health practitioners, police officers, educators and social workers, to report suspected child abuse or face possible professional sanctions.[13] The law requires that anyone who suspects a child has been, or is being, mistreated must report the matter to the *Department of Social Services* *https://mmcp.health.maryland.gov/epsdt/healthykids/Section%208/Local-Departments-of-Social-Services.pdf* (Refer to Section 8) or the police. Any person who, in good faith, makes a report of abuse or neglect is immune from civil liability or criminal penalty.

- [12]See American Academy of Pediatrics. (2015). The evaluation of Suspected Child Physical Abuse. *Pediatrics*. 135(5). Retrieved on 01/14/2016, from *http://pediatrics.aappublications.org/content/135/5/e1337.*
- 2010 Maryland Code Family Law Title 5 - Children Subtitle 7 - Child Abuse and Neglect Section 5-704

Bullying and Cyber-bullying

- Bullying including cyber-bullying is of increasing concern in the pediatric population.
- Health care providers should:
    - Ask children and adolescents about their experiences, if any, regarding bullying and cyber bullying,
    - Provide information in their offices for families to educate them on this topic,
    - Encourage parents to work with schools to promote awareness, prevention, and appropriate intervention.

- For more information on youth violence including bullying and dating violence, review *2009 AAP Policy on the Role of Pediatrician in Youth Violence Prevention*.[14] A specific assessment tool measuring bullying victimization is the *Victimization Scale* (refer to Section 7, Appendix II for the *English* and *Spanish* versions of the tool). For other assessment tools, see *Measuring Bullying Victimization, Perpetration, and Bystander Experiences: A Compendium of Assessment Tools*, published by the Centers for Disease Control and Prevention (CDC) in 2011.[15]

Alcohol and Substance Use Disorder Assessment

- Performing an assessment or screening for substance use is critical, because of the increased number of adolescents and young adults using drugs and alcohol.[16] Primary care providers play an important role in identifying those who abuse substances. Completion of at least an assessment for substance use at every well child visit is required annually starting at 12 years of age. Screening for substance use should be performed by using a standardized tool such as *CRAFFT* (Refer to Section 7, Appendix II, for the *English* and *Spanish* language versions of the tool).[17] For availability of CRAFFT in other languages, refer to the ***Center for Adolescent Substance Abuse Research*** website at *https://www.childrenshospital.org/research/centers/center-adolescent-substance-abuse-research*. For further guidance, refer to *2015 AAP Report of Binge Drinking*.[18]

- [14]See AAP. (2009). Role of Pediatrician in Youth Violence Prevention. Pediatrics. 124(1), 393-402. Retrieved on 06/03/2015, from *http://pediatrics.aappublications.org/content/124/1/393.full.*
- [15]See CDC (2011). Measuring Bullying Victimization, Perpetration, and Bystander Experiences: A Compendium of Assessment Tools. Retrieved on 06/03/2015, from *http://www.cdc.gov/violenceprevention/pdf/bullycompendium-a.pdf*.
- [16]See AAP (2005). Tobacco, Alcohol, and Other Drugs: The Role of the Pediatrician in Prevention, Identification, and Management of Use. *Pediatrics*.115(3), 816–821. Reaffirmed March 2013. Retrieved on 08/18/2014, from *http://pediatrics.aappublications.org/content/115/3/816.full.*
- [17]See AAP (2011). Policy Statement: Substance Use Screening, Brief Intervention, and Referral to Treatment for Pediatricians. *Pediatrics*. 128 (5), 1330 -1340. Retrieved on 08/18/2014, from *http://pediatrics.aappublications.org/content/128/5/e1330.full?sid=f5722c8f-0064-40c2-927f-da32a3a674ef.*
- [18]See AAP (2015). Binge Drinking. *Pediatrics*. 136(3). Retrieved on 01/14/2016, from https://pediatrics.aappublications.org/content/136/3/e718

SECTION 3 - ADDENDA DEVELOPMENTAL SCREENING TOOLS

https://mmcp.health.maryland.gov/epsdt/healthykids/Addendum3/Developmental-Screeni ng-Tools.pdf

ADDITIONAL EVALUATION AND INTERVENTION FOR DEVELOPMENTAL DISORDERS

https://mmcp.health.maryland.gov/epsdt/healthykids/Addendum3/Additional-Evaluation-I ntervention-Developmental-Disorders.pdf
https://www.cdc.gov/ncbddd/actearly/index.html
http://marylandpublicschools.org/programs/Pages/Special-Education/MITP/index.aspx
http://marylandpublicschools.org/programs/Pages/Special-Education/MITP/PreschoolSer vices.aspx
https://www.cdc.gov/ncbddd/developmentaldisabilities/index.html

MODIFIED CHECKLIST FOR AUTISM IN TODDLERS-REVISED, WITH FOLLOW UP (MCHAT-R/F)

https://cms.m-chat.org/LineagenMChat/media/Lineagen-M-Chat-Media/mchatDOTorg.pdf
https://mchatscreen.com/
https://mchatscreen.com/mchat-rf/translations/

B. COMPREHENSIVE PHYSICAL EXAMINATION REQUIREMENT

The comprehensive physical examination component of a Healthy Kids preventive visit must include documentation of an unclothed physical examination in a systems approach with age-appropriate assessments of vision and hearing, blood pressure measurement, growth measurements with BMI and nutritional assessment.

Unclothed Physical Examination by Systems

A licensed physician, MD or osteopath, or certified nurse practitioner must perform an unclothed physical examination.[1] A certified physician's assistant working under a licensed MD or osteopath may also perform the exam. Documentation of a systems approach is required. A minimum of five systems constitutes a complete physical examination. Recording "PE within-normal-limits" or "PE WNL" as complete physical is not acceptable. Documentation of individual systems as "within normal limits" or "WNL" is acceptable. Document all suspect findings, discuss with the parent/child, and develop a plan of care. Monitor, treat, and/or refer the child to an appropriate specialty service for any identified problems.

The physical examination includes assessment of the following:

- General physical appearance
- Skin (evidence of scars, burns, bruises) and hair
- Head & neck (including facial features, thyroid palpation and fontanels for infants)
- Eyes and ears, including ability to see and hear
- Nose/throat
- Age-appropriate growth parameters with BMI, graphing and interpretation of measurements
- Oral cavity including palate, cheeks, tongue, and floor of mouth; dental ridges (including erupting teeth); gums for evidence of infection, bleeding or inflammation; malformation or decay of erupting teeth
- Blood pressure measurement (≥ 3 years of age)
- Cardiopulmonary evaluation, including pulses (palpation of femoral arteries)
- Abdomen (musculature, organs, masses)
- Urogenital evaluation
- Orthopedic evaluation, including muscle tone and scoliosis
- Neurological evaluation, including gross and fine motor coordination

[1] American Academy of Pediatrics. (2011). Use of Chaperones during the Physical Examination of the Pediatric Patient. *Pediatrics*. 127 (5), 991-993. Retrieved on 09/04/2014, from http://pediatrics.aappublications.org/content/127/5/991.full

Assessment of Hearing

An assessment of the child's ability to hear is required at each Healthy Kids preventive visit. Screen using the health history, physical examination and a gross subjective or an objective hearing assessment. The physical examination includes an external and internal (otoscopic) examination of the ears.

The hearing of all newborns should be screened.[2] Maryland hospitals test for hearing impairments in newborn infants. Contact the **MDH Infant Hearing Helpline** at **1-800-633-1316** with questions or for assistance with follow-up of suspect or positive screens. Refer to the *Early Hearing Detection and Intervention (EHDI) Guidelines for Pediatric Medical Home Providers* https://phpa.health.maryland.gov/genetics/docs/Guidelines_Medical_Home.pdf (Refer to Section 3, Addendum).

Assess children through 5 years of age for hearing impairment by means of a complete health history, physical examination, and gross subjective assessment. The initial health history should include an assessment for a family history of hereditary deafness, in particular any blood relative, e.g., grandparents, aunts, uncles, or cousins known to have a childhood hearing impairment. This does not include hearing impairment due to aging, ear infections, meningitis, measles, mumps, trauma, or serious complications at birth.

Subjective Hearing Assessment

A gross subjective assessment can be completed during the developmental assessment by noting response to auditory stimuli and assessing for speech and language delays. Assess school-age children and adolescents for hearing impairment by means of a health history, physical examination, and gross subjective or objective assessment. A subjective assessment is required at every well visit. Schools generally conduct hearing and vision screening in grades K, 3, 5 and 9. Results of these hearing screens suffice as a "subjective assessment."

Objective Hearing Test Using an Audiometer/Audioscope

Objective testing is recommended at birth, 3-6 years of age, and at the following ages: 8, 10, 12, 15, and 18 years of age. Providers can bill Medical Assistance for objective hearing tests on children not enrolled in a MCO. *Objective Hearing Forms* are available to document the results (Refer to Section 7, Appendix I). The audiometer must be used according to the manufacturer's specifications and meet with ANSI l969 standards. Yearly calibration of equipment is required. Recommended test frequencies and screening levels are 1000 HZ, 2000 HZ and 4000 HZ at 20 decibels (dB); test each ear separately.

[2]AAP. (2007). Principles and Guidelines for Early Hearing Detection and Intervention Programs. *Pediatrics*. 120, (4), 898-924. Retrieved on 09/04/2014, from *https://pediatrics.aappublications.org/content/120/4/898.short*

Tympanometry and impedance testing are not required for a Healthy Kids preventive visit. These tests are covered if they are medically necessary for diagnosis and treatment.

Referral and Follow-up

If the child responds to all presented tones at 20 dB in each ear, the test is normal. If the child fails to respond to any one frequency in either ear at 20 dB, the test is suspect/positive. Providers may elect to re-screen the child in approximately 2 weeks or refer directly for evaluation. For assistance in locating community-based services for children with suspect or positive hearing problems, contact the appropriate MCO network or the **Division of Children's Services** at **410-767-3998**.

Assessment of Vision

An assessment of the ability to see is required at each Healthy Kids preventive visit.[3] Screen using the health history, physical examination and a gross subjective or an objective vision assessment. Children should have age-appropriate assessments for eye problems in the newborn period and at all subsequent health supervision visits. Vision screening and eye examinations are vital for detection of conditions that distort or suppress the normal visual image that may lead to inadequate school performance or blindness in children. Retinal abnormalities, cataracts, glaucoma, retinoblastoma, eye muscle imbalances, and systemic diseases with ocular manifestations may all be identified by careful examination. Before objective testing, obtain an adequate history to elicit evidence of any visual difficulties.

The physical examination should include an ophthalmoscopic examination of the eye; response to light stimulation and direction of light; an estimate of alignment of the eyes using the monocular cover test (as early as one year of age) and the Hirschberg (corneal) reflex to observe eye movements. The examination of ocular mobility, muscle balance, and visual acuity may be performed together. The assessment of ocular alignment in the preschool and early school-age child is of considerable importance. The development of ocular muscle imbalance may occur at any age in children and may represent not only simple strabismus, but also serious orbital, intraocular, and intracranial disease. Examination of the eyelids and orbits consists of evaluating the structures for symmetry and function, such as the ability to open both eyes. External examination of the eyes consists of a penlight evaluation of the eyelids, conjunctiva, sclera, cornea, and iris. For more information, refer to 2016 AAP Clinical Report titled "Procedures for the Evaluation of the Visual System by Pediatrician."[4]

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[3] AAP.(2016). Visual System Assessment in Infants, Children, and Young Adults by Pediatricians. *Pediatrics.*37 (1). Retrieved on 09/04/2014, from *http://pediatrics.aappublication.org/content/pediatrics/early/2015/12/07/peds.2015-3596.full.pdf*

[4] *https://publications.aap.org/pediatrics/article/137/1/e20153597/52806/Procedures-for-the-Evaluation-of-the-Visual-System*

Subjective Vision Assessment

Assess children through 5 years of age for vision impairment by means of a health history, physical examination, and gross subjective assessment. A gross subjective assessment can be completed during the developmental assessment by noting response to visual stimuli and assessing for delays in fine motor development. If poor binocular fixation and following behavior is noted after 3 months of age, an ocular or neurologic abnormality may be present.

For children who are old enough (typically at 3 years of age) to delineate objects on a wall-mounted or handheld eye chart, a direct measurement of visual acuity may be used.

For school-aged children and adolescents, providers may use the results of school vision screening reports in their assessment in addition to the history and complete physical examination. Schools generally conduct vision screenings in grades K, 3, 5 and 9. The Snellen eye chart can also be used for a gross vision assessment.

Objective Vision Tests

An objective vision test is recommended at birth, 3-6 years of age, and at 8,10, 12, 15 and 18 years of age. *Objective Vision Forms* are available to document vision results (See Section 7, Appendix I). In general, the following vision screens are conducted according to Maryland standards:

Screening Test	Age at Screening
Acuity	3 through 20 years
Muscle Balance	3 through 20 years
Visual Fusion	3 through 6 years
Hyperopia	7 through 20 years

Referral and Follow-up

For assistance in locating community-based services for children with suspect or positive vision problems, contact the appropriate MCO network or the **Division of Children's Services** at **410-767-3998.**

Blood Pressure Measurements

Blood pressure (BP) measurement is a standard procedure of physical examination for all children 3 through 20 years of age. Correct measurement of BP in children requires use of a cuff that is appropriate to the size of the child's upper right arm. The right arm is preferred for consistency and comparison to the standard tables. Ideally, BP should be recorded at least twice on each occasion, and the average of

each of the systolic and diastolic BP measurements should be used to estimate BP level. Automated blood pressure devices can be used if properly maintained and calibrated yearly.

The definition of normal BP is a systolic and diastolic BP below the 90th percentile for age, sex, and height. High-normal BP is defined as average systolic or diastolic BP greater than or equal to the 90th percentile but less than the 95th percentile. The definition of hypertension is an average systolic or diastolic blood pressure greater than or equal to the 95th percentile for age and sex measured on at least three separate occasions (Refer to Section 3, *Table 1: Girls SBP by Age and Height* & *Table 2, Boys SBP by Age and Height*).

Introduce non-pharmacological therapy including weight reduction, exercise, and dietary intervention in the care of patients with hypertension, as well as in children with high-normal BP. Employ these strategies for non-pharmacological therapy as initial treatment maneuvers for children with BP above the 90th percentile for age, gender, and height. Additionally, ethnic groups with a higher prevalence of hypertension or individuals with a family history of high BP need to have more intense education regarding a healthy diet, exercise, and weight control.

It is appropriate to consult with a physician experienced in the field of childhood hypertension for those children where further testing for underlying causes of hypertension is indicated to determine the type and extent of diagnostic testing necessary. According to the National Institute of Health, if recommendations for follow-up of the child's diastolic and systolic blood pressure differ, follow the shortest recommended time for recheck and referral.[5]

For further guidance, refer to 2004 *Fourth Report on the Diagnosis, Evaluation, and Treatment of High Blood Pressure in Children and Adolescents* and 2011 *Expert Panel on Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents* at *http://www.nhlbi.nih.gov/files/docs/peds_guidelines_sum.pdf*.

Physical Growth Measurements

Growth parameters are important indicators of appropriate nutrition and normal physical development. Therefore, measure each child/adolescent's height and weight at all Healthy Kids visits and plot on growth charts from birth through 20 years of age. Use the *WHO & CDC Growth Charts* https://www.cdc.gov/growthcharts/who_charts.htm to monitor growth for infants and children and adolescents ages 0 to 20 years of age (Refer to Section 7, Appendix I).

[5]See National Heart, Lung and Blood Institute (2004). *Fourth Report on the Diagnosis, Evaluation, and Treatment of High Blood Pressure in Children and Adolescents*. Retrieved on 12/23/2014, from *https://www.nhlbi.nih.gov/files/docs/resources/heart/hbp_ped.pdf*

Guidelines for Obtaining Measurements

Head circumference is required on each visit from birth to 2 years of age. Measurement of head circumference may continue past 2 years of age for children with suspected abnormal growth patterns. Measure the occipital prominence to the brow using a non-stretchable flexible tape; measure to the nearest eighth-inch or millimeter.

Weight is required at each visit for all ages. Weigh infants and small children on a table model beam scale. Weigh older children who can stand without support on a floor model beam scale. Balance scales prior to weighing and check and adjust for accuracy according to the manufacturer's specifications.

Height is required at each visit for all ages. Use a firm surface with, when possible, a fixed headboard and footboard, for supine measurement of infants and children up to 2 years of age and those who cannot stand. Older children, who are able to stand without support, use a non-stretchable measuring tape, or ruler, fixed to a true vertical flat surface.

Body Mass Index (BMI)

Plotting weight and height for age allows comparison with all children the same age and is the best initial indicator of growth problems. The use of Body Mass Index (BMI) is required to monitor changes in body weight and to consistently assess risk of underweight and overweight in children and adolescents from 2 to 20 years of age. Calculate BMI using the English or metric formula, or by using ***BMI Percentile Calculator for Child and Teen*** at https://www.cdc.gov/healthyweight/bmi/calculator.html (Refer to Section 7, Appendix I).

Once BMI is calculated, plot the result on gender specific BMI-for-age growth charts, available from the CDC, to determine the BMI-for-age percentile. It is important to review and interpret the results of the automatic BMI calculations provided by electronic medical records (EMR) or electronic health records (EHR) used in many practices today. Provider interpretation of results is paramount in identifying underweight, overweight, and obese children and those at risk for obesity related complications.

How to Calculate Body Mass Index (BMI)

English Formula: **BMI = weight (lb) ÷[height (in)]^2 x 703**

Metric Formula: **BMI = weight (kg) ÷[height (cm)]^2 x 10,000**

What do BMI-for-age and gender percentiles mean?

≥99th percentile……"Morbid" Obesity

95th to 98th percentile……. Obesity

85th to 94th percentile……. Overweight

5th to 84th percentile……... Healthy weight

<5th percentile…… Underweight

An excellent learning module on overweight and obesity in children and adolescents and the use and interpretation of the CDC growth charts can be found on the CDC web site: https://www.cdc.gov/healthyweight/assessing/bmi/childrens_bmi/about_childrens_bmi.html

BMI-for-age and gender is an effective screening tool, but it is not a diagnostic tool.
Children who fall into the following categories need further assessment:

- If BMI is below fifth percentile, assess for acute or chronic illnesses that can lead to underweight
- If BMI is between 85th and 94th percentiles, child is overweight and needs further screening
- If BMI is at or above 95th percentile for age and sex, the child is obese and needs in-depth medical and dietary assessment according to current guidelines.[6]

Medical Management of Overweight and Obesity in Children and Adolescents

Consequences of overweight and obesity in youth are Type 2 diabetes, high blood pressure, high blood lipids, early maturation, orthopedic problems, and social problems related to stigmatizing and discrimination. Childhood overweight often leads to adult obesity. Obese children have a 50% probability of becoming obese adults; obese adolescents have a 70-80% probability of becoming obese adults. Establishing good eating habits and activity patterns in childhood is the key to preventing future health problems and postponing the health consequences of chronic diseases. Health care and other economic costs are rising with the increasing prevalence of childhood overweight and obesity.[7]

[6]AAP. (2007). Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report. *Pediatrics*. 120 (4) 164-192 Retrieved on 08/18/2014 from *http://pediatrics.aappublications.org/content/120/Supplement_4/S164.full?sid=96871aff-5e0c-4c9b-ad26-d97d2b61e47b.*

Section 3: Healthy Kids/EPSDT Screening Components

The AAP-endorsed 2007 *Expert Committee Recommendations Regarding the Assessment, Prevention, and Treatment of Child and Adolescent Overweight and Obesity* and the 2015 AAP *Clinical Report on the Role of the Pediatrician in Primary Prevention of Obesity*[8] provide guidance on management of weight in all children[9]. **Primary care providers are urged to implement Step 1, Obesity Prevention at Well Care Visits at least once a year** that includes the following:

- Assess key dietary habits (e.g., consumption of sweetened beverages)
- Assess physical activity habits
- Assess readiness to change lifestyle habits
- Conduct a focused family history of obesity and obesity-related illnesses

Laboratory testing recommendations depend on the degree of obesity and associated risk factors as follows:

- Children with a body mass index between the 85th and 94th percentiles with no obesity-related risk factors should have a fasting lipid profile
- Children ages 10 years and older with body mass index between the 85th and 94th percentiles and obesity-related risk factors should have additional testing for liver function (ALT and AST) and fasting blood glucose
- Children ages 10 years and older with a body mass index above the 95th percentile should have measurement of blood urea nitrogen and creatinine levels added to the above tests

A four-stage approach to treatment of childhood obesity is recommended and includes advising parents and children to:

- Limit consumption of sweetened beverages and fast food
- Limit the amount of screen time (TV and Computers) per day
- Increase physical activity for at least 60 minutes per day
- Eat family meals on most, and preferably all, days of the week

[8]AAP. (2015). The Role of the Pediatrician in Primary Prevention of Obesity. *Pediatrics*. 36 (1). Retrieved on 10/09/2015 from *https://pediatrics.aappublications.org/content/136/1/e275*

[9]AAP. (2007). Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report. *Pediatrics*. 120 (4) 164-192 Retrieved on 08/18/2014 from *http://pediatrics.aappublications.org/content/120/Supplement_4/S164.full?sid=96871aff-5e0c-4c9b-ad26-d97d2b61e47b*.

Section 3: Healthy Kids/EPSDT Screening Components

For more details, refer to the *Implementation Guide from the Childhood Obesity Action Network* (Refer to Section 3, Addendum). It combines key aspects of the 2007 Expert Commission Recommendations and 2006 practice tools identified by the *National Institute for Children's Health Quality*.[10]

Additional information on obesity can be found at:

- ***National Institute for Children's Health Quality*** at *www.nichq.org*;
- CDC web page on ***Obesity and Overweight: Strategies and Solutions*** at https://www.cdc.gov/obesity/strategies/
- The National Institutes of Health's ***We Can*** campaign at *http://www.nhlbi.nih.gov/health/educational/wecan/*.

Nutritional Status Assessment

Assessment of eating and physical activity habits should be part of every office visit for all children regardless of current weight. At a minimum, during a preventive care visit, the Healthy Kids Program requires review and documentation of current diet addressing all food groups, preventive dietary counseling and education, and assessment of child's physical activities. Monitor children/adolescents with nutritional risk factors and refer when appropriate to resources and/or for counseling.

Age Specific Nutrition Questionnaires *https://health.maryland.gov/mmcp/epsdt/healthykids/pages/Nutrition-Questionnaires.aspx* are available from Bright Futures (Refer to Section 7, Appendix II).[11] Additional nutrition and physical activity assessment tools with guidelines for interpreting responses are also available on the ***Bright Futures*** web site at *https://www.brightfutures.org/physicalactivity/pdf/Front%20matter.pdf*. Refer children/adolescents enrolled in a MCO to nutrition services within the MCO network. For assistance in locating Medicaid enrolled nutritionists/dieticians who accept referrals for fee-for-service, contact the **Division of Children Services** at **410-767-1903.**

Give special emphasis to referrals for the following groups:

- Children who demonstrate weight loss or no weight gain (according to age) at scheduled pediatric visits
- Overweight and obese children
- Children with other variations from expected growth, such as weight for age and height for age that are below the 5th percentile - adjust for:
- Prematurity (at least up to 2 years of age)

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[10] See *http://www.nichq.org/*.

[11] *brightfutures.aap.org/materials-and-tools/nutriton-and-pocket-guide/Pages/default.aspx*

- Parental height
- Ethnic group or race
- Congenital conditions such as Down Syndrome or cerebral palsy
- Children with congenital or chronic conditions affecting ability to meet nutrient needs, for example: cleft palate, congenital heart defects, cystic fibrosis, inborn errors of metabolism and physical or mental disabilities
- Children with elevated blood lead levels, iron-deficiency anemia, food allergies or intolerances/sensitivities, high cholesterol and/or drug-nutrient interactions
- Children at risk for sub-optimal nutritional status as a result of environmental influences such as:
    - Inappropriate feeding practices including over-dilution of infant formula
    - Unhealthy feeding relationships (such as consistently using food as a reward for good behavior, etc.)
    - Inadequate financial resources in the family
    - Attitudes or behaviors of the primary caregiver and/or persons with significant influence on the primary caregiver

Nutritional Education

Provide all children or their caregivers with anticipatory guidance on nutrition according to the age and developmental stage of the child. Guidance can include discussion of the following:

- Nutritional needs of infants, children, and adolescents
- Developmental readiness of the infant for complementary foods
- Transition of the older infant to table foods and the development of self-feeding skills
- Normal eating and activity habits of young children
- Development of healthful eating and activity habits in school-age children and adolescents

Use the *Dietary Guidelines for Americans*[12] and the *My Plate*[13] as guides for children and adolescents to select healthy foods for meals and snacks (Refer to Section 7, Appendix IV). Further nutrition and physical activity education should include the following evidence-based messages for all children regardless of age:

- Limit sugar-sweetened beverages
- Fill half the plate with fruits and vegetables. Grains and proteins should each incorporate less than one quarter of the plate. Dairy should include fat-free or low-fat milk or yogurt products.
- Eat breakfast every day
- Limit eating out, especially fast food
- Have regular family meals
- Limit portion sizes
- Engage in moderate to vigorous physical activity for at least 60 minutes a day
- Limit screen time to no more than 2 hours/day
- Remove television from children's bedrooms

Nutrition Resources and Referral Information

Children up to 5 years of age may be eligible for the *Special Supplemental Nutrition Program for Women, Infants and Children (WIC) Program*.[14] This federal program provides nutritious food and nutrition education, including breast-feeding counseling and support. Use the *Maryland WIC Medical Documentation Form* (Refer to Section 3, Addendum), or contact **1-800-242-4942** to refer patients to a licensed dietitian or licensed nutritionist.

The WIC program provides individual breastfeeding support and assistance. The International Board Certified Lactation Consultants and peer counselors provide breastfeeding education. For more information on WIC breastfeeding support services, contact a local *WIC Agency*, or contact **1-800-242-4942**.

There is growing interest in childhood obesity prevention. The Maryland Department of Health (MDH) continues to address the issue of childhood overweight and obesity. For information, contact the MDH *Maternal & Child Health Bureau* at **410-767-6713**.[15]

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[12] See *http://www.health.gov/dietaryguidelines/.*
[13] See *http://www.choosemyplate.gov/.*
[14] See *https://phpa.mch.maryland.gov/wic/Pages/Home.aspx*
[15] Refer to *https://health.maryland.gov/phpa/mch/pages/Home.aspx#:~:text=The%20Maternal%20and%20Child%20Health,families%2C%20and%20communities%20in%20Maryland.*

Oral Health

Oral assessment by the PCP is a part of the physical examination and includes an oral examination, medical and dental history and parental counseling.[16] Refer to the tooth eruption schedules (Refer to Section 3, *Chart 1: Primary Tooth Eruption* & *Chart 2: Permanent Tooth Eruption*). An excellent reference tool is the 2014 Bright Future's *Pocket Guide of Oral Health*.[17]

The oral screening, provided as part of a Healthy Kids preventive health visit, should include the following:

- Intraoral exam – tonsils, throat, palate, cheeks, tongue, and floor of mouth
- Extraoral exam – lips, head, and neck region
- Dental ridges (including gums for evidence of infection, bleeding or inflammation and erupting teeth)
- Tooth decay
- Malformation of teeth
- Need for dietary fluoride supplements (if on non-fluoridated water system and fluoride content of water is known and/or has been tested)
- Early predictor of tooth decay (white spot lesions)
- Presence of dental plaque
- Signs of orofacial trauma from accidental injury
- Signs of orofacial trauma from intentional abuse and/or neglect
- Other risk factors for oral diseases
- Tobacco use including smokeless/spit tobacco

The first visit to the dentist should occur within 6 months of the eruption of the first primary tooth and no later than 12 months of age.[18] A child should see the dentist once every six months beginning at 12 months of age. Advise any patient, regardless of age, to seek dental care if problems are identified in the oral assessment. Providers may contact the *Maryland Healthy Smiles Program* at **844-275-8753** for questions about dental services and assistance in locating a dentist.[19] The *Member Handbook* may be accessed online.[20] Parents or caregivers can self-refer to a dentist without a referral from the primary care provider (PCP).

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[16] AAP. (2008). Preventive Oral Health Intervention for Pediatricians. *Pediatrics*.122 (6), 1387-1394. Retrieved on 09/04/14, from *http://pediatrics.aappublications.org/content/pediatrics/122/6/1387.full.pdf*

[17] Refer to *https://.www.mchoralhealth.org*

[18] AAP. (2003). Oral Health Risk Assessment Timing and Establishment of the Dental Home. *Pediatrics*. *https://pediatrics.aappublications.org/content/111/5/5/113.full*

[19] *https://mmcp.health.maryland.gov/Pages/Maryland-healthy-smiles-dental-program.aspx*

[20] To view and print a copy of the handbook, follow the link *https://mmcp.health.maryland.gov/Pages/Maryland-healthy-smiles-dental-program.aspx*

An additional benefit for children 9 months to 60 months old at their Healthy Kids preventive health visit is the application of fluoride varnish by an appropriate and trained medical provider. The Maryland Department of Health and Mental Hygiene implemented the *Maryland's Mouths Matter Fluoride Varnish and Oral Health Screening Program for Kids https://www.mchoralhealth.org/flvarnish/* on July 1, 2009.[21] Maryland Medicaid reimburses for the application of fluoride varnish in PCP offices. Reimbursement by Medicaid is limited to EPSDT certified PCPs who:

- Participate in the Maryland Medicaid Program with an active Medicaid provider number, and
- Have successfully completed a state approved oral health screening and fluoride varnish program training program

To register for the fluoride varnish training, contact the MDH Office of Oral Health:

- By email at mdh.fvprogram@maryland.gov
- By phone at 410-767-3081
- Access the Online Training Curriculum at: https://www.mchoralhealth.org/flvarnish/. Refer to Section 6 of this Manual for billing information on fluoride varnish application.

Prior to the fluoride varnish application, the EPSDT certified provider **must** conduct an oral health screening. The provider should record any notable findings in the oral cavity, preventive oral health and dietary counseling, the administration of topical fluoride varnish, and if necessary, a referral to a dentist.

A notation of "negative oral assessment" is an accepted method of documentation in the patient's record. Record any positive findings. Advise that all children through 20 years of age see a dentist twice yearly for a comprehensive dental examination, regardless of oral health status. This exam includes a treatment plan recording the need for prophylaxis and the prevention and treatment of oral diseases including dental caries, gingival and periodontal diseases, tissue lesions, or other abnormalities. Document education given to seek dental care at each preventive health visit.

Provide oral health education, counseling and disease prevention and the need to make and keep dental appointments, stressing self-responsibility, at each visit to parents/caregivers and children. The content of these oral health education and counseling activities includes but is not limited to the following topics:

[21] For more information, refer *to www.mchoralhealth.org/flvarnish/mod1-0.html*

Prevention of Infant and Early Childhood Caries (cavities)

- Assessment of systemic fluoride sources; follow the https://www.aapd.org/globalassets/media/policies_guidelines/bp_fluoridetherapy.pdf (Refer to Section 3, Table 3) and the *Guidelines on Fluoride Therapy* revised and approved by the American Academy of Pediatric Dentistry in 2014.[22]
    - Home water content
    - Bottled water
    - Community water fluoridation
    - Dietary fluoride supplements
- Assessment of topical fluoride use
    - Monitored use and amount of fluoride dentifrices
    - Professionally applied topical fluoride application including gel and varnish
    - Self or parentally applied topical fluoride rinses
- Use of pit and fissure dental sealants
- Adequate oral hygiene practices
- Proper diet
    - Appropriate bottle and other feeding practices
    - Daily sugar intake
    - Snacking content and frequency
- Recognizing early signs of dental cavities (white spot lesions and plaque)
- Routine visits to a dentist

Prevention of Gingival and Periodontal Diseases (gum diseases)

- Role of plaque
- Plaque removal
- Tooth brushing with fluoridated toothpaste
- Flossing
- Professional prophylaxis
- Routine visits to a dentist

[22]See https://www.aapd.org/globalassets/media/policies_guidelines/bp_fluoridetherapy.pdf

Prevention of Oral Cancers

- Knowledge of risk factors, early signs and symptoms
- Need for age-appropriate annual oral cancer exam
- Assessment of risk behaviors including tobacco use

Prevention of Oral and Facial Injuries (all ages)

- Use of athletic mouth guards
- Use of playground and other age-appropriate equipment
- Use of seat belts and bicycle helmet
- Knowledge, awareness, and management of signs of abuse and neglect.

MARYLAND NEWBORN HEARING SCREEN AND INTERVENTION GUIDE
https://mmcp.health.maryland.gov/epsdt/healthykids/Addendum3/Early-Hearing-Detectio n-Intervention.pdf
https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/PEHDIC/Pages/Earl y-Hearing-Detection-and-Intervention.aspx

JAEB VISUAL ACUITY SCREENER/VISION SCREENING
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4537792/
https://aapos.org/members/guidelines/vision-screening-guidelines
https://www.healthychildren.org/English/health-issues/conditions/eyes/Pages/Vision-Screenings.aspx

MARYLAND WIC PROGRAM MEDICAL DOCUMENTATION FORM
https://phpa.health.maryland.gov/wic/Pages/Home.aspx
https://phpa.health.maryland.gov/wic/Pages/wic-nutrition.aspx
https://health.maryland.gov/phpa/wic/Documents/certification/AG_WIC_AFL2021_TNT_FINAL_compressed.pdf

EXPERT COMMITTEE RECOMMENDATIONS ON THE ASSESSMENT, PREVENTION, AND TREATMENT OF CHILD AND ADOLESCENT OVERWEIGHT AND OBESITY
https://www.cdc.gov/obesity/childhood/defining.html
https://mmcp.health.maryland.gov/epsdt/healthykids/Addendum3/Recommendations-Guide-for-Childhood-Obesity-2007.pdf
https://www.aap.org/en/patient-care/institute-for-healthy-childhood-weight#search=OBESITY
https://www.chopchopfamily.org/recipes/?recipe_types=dinner&language=english

C. LABORATORY TESTS

Hereditary/Metabolic Screening

Maryland hospitals and birthing centers are required to offer newborn screening for hereditary/metabolic diseases. Most of the tests require that the infant have a minimum of 24 hours of milk feedings prior to the collection of the specimen. The minimum length of stay in the hospital following delivery has been extended to at least 48 hours; however, the mother may request a shorter length of stay. Early maternal/infant discharge can interfere with effective screening. If the infant is discharged before having 24 hours of milk feedings, the primary care provider (PCP) should repeat the test before the infant is 2 weeks old.

The Healthy Kids Program requires a second routine hereditary/metabolic screen at 2-4 weeks of age with documentation of the results in the medical record. A list of the most common metabolic disorders included in the hereditary/metabolic screen can be found in the following link. (Refer to Section 3, Table 4). https://phpa.health.maryland.gov/genetics/Pages/metabolic.aspx

Obtain newborn screening results for children born in Maryland from the State of Maryland's Public Health Laboratory–https://health.maryland.gov/laboratories/Pages/home.aspx. A paper copy of the newborn screening report can be obtained by sending a fax using your practice coversheet to **443-681-4505**. The faxed request should include the baby's birth name, mother's name at the time of birth, the baby's birth date, and hospital of birth. Results can also be obtained by contacting **443-681-3900**. Have the information listed above when calling.[1]

Document results in the child's medical record. A positive screening test does not establish a diagnosis, but is an indication for further evaluation. Consult the *Maryland State Newborn Screening Follow-Up Unit*[2] at **443-681-3900** for assistance with interpretation of results and arranging an appropriate evaluation. Additionally, the MDH *Office for Genetics and People with Special Health Care Needs*[3] (OG/PSHCN) at **410-767-6730** can provide clinical information to assist in the management of a child diagnosed with sickle cell disease. Immunization records and other clinical history may also be available through the OG/PSHCN for newly established patients with a known history of sickle cell disease.

Hemoglobinopathy Screening

It is important to screen all infants for hemoglobin disorders, regardless of apparent racial or ethnic group. Tests for both sickle cell disease and trait have been included in the initial newborn screen since 1985. A negative sickle cell test documented on the newborn screen for hereditary/metabolic diseases is sufficient. Screen any infant who does not have a documented negative hemoglobinopathy screen. Document attempts to get test results from prior PCPs.

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[1] For more information, refer to https://health.maryland.gov/laboratories/Pages/nbs_provider.aspx
[2] See ://phpa.health.maryland.gov/genetics/Pages/NBS_Program.aspx
[3] See https://phpa.health.maryland.gov/genetics/Pages/NBS_Program.aspx

If using the State Lab and the infant is under 3 months of age, use the order form for the Newborn Screening Blood and Collection Kits https://health.maryland.gov/laboratories/docs/Kit%20Request%20Form.pdf **Maryland's Public Health Laboratory** will provide lab slips to providers who have their tests analyzed by the Maryland State lab and can be reached by calling 443-681-3900.

Hemoglobinopathy Testing

Review sickle cell trait results at 12 years of age. If a negative sickle cell trait result is not documented in the child's medical record, and the child/adolescent was born in Maryland, contact Maryland's Public Health Laboratory https://health.maryland.gov/laboratories/Pages/nbs_provider.aspx at **410-681-3900** for assistance in determining the results. If results are not available or the child was not born in Maryland, a hemoglobin electrophoresis is recommended, regardless of apparent racial or ethnic group. Refer the adolescent for genetic counseling if sickle cell trait is present.

Anemia Screening

Perform a hematocrit (Hct) or hemoglobin (Hgb) determination to screen for the presence of anemia at 12 months and 24 months of age.[4] Additionally, complete an anemia screen on the initial visit for all children up to 6 years of age unless results are available from the previous provider. Age specific hematocrit and hemoglobin values for healthy children are available (Refer to Section 3). Periodic anemia screens are not required for a Healthy Kids visit after 2 years of age, unless clinically indicated, or the results of a previous test are not available (Refer to Section 4, *Adolescent Anemia Screening*).[5]

Critical Congenital Heart Disease Screening (CCHD)

CCHD is defined as a heart defect that is present at birth and can cause serious illness or even death if not detected the first few weeks of life. According to CDC CHDs are a leading cause of birth defect-associated infant illness and death.[6] Since 2012, all hospitals and birthing centers in Maryland are required to screen babies within 24-48 hours of age for CCHD.[7]

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[4] American Academy of Pediatrics (AAP). (2010). *Diagnosis and Prevention of Iron Deficiency and Iron Deficiency Anemia in Infants and Young Children (0-3 Years of Age).* 126(5), 1040-1050. Retrieved on 09/22/14, from https://pediatrics.aappublications.org/content/126/5/1040

[5] CDC (1998). *Recommendations to prevent and control iron deficiency in the United States*, MMWR, 47(RR-3), 1-36. Retrieved on 12/01/14, from https://www.cdc.gov/mmwr/preview/mmwrhtml/00051880.htm

[6] CDC. *Congenital Heart Defects (CHDs): Data and Statistics*. Retrieved on 06/16/2015, from https://www.cdc.gov/ncbddd/heartdefects/data.html

[7] See COMAR 10.52.15.

Not all CCHD can be detected at birth, but some types of CCHD can be detected most of the time using pulse oximetry screening. If a newborn does not pass the pulse oximetry test, further evaluation is needed immediately to see if the newborn has a CCHD. This evaluation should be done before the newborn leaves the hospital. For more information, contact the *OG/PSHCN Critical Congenital Heart Disease Prevention Program*[8] **443-681-3916**
https://phpa.health.maryland.gov/genetics/Pages/CCHD_Program.aspx

Lead Risk Assessment and Blood Lead Testing

A lead risk assessment is a series of questions used to determine if the child is at risk for high-dose lead exposure. The *Preventive Screen Questionnaire* (Refer to Section 7, Appendix II for the *English* and *Spanish* versions) can be used for this assessment. A lead risk assessment is required at each preventive health care visit starting at 6 months of age up to 6 years of age. Consider a "yes" or "I don't know" response to any of the questions a positive risk assessment. Documented results of the lead risk assessment must be in the clinical record at each well child visit. Document the results of the lead risk assessment on either the visit sheet or the Preventive Screen Questionnaire.

Lead Risk Assessment Follow-Up

If the child is at risk, i.e., if the response to any of the lead risk assessment questions is "yes" or "don't know" or if there is any history, symptoms, or signs that may be related to possible lead poisoning, a blood lead level must be done.

Blood Lead Level (BLL) Testing and Laboratory Information

Regardless of the results of the lead risk assessments or zip code of residence, all MA children must have a BLL at 12 months of age and again at 24 months of age. Additionally, obtain a baseline blood lead level on the initial visit for all children up to 6 years of age, if the child has not been previously tested or if results are not available. As noted above, initiate testing at any age, whenever a child is determined to be at risk for lead exposure using a lead risk assessment. The PCP must document that a blood lead level was ordered. Direct any questions regarding the lead testing requirements for Medicaid children to the **Healthy Kids Program** at **410-767-1903**.

The PCP may refer the child to a CLIA (Clinical Laboratory Improvement Amendments of 1988) certified laboratory to obtain and process the blood lead specimen. All laboratories must be CLIA certified to participate in the Maryland Medical Assistance Program. The Managed Care Organizations (MCOs) have contracts with specific laboratories in your geographical area. Contact each MCO to determine which laboratory to use.

Based on MCO contracts, the PCP may have the option of collecting the blood lead specimen in his/her office. The venipuncture method for specimen collection is recommended to minimize false positive results.

[8]See https://phpa.health.maryland.gov/genetics/Pages/CCHD_Program.aspx

State law requires that all laboratories send blood lead results to the *Childhood Lead Registry* at the *Maryland Department of the Environment, Childhood Lead Poisoning Prevention Program* (CLPPP).

https://mde.state.md.us/programs/Land/LeadPoisoningPrevention/Pages/PoisoningPreventionProgram2.aspx

Laboratory slips should contain all patient demographic information: name, complete street address, and zip code. This information is used to track children exposed to lead and identify areas at risk for lead poisoning.

Maryland Targeting Plan for Childhood Lead Poisoning

In addition to the blood lead testing requirements for MA participants, there are requirements for all children, regardless of insurance coverage. To review the revised

2015 *Maryland Targeting Plan*, follow the link https://phpa.health.maryland.gov/IDEHASharedDocuments/MD%202015%20Lead%20Targeting%20Plan.pdf

Elevated Blood Lead Level Follow-Up

Lead poisoning is a serious disease, and elevations require confirmation, assessment of increasing/decreasing trend, and prompt follow-up. The child's PCP is responsible for the child's medical case management. When children have documented blood lead levels between 1-5 mcg/dl, venous and capillary, the child's caregiver needs health education and anticipatory guidance about lead and lead poisoning. The second blood lead level at 24 months is still required, even if the blood lead level at 12 months is between 0-9 mcg/dl. Continue to conduct lead risk assessments at every visit up to 6 years of age. Perform additional testing if lead risk has increased.

Children who have blood lead levels between 3.5-9 mcg/dl must be retested in 3 months. In addition, families whose children have a confirmed level of 5 mg/dl and above should receive lead and nutritional education and be assessed for possible sources of lead exposure[9]. Children who have blood lead levels of 10 mcg/dl and above need follow-up according to the protocols established by the Centers for Disease Control and Prevention (CDC) and the Maryland Department of the Environment, CLPPP (Refer to Section 3, https://mde.maryland.gov/programs/LAND/LeadPoisoningPrevention/Pages/healthcare_followupreports.aspx and *Table 7: Maryland DOE Case Coordination Guidelines for Lead Poisoned Children*). For assistance in locating tertiary centers that provide chelation treatment for BLL over 40, contact the *Department of the Environment* at **1-800-776-2706 / 410-537-3000.** The *Community Health Nurses* at the local Health Departments provide environmental inspections, nursing case management, and individualized health education to families with lead poisoned children (Refer to Section 8).

[9] See *https://www.cdc.gov/media/releases/2021/p1028-blood-lead.html*

HELPFUL LINKS

Blood Lead Level Resources

https://mde.maryland.gov/programs/Land/Documents/LeadFactSheets/NewGuidelinesChildhoodLeadExposure_2020_Final.pdf
https://mde.maryland.gov/programs/Land/Documents/LeadFactSheets/Parent%20Letter%20Final%2011.17.21%20signed.pdf
https://mde.maryland.gov/programs/Land/Documents/LeadFactSheets/LeadfsHealthDeptNursingContacts.pdf

Maternal Depression Resources

Case Study: How Minnesota Uses Medicaid Levers to Address Maternal Depression and improve Healthy Child Development – https://www.nashp.org/wp-content/uploads/2017/03/Minnesota-PPDQIP-Case-Study1.pdf

AAP Policy: incorporating Recognition and Management of Perinatal and Postpartum Depression into Pediatric Practice: https://publications.aap.org/pediatrics/article/126/5/1032/65293/Incorporating-Recognition-and-Management-of?autologincheck=redirected

Screening in Practices AAP Web site: https://www.aap.org/en/patient-care/screening-technical-assistance-and-resource-center/screening-tool-finder/?page=1

Coding for Pediatric Preventive Care - page 13
NOTE: Code 96161 can be reported for a postpartum screening administered to a mother as part of a routine newborn check but billed under the baby's name. Link to ICD-10-CM code 200.121 or Z.00J29 for normal screening results during a routine well-baby examination
https://downloads.aap.org/AAP/PDF/Coding%20Preventive%20Care.pdf

CMS Bulletin - Maternal Depression Screening and Treatment: A Critical Role for Medicaid in the Care of Mothers and Children: https://www.medicaid.gov/federal-policy-guidance/downloads/cib051116.pdf

Additional Health Risk Assessments

Health risk assessments are used to determine risks for a variety of health-related problems. A risk assessment consists of a series of questions asked to determine if the child/adolescent needs counseling, education, testing, and/or referral to a specialty care provider. The age-appropriate risk assessments are described below.

Tuberculosis Risk Assessment

Diagnosis of tuberculosis in children is difficult and poses problems that are not present in adults. Children are less likely to have obvious symptoms of tuberculosis. Tuberculosis in infants and children younger than four years of age is much more likely to spread throughout the body through the bloodstream. As a result, children are at much greater risk of developing life-threatening forms of TB disease (e.g., disseminated TB, TB meningitis).

Perform a tuberculosis risk assessment annually at the Healthy Kids preventive visit beginning at 1 month, 6 months, 12 months of age or on the first visit and yearly thereafter, to determine if the child is at risk. The questions for the tuberculosis risk assessment are on the *Preventive Screen Questionnaire* (Refer to Section 7, Appendix II for the *English* and *Spanish* versions). A "yes" response to any of the questions indicates a "positive" tuberculosis risk assessment. Document the result of the tuberculosis risk assessment, "positive" or "negative", on the questionnaire form or on the visit sheet. Be sure to date and sign off on the questionnaire after review. If a child has a "positive" tuberculosis risk assessment, perform testing. Routine Tuberculin Skin Testing (TST) is discouraged for low-risk children, because of possible false-positive skin tests. If the practice is completing a pediatric health form requesting TST results for a child assessed as low risk, document "not indicated" on the form.

Current Professional Recommendations Regarding TB:

- Carefully screen for risk of tuberculosis exposure; tuberculin skin testing for low-risk children is NOT recommended
- Selectively and appropriately test those at risk for tuberculosis using intra-dermal TST
- Use only trained health care providers to administer and read the results
- Implement prompt medical evaluation for anyone with positive a TST

Targeted TB testing discourages screening of children from low-risk populations and focuses on identifying children and adolescents at risk for latent tuberculosis infection (LTBI), who would benefit from drug treatment to prevent progression to TB disease.[10]

[10] Pediatric TB Collaborative Group (2004). *Targeted tuberculin skin testing and treatment of latent tuberculosis infection in children and adolescents.* Retrieved from *http://pediatrics.aappublications.org/content/pediatrics/114/Supplement_4/1175.full.pdf*

Children/adolescents with LTBI have inactive TB bacteria in their body. They do not have TB disease symptoms and cannot spread TB disease to others. However, they can develop TB disease in the future and then may be capable of spreading active TB bacteria. For further clarification of LTBI vs. TB disease, refer to the ***CDC's Basic TB Facts*** webpage at: https://www.cdc.gov/tb/topic/basics/default.htm

Testing: Determine the frequency and timing of tuberculin skin testing (Refer to Section 3, Table 8: *Priority Groups for Targeted Testing and Treatment of Latent TG Infection with TST Cut-Points and Recommended Testing Frequency* https://www.cdc.gov/mmwr/preview/mmwrhtml/rr4906a1.htm based on individual health history and evidence of risk factors. Use only the Mantoux TST test (5 tuberculin units of purified protein derivative placed intradermally. Multiple puncture or Tine tests are inadequate for TST and should not be used.

A child who has received a TST must return within 48-72 hours to have the injection site inspected or "read" by a trained health care provider.

Use a ruler to measure, in millimeters, the induration (not erythema). Record the results in the medical record based on correct interpretation of skin-test reactions (Refer to Section 3, https://www.cdc.gov/tb/topic/testing/tbtesttypes.htm. Do not allow parents or other caregivers to read the skin test. A history of BCG vaccinations is not a contraindication to tuberculin skin testing and is generally not a factor in interpretation of results. For more information about the BCG vaccination and the testing for TB in BCG vaccinated children refer to ***CDC's BCG Vaccine Fact Sheet*** webpage at https://www.cdc.gov/tb/publications/factsheets/vaccines.htm.

Treatment: A positive skin test requires further assessment for tuberculosis, including a chest X-ray to rule out active disease. Children with negative chest X-rays and positive skin test are considered latently infected and should receive isoniazid prophylaxis for a minimum of nine months to prevent active disease in the future (Refer to Section 3, *Table 10: Regiments for Treatment of Latent TB Infection and Recommended Monitoring*). Treat a child/adolescent with active disease according to Maryland and national standards. Contact the MDH Center for Tuberculosis Control and Prevention https://phpa.health.maryland.gov/OIDPCS/CTBCP/Pages/tb-clinics-and-health-departsments.aspx at **410-767-6698** for further information. Administer medications via Directly Observed Therapy (DOT). Notify the Tuberculosis Control Coordinators https://mmcp.health.maryland.gov/epsdt/healthykids/Section%208/Local-TB-Units.pdf at the local Health Departments (Refer to Section 8) of anyone with a positive TST and an abnormal chest x-ray, or a child with symptoms of tuberculosis.[11]

[11] See Maryland Guidelines for the Treatment and Prevention of Tuberculosis — 2007 at https://phpa.health.maryland.gov/OIDPCS/CTBCP/CTBCPImages/2019_November_Revised.pdf

Cholesterol/Heart Disease Risk Assessment

The Maryland Healthy Kids Program requires cholesterol/heart disease risk assessment by questionnaire starting at 2 years of age. Since family health history can change, the risk assessment is required annually. The *Preventive Screen Questionnaire* (Refer to Section 7, Appendix II for the *English* and *Spanish* versions) is provided to assist providers in determining risk for heart disease. A "yes" response to any question indicates a "positive" risk. Be sure to date and sign off on the questionnaire after review. Document the result of the cholesterol/heart disease risk assessment, positive or negative, on the questionnaire form or on the visit sheet.

When a child has a positive cholesterol/heart disease risk assessment, the first fasting lipid profile test (FLP) should be completed minimally at 2 years of age, but no later than 10 years of age based on the 2008 guidelines of the American Academy of Pediatrics[12] and the 2007 Expert Committee on the Assessment, Prevention, and Treatment of Child and Adolescent Overweight and Obesity.[13] Test children and adolescents:

- With a positive family history of dyslipidemia or premature cardiovascular disease beginning at ≤ 55 years of age for men and ≤65 year of age for women

  (This includes documented angioplasty, coronary artery bypass surgery, diagnosed coronary atherosclerosis, myocardial infarction, angina pectoris, peripheral vascular disease, or sudden cardiac death),

- Whose family history is unknown for CVD risks,
- Whose parent has TC≥240 mg/dL or known dyslipidemia,
- Who are overweight and obese-above the 85% on the BMI chart,
- With hypertension, BMI≥95th %ile, or smokes cigarettes,
- With a moderate- or high-risk medical conditions- (diabetes mellitus, chronic kidney disease/end-stage renal disease/post renal transplant, post orthotopic heart transplant, Kawasaki diseases, chronic inflammatory disease, HIV, nephritic syndrome),
- Who have FLP results in the normal range, but who continue to be at risk, every 3-5 years

[12]AAP. (2008). Lipid Screening and Cardiovascular Health in Childhood, *Pediatrics;* 122,198-208; Retrieved on 12/22/2014, from https://pediatrics.aappublications.org/content/122/1/198.

[13]AAP. (2007). Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report . *Pediatrics*. 120 (4), 164-192. Retrieved on 08/18/2014 from *http://pediatrics.aappublications.org/content/120/Supplement_4/S164.full?sid=96871aff-5e0c-4c9b-ad26-d97d2b61e47b*.

The physician must measure the FLP on two separate occasions at least 2, but not more than 12 weeks apart and average the values.

Effective January 1, 2016, the DHMH added a new requirement of dyslipidemia lab tests. One test is required between the ages 9-11, and a second one between the ages of 18-21. For more information, refer to the AAP-endorsed *2011 Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents* from the National Heart Blood and Lung Institute.[14]

For management of hypercholesterolemia in children, refer to the AAP -endorsed *2011 Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents* from the National Heart Blood and Lung Institute[15] (Refer to Section 3, *Table 11: Acceptable, Borderline-High and High Plasma Lipid, Lipoprotein and Apolipoprotein Concentrations (mg/dL) for Children and Adolescents*). Children with persistent elevated blood cholesterol levels should receive a referral to a nutritionist for further dietary intervention. Drug therapy should be considered in children 10 years of age and older with an:

- No CVD risk factors, but with LDL-C≥190 mg/dL after 6 months of lifestyle/diet changes, or
- LDL-C 160-189 mg/dL with positive family history or presence of 2 or more additional risk factors (obesity, smoking or hypertension), after 6 months of lifestyle/diet changes, or
- LDL of ≥ 130 mg/dL if diabetes mellitus is present, or
- Average fasting TG level ≥500 mg/dL or average LDL≥250 mg/dL.

Children younger than 10 years of age should not be treated with a medication unless they have:

- Severe primary hyperlipidemia, or
- High-risk condition associated with serious medical morbidity (LDL-C ≥400 mg/dL; TG≥500 mg/dL; evident CVD; post-cardiac transplantation)

Please note: The goal of LDL-lowering therapy in childhood and adolescence is LDL-C below the 95th percentile (≥130 mg/dL).

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[14] National Heart, Blood and Lung Institute. (2011). *Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents.* Retrieved on 09/18/2014, from *https://www.nhlbi.nih.gov/health-topics/integrated-guidelines-for-cardiovascular-health-and-risk-reduction-in-children-and-adolescents/integrated-guidelines-for-cardiovascular-health-and-risk-reduction-in-children-and-adolescents-full-report*.

[15] *Ibid.*

STI/HIV Risk Assessment

The Maryland Healthy Kids Program currently requires PCPs to conduct risk assessments for Sexually Transmitted Infections/Human Immunodeficiency Virus (STI/HIV) at each Healthy Kids visit beginning at 11 years of age or earlier if indicated by the child's history. The questions for the STI/HIV risk assessment are on the *Preventive Screen Questionnaire* (Refer to Section 7, Appendix II for the *English* and *Spanish* versions). Document results of the assessment on the questionnaire form or on the visit sheet. Be sure to date and sign off on the questionnaire after review. A "yes" response to any of the questions indicates a positive risk and the need for further assessment and appropriate testing with results documented in the medical record. The CDC recommendation is to screen, through opt-out testing, all patients aged 13 to 64 years in all healthcare settings.[16]

Diagnosis of a STI often requires multiple specific diagnostic tests and all sexually active adolescents should be counseled and tested for sexually transmitted infections, and educated about safe sex and contraception. Effective contraceptive management is important for the sexually active adolescent but if the PCP does not perform these services, an appropriate specialty referral is indicated to a gynecologist for female adolescents or adolescent medicine specialist for males and/or females.[17] For more information about contraceptives, refer to *Contraceptive Options* subsection of Section 4 of this Manual.

The US Preventive Task Force recommends that pap smears be deferred until the female adolescent turns 21 years of age. This recommendation is based in part on the very low incidence of invasive cancer and the potential for adverse effects of the follow-up of abnormal cytology screening results.[18]

Indications for pelvic examinations prior to age 21 are noted in the 2010 AAP statement "*Gynecologic Examination for Adolescents in the Pediatric Office Setting*".[19]

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[16] CDC https://www.cdc.gov/hiv/testing/index.html;

https://health.maryland.gov/phpa/OIDPCS/CHP/pages/home.aspx

[17] See U.S Preventive Services Task Force. (2014). *Sexually Transmitted Infections: Behavioral Counseling.* Retrieved on 11/24/14, from *https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/sexually-transmitted-infections-behavioral-counseling*

[18] See U.S. Preventive Services Task Force. (2012). Cervical Cancer: Screening. https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6151a2.htm

[19]AAP. (2010). Gynecologic Examination for Adolescents in the Pediatric Office Setting. *Pediatrics*. 126(3), 583-590. Retrieved on 09/05/2014, from https://pediatrics.aappublications.org/content/126/3/583

D. IMMUNIZATIONS

The Maryland Healthy Kids Program requires the primary care provider (PCP) to review the child/adolescent's immunization status and to administer any vaccines needed to bring the immunization status up-to-date according to the current *Maryland Department of Health and Mental Hygiene Recommended Childhood Immunization Schedule* (Refer to Section 7, Appendix III).[1] This immunization schedule provides the most current recommendations of the Public Health Service's Advisory Committee on Immunization Practices (ACIP) and the American Academy of Pediatrics (AAP) and is endorsed by the Medical and Chirurgical Faculty of Maryland (Med-Chi). Refer to the vaccine manufacturer's current guidelines and the latest ACIP and AAP recommendations for specific vaccine use. When administering combination vaccines, the physician has to refer to the *Maryland Suggested Immunization Schedule Using Combination Vaccines*. (Refer to Section 7, Appendix III).[2]

The immunization requirements for entry into school and childcare may be slightly different. Infants may enter a childcare center at 6 weeks if they have received their initial series of immunizations.

To check the current immunization schedules for childcare and school entry, follow the link below:
https://phpa.health.maryland.gov/OIDEOR/IMMUN/Shared%20Documents/Min_Vacc_Req%2020_21_Final.pdf

For additional information, contact the *Center for Immunization* by phone at **410-767-6679** or by e-mail at ***MDH.IZInfo@maryland.gov***.

Immunization Records

Immunizations should be summarized and recorded on one immunization record, such as the *VFC Vaccine Administration Record* https://phpa.health.maryland.gov/OIDEOR/IMMUN/Shared%20Documents/Vax%20Admin%20Record%20April%202018-visdated.pdf *(DHMH 4500)* (Refer to Section 7, Appendix III) in a standard location that is prominent and easily available for reference in the child/teen's medical record. Federal law requires the following information:

- The vaccine manufacturer and lot number of the vaccine used
- The date of administration
- The name and title of the person administering the vaccine as well as the address of practice site
- The edition date of the Vaccine Information Statement
- The date these materials were provided

[1] To access the most current schedule, follow the link: *http://www.marylandvfc.org/vfc-program-documents/.*

[2] To access the suggested schedule, follow the link: *http://www.marylandvfc.org/wp-content/uploads/2013/11/VFC-Combination-Products.pdf.*

Baltimore City Law requires Baltimore City based pediatric, family, and general providers to submit a record of immunizations administered to a preschool child (up to 5 years of age).[4] For more information, contact the **Baltimore Immunization Registry Program (BIRP**) at **410-545-3048**.

Review the immunization record at each visit. Instruct the parent or guardian to bring the immunization record with them on the initial visit. If the record is not available from the parent, the child's previous health care provider, school or childcare facility should be able to provide the child's immunization history. Obtain a signed medical release of information and document these efforts in the medical record.

The following Maryland area immunization registries may assist the primary care provider in obtaining a child's immunization record:

- ***ImmuNet*** **– Maryland's Immunization Registry**[5]
  - An internet-based system that receives and stores childhood and adult immunization records
  - Contact the Help Desk at **410-767-6606** to enroll
- **Baltimore Immunization Registry Program**
  - For a child/adolescent who lived in the city or attends a Baltimore City Public School
  - Contact **410-545-3048**
- **Washington DC Immunization Registry**
  - For a child/adolescent who lived in or attended school in Washington DC
  - Contact **202-576-9301**

In rare instances when records cannot be located, the DHMH Center for Immunization recommends beginning the immunizations again following the appropriate *Catch-up Schedule*, using minimum intervals between doses (Refer to Section 7, Appendix III). Continue immunizing until the child is brought up to date or the record is located. Positive titers for measles, mumps, rubella, varicella, and polio can substitute for vaccination.

If parents indicate that their religious beliefs conflict with the immunization requirement, a signed waiver or objection should be placed in the medical record.

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[4] Baltimore City Code, Subtitle 5, § 4-510

[5] For more information, visit the ***Immunet*** website at *https://www.mdimmunet.org/.*

Adverse Events

Specific adverse events should be reported to the ***Vaccine Adverse Event Reporting System (VAERS)*** following vaccination with any vaccine. Contact **1-800-822-7967** to obtain reporting forms and other related information, or visit the *VAERS* web site at *http://www.vaers.hhs.gov*. In Maryland, adverse pertussis vaccine events are also reportable to the local health departments.

Vaccine Information Statements

Federal regulation under the National Childhood Vaccine Injury Act requires providers to supply, **prior to administration of each dose of vaccine**, a copy of the relevant, current edition of Vaccine Information Statements (VIS) produced by the Centers for Disease Control and Prevention (CDC) to the parent or legal representative of any child about to receive that vaccine.[6] Camera-ready Vaccine Information Statements may be obtained in English, Spanish and a variety of other languages on the CDC web site by following the link *http://www.cdc.gov/vaccines/hcp/vis/current-vis.html* or contacting **Vaccines for Children Program** at **410-767-6679**.

The Vaccines for Children (VFC) Program

The Maryland Healthy Kids Program requires that providers enroll in the *Maryland VFC Program*,[7] regardless of whether the provider is participating with a MCO or fee-for-service Medical Assistance. The VFC Program is a federal initiative implemented in 1994 that provides vaccines to health care providers, at no cost, for children/adolescents from birth through 18 years of age who are:

- Eligible for Medical Assistance
- Uninsured, without health insurance
- Under-insured, covered by private insurance that does not pay for immunizations[8]
- Native American Indian or Alaskan Native

The Vaccines for Children Program requires providers to submit a practice profile (e.g., MCO panels, *Log of Children Receiving VFC Vaccines*) representing populations served by the practice/facility annually (Refer to Section 7, Appendix III). Providers must also submit a *VFC Vaccine Inventory Form* (Refer to Section 7, Appendix III) six times a year (January, March, May, July, September, and November).

[6] See *http://www.immunize.org/catg.d/p2027.pdf.*

[7] See *http://www.marylandvfc.org/.*

[8] Underinsured children are eligible to receive VFC vaccine only through a Federally Qualified Center (FQHC), Rural Health Clinic (RHC) or Maryland Local Health Department.

The provider must identify the number of VFC eligible children in their practice in order to receive an adequate supply of vaccine. Complete the *VFC Patient Eligibility Screening Record* (Refer to Section 7, Appendix III) for every child/adolescent who receives the free vaccines.

Providers must also maintain a privately purchased stock of vaccines to cover required immunizations not provided through the VFC Program for children and adolescents on Medical Assistance. Examples include hepatitis B, Td, varicella and meningococcal vaccines for young adults, 19 to 20 years of age. Synagis for at risk premature infants is also not available through VFC. However, it is available and covered when prior approval is obtained from infant's MCO. To print prior authorization forms for infants on Medicaid Fee-For-Service, follow the link: https://health.maryland.gov/mmcp/pap/docs/PA%20Forms/Synagis%20Service%20PA%20Form%20(Weight)%20(09.2021).pdf

The *VFC Program Contact Center* provides a full range of support for VFC Providers including answering questions related to VFC vaccine supply, vaccine delivery, vaccine allocations and other related issues. To improve customer service, VFC Providers in each jurisdiction have been assigned a phone number to reach the VFC Contact Center: **410-274-6240 (Baltimore County, Baltimore City, Howard and Harford counties), 410-299-5647 (Frederick, Montgomery and Prince George's counties), and 410-404-4128 (all other counties)** (Refer the Section 7, Appendix III). The VFC Center can also be reached by e-mail at ***IZinfo.@dhmh.state.md.us*** or by fax at **410-333-5893.**

Per federal CDC regulations, VFC providers are required to re-enroll annually in order to receive VFC vaccine. For instructions on how to re-enroll, follow the link: *http://www.marylandvfc.org/vfc-provider-enrollment/*.

The VFC provider site visits are conducted by VFC Site Reviewers who visit each practice every other year to review records for the federally required vaccine administration documentation and adequate vaccine storage.

Proper storage of vaccines involves maintaining refrigerator temperatures at 35 to 46 degrees Fahrenheit (2 to 8 degrees Centigrade) and freezer temperatures at 5 degrees

Fahrenheit or lower (-15 degrees Centigrade or lower).[10] Use the *Vaccine Storage/Temperature Record* (Refer to Section 7, Appendix III) or a similar record to record the temperatures of the refrigerator and freezer twice daily. The freezer should be a separate storage area with a separate door from the refrigerator storage area. Remove expired vaccines from the refrigerator/freezer, complete a *Vaccine Return and Wastage Form* (Refer to Section 7, Appendix III) and notify the VFC Program. The Maryland Healthy Kids nurse consultants may also check for appropriate vaccine storage and monitor vaccine expiration dates when they conduct their on-site medical record review.

For more information visit the **Vaccines for Children** website at *http://www.marylandvfc.org* or contact **410-767-6679**.

Direct any questions regarding immunization reimbursement to the *Healthy Kids Program Nurse Consultants* at **410-767-1903** (Refer to Section 8). For answers to questions regarding vaccine administration, contact the **Vaccines for Children Program** at **410-767-6679**.

E. HEALTH EDUCATION/ANTICIPATORY GUIDANCE

Age-Specific Health Education

The preventive care visit is the opportune time to integrate health education and anticipatory guidance to both the parent and the child throughout the visit. Health education and anticipatory guidance should include information that will:

- Assist the family in understanding what to expect in terms of the child's development
- Provide information about the benefits of healthy lifestyles and practices
- Promote the prevention of diseases and injuries

Age-specific information is included on each of the Healthy Kids visit sheets. **Age specific Anticipatory Guidance topics are listed below**. Address at least three general age specific topics below.

Infant to Preschool

Developmental tasks
Parenting
Injury Prevention
Nutrition
Dental Care
Family planning (mother)
Behavior/Discipline
Sleep
Child Care
Toilet training
Self-comforting behaviors
School Readiness

School-Age Child - Increase the involvement of the child in discussion and decision-making.

Developmental tasks
School Progress
Parenting
Dental Care
Behavior/Discipline
Health habits/Self care
Sex Education (counsel parents)
Social Interactions
Injury Prevention
Nutrition

Adolescence - Focus on the adolescent's increasing responsibility in decision-making.

Developmental tasks	Sexual activity
Health habits/Self care	Contraception
Smoking/Alcohol/Drugs/Vaping	STIs and AIDS prevention
Nutrition	Injury Prevention
Dental Care	Suicide Prevention
School Progress Violence	Social Interactions
Social Responsibilities	Peer Pressure/Bullying
Safe driving/riding in car	Future Career Plans/Ideas
Respect self/others	

In addition, document health education in the medical record to address the following:

- Health problems identified by the provider, parent or child that includes needed treatments, counseling and/or referrals for additional specialty services
- Education about the scheduling of the next Healthy Kids visit following the Schedule of Preventive Health Care
- Education to seek annual dental care

Injury Prevention

According to the *Safe Kids USA*, unintentional injury is the number one killer of America's children.[1] By taking simple precautions, it is estimated that almost 90 percent of these unintentional injuries can be avoided. Discuss injury prevention as part of anticipatory guidance and document topics covered. Possible topics are noted below.

Bicycle Safety

A bicycle helmet should be appropriate for the size and age of the child and meet the safety standards of the American National Standards Institute (ANSI) https://blog.ansi.org/2018/09/standard-bicycle-helmets-astm-f1447-18/, the Snell Memorial Foundation, or the American Society for Testing and Materials (ASTM). Have parents periodically review bicycle safety rules and traffic laws with their child. Laws that apply to motor vehicle operators also apply to cyclists. Maryland law requires helmets be worn through 16 years of age. Encourage parents to act as role models and purchase helmets to wear when they ride.

[1] See https://safekids.org/why-it-matters

For more information, use the https://www.safekids.org/bike handout on the Safe Kids USA website at *http://www.safekids.org* (Refer to Section 7, Appendix IV).

Car Passenger Safety

The use of child restraint systems including infant seats, convertible seats, forward facing child safety seats, booster seats, and seat belts are effective in reducing injury.

Maryland's current law requires that children under eight years old ride in an appropriate child restraint, unless the child is 4'9" or taller.[2] Every child from 8 to 16 years old who is not secured in a child restraint must be secured in the vehicle's seat belt, in every seating position in the vehicle. The law also prohibits passengers younger than 16 years of age from riding in the unenclosed bed of a pick-up truck.[3]

Child safety advocates recommend that children under 13 years of age ride secured in the back seat of a car.[4] More car seats guidelines for children can be found on the *Parents Central* website by following the link: *http://www.safercar.gov/parents/RightSeat.htm* (Refer to Section 7, Appendix IV).

Families who are unable to purchase a child restraint can contact the *Maryland Kids in Safety Seat (KISS) Program* at **1-800-370-7328** or e-mail *mdh.kiss@maryland.gov* for a referral to a local car seat loaner program. For more information, visit the KISS Program web page at https://phpa.health.maryland.gov/oehfp/kiss/Pages/Home.aspx (Refer to Section 7, Appendix IV).

Fire Prevention

Ask parents if there are working smoke alarms in the family home. Since the primary job of a smoke alarm is to awaken sleeping family members, the alarms should be located as close to each bedroom as possible. Because smoke rises, smoke alarms should be located on the ceiling or on the wall between 6 and 12 inches below the ceiling.

Families should also have a fire escape plan. Have primary and alternate routes marked and everyone practice them to escape the home. Choose a location outside the home as the meeting place. Contact the office of *Maryland State Fire Marshal* by phone at **410-653-8980/1-800-525-3124.** For more information, use the *Safe Kids Fire Prevention* handout on the Safe Kids USA website at *http://www.safekids.org* (Refer to Section 7, Appendix IV).

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[2] Child restraint includes car seats, booster seats and other federally approved safety devices.
[3] COMAR §22–412.2.
[4] https://www.safercar.gov/Vehicle%20Shoppers/Air%20Bags/Parents%20&%20Caregivers

Gun Safety

All children are potentially at risk of unintentional firearm injury, whether a gun is present in the home or not. To help protect children in the state, Maryland enacted The Child Access Protection Law. This law states: "No person shall store or keep any loaded firearm on any premise under their control if it is known, or reasonably should be known, that a minor, age 15 and under, is likely to gain access to the firearm without permission, unless the firearm is properly stored." Maryland also mandates that, beginning January 1, 2003, all handguns sold in the state and manufactured after December 2002 have an integrated mechanical safety-locking device.

Even with these laws in place in Maryland, not everyone is aware of these requirements or, if there are no children in the home, may think the laws do not apply to them. Parents and caregivers need to act to protect their children.

Gun owners should:

- Store them unloaded, locked up and out of children's reach
- Store ammunition in a separate, locked location
- Use quality gun locks, lock boxes or gun safes for every firearm
- Keep gun storage keys and lock combinations hidden in a separate location
- Take a course in using, maintaining, and storing guns safely

All parents and caregivers should:

- Talk to their children about the potential dangers of guns
- Teach children never to touch or play with a gun
- Teach children to tell an adult if they find a gun or call 911 if no adult is present
- Ask neighbors, friends, relatives, and adults in any homes where their children visit, if firearms are present in the home and how they are stored
- Not allow their children to visit the home if the firearms are not properly stored

For more information, use the *Guns in the Home: How to Keep Kids Safe* guidance from the American Academy of Pediatrics: https://healthychildren.org/English/safety-prevention/at-home/Pages/Handguns-in-the-Home.aspx

Poison Safety

Many common household products can poison children, including cleaning supplies, cosmetics, art supplies, alcohol, medicines, and vitamins. Parents and caregivers can protect their families by using the KidsHealth for Nemours safety tips to identify and eliminate potential hazards and prepare the home for children. https://kidshealth.org/en/parents/safety-poisoning.html (Refer to Section 7, Appendix IV). In addition, parents and caregivers should:

- Store all medicines prescription and nonprescription in a cabinet using a safety latch. Kids can climb up using the toilet and countertops to get to items placed up high, so locking the cabinet is key. Never leave potentially poisonous household products unattended when in use
- Read labels and follow the exact directions – giving medications based on the child's weight and only with the dispenser packaged with that medication
- Don't leave alcoholic drinks where kids can reach them. Take special care during parties and keep an eye on guests' drinks too. Clean up promptly after the party so kids don't find drinks left behind.
- Wash children's hands and faces, toys, and pacifiers frequently to reduce the risk of ingesting lead-contaminated dust
- Keep up on toys recalled for using lead paint. You can sign up to get emails about recalls on the U.S. Consumer Product Safety Commission (CPSC) website.
- Cover lead paint with a sealant or hire a professional to remove it in homes built before 1978
- Know which plants in and around the home are poisonous; remove them or make them inaccessible to children

Advise parents to post the national toll-free poison hotline number at every telephone: **1-800-222-1222**. This same number can be used anywhere in the United States to be connected to the closest poison center. For more information about educational resources and materials from the *Maryland Poison Center*, call **410-706-7604** or visit their website at *http://www.mdpoison.com/*. For educational resources and materials in Prince George's and Montgomery counties, contact the *National Capital Poison Center* at **202-362-3867** or visit their website at *http://www.poison.org/.*

Sun Safety

Exposure to the sun's ultraviolet (UV) rays appears to be the most important factor in the development of skin cancer, which is largely preventable with consistent sun protection. Parents and caregivers, to protect children from the sun, should assure that they:

- Stay out of the sun between 10 a.m. and 4 p.m.
- Play in the shade whenever possible – caution: reflective surfaces (such as water) can cause sunburns even in the shade
- Wear protective, tightly woven clothing
- Wear a hat with a 4" brim all around
- Avoid reflective surfaces – they can reflect up to 85% of the sun's rays
- Wear a broad-spectrum sunscreen with a Sun Protection Factor (SPF) of 15 or higher that protects against UVA and UVB rays – reapplied every 2 hours.[5]

For more information about ways to protect children from over exposure to the sun, contact the *Center for a Healthy Maryland* at MedChi, **410-539-0872, ext. 3340**, or visit their website at *www.healthymaryland.org* and click on skin cancer prevention.

Pediatric Vehicular Heat Stroke

According to *Pediatrics* which is the official Journal of the American Academy of Pediatrics, 850 children have died due to Pediatric Vehicular Heatstroke (PVH) since 1998. https://pediatrics.aappublications.org/content/pediatrics/116/1/e109.full.pdf In the State of Maryland, there have been 14 PVH deaths reported since 1998 through 2019. Parents and caregivers can avoid injuries and death due to PVH by following the safety recommendations below. Additional information can be found on the "No Heat Stroke" website at https://www.noheatstroke.org/index.htm and Healthy Children.org https://www.healthychildren.org/English/safety-prevention/on-the-go/Pages/Prevent-Child-Deaths-in-Hot-Cars.aspx

[5] https://www.cdc.gov/cancer/skin/basic_info/sun-safety.htm

NEVER LEAVE A CHILD UNATTENDED IN A VEHICLE. NOT EVEN FOR A MINUTE!

IF YOU SEE A CHILD UNATTENDED IN A HOT VEHICLE CALL 9-1-1.

Be sure that all occupants leave the vehicle when unloading. Don't overlook sleeping babies.

Always lock your car and ensure children do not have access to keys or remote entry devices. Teach children that vehicles are never to be used as a play area.

IF A CHILD IS MISSING, ALWAYS CHECK THE POOL FIRST, AND THEN THE CAR, INCLUDING THE TRUNK.

Keep a stuffed animal in the car seat and when the child is put in the seat place the animal in the front with the driver. Or place your purse, briefcase, or cell phone in the back seat as a reminder that you have your child in the car.

Make "look before you leave" a routine whenever you get out of the car.

Have a plan that your childcare provider will call you if your child does not show up for school.

Water Safety

Children can drown or nearly drown in seconds and should never be left alone near water, at the pool, beach, or home. Drowning and near drowning typically occurs when a child is left unattended or during a brief lapse of supervision. Inside the home, water dangers include bathtubs, sinks, toilets, and buckets. While outside the home, water dangers include natural bodies of water, pools, water features, hot tubs, and wading pools.

Parents also need to be aware of the temperature of the water in the home. The National Safe Kids Campaign reports that it takes just 3 seconds for children to sustain 3rd degree burns from a water temperature of 140°F. The home hot water heater temperature should be set at 120°F. For more information about water safety, refer to the *Water Safety at Home* and the *Swimming Safety Tips* handouts on the Safe Kids USA website at *http://www.safekids.org* (Refer to Section 7, Appendix IV).

Section 4: Adolescent Preventive Health

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Section 4: Adolescent Preventive Health

A. INTRODUCTION

Adolescence is characterized by marked physical, emotional, and intellectual changes, as well as by changes in social roles, relationships, and expectations. It is also a period of dynamic growth and presents the health care provider with many challenges and opportunities to identify, encourage, and reinforce positive health behaviors. The rapid growth and development in adolescence leads to changes in body proportions, size, weight and image, emotional changes, new sleep patterns and needs, developing sexuality and reproductive functioning, and influence from social/peer pressures. These changes represent a normal transition between childhood and adulthood, and adolescents experience these transitions in various ways. Primary Care Providers (PSPs) are required to offer comprehensive services according to the Maryland Healthy Kids Program's Schedule of Preventive Health Care The annual preventive care visit is an excellent opportunity to identify potential and actual health problems and develop a plan to maintain good health.

The Health Resources and Services Administration (HRSA), in its Bright Futures in Practice Guide for health supervision, defines the age range for adolescence as 11-21 years of age, subdivided into three stages: early (11-14 years); middle (15-17 years); and late (18-21 years).[1] Adolescence is a time of great resilience for many youths. During adolescence, many life-long patterns of behavior are established, including health promotion/disease prevention behaviors and care-seeking patterns. Preventable health problems in adolescence can become chronic health conditions in adulthood. Adolescent obesity, low-calcium intake, sexually transmitted diseases, smoking and substance use, for example, can all result in serious, long-term health conditions later in life.

The adolescent section addresses issues specifically related to providing comprehensive preventive care to adolescents. The Maryland Healthy Kids Program Schedule of Preventive Health Care summarizes the minimum standards of preventive care for all children and adolescents to 21 years of age (Refer to Section 2). For a more detailed explanation of the standards, refer to Section 3 of the Healthy Kids Manual. In addition, numerous other resources are used to provide clinical information in this section.

Maryland Minor Consent Law and Confidentiality

An important aspect of adolescent development is the gradual acquisition of independence from parents or guardians. Spending time alone with the adolescent during a portion of the interview is an effective way of giving the adolescent an opportunity to discuss his/her concerns. This allows the provider to assess sensitive issues and provides the opportunity to get to know the adolescent as an individual.

It is also important for the PCP to meet with the adolescent and family together to collect a comprehensive medical, family, and psychosocial history. Valuable information can be gathered regarding the family dynamics and relationships. Providers will gain insight about the parent's concerns during the health history. Additionally, the family needs to be a part of the solution to any identified problems, unless the adolescent considers them confidential. However, even confidential services may need to be discussed with parents under certain circumstances.

It is important to establish a sense of confidentiality with the adolescent within the confines of current Maryland law. Under the Maryland Minor Consent Law Adolescents are permitted to seek confidential services and information for sexually transmitted diseases (STIs), contraception, substance use, and pregnancy. The adolescent and the parents should be aware that the adolescent may choose to obtain these services without parental consent.

The Maryland Minor Consent Law also allows, but does not require, providers to disclose information about services provided under the minor consent provision. This confidentiality provision helps providers establish and maintain trust with their adolescent patients without necessarily excluding parental involvement. Providers may have personal or professional limits to providing confidential services, and these limits should be discussed with the adolescent and his/her parent(s). For example, providers may elect to notify a parent when the adolescent's health or safety is at risk and the adolescent is not following through with the recommended treatment. Additionally, providers must disclose information regarding suicidal ideation, or whether the adolescent is a danger to self or others.

B. HEALTH AND DEVELOPMENTAL HISTORY

Medical and Family History

For adolescents, health history is an important tool for identifying health problems and risks. Both the medical and family history are important to obtain information relevant to health supervision, compile demographic information, and help the Primary Care Provider (PCP) develop a general understanding of the history, functioning, questions and concerns of the family. An adolescent history, in addition to history of illness, injuries, and hospitalizations, includes reproductive and gynecological history and assessments for substance use and mental health. The Medical/Family History Questionnaire (Refer to Section 7, Appendix I for the English and the Spanish versions) and the Pediatric Visit Sheets (Refer to Section 7, Appendix I) can be utilized to obtain the family and personal health histories. Updating these histories annually **is required** to help identify emerging health problems of significance to the adolescent.

On the initial visit with an adolescent, the practitioner should establish himself/herself as the adolescent's practitioner and focus on encouraging the adolescent to take responsibility for his/her personal health care. This empowers the adolescent to comply with recommendations and take responsibility for his/her personal progress.

Adolescents will often present with chief complaints that are unrepresentative of their true concerns. An adolescent presenting with mild acne or pelvic pain, in fact, may be afraid she is pregnant. An adolescent male with chest pains may be concerned about gynecomastia. Gentle but persistent exploration of the adolescent's concerns is often necessary before the true chief complaint is evident.

Psychosocial History and Developmental Surveillance

Healthy adolescent development is a complex and evolving process that requires supportive and caring families, peers, and communities; access to high quality services (health, education, social and other community services), and opportunities to engage in skill building activities to succeed in the developmental tasks of adolescence. Therefore, a comprehensive psychosocial history is required to determine the impact of the environment at home, at school, and in the community on the adolescent's physical health, development, and emotional well-being.

Significant changes in the adolescent's environment should be documented as part of the psychosocial history. The psychosocial history may include, but is not limited to new hobbies or activities, recent achievements in and out of school, separation or divorce of parents, recent death of a family member or friend, job loss of a family member, loss of a house or frequent moving, a recent birth in family, adolescent pregnancy, or exposure to violence in the home, school, or community. It also should address certain environmental factors in the adolescent's household, such as smoking in the house, pets living in the house, and the general living conditions in the house.

Section 4: Adolescent Preventive Health

Adolescents are well past the age when traditional objective developmental tests of younger ages can be used. Therefore, providers need to assess the adolescent's progress toward independence and adulthood as part of the developmental surveillance. Assessment of grade level, school performance and/or job performance, extracurricular activities, peer relations and future plans are all components of adolescent developmental surveillance.

In addition, demonstrating a positive attitude toward family and community, and exhibiting a sense of self-confidence and resiliency when confronted with live stressors are important indicators of achieving developmental tasks. When problems are identified, the provider should refer the adolescent for specialty services appropriate to the problem. Referral to school counseling services may be helpful in assisting the adolescent when school related problems are identified.

Providers can use the HEEADSSS (Home, Education/Employment, Eating, Activities, Drugs, Sexuality, Suicide/Depression, and Safety) tool to assess the adolescent's psychosocial and developmental status (Refer to Section 4, Addendum).[3] Using the HEEADSSS framework, providers can discuss many sensitive issues that are potential threats to good health, such as initiation of drug use. The adolescent can complete this assessment questionnaire prior to the medical interview, and the provider can use it to trigger a dialog and elicit further information during face-to-face interview.

Mental Health Assessment

During the transition to adulthood, young people experience many emotional challenges that have a significant impact on their character and personal development. Annual preventive health visits are important opportunities to identify early evidence of mental health problems that emerge during this time of growth and change. Similarly, behaviors such as eating disorders or drug/alcohol abuse often begin during adolescence.

It is the responsibility of the PCP to conduct a mental health assessment at each adolescent preventive health visit to identify risks associated with behavioral or emotional problems.

Validated screening tools, such as PHQ-9 Modified for Teens (PHQ-Modified) and the Pediatric Symptom Checklist (PSC-Y) should be used for adolescents 11 – 18 years of age. They were developed by Columbia University and are brief questionnaires that the adolescents can complete in the waiting or exam rooms (Refer to Section 4, Addendum).

PCPs can use these screening tools to help evaluate whether an adolescent is suffering from depression, anxiety, or other conditions. When identified early, adolescents with mental illness have the best chance to lead healthy lives and reach their full potential.

Note the results of the mental health assessment in the adolescent's medical record. In some cases, when a mental health problem is identified, the PCP can counsel the patient and note it in the record. However, when specialty mental health services are needed, refer the patient directly to the **Maryland Public Mental Health System** by contacting **1-800-888-1965 (consumers and providers)**. Access additional mental health information and resources online at: https://maryland.optum.com/. Document the referral in the medical record.

Maryland Behavioral Health Integration in Pediatric Primary Care (B-HIPP) is a free service for PCPs caring for patients with mental health needs from infancy through the transition to young adulthood. It provides support to PCP through four main components: telephone consultation, continuing education, resource and referral networking and social work co-location. For more information, refer to B-HIPP website at www.mdbhipp.org at or call **855-632-4477.**

Bright Futures in Practice, in a series of publications from the Maternal and Child Health Bureau and the National Center for Education in Maternal & Child Health, provides additional information regarding mental health assessment for children and adolescents.

A review by the National Adolescent Health Information Center found that the most common mental health disorder among adolescents is depression. Adolescents with unidentified mental health disorders have poorer physical health and engage in more risky behaviors. Both the Institute of Medicine (IOM) and United States Preventive Services Task Force (USPSTF) recommend that

physicians in primary care settings screen adolescents for major depressive disorders with its associated potential for suicide. Using a validated screening tool, such as PHQ-9 Modified for Teens (PHQ-Modified) and the Pediatric Symptom Checklist (PSC-Y) will help early identification and treatment of adolescent depression (Refer to Section 4, Addendum). PCPs should also educate families about signs of depression in children and adolescents. For more information, review to the endorsed by AAP Guidelines for Adolescent Depression in Primary Care (GLAD-PC) I and GLAD-PC II and the AAP Policy on Suicide and Suicide Attempts.

The American Medical Association's Guidelines for Adolescent Preventive Services (GAPS) also recommends annual screening of adolescents about behaviors or emotions that indicate recurrent or severe depression or risk of suicide. A copy of the GAPS recommendations and an algorithm for suicide and depression can be obtained from the American Medical Association (AMA) website at http://www.ama-assn.org/ama.

Eating Disorders

Concerns about weight related issues including over-eating, binging, and purging, and excessive dietary restriction may increase during adolescence. Eating disorders such as anorexia nervosa and bulimia nervosa are chronic illnesses that can lead to long-term medical consequences. Because eating disorders are prevalent in middle childhood and adolescence, it is important for the PCP to screen for them. For additional information on eating disorders, and how to assess them, refer to the Bright Futures website at http://brightfutures.aap.org/

Management of Eating Disorders in Children and Adolescents.[9] Once identified, it is important that treatment be initiated. Treatment of adolescents with eating disorders optimally takes place with the support of an interdisciplinary team, including a primary care health professional, a dietitian, a dentist and mental health professional. Contact the adolescent's Managed Care Organization (MCO) for assistance with referrals.

Attention Deficit Hyperactive Disorders (ADHD)

ADHD is a disorder characterized by behavior and attention difficulties exhibited in multiple settings. It begins in childhood and is identified by specific attention, hyperactivity and impulsiveness criteria found in the American Psychiatric Association's Diagnostic and Statistical Manual (DSM5). ADHD is relatively common affecting up to 11% of children/adolescents. However, some adolescents may not be diagnosed and treated early in childhood and are at risk for school failure, substance abuse, and depression. In its most recent guidelines, AAP expanded the age range for diagnosis and treatment of ADHD to include preschool-aged children and adolescents. Currently, the AAP guideline addresses the diagnosis and treatment of ADHD in children 4 through 18 years of age.

The overall approach to diagnosing an adolescent with ADHD involves the following:

- A comprehensive interview with the adolescent's parent or guardian,
- A mental status examination of the adolescent,
- A medical evaluation for general health and neurological status,
- A cognitive assessment of ability and achievement,
- Use of ADHD-focused parent and teacher rating scales,
- School reports and other adjunctive evaluations separate from the school reports such as speech, language assessment, etc.

A clinician with skills and knowledge in mental health, developmental or behavioral pediatrics must perform the ADHD evaluation. A provider who specializes in developmental or behavioral pediatrics can become a specialty mental health provider through Maryland Medical Assistance by registering with the Community Mental Health Unit at the MDH Office of Health Care Quality (MHA). To print the Community Mental Health Program Application, follow the link: For more information, call the **Community Mental Health Unit** at **877-402-8220/410-402-8060** A adolescent diagnosed with ADHD without any accompanying emotional disorders can receive care from a primary care provider for management of medications. Medication is one component in the treatment of ADHD and does not appear to increase the likelihood of future cigarette smoking or substance abuse. Additionally, adjunctive services may improve an adolescent's outcome. Teaching and reinforcing organizational skills and social skills are interventions that can significantly improve outcomes. Ongoing contact and follow-up with the parents of an adolescent with ADHD who is on medication is a critical component of the medication management.

ADHD is classified as a mental health disorder**,** possibly requiring multiple therapeutic approaches. A number of psychiatric conditions frequently occur with ADHD, i.e. mood disorder, conduct disorder, oppositional defiant disorder and bipolar disorder, possibly requiring multiple therapeutic approaches (Refer to Section V, Public Mental Health System). If the adolescent's behavior changes significantly, reevaluation is necessary through a mental health referral by calling **Maryland Public Mental Health System** at **1-800-888-1965** (consumers and providers).

Violence

PCPs are often the first health professionals to become aware of violence in the adolescent's family, school, and/or community. A violence risk assessment is recommended annually using questions concerning violence, access to guns, and potential violence in personal relationships (sexual assault, partner violence). Advise parents and guardians to avoid the use of physical punishment as a means of resolving conflicts with children and adolescents.

Bullying and Cyber-bullying

Bullying including cyber-bullying is of increasing concern in the pediatric population. Health care providers should:

- Ask children and adolescents about their experiences, if any, regarding bullying and cyber bullying,
- Provide information in their offices for families to educate them on this topic,
- Encourage children and adolescents to "report" if they are victims so that appropriate referrals can be initiated,
- Encourage parents to work with schools to promote awareness, prevention, and appropriate intervention.

For more information on youth violence including bullying and dating violence, review 2009 AAP Policy on the Role of Pediatrician in Youth Violence Prevention.[15] A specific assessment tool measuring bullying victimization is the Victimization Scale (refer to Section 7, Appendix II for the English and Spanish versions of the tool). For other assessment tools, see Measuring Bullying Victimization, Perpetration, and Bystander Experiences: A Compendium of Assessment Tools, published by the Centers for Disease Control and Prevention (CDC) in 2011.[16]

Physical and Sexual Abuse

In addition to the signs of physical abuse, noted in Section 3 of the Manual, be alert for signs of possible sexual abuse in both males and females and, when indicated, screen for sexually transmitted diseases by using the Preventive Screen Questionnaire (Refer to Section7, Appendix II). Possible signs of sexual abuse may include the following:

Direct Evidence

- ➢ Injury
- ➢ Infections including sexually transmitted infections
- ➢ Pregnancy

Indirect Evidence

- ➢ Behavior disorders
- ➢ Running away
- ➢ Substance use
- ➢ Physical complaint
- ➢ Depression/suicidal behavior

In Maryland, Subtitle 7 of the Maryland Family Law Code Annotated requires professionals, including health practitioners, police officers, educators, and social workers, to report suspected child abuse or face possible professional sanctions. The law mandates that primary care providers should report any suspected abuse or neglect to the local Department of Social Services (Refer to Section 8) or the police. Providers are to identify the potential conditions for abuse and make appropriate referrals for assistance (Refer to Section 3, Child Abuse Assessment).

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[15] https://publications.aap.org/pediatrics/article/124/1/393/71745/Role-of-the-Pediatrician-in-Youth-Violence

[16] https://stacks.cdc.gov/view/cdc/5994

A minor may disclose violent or sexually exploitive behavior such as dating violence, sexual assault, or sexual activity with a partner who is significantly older and is neither a family or household member, nor an individual with any past or present responsibility for the care or supervision of the minor. When this occurs, the client should be advised that the provider and/or staff are there to help any adolescent who requests assistance. The adolescent may need support in seeking the involvement of a parent or family member and/or in accessing community resources, including law enforcement or emergency medical facilities and shelters.

Substance Use Disorder Assessment

Because of the increased number of young adolescents and young adults using drugs and alcohol in our society, primary care providers are in a unique position to identify substance abuse during routine office visits and offer appropriate treatment. The Maryland Healthy Kids Program requires that any provider seeing Medicaid children perform yearly assessment for substance abuse beginning at 12 years of age and recommends assessment at earlier ages when the provider suspects problems.

Use of a standardized tool for screening for substance abuse is strongly recommended The CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble) is a brief, self-administered, validated, adolescent substance abuse screening tool (Refer to Section 7, Appendix II for both English and Spanish language versions of the tool). For availability of CRAFFT in other languages, refer to the Center for Adolescent Substance Abuse Research website at http://www.ceasar-boston.org/. Both physicians and general clinicians may administer the tool. The CRAFFT can assist primary care providers to determine which adolescent patients are appropriate for brief office interventions and those that need prompt referral to substance abuse specialists.

One positive answer indicates further assessment of quantity and frequency of substance use is needed. If an incident happened only once, three years ago, then it may not be cause for great concern. However, if the substance abuse occurred several times during the past year, then the situation warrants additional follow-up.

Two or more “yes” answers on the CRAFFT indicate that the adolescent is at risk for substance abuse, requiring further assessment, counseling, and/or referral that should be documented in the adolescent’s record.

Access additional substance abuse health information and resources online maryland.optum.com.

Common Indicators of Adolescent Drug and Alcohol Abuse *

- ➢ Changes in school attendance and grades,
- ➢ Unusual flare-ups or outbreaks of temper,
- ➢ Poor physical appearance (often becomes slovenly),
- ➢ Furtive behavior regarding drugs (especially when in possession),
- ➢ Wearing of sunglasses at inappropriate times to hide dilated or constricted pupils,
- ➢ Long-sleeved shirts worn consistently to hide needle marks (if injecting drugs),
- ➢ Association with known drug abusers,
- ➢ Borrowing money from students to purchase drugs,
- ➢ Stealing small items from school or home,
- ➢ Hiding in odd places, i.e., closets, storage area, to take drugs,
- ➢ Attempting to appear inconspicuous in manner and appearance to mask usage,
- ➢ Withdrawal from responsibility,
- ➢ Change in overall attitude – depression, low self-esteem, poor social skills, and school problems.

***** *Note that some of these changes may occur in normal adolescents or result from other problems.*

A "diagnostic" referral for addiction treatment will either rule out a problem or identify the problem at an early stage before the adolescent reaches the disease stage of alcohol or substance abuse. Treatment is much more likely to succeed when the problem is identified at an early stage.

Tobacco

Tobacco use continues to be a health care concern among children and adolescents. Therefore, providers who see adolescents should screen adolescents for tobacco use, offer smoking cessation advice and interventions to both adolescents and parents, and teach the importance of decreasing exposure to secondhand smoke.

The term 'vaporizer' refers to battery-powered devices with a heating element and is a term that includes the specific vaporizer device of e-cigarettes. Vaporizers produce an aerosol, small particles suspended in air and vapor, the gas phase of chemicals, which users inhale. The liquid that is used in vaporizers comes in hundreds of flavors, which are available both with and without nicotine per the user's choice.

Adolescents' use of vaporizers such as e-cigarettes has increased rapidly in recent years in the USA. In 2015, 30-day prevalence of e-cigarettes was 16% among 12th graders, 14% among 10th graders and 10% among 8th graders. This is a rapid growth from a 30-day prevalence of near 1% among secondary school students in 2011.2 The use has grown to such an extent that among adolescents 30-day prevalence of e-cigarette use in 2015 was higher than prevalence of any tobacco product, including traditional tobacco cigarettes. A common assumption among researchers and policymakers is that adolescents are vaping nicotine, although this assumption has yet to be examined closely.

C. COMPREHENSIVE PHYSICAL EXAMINATION

As with younger children, a complete physical examination that includes a minimum of five systems is required each year for all adolescents (Refer to Section 3, Unclothed Physical Examination by Systems). Additionally, the physical examination provides an excellent opportunity to educate the adolescent about his or her changing body. For example, the adolescent female may be taught to perform routine breast examinations, or the young adolescent male may be reassured about genital development. The adolescent may also raise concerns not mentioned during the initial interview. The true chief complaint may, in fact, be revealed during the physical examination.

The US Preventive Task Force recommends that a woman should have her first cervical cancer screening (Pap smear) at 21 years of age, no matter when she became sexually active. This recommendation is based in part on the very low incidence of invasive cancer and the potential for adverse effects of the follow-up of abnormal cytology screening results. [23]

Indications for pelvic examinations prior to age 21 are noted in the 2010 AAP statement "Gynecologic Examination for Adolescents in the Pediatric Office Setting".[24]

A provider may still wish to refer a sexually active adolescent for reproductive health services including contraception. The adolescent should be given the name of the provider and a referral for services. Coordination of such services remains the responsibility of the primary care provider.

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[23] See U.S. Preventive Services Task Force. (2012). Cervical Cancer: Screening. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/cervical-cancer-screening

[24] US preventive services task force Updated from 2012 to 2018 Gynecologic Examination for Adolescents in the Pediatric Office Setting. (2010). Pediatrics. 126 (3), 583-590. Retrieved on 09/05/2014, from http://pediatrics.aappublications.org/content/pediatrics/126/3/583.full.pdf

Vision and Hearing Assessments

At least a gross assessment of hearing and vision is required as part of every adolescent preventive care visit. An objective testing is required at ages of 12, 15, and 18. Document results of a gross assessment based on provider observation and questioning of the adolescent's ability to see and hear. Objective vision and hearing results from the school can be documented in the medical record as a sufficient assessment (Refer to Section 3, Hearing Assessment and Vision Assessment).

Blood Pressure Measurements

The Maryland Healthy Kids Program requires assessment of blood pressure on the yearly adolescent visit with documentation in the medical record according to recommended standards (Refer to Section 3, Blood Pressure Measurements).[25]

For further guidance, refer to the 2004 Fourth Report on the Diagnosis, Evaluation, and Treatment of High Blood Pressure in Children and Adolescents at http://www.nhlbi.nih.gov/files/docs/resources/heart/hbp_ped.pdf and the 2011 Expert Panel on Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents at http://www.nhlbi.nih.gov/files/docs/peds_guidelines_sum.pdf.

Height, Weight, and BMI Measurements

Early adolescence is a time of considerable change in body stature. Plotting weight and height for age allows comparison with all adolescents the same age and is the best initial indicator of growth problems. The use of Body Mass Index (BMI) is required to monitor changes in body weight and to consistently assess risk of underweight and obesity in children and adolescents from 2 to 20 years of age. Calculate BMI using the English or metric formula, or by using BMI Percentile Calculator for Child and Teen located at the following link: http://nccd.cdc.gov/dnpabmi/. Once BMI is calculated, plot the result on gender specific BMI-for-Age Growth Charts, available from the CDC, to determine the BMI-for-age and gender percentile (Refer to Section 7, Appendix I). It is important to review and interpret the results of the automatic BMI calculations provided by electronic medical records (EMR) or electronic health records (EHR) used in many practices today. Provider interpretation of results is paramount in identifying overweight and obese children and those at risk for obesity related complications.

How to Calculate Body Mass Index (BMI)

English Formula: **BMI = weight (lb) ÷ [height (in)]^2 x 703**

Metric Formula: **BMI = weight (kg) ÷ [height (cm)]^2 x 10,000**

[25] See http://www.nhlbi.nih.gov/files/docs/bp_child_pocket.pdf

What do BMI-for-age and gender percentiles mean?

>99th percentile.....“Morbid” Obesity 95th to 98th percentile..... Obesity 85th to 94th percentile..... Overweight 5th to 84th percentile..... Healthy weight <5th percentile..... Underweight

BMI Calculator new website address page 16

https://www.cdc.gov/healthyweight/bmi/calculator.html%

An excellent learning module on overweight and obesity in children and adolescents and the use and interpretation of the CDC growth charts can be found on the CDC web site: http://www.cdc.gov/healthyweight/assessing/bmi/childrens_bmi/about_childrens_bmi.html.

BMI-for-age and gender is an effective screening tool, but it is not a diagnostic tool. Adolescents who fall into the following categories need further assessment.

- If BMI is below fifth percentile, assess for acute or chronic illnesses that can lead to underweight.
- If BMI is between 85th and 94th percentiles, child is overweight and needs further screening.
- If BMI is at or above 95th percentile for age and sex, the child is obese and needs in depth medical and dietary assessment according to current guidelines.[26]

Nutritional Assessment

As children enter adolescence, many of them become more independent with respect to food choices and food preparation. Adolescents spend less time at home; therefore, they eat more commercially prepared foods ("fast food"). Some adolescents will restrict their intake; still others will consume excessive amounts of food. As a result, many young people are at risk for health problems related to poor eating patterns such as eating disorders and obesity.

Ask questions regarding current dietary habits when taking the medical history. During the physical examination, take time to measure the patient's weight in an examination gown to standardize the measurements. Track height, weight, and Body Mass Index (BMI) longitudinally, in order to monitor trends over time. This is essential for the early identification of eating disorders and obesity.

During the nutritional assessment, the provider should ask open-ended questions that permit the adolescent and the parents to describe their current behaviors, their level of physical activity, and their attitudes about their weight and body appearance. Use the Nutrition Questionnaire (Refer to Section 7, Appendix II) as an opportunity to identify adolescents at risk for eating disorders and intervene early to prevent their onset.[27] Additional nutrition and physical activity assessment tools with guidelines for interpreting responses are also available on the Bright Futures web site at http://www.brightfutures.org/physicalactivity.

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[26] Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report. (2007). Pediatrics. 120 (4) 164-192. Retrieved on 08/18/2014 from https://publications.aap.org/pediatrics/article-abstract/120/Supplement_4/S164/70091/Expert-Committee-Recommendations-Regarding-the?redirectedFrom=fulltext

[27] See http://brightfutures.aap.org/Nutrition_3rd_Edition.html

Nutritional Education

Provide all adolescents and their caregivers with anticipatory guidance on nutrition according to the age and developmental stage of the child. Guidance can include discussion of the following:

- Nutritional needs of adolescents
- Development of healthful eating and activity habits in school-age children and adolescent

Use the *Dietary Guidelines for Americans*[28] and the *My Plate*[29] as guides for children and adolescents to select healthy foods for meals and snacks (Refer to Section 7, Appendix IV). Further nutrition and physical activity education should include the following evidence-based messages for all children regardless of age:

- Limit sugar-sweetened beverages
- Fill half the plate with fruits and vegetables. Grains and proteins should each incorporate less than one quarter of the plate. Dairy should include fat-free or low-fat milk or yogurt products.
- Eat breakfast every day
- Limit eating out, especially fast food
- Have regular family meals
- Limit portion sizes
- Engage in moderate to vigorous physical activity for at least 60 minutes a day
- Limit screen time to no more than 2 hours/day
- Remove television from children's bedrooms

[28] See http://www.health.gov/dietaryguidelines/

[29] See http://www.choosemyplate.gov/

Obesity in Adolescence

Obesity is a pressing national health concern. Most children and adolescents who are overweight are at risk for becoming obese adults. Adolescence is a critical time to prevent the development of excess weight and reverse unhealthy weight gain. Work with adolescents to establish healthy behaviors, and undo or prevent negative behaviors before they become established. Adolescents with a genetic predisposition to gain weight are more likely to become overweight if they are sedentary and consumers of high-fat, high- calorie diets. Although some adolescents exercise, many do not. Obesity affects both the physical and mental health of the adolescent. Every overweight adolescent should have a thorough history and physical examination to rule out the less common causes of obesity. Simple nutritional recommendations from the primary care physician may be helpful or a nutritional consultation may be necessary. Contact the adolescent's MCO to refer to a licensed dietician or nutritionist within the MCO specialty network. For assistance in locating Medicaid enrolled nutritionists/dieticians who accept referrals for fee-for-service, contact the **Division of Children's Services** at **410-767-1903.**

Medical Management of Overweight and Obesity in Adolescents

The 2007 *Expert Committee Recommendations Regarding the Assessment, Prevention, and Treatment of Child and Adolescent Overweight and Obesity* provide guidance on management of weight in all children.[30] **Primary care physicians are urged to implement Step 1, Obesity Prevention at Well Care Visits at least once a year**. Obesity prevention includes the following:

- Assess key dietary habits (e.g., consumption of sweetened beverages)
- Assess physical activity habits
- Assess readiness to change lifestyle habits
- Conduct a focused family history of obesity and obesity-related illnesses

Laboratory testing recommendations depend on the degree of obesity and associated risk factors as follows:

- Adolescents with a body mass index between the 85thand 94thpercentiles, but who have no obesity-related risk factors should receive a fasting lipid profile blood test

- Adolescents 10 years of age or older who have a body mass index between the 85th and 94th percentiles with obesity-related risk factors should have additional testing for liver function (ALT and AST) and fasting blood glucose

[30] Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report. (2007). Pediatrics. 120 (4) 164-192. Retrieved on 08/18/2014 from https://pubmed.ncbi.nlm.nih.gov/18055651/

- Adolescents 10 years of age or older with a BMI above the 95th percentile should also have measurement of blood urea nitrogen and creatinine levels

A four-stage approach to treatment of childhood obesity is recommended and includes advising parents and adolescents to:

- Limit consumption of sweetened beverages and fast food
- Limit the amount of screen time (TV and Computers) per day
- Increase physical activity for at least 60 minutes per day
- Eat family meals on most, and preferably all, days of the week

For more details, refer to the *Implementation Guide from the Childhood Obesity Action Network* (Refer to Section 3, Addendum). It combines key aspects of the 2007 Expert Commission Recommendations and 2006 practice tools identified by the *National Institute for Children's Health Quality*.

Additional information on these recommendations can be found at:

- The First Lady Let's Move initiative at https://letsmove.obamawhitehouse.archives.gov/
- National Institute for Children's Health Quality at www.nichq.org
- CDC web page on Obesity and Overweight: Strategies and Solutions at http://www.cdc.gov/obesity/childhood/solutions.html
- The National Institutes of Health We Can campaign at http://www.nhlbi.nih.gov/health/educational/wecan/.
- https://pediatrics.aappublications.org/content/145/3/e20193992

Type 2 Diabetes Mellitus

Another emerging health issue is the growing number of adolescents and preadolescents with Type 2 Diabetes Mellitus (T2DM). As the prevalence of obesity increases, so does the incidence and prevalence of T2DM. Most adolescents with T2DM have a BMI over the 85th percentile. Many adolescents with T2DM may present with asymptomatic hyperglycemia or glycosuria. Adolescents with T2DM are usually diagnosed in middle to late adolescence. Overweight adolescents who do not develop diabetes in adolescence may develop it later as adults.

The American Diabetes Association recommends a fasting glucose test every three years for children starting at 10 years of age or at onset of puberty if puberty occurs earlier, and who have two of the following risk factors:

- Are overweight (BMI > 85th percentile for age and sex),
- Have a family history of T2DM in first- and second-degree relatives, or

[31] See http://www.nichq.org/

- Belong to certain ethnic groups (American Indians, African Americans, Hispanic Americans, Asian/South Pacific Islanders)

- Have signs of insulin resistance or conditions associated with insulin resistance (acanthosis nigricans, hypertension, dyslipidemia, polycystic ovarian syndrome, or small-for-gestational-age birth weight)

- Have maternal history of diabetes or GDM during the child's gestation. [32]

For the treatment of T2DM in children and adolescents, refer to 2013 *AAP Guidelines on the Management of Newly Diagnosed Type 2 Diabetes Mellitus (T2DM) in Children and Adolescents*.[33]

[32] American Diabetes Association. Standards of medical care in diabetes--2014. (2014). Diabetes Care. 37(1), 14-80. Retrieved on 11/14/2014, from https://care.diabetesjournals.org/content/43/Supplement_1/S1

[33] American Academy of Pediatrics. 2013 AAP Guidelines on the Management of Newly Diagnosed Type 2 Diabetes Mellitus (T2DM) in Children and Adolescents. (2013). Pediatrics. 131, 364-382. Retrieved on 11/14/2014, from https://pediatrics.aappublications.org/content/131/5/1014.1

D. LABORATORY TESTS

Health Risk Assessments

Age-appropriate health risk assessments are a required element of the laboratory component for the adolescent population and include assessment for risk of tuberculosis, elevated cholesterol and heart disease, STIs and HIV. When risk factors are identified, document counseling, and referral for testing in the medical record. If the test results are abnormal, document appropriate follow-up: counseling, further testing and/or referral to a specialist.

Tuberculosis Risk Assessment

The Maryland Healthy Kids Program requires an annual risk assessment by questionnaire instead of routine skin testing. The Preventive Screen Questionnaire (Refer to Section 7, Appendix II for the English and Spanish versions) may be used to assess risk for TB on every adolescent preventive care visit. Routine skin testing **is not required** and should be conducted only when a risk of exposure is determined by questionnaire. For more information refer to Section 3, Tuberculosis Risk Assessment).

Heart Disease/Cholesterol Risk Assessment

With the increasing concern of overweight and obesity in adolescents, assessment by questionnaire for potential heart disease is warranted. The Healthy Kids Program requires assessment for risk of heart disease and hypercholesterolemia at every adolescent preventive care visit. The Preventive Screen Questionnaire (Refer to Section 7, Appendix II for the English and Spanish versions) is available to assist in performing this risk assessment. Document results of the screen, and if positive, obtain a baseline blood cholesterol level. Appropriate follow-up of elevated blood cholesterol levels includes further testing, counseling and/or referral for specialty services when indicated (Refer to Section 3, Cholesterol/Heart Disease Risk Assessment).

Effective January 1, 2016, the MDH added a new requirement of dyslipidemia lab tests. One test is required between the ages of 9-11, and a second one between the ages of 18- 21. For more information, refer to the AAP-endorsed 2011 *Expert Panel on Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents* at http://www.nhlbi.nih.gov/files/docs/peds_guidelines_sum.pdf

STI/HIV Risk Assessment

The Maryland Healthy Kids Program currently requires that primary care providers (PCPs) conduct risk assessments for Sexually Transmitted Infections and Human Immunodeficiency Virus (STI/HIV) at each preventive health care visit beginning at 11 years of age, or younger if the

adolescent is sexually active. The Preventive Screen Questionnaire (Refer to Section 7, Appendix II for the English and Spanish versions) is available to assist with this assessment. Document results of the assessment in the medical record. PCPs may refer their female patients to a gynecologist but are still required to obtain a STI/HIV risk assessment.

The U.S. Preventive Services Task Force recommends that PCPs counsel adolescents regarding measures to prevent STIs based on the risk factors, needs, and intellectual abilities of each patient. PCPs should also communicate effectively with patients regarding healthy sexual behaviors and risks of STIs during the annual preventive health care visit and any other clinical encounter.[34]

Young people (ages 15-24) are at highest risk for STIs, accounting for half (50 percent) of all new STIs, although they represent just 25 percent of the sexually experienced population. While the consequences of untreated STIs are often worse for young women (infertility, ectopic pregnancy and chronic pelvic pain), SDC surveillance data reveals that the annual number of new infections is roughly equal among young women and young men (49 percent of incident STIs occurs among young men, vs. 51 percent among young women).[35] Among women, adolescent females 15 to 24 years of age are at highest risk for most bacterial and viral STIs. For example, the prevalence of chlamydia in women aged 14 to 19 years is nearly 5%, the highest proportion of any age group.[36] Other adolescents at high risk for STIs include male homosexuals and bisexuals, adolescents with multiple sexual partners in the last three months, and adolescents with a history of drug and/or alcohol abuse. All sexually active adolescents should be counseled and tested for all STIs/HIV or referred for testing as a routine part of preventive care. [37]

Counseling of adolescents regarding HIV prevention includes an assessment of sexual and drug-using behaviors associated with high risk of HIV infection. Both ulcerative STIs, such as

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[34] See U.S Preventive Services Task Force. (2014). Sexually Transmitted Infections: Behavioral Counseling. Retrieved on 11/24/14, from http://www.uspreventiveservicestaskforce.org/Page/Topic/recommendation-summary/sexually- transmitted-infections-behavioral-counseling1

[35] See Centers for Disease Control (CDC) (2013). Fact Sh//eet: Incidence, Prevalence and Cost of Sexually Transmitted Infections in the United States. Retrieved on

Incidence, Prevalence, and Cost of Sexually Transmitted Infections in the United States | Fact Sheets | Newsroom | NCHHSTP | CDC

[36] See Knight, J.,Roberts, T., Gabrielli, J., & Hook, S.(). Performing Preventive Services: A Bright Future Handbook. Retrieved on 05/31/2015, from ht,tps://brightfutures.aap.org/Bright%20Futures%20Documents/Screening.pdf#search=depression

[37] See U.S Preventive Services Task Force. (2014). Sexually Transmitted Infections: Behavioral Counseling. Retrieved on 11/24/14, from https://www.uspreventiveservicestaskforce.org/uspstf/draft-update-summary/sexually-transmitted-infecti ons-behavioral-counseling2

chancroid, syphilis, and genital herpes, and inflammatory STIs such as gonorrhea, chlamydia infection and trichomoniasis, increase the risk of HIV infection. Early detection and treatment of STIs can have a major impact on sexual transmission of HIV.[38]

STI and HIV Risk Reduction Messages for Sexually Active Adolescents[39]

- Abstinence
- Mutually monogamous relationship with an uninfected partner
    - Caution: adolescents may consider a short-term monogamous relationship to be safe - regardless of the number of relationships encountered within the year
    - Explain that serial monogamy can be very dangerous
- Reduce the number of sexual partners
    - Adolescents can't tell who has the HIV virus
    - A negative HIV screen may not be an accurate reflection of the HIV status
- Consistent use of protective barriers during sex
    - Latex condoms with water-based lubricant (oil-containing lubricants weaken condoms)
    - Use of lubricants/ spermicides containing nonoxynol-9

STI and HIV Risk Reduction Messages for Drug-Using Adolescents

- Abstinence
- Enter a drug treatment program
- Avoid sharing any drug-injecting paraphernalia
    - Disinfect needles and syringes using household bleach:
        - Draw bleach into syringe and expel (twice)
        - Draw clean water into syringe and expel (twice)
- Beware of injection "works" sold as clean on the streets
- Use protective barriers (latex condoms) during sex

[39] See CDC. Sexually Transmitted Diseases: Prevention at *http://www.cdc.gov/std/prevention/default.htm*

HIV Testing

CDC currently recommends routine HIV testing for all adults and adolescents 13-64 years of age in all healthcare settings. In addition, youth at high risk, which include injection-drug users and their sex partners, persons who exchange sex for money or drugs, sex partners of HIV-infected persons, and MSM or heterosexual persons who themselves or whose sex partners have had more than one sex partner since their most recent HIV test should be tested annually. The testing is performed without a separate written informed consent or pretest counseling. [40]

The MDH requires an HIV lab test between the ages of 15-18 years of age regardless of HIV risk.

The objectives of the recommendations are to:

- Increase HIV testing of patients, including pregnant women, in health-care settings
- Foster earlier detection of HIV infection
- Identify and counsel persons with unrecognized HIV infection and link them to **clinical and prevention services**
- Reduce sexual and perinatal transmission of HIV in the US

Opt-Out HIV Testing Recommendations [41]

Opt-out testing means performing an HIV test after notifying the patient

- The test will be performed, and
- The patient may elect to decline or defer testing

No one should ever be tested for HIV without his/her knowledge. HIV testing is recommended for patients in all health-care settings after the patient is notified that testing will be performed unless the patient declines.

There are many reasons a patient may decline an HIV test, including lack of perceived risk, fear of the disease, concerns about partner violence, potential stigma, concerns about the cost of treatment and/or discrimination. Providers should discuss and address reasons for declining an HIV test. If the patient still opts out, then he/she can be encouraged to be tested at a subsequent visit. The patient's decision should be respected and documented in his/her medical record.

Practice settings that have opt-out testing policies for pregnant women and for recipients of STI services have higher HIV testing rates than those that use opt-in policies (where the patient is

[40] CDC (2006). Revised Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Health-Care Settings. Retrieved on 11/25/14, from http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm.
[41] *Ibid*.

given the opportunity to choose the HIV test) or those that require specific counseling for testing. Patients prefer when the testing is routine and offered to everyone
rather than feeling singled out for testing because they are perceived to be "at-risk." For these reasons, CDC believes an opt-out approach provides the best opportunity for more people to know.

Maryland law requires a health care provider to inform a person that an HIV test will be administered, and that the person may decline the test without penalty. All health care providers must provide pre-test counseling to the individual prior to obtaining informed consent. If the test is administered in a healthcare facility, informed consent to the test must be obtained and documented in the medical record. **However, a written, signed consent to specifically perform an HIV test is not required**. If the HIV test is **ordered** at a location that is not a healthcare facility, informed consent must be in writing and signed by the individual on an Informed Consent for HIV Testing document (available in English and Spanish) that is approved by the Department (Refer to Section 4, Addendum)[42]. For additional guidance on HIV prevention, care services, surveillance and epidemiology, contact:

- Maryland Center for HIV Prevention and Health Services[43]: https://health.maryland.gov/phpa/OIDPCS/CHP/pages/home.aspx
- Maryland Center for HIV Care Services[44] at **410-767-6535**
- MADAP Maryland Aids Drug Assistance Program MEpidemiology[45] at
- **Maryland Center for HIV Surveillance &Epidemiology at 410-767-5939**

Anemia Testing

Healthy adolescents are generally at low risk for iron deficiency anemia. The Preventive Screen Questionnaire (Refer to Section 7, Appendix II for the English and Spanish versions) can be used for anemia assessment. Adolescents who have an underlying disease associated with blood loss, or those who have used restrictive diets that are low in iron, especially obese adolescents should be screened annually for anemia. A hemoglobin or hematocrit is sufficient to screen adolescents for anemia.

Hemoglobinopathy Testing

Review sickle cell trait results at 12 years of age if a negative sickle cell trait result is not documented in the child's medical record. If the child/adolescent was born in Maryland

[42] Maryland Code of Regulations-Health-General Article 10.18.08
[43] See https://health.maryland.gov/phpa/OIDPCS/CHP/pages/home.aspx
[44] See https://health.maryland.gov/phpa/OIDPCS/Pages/CHCS.aspx
[45] See https://health.maryland.gov/phpa/OIDPCS/Pages/MADAP.aspx#:~:text=The%20Maryland%20AIDS%20Drug%20Assistance,the%20Ryan%20White%20CARE%20Act.

contact the Maryland's Public Health State Laboratory **at 443-681-3900** for assistance in determining the results. If results are not available or the child was not born in Maryland, a hemoglobin electrophoresis is recommended, regardless of apparent racial or ethnic group. Refer the adolescent for genetic counseling if sickle cell trait is present.

E. IMMUNIZATIONS

The immunization history is an important component of the adolescent's medical history. Most adolescents are unaware of the immunizations they have received in childhood, and their records may be incomplete. Immunization registries are useful, accurate sources of immunization information and records. Maryland has a registry known as **ImmuNet** that is an internet-based system that receives and stores childhood and adult immunizations. Providers may enroll free of cost. To obtain more information, contact an **Immunet** representative at **410-767-6606** or visit the Immunet website at https://www.mdimmunet.org/.

The Baltimore City Immunization Registry Program is a vaccine registry that may assist the Primary Care Provider (PCP) in obtaining the adolescent's immunization record when the immunization history offered by the adolescent or the parents is incomplete. If the adolescent attends a Baltimore City Public School, contact the **Baltimore Immunization Registry Program at 410-545- 3048**.

Another source of immunization records for adolescents that formerly lived in the District of Columbia is the **Washington DC Immunization Registry**. Providers can access the registry by calling **202-576-9301**.

Adolescents and young adults who have not received adequate immunizations are at significant risk for developing serious infections. Thus, the immunization history should be a priority for all adolescents at their initial preventive health care visit. Make every effort to gather all available medical information to determine whether additional immunizations are necessary. Positive titers for varicella, Hepatitis B, and polio can substitute for vaccination. Administer any vaccines needed to bring the immunization status up-to-date according to the current Maryland Recommended Childhood Immunization Schedule (Refer to Section 7, Appendix III).[46]

When administering combination vaccines, refer to the Maryland Suggested Immunization Schedule Using Combination Vaccines (Refer to Section 7, Appendix III).

To check the current immunization schedules for child care and school entry, follow the link: http://www.marylandvfc.org/wp- content/uploads/2016/04/Min_Vacc_Req-16_17_Final.pdf.

For additional information, contact the Center for Immunization[47] by calling **410-767- 6679** or emailing mdh.mdimmunet@maryland.gov.

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[46]Maryland Recommended Schedule site: https://mmcp.health.maryland.gov/epsdt/EPSDT%20Resources/Maryland%20Recommended%20Childhood%20and%20Adolescent%20Immunization%20Schedules%202019.pdf

[47] See https://health.maryland.gov/phpa/OIDEOR/IMMUN/pages/home.aspx

Section 4: Adolescent Preventive Health

Assess adolescents for the following vaccines:

- **Varicella***– Varicella virus vaccine should be administered to adolescents if they have not been vaccinated with **two** doses of the vaccine and do not have a reliable history of chickenpox. If the adolescent did not have the infection in childhood, they remain at risk for this infection. Adolescents who did not receive any previous Varicella vaccine must have two doses of Varicella vaccine. For children aged 7 through 12 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid). For persons aged 13 and older, the recommended minimum interval between doses is 4 weeks. Adolescents who received only one prior dose of Varicella during childhood should receive another dose as an adolescent.

- **Tetanus and Diphtheria Toxoids and Acellular Pertussis (Tdap)***The minimum age for Boostrix is 10 years and for Adacel is 11 years. Td boosters have long been recommended for long-lasting immunity against tetanus. Now a booster dose of Pertussis is also recommended for adolescents. Therefore, one dose of Tdap should be administered at 11-12 years of age and older, and a routine Td booster is recommended every ten years thereafter.

- **Hepatitis B*** – The Advisory Committee on Immunization Practice (ACIP) recommends that hepatitis B vaccine be given to all adolescents who have not been previously vaccinated.[48] Hepatitis B may be transmitted by sexual contact and therefore all adolescents should be immunized against this infection. Assess every adolescent for the complete hepatitis B series. Adolescents, 11 to 15 years of age, may receive two doses of adult vaccine (Merck Recombivax HB only) with the 2nddose administered 4-6 months after the first.

- **Hepatitis A***– Immunize at risk adolescents with the hepatitis A vaccine, particularly if they live in areas where the average annual rate of hepatitis A infection is between 10 and 20 cases per 100,000. This vaccine requires two doses, separated by 6 to 18 months.

- **Influenza*** – Influenza vaccine is recommended annually for all adolescents to 18 years of age and those 18 through 20 years of age with high-risk conditions (chronic pulmonary, cardiovascular and/or metabolic disease, renal dysfunction, hemoglobinopathies, or conditions associated with immunosuppression, including HIV infection).

- **Meningococcal conjugate vaccine*** –Meningococcal conjugate vaccine is recommended for all adolescents at 11-12 years of age. Administer a single dose of Menactra or Menveo vaccine at age 11 through 12 years, with a booster dose at age of 16 years. If the first dose is

[48] ACIP (2005). A Comprehensive Immunization Strategy to Eliminate Transmission of Hepatitis B Virus Infection in the United States-Part I: Immunization of Infants, Children and Adolescents. Retrieved on 12/04/14, from http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5416a1.htm.

administered at age of 16 years or older, a booster dose is not needed. Adolescents aged 11 through 18 years with HIV infection should receive a 2-dose primary series of Menactra or Menveo with at least 8 weeks between doses. For instructions about the vaccination of adolescents with high-risk conditions, refer to ACIP Vaccine Recommendation at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6202a1.htm. Maryland law requires that individuals in Maryland institutions of higher education, residing in on-campus housing, be vaccinated against meningococcal disease, or sign a waiver.[49]

➢ **Pneumococcal Polysaccharide Vaccine** – Pneumococcal Polysaccharide vaccine is recommended for adolescents who have cerebrospinal fluid leak, cochlear implant; sickle cell disease and other hemoglobinopathies; anatomical of functional asplenia; congenital or acquired immunodeficiencies; HIV infection; chronic renal failure; nephritic syndrome; diseases associated with treatment with immunosuppressive drugs or radiation therapy, including malignant neoplasms, leukemias; lymphomas, and Hodgkin disease; generalized malignancy; solid organ transplantation; or multiple myeloma. It is also recommended for adolescents with chronic heart disease (particularly cyanotic congenital heart disease and cardiac failure), chronic lung disease (including asthma if treated with high-dose oral corticosteroid therapy), diabetes mellitus, alcoholism, or chronic liver disease. For the administration and dosage guidance, refer to the ACIP Vaccine Recommendations at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6225a3.htm.

➢ **Human Papillomavirus (HPV)*** – Either the HPV2 (Cervarix) or HPV4(Gardasil) HPV vaccine is routinely recommended for adolescent and young adult females, with the first of 3 doses at 11-12 years of age on a schedule of 0,1-2, and 6 months. Either HPV2 or HPV4 may be administered on females, and only HPV4 may be used for males. The vaccines are used to prevent infection with specific HPV virus strains that are sexually transmitted and known to increase risk of cervical cancer. HPV4 also prevents two strains of HPV responsible for causing genital warts in women and penil and ano-rectal warts in men. Vaccinate older adolescents who did not complete the series earlier. Adolescent males may be vaccinated with the HPV4 series upon parental request.

**Vaccines available from the VFC Program through age 18 years.*

For more information about administering the vaccines, refer to ACIP Vaccine Recommendations at http://www.cdc.gov/vaccines/hcp/acip-recs/index.html.

For information on vaccine safety, refer to CDC's HPV Vaccine Safety and Effectiveness Data at https://www.cdc.gov/hpv/hcp/vaccine-safety-data.html.

[49] Maryland Health-General Code Ann. § 18-102 (2000).

The Vaccines for Children (VFC) Program

It is very important to note that adolescents, younger than 19 years of age, are eligible to receive free vaccines from this program. Healthy Kids providers serving adolescents, less than 19 years of age, are required to enroll in the Maryland Vaccines for Children (VFC) Program (Refer to Section 3, The Vaccines for Children Program).

The VFC Program Contact Center provides a full range of support for VFC Providers including answering questions related to VFC vaccine supply, vaccine delivery, vaccine allocations, and other related issues. To improve customer service, VFC Providers in each jurisdiction have been assigned a phone number to reach the VFC Contact Center: **410-274-6240 (Baltimore County, Baltimore City, Howard and Harford counties), 410-299-5647 (Frederick, Montgomery and Prince George's counties), and 410-404-4128 (all other counties).** The VFC Center can be also reached by email at IZinfo.@dhmh.state.md.us or by fax at **410-333-5893** (Refer to Section 8).

Note: For vaccines administered to MA recipients 19 through 20 years, bill the adolescent's MCO (or straight MA if the adolescent is in Fee-For-Service) (Refer to Section 6, Billing and Encounter Data Reporting).

F. HEALTH EDUCATION AND ANTICIPATORY GUIDANCE

Provide health education and anticipatory guidance at each preventive visit and document in the patient record. The education should focus on both adolescents and parents, and it should be integrated throughout the encounter. Anticipatory guidance for the parents or guardians is essential, given the many rapid changes of adolescence. It may be an opportunity for parents to voice their concerns about the adolescent's emotional or physical well-being. It provides a vehicle for parents to establish a relationship with the provider, and it may improve their parenting skills. Parents frequently have additional questions, and providers will need to reinforce their health guidance and clarify their instructions. The adolescent patient should also participate in this experience, so that he/she clearly accepts the responsibility for good health outcomes.

Present health education and anticipatory guidance in a manner that will:

- Assist the family in understanding what to expect in terms of the adolescent's development
- Provide information about the benefits of healthy lifestyles and practices
- Promote the prevention of diseases and injuries
- Provide support to adolescents, as they become responsible for their health and lifestyle choices

Although the adolescent spends less time under the direct supervision of the parent, adults should be reminded of the need to stay involved with their teenagers. Effective parenting requires adults to set limits for their children and to provide a nurturing and supportive environment that promotes healthy lifestyles. The provider needs to remind parents about successful strategies to improve the health status of their child. Open lines of communication are necessary if these goals are to be achieved. Intentional and unintentional injuries are the principal causes of morbidity and mortality in adolescents. It is essential to evaluate the extent to which adolescents have experienced injuries. Additionally, the provider needs to determine what measures have been taken to reduce injury.

Age-specific information is included on each of the Healthy Kids Encounter Forms (Refer to Section 7, Appendix I). The focus of adolescent health education and anticipatory guidance should be on the adolescent's increasing responsibility in decision-making (Refer to Section 3, Age-Specific Health Education).

Adolescent Sexuality/Reproductive Health

Assess what the adolescent knows about the reproductive process. Adolescents will have a broad range of understanding regarding pubertal development and the reproductive process.

Discussions of these issues should be structured to meet the needs of the patient, and they may need to be simplified for the young adolescent patient. Provide guidance based on the level of maturity and sexual activity of the individual, not on chronological age. Puberty for girls may begin as early as 8 years of age. Menstruation begins between 10 and 14 years of age. In boys, puberty usually begins about two years later than in girls. Address the risks of pregnancy and sexually transmitted diseases, including HIV, with both females and males.

Adolescents should also be given the message that force and coercion have no place in sexual relationships and may be illegal. Informational materials and referrals to community resources, including law enforcement, that deal with domestic and sexual violence should be readily available. Information is available from the following resources:

- Maryland Network Against Domestic Violence (MNADV)[50] at **1-800-MDHELPs**
- Maryland Coalition Against Sexual Assault (MCASA)[51] at **301-328-7023**
- National Teen Dating Abuse at **1-866-331-9474;** online chat at www.loveisrespect.org; or text Loveis to 22522
- National Sexual Assault Hotline – **1-800-656-HOPE**

For information about local domestic violence organizations offering counseling and assistance to victims of domestic violence in finding a safe home and shelter, use the Local Domestic Violence Directory (Refer to Section 8).

Contraceptive Options

In order for the adolescent to consent to any contraception method, explain the benefits and/or risks of each method. In general, adolescents initiate sexual intercourse using no contraception, progress to methods available from pharmacies, and finally, use methods prescribed by a physician. Advise specifically against the use of withdrawal and douching as methods of contraception. Similarly, discourage unprotected extra-genital sex.

Methods of contraception currently available to adolescents:

➢ **Abstinence –** This is the preferred contraceptive method for use by adolescents. Support and encourage them in this decision, as it is the most effective way to prevent pregnancy, STIs and HIV. However, existing data suggest that, over time, perfect adherence to abstinence is low. Therefore, do not rely on abstinence counseling alone, but provide access to comprehensive sexual health information to all adolescents.

[50] See http://mnadv.org/
[51] See http://www.mcasa.org/

➢ **Progestin Implants –** Implants (Implanon and Nexplanon) are highly effective with failure rates of less than 1%. They may remain in place for 3 years. A physician who has completed the requisite training inserts the implant into the inside of the upper arm. A common reason for their discontinuity is unpredictable bleeding and spotting.

➢ **Intrauterine Device (IUD) –** IUDs inserted into the uterus also provide long-acting reversible contraception. Despite the low but increasing use of IUDs in the U.S.A., they are used extensively worldwide because of their safety and effectiveness (failure rates of less than 1%) The disadvantages of IUDS are increased risk of expulsion for adolescents and reported moderate to severe pain with insertion. If the Primary Care Provider (PCP) believes that this method is an option for a young patient, the patient should be referred to a gynecologist for consultation.

➢ **Depo-Provera –**This is an injectable, progestin-only contraceptive. It is effective for 13 weeks and well tolerated by most women who have no contraindications to its use. Depo-Provera is a favored method used by women who wish to defer childbearing for an extended period of time. In the first year of use, its failure rates are 6%. In addition, this contraceptive is easy to use and is considered to improve dysmenorrhea and protect against iron deficiency anemia and endometrial cancer. The major disadvantages of Depo-Provera include the need for an injection every 13 weeks and the menstrual cycle irregularities present for nearly all patients initially. Other possible adverse effects include headache, mastalgia, hair loss, and change in libido and weight gain. This contraceptive also causes reduction in bone mineral density. All patients should be counseled about measures promoting skeletal health, such as daily intake of 1300 mg of calcium and 600 IU of vitamin D and regular weight-bearing exercise.

➢ **Combined Oral Contraceptive Pills (COC) –** COCs are the most popular method of hormonal contraception for adolescents available with prescription. COCs all contain a progestin and an estrogen. The Centers for Disease Control (CDC) recommends prescribing them up to 1 year at a time to healthy non-pregnant females. Typical use failure rates are 9% in adults and may be higher in adolescents. Common adverse effects of COCs include irregular bleeding, headache, and nausea. The most serious side effect associated with their use is the increased risk of blood clots, which increases from 1 per 10 000 to 3 to 4 per 10 000 woman-years during COC use. Observational data indicate that COC use does not increase the risk of infertility or breast cancer. Their use for more than 4 years also provides significant protection against endometrial and ovarian cancers.

➢ **Contraceptive Vaginal Ring –** The vaginal ring releases a combination of estrogen and progestin and therefore has the same eligibility criteria for use as COCs. The ring is inserted in the vagina and stays in place for 3 weeks, with removal for 1 week to induce withdrawal bleeding, followed by insertion of a new ring. The ring has the same efficacy, risks and benefits as other combined COCs, but provides the simplest regimen, especially for women that prefer extended use, because it contains sufficient medication to be used for up to 35 days. Adverse effects are also similar to those of COCs, with the additional virginal symptoms of discharge, discomfort, and expulsion.

➢ **Transdermal Contraceptive Patch –** The contraceptive patch containing estrogen and progestin) is placed on the abdomen, upper torso, upper outer arm, or buttocks using 1 patch for each of 3 weeks in a row, followed by 1 week off the patch, during which a withdrawal bleed occurs. The failure rates are similar to those of COCs at 9%. The patch has comparable efficacy, benefits, and side effects as other COCs. Additional adverse effects include dislodged patches, and skin effects, such as hyperpigmentation, contact dermatitis, and other irritation. The FDA has identified increased estrogen exposure (1.6 times higher than with a low- dose COC) and potential increased risk of venous thromboembolism with the patch. The risk of pregnancy with correct use of the patch is slightly higher for women who weigh more than 198 pounds.

➢ **Progestin-Only Pills –** The progestin-only pills (also known as "mini- pills") have significantly higher failure rates than those of other combined hormonal and progestin-only methods due to the requirement for very stringent adherence. However, they provide an additional option for patients who have safety concerns about estrogen use.

➢ **Male Condoms –** This is the most effective contraceptive method for the prevention of STIs (latex condoms). It is also the most common contraceptive method used by adolescents. However, condom use requires commitment at every sex act, and is influenced by individual, relationship, and broader social factors. The failure rates are 18% for all users, and can be higher among adolescents. The high failure rate coupled with the condom's high STI protection, has led to the recommendation for dual contraception: condoms plus a highly effective hormonal or other long- acting method. Instruct all sexually active adolescents in the use of condoms. Change to **contraceptive**

➢ **Emergency contraception –** This method is used after having unprotected intercourse. Adolescents may elect to use this method following sexual assault, or after contraceptive failure (e.g., when the condom breaks). It is available as oral levonorgestrel; an oral progesterone receptor modulator ulipristal acetate (Ella); high-dose combined estrogen-progestin oral contraceptive pills (Yuzpe regimen); and placement of copper IUD.

Levonorgestrel EC is preferred to the Yuzpe regimen, because of the superior adverse effect profile and effectiveness. Levonorgestrel is available either as 2 pills or as 1 pill (Plan B One-Step). Plan B One-Step is approved by the FDA as a nonprescription product for all women of childbearing potential. Generic versions are approved as a nonprescription product for women 17 years of age; however, proof of age is not required to purchase them EC should be prescribed or recommended in advance for use for up to 5 days after an event or unprotected intercourse. More details on EC mechanisms and use can be found in the AAP Policy Statement on Emergency Contraception.[52] For additional assistance, contact the **Emergency Contraception Hotline at 1-800-584-9911**, at the **Emergency Contraception-Princeton** at http://ec.princeton.edu/, the LHD Family Planning Clinic, or refer the patient to the gynecologist for immediate attention.

➢ **Withdrawal –** It has limited effectiveness (22% failure rate among all users) and lack of STI protection. Pediatricians should encourage adolescents to adopt methods that are more effective.

➢ **Other Methods –** The female condom, periodic abstinence, vaginal spermicides, the cervical cap, and the diaphragm are methods less commonly used by adolescents. For more guidance, refer to 2014 AAP Policy Statement on Contraception for Adolescents.[53]

[52] See American Academy of Pediatrics (AAP) (2012). Policy Statement: Emergency Contraception. Pediatrics, 130 (6). 1174-1182. Retrieved on 12/08/14, from http://pediatrics.aappublications.org/content/130/6/1174.full.pdf+html.

[53] See AAP (2014). Policy Statement: Contraception for Adolescents. Pediatrics.134 (4). Retrieved on 12/08/14, from http://pediatrics.aappublications.org/content/134/4/e1244.full.pdf+html?sid=fefca3fd-6ad5-42c1-a86f-301af422ae12

https://www.cdc.gov/reproductivehealth/contraception/mmwr/spr/summary.html

Dental Care

For children and adolescents, the dental administrator for the dental Medicaid, Maryland Healthy Smiles Program,[54] SKYGEN USA, LLC.[55], at **1-855-934-9812** will assist in locating appropriate dental care within reasonable distance from the enrollees' residence to ensure adequate access to oral health care services. The Maryland Healthy Smiles Dental Program Handbook may be accessed online[56]. Providers may contact the Office of Oral Health [57] **at 410-767-5300** to assist children not enrolled in the Maryland Healthy Smiles Program and request the Oral Resource List Booklet.[58] Parents or caregivers can self-refer to a dentist, without a referral from the PCP. SKYGEN USA, LLC (Formally Scion Dental) administers the Maryland Healthy Smiles Dental Program.

For Members:

Members may choose to download a copy of the Member Handbook or contact Member Services to request a hard copy to mail.

Maryland Healthy Smiles Member Services:

Phone: 855-934-9812

Email: outreachcoordinator@skygenusa.com

TDD: 855-934-9816

Web Portal: http://member.mdhealthysmiles.com

Provide oral health education, counseling, and disease prevention information. Emphasize the need to make and keep dental appointments, stressing self- responsibility, at each visit to parents or caregivers and adolescents.

Scheduling the Return Preventive Care Visit

Educate the adolescent and the family regarding the need to have annual preventive care visits. Document the education and the next scheduled preventive visit in the medical record. **When the adolescent presents for an initial visit, a school or sports physical, or an employment physical, all components of the well child visit must be completed.** If the last preventive visit was more than a year ago, and the adolescent presents for a "sick" or problem-oriented visit, make every effort to conduct a preventive care visit.

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[57] To view and print a copy of the handbook, see https://health.maryland.gov/mmcp/Documents/Member%20Handbook.pdf

[58] For an electronic copy of the guide, follow the link https://health.maryland.gov/phpa/oralhealth/Documents/OralHealthResourceGuide.pdf

4A.1 HEADSSS Psychological Interview *Reviewed 2022*

http://www.trapeze.org.au/sites/default/files/2014_01_Klein_Goldenring_HEEADSSS3.0_Contemporary%20Pediatrics.pdf

4A.2 Identify and Treat Adolescent Depression *Reviewed 2022*

4A.3 Pediatric Symptoms Checklist for Teens (PHQ-9 Modified) *Reviewed 2022*

4A.4 Patient Health Questionnaire Modified for Teens (PSC-Y) *Reviewed 2022*

4A.5 Informed Consent and Agreement to HIV Testing- English & Spanish *Reviewed 2022*

HEEADSSS 3.0

The psychosocial interview for adolescents updated for a new century fueled by media

DAVID A KLEIN, MD, MPH; JOHN M GOLDENRING, MD, MPH, JD; AND WILLIAM P ADELMAN, MD

The HEEADSSS psychosocial interview is a practical, time-tested strategy that pediatricians can use to evaluate how their teenaged patients are coping with the pressures of daily living, especially now in the context of electronic and social media.

For most teenagers, a psychosocial history is at least as important as the physical exam. This essential psychosocial history can be obtained using the HEEADSSS method of interviewing adolescents. The HEEADSSS interview focuses on assessment of the **H**ome environment, **E**ducation and employment, **E**ating, peer-related **A**ctivities, **D**rugs, **S**exuality, **S**uicide/depression, and **S**afety from injury and violence (Table 1).[1,2]

Because adolescence is a time of growth and development when threats to health can arise, these threats are often related to physical and social exploration. For example, sexual exploration may lead to sexually transmitted infections or unintended pregnancies. Experimentation with drugs or alcohol is another cause of morbidity and mortality that is implicated in deadly motor vehicle crashes in the age group. In fact, unintentional injuries, homicide, and suicide are among the leading causes of adolescent deaths in the United States, and are the top 3 causes for those aged 15 years and older.[3]

Moreover, consequences of adolescents' stressors may include obesity, eating disorders, depression, or other mental health problems. These issues are not easily identified or addressed using a strictly physiologic orientation.

Without an adequate psychosocial history, one is unlikely to spot problems early enough to significantly reduce adolescent morbidity and mortality. The HEEADSSS interview is a practical, time-tested strategy that physicians can use to obtain a "psychosocial review of systems" for adolescent patients.

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Since the second version of HEEADSSS was created in 2004, nearly all teenagers have obtained access to the Internet and three-quarters of them use cell phones and send text messages.[4-7] This utilization of media profoundly affects the lives of adolescents; media may now contribute to 10% to 20% of any specific health problem.[7] Thus, questions on new media use are critically important and are included in this HEEADSSS 3.0 update. In addition, this update emphasizes a strengths-based approach to the adolescent interview to foster patient-physician rapport and successful interventions.

How to use the psychosocial screen

You should begin spending time alone with your patients at whatever age they first exhibit the psychosocial changes associated with puberty. Generally, it is preferable to conduct the psychosocial interview when the adolescent is relatively well.[8] Nonetheless, situations of crisis or illness may sometimes facilitate effective history taking because vulnerability may foster trusting relationships. At every visit, the adolescent should be assessed for new stressors and overall well-being.

Working with parents

If the parents are present, first introduce yourself to the adolescent to make clear that the teenager is the patient. Then try having the adolescent introduce the other people in the room. Parents, family members, or other involved adults should not be present during the HEEADSSS interview because a parent's presence is likely to limit how much sensitive information the patient will provide. Allowing a parent to sit in on the interview also makes it more difficult to exclude him or her at subsequent visits when the patient may have more private issues to discuss.

This does not mean that parents should be ignored. Before asking adults to leave the room, always ask whether they have any concerns and assure them of further interaction once the interview is over. Be certain to explain the purpose, such as: "We speak privately with our patients about stressors that may appear during adolescence so they can practice taking responsibility for their health care needs." With explanation, adults accept the need for confidential care.[9]

DISCUSSING CONFIDENTIALITY

You may say, for example: "During this visit, I'll ask you some very personal questions to best help you. I promise that whatever you say will be kept private between us, and not be passed along to your parents or anybody else outside this office, unless you give permission."

Clinicians may end the introduction with: "The only exception would be in a circumstance in which a disclosure to someone is required by law." Some specify the circumstances (eg, the patient is planning to kill or seriously injure himself or someone else; or the patient is experiencing, or is planning to commit, physical or sexual abuse or neglect).

Other clinicians prefer a nonqualified ending: "If you tell me something that is so bad for your health that I think it is best to get somebody else involved in your care, like a parent or another doctor, I will tell you that. If you disagree, then together we can discuss the way to proceed." This method reinforces the strength of the physician-patient relationship.

Each physician must determine what limits on confidentiality are prescribed by the laws of the particular state in which the physician practices.[a] State-by-state confidentiality guidelines are available from the Guttmacher Institute (www.guttmacher.org) and from the National Center for Adolescent Health and Law (www.adolescenthealthlaw.org).

REFERENCE

[a]Guttmacher Institute. State policies in brief. An overview of minors' consent law. http://www.guttmacher.org/statecenter/spibs/spib_OMCL.pdf. Updated December 1, 2013. Accessed December 4, 2013.

Making a good beginning

Starting the interview with nonthreatening conversation about the patient's hobbies or current events may help to ease anxiety, foster rapport and trust, and encourage disclosure. Then you might say: "I would like to take a few minutes to see how you are handling stress and whether your behaviors are safe."[10,11] Once young people start talking, they are likely to keep talking. You will succeed better, however, if you explain the concept and limitations of confidentiality as part of this initial conversation.[12,13] (See "Discussing confidentiality," above.)

The beauty of HEEADSSS is that by using the acronym, you can naturally proceed from very important but usually less threatening questions

TABLE 1 The HEEADSSS psychosocial interview for adolescents

	Potential first-line questions	*Questions if time permits or if situation warrants exploration*
Home	Who lives with you? Where do you live? What are relationships like at home? Can you talk to anyone at home about stress? (Who?) Is there anyone new at home? Has someone left recently? Do you have a smart phone or computer at home? In your room? What do you use it for? (May ask this in the activities section.)	Have you moved recently? Have you ever had to live away from home? (Why?) Have you ever run away? (Why?) Is there any physical violence at home?
Education and employment	Tell me about school. Is your school a safe place? (Why?) Have you been bullied at school? Do you feel connected to your school? Do you feel as if you belong? Are there adults at school you feel you could talk to about something important? (Who?) Do you have any failing grades? Any recent changes? What are your future education/employment plans/goals? Are you working? Where? How much?	How many days have you missed from school this month/quarter/semester? Have you changed schools in the past few years? Tell me about your friends at school. Have you ever had to repeat a class/grade? Have you ever been suspended? Expelled? Have you ever considered dropping out? How well do you get along with the people at school? Work? Have your responsibilities at work increased? What are your favorite subjects at school? Your least favorite subjects?
Eating	Does your weight or body shape cause you any stress? If so, tell me about it. Have there been any recent changes in your weight? Have you dieted in the last year? How? How often?	What do you like and not like about your body? Have you done anything else to try to manage your weight? Tell me about your exercise routine. What do you think would be a healthy diet? How does that compare to your current eating patterns? What would it be like if you gained (lost) 10 lb? Does it ever seem as though your eating is out of control? Have you ever taken diet pills?
Activities	What do you do for fun? How do you spend time with friends? Family? (With whom, where, when?) Some teenagers tell me that they spend much of their free time online. What types of things do you use the Internet for? How many hours do you spend on any given day in front of a screen, such as a computer, TV, or phone? Do you wish you spent less time on these things?	Do you participate in any sports? Do you regularly attend religious or spiritual activities? Have you messaged photos or texts that you have later regretted? Can you think of a friend who was harmed by spending time online? How often do you view pornography (or nude images or videos) online? What types of books do you read for fun? How do you feel after playing video games? What music do you like to listen to?
Drugs	Do any of your friends or family members use tobacco? Alcohol? Other drugs? Do you use tobacco or electronic cigarettes? Alcohol? Other drugs, energy drinks, steroids, or medications not prescribed to you?	Is there any history of alcohol or drug problems in your family? Does anyone at home use tobacco? Do you ever drink or use drugs when you're alone? (Assess frequency, intensity, patterns of use or abuse, and how patient obtains or pays for drugs, alcohol, or tobacco.) (Ask the CRAFFT questions in Table 5, page 25.)

	Potential first-line questions	Questions if time permits or if situation warrants exploration
Sexuality	Have you ever been in a romantic relationship? Tell me about the people that you've dated. Have any of your relationships ever been sexual relationships (such as involving kissing or touching)? Are you attracted to anyone now? OR: Tell me about your sexual life. Are you interested in boys? Girls? Both? Not yet sure?	Are your sexual activities enjoyable? Have any of your relationships been violent? What does the term "safer sex" mean to you? Have you ever sent unclothed pictures of yourself on e-mail or the Internet? Have you ever been forced or pressured into doing something sexual that you didn't want to do? Have you ever been touched sexually in a way that you didn't want? Have you ever been raped, on a date or any other time? How many sexual partners have you had altogether? (Girls) Have you ever been pregnant or worried that you may be pregnant? (Boys) Have you ever gotten someone pregnant or worried that might have happened? What are you using for birth control? Are you satisfied with your method? Do you use condoms every time you have intercourse? What gets in the way? Have you ever had a sexually transmitted infection or worried that you had an infection?
Suicide/ depression	Do you feel "stressed" or anxious more than usual (or more than you prefer to feel)? Do you feel sad or down more than usual? Are you "bored" much of the time? Are you having trouble getting to sleep? Have you thought a lot about hurting yourself or someone else? Tell me about a time when someone picked on you or made you feel uncomfortable online. (Consider the PHQ-2 screening tool [Table 6, page 26] to supplement.)	Tell me about a time when you felt sad while using social media sites like Facebook. Does it seem that you've lost interest in things that you used to really enjoy? Do you find yourself spending less time with friends? Would you rather just be by yourself most of the time? Have you ever tried to kill yourself? Have you ever had to hurt yourself (by cutting yourself, for example) to calm down or feel better? Have you started using alcohol or drugs to help you relax, calm down, or feel better?
Safety	Have you ever been seriously injured? (How?) How about anyone else you know? Do you always wear a seatbelt in the car? Have you ever met in person (or plan to meet) with anyone whom you first encountered online? When was the last time you sent a text message while driving? Tell me about a time when you have ridden with a driver who was drunk or high. When? How often? Is there a lot of violence at your home or school? In your neighborhood? Among your friends?	Do you use safety equipment for sports and/or other physical activities (for example, helmets for biking or skateboarding)? Have you ever been in a car or motorcycle accident? (What happened?) Have you ever been picked on or bullied? Is that still a problem? Have you gotten into physical fights in school or your neighborhood? Are you still getting into fights? Have you ever felt that you had to carry a knife, gun, or other weapon to protect yourself? Do you still feel that way? Have you ever been incarcerated?

Abbreviations: CRAFFT, Car, Relax, Alone, Forget, Friends, Trouble; HEEADSSS, Home, Education and employment, Eating, Activities, Drugs, Sexuality, Suicide/depression, Safety; PHQ-2, Patient Health Questionnaire 2.
Adapted from Goldenring JM, et al[1]; Goldenring JM, et al.[2]

TABLE 2 Characteristics of resilient teenagers

Home	Connected, caring parents or family members Acceptance of responsibility Chores Care of siblings or other relatives
Education and employment	Better than average school performance Feelings of connection to school Limited employment (<20 hr/wk) Strong participation in extracurricular, school-related activities, including sports
Activities	Leadership among peers Religious affiliation
Drugs	Pledge to abstain Refusal skills
Sexuality	Pledge to abstain Refusal skills Consistently responsible sexual behavior
Suicidality	No personal history of attempted suicide No family history of attempted or accomplished suicide Access to a confidant Successful coping skills Substance free
Safety	Seat belt and helmet use Conflict resolution skills Substance free Refusal to ride in cars with potentially intoxicated driver

Goldenring JM, et al[1]; Ginsburg KR[10]; Resnick MD, et al.[14]

to those most often considered highly personal. Nothing about the HEEADSSS interview, however, including the order of questioning should ever be treated rigidly. Although teenagers typically feel comfortable progressing in the order of the acronym, be aware of clues from the chief complaint or previous interactions that would modify your approach. For example, the home environment may be much more stressful to some adolescents than any issues they may have about sexuality.

Remember to search for the patient's strengths because positive attributes suggest the presence of resilience.[8,10,11] In fact, some experts recommend first screening for markers of strength and resiliency to use throughout the rest of the visit (Table 2).[1,10,14] Consider: "To help me get to know you, tell me something about yourself that makes you proud" or "Tell me how your friends describe you."[10] This may be postponed when patients are anxious to address their psychosocial concerns; however, positive factors may mitigate risks or point to productive interventions or an improved outlook.[10,11,14]

While counseling about risks you have uncovered, be certain to assess the patient's readiness to change, the context of the patient's situation, opportunities to praise the patient for significant accomplishments or avoiding risks, and implementation of patient-created solutions and coping strategies (Table 3).[1,10,14]

Consider starting at *Home*

Questions about the teenager's home environment are generally expected and are a good beginning for the psychosocial interview. Instead of making assumptions, ask open-ended questions if possible (Table 4).[1] It is a mistake, for example, to say "Tell me about your mom and dad," which assumes that the patient lives with 2 parents and that the parents are of different genders. Rather, start by asking "Where do you live?" or "Tell me about your living situation." Then ask: "Who lives with you?" These questions allow the adolescent to describe what is most important in his or her home setting.

Proceed by asking what relationships are like at home and whether there has been a recent change: moving, running away, divorce, or having someone join or leave the household. Such events are often extremely stressful to teenagers, who prefer a stable environment in which to undertake the developmental tasks of adolescence, such as separating from parents, connecting with peers, and developing a positive self-image.

Because media-related morbidity can be reduced by enlisting parental supervision, it is important to screen for the patient's home use (especially bedroom use) of computers, TVs, video games, smart phones, or other media devices.[7] (See "Screening for media use and misuse," page 24.)

It is extremely useful to ask in whom the teenager trusts to confide. Connection to supportive

TABLE 3 A strengths-based approach

When talking to adolescents, search for positives in the history. Approaches based on risk factors alone may induce feelings of shame and deter patient engagement. It also sets low expectations—absence of risk factors does not equate to success. Here are some tips:

1 **Identify strengths early** so that they can be "built on" when motivating the patient to change or when encouraging ongoing success. An alternative acronym, SSHADESS, accounts for this strategy.[10]

2 **Look for examples of past difficulties that your patient has successfully overcome.** The ability to adapt to and overcome adversity is known as resilience and is highly protective against a wide range of bad outcomes.

3 **Praise** when praise is warranted! Many adolescents, especially those at high risk, never hear any praise from adults!

4 **Use reflective listening and pause.** This allows the teenager time to confirm and expand on his or her thoughts.

5 **Create a comfortable, trusting, nonjudgmental setting** that communicates respect. Consider: "I want you to feel comfortable coming to me for health information and comfortable telling me what is going on in your life."

6 **Share your concerns.** It is acceptable to gently challenge your patient by saying, for example, "I'm worried that daily marijuana use may be a barrier to your achieving your goal of serving in the military."

Abbreviation: SSHADESS, Strengths, School, Home, Activities, Drugs/substance abuse, Emotion/depression, Sexuality, Safety.
Goldenring JM, et al[1]; Ginsburg KR[10]; Resnick MD, et al.[14]

adults—parents or others—is highly protective against many health risks and high-risk behaviors.[14] It is also important to remember to praise solid relationships with adults and assumption of responsibilities at home.

E is for *Education and Employment*

Most young people expect questions about their education and are seldom threatened by them. A common error is to ask "How are you doing in school?" Invariably, the patient will simply answer "fine" or "good," necessitating additional questioning. Instead, try asking: "Tell me about school. What do you like about it, and what don't you like?"

Search for the patient's degree of connectedness to the school and education; high connectedness predicts lower rates of substance use, early sexual initiation, violence, school absenteeism, and other causes of adolescent morbidity.[14] Connectedness is specifically increased not only by educational commitment and adult mentorship but also by peer group belonging and a safe environment.[15] Be certain to inquire about involvement in extracurricular activities and occurrences of bullying.

Ask specifically about academic performance (generally measured by grades). Declining academic performance correlates highly with psychosocial problems, such as drug use or suicide risk, and may indicate an underlying learning or attention disorder.

When an adolescent lives in a high-risk environment, begin the school section of the interview by ascertaining whether he or she regularly attends school. In some inner-city areas, the absenteeism rate for teenagers ranges from 15% to 40%.[16] It also may be helpful to check how many schools and new sets of friends the student has adapted to in recent years. This is particularly important in military families for whom moving is often a way of life.[17]

The older the teenager, the more you should expect him or her to have some plans for future education or employment. Ask teenagers who are employed part time whether the work is intrusive and if economic circumstances necessitate it. Working more than 20 hours a week has been associated with negative outcomes of emotional distress and substance use.[14] When interviewing adolescents who are employed full time, inquire about their strengths and weaknesses on the job, satisfaction level, nature of relationships at work, goals, and recent or frequent changes in employment.

Again, remember to look for and praise successes at school and at work. Such successes include not only academic ones but also leadership and achievement in extracurricular school activities or in the workplace.

TABLE 4 Opening lines, poor and better

Category	Poor	Better
Home	"Do you get along with your mom and dad?"	"Where do you live and who lives there with you? (No assumptions made.)
Education	"How are you doing in school?"	"Tell me about school." **OR:** "What do you enjoy about school? What do you dislike? (Open-ended; harder to answer "OK.")
Eating	"What do you eat?"	"Tell me what you think about your weight and shape." **OR:** "Tell me about what you like and don't like about your body." (Open-ended; can't answer "OK.")
Activities	"Do you have any activities outside school?"	"What do you and your friends like to do for fun?" (Open-ended.)
Drugs	"Do you use drugs?"	"What kinds of drugs have you seen around your school or at parties?" **OR:** "Do any of your friends use drugs or alcohol?" (Less personal; eases into a difficult discussion.)
Sexuality	"Have you ever had sex?"	"You told me you've been going out with Steve for the past 3 months. Has your relationship become sexual?" (Context makes question seem less intrusive.) **OR:** "Are you attracted to anyone currently?" (Nonjudgmental.)

From Goldenring JM, et al.[1]

E is also for *Eating*

Adolescents often have unhealthy eating habits, and the prevalence of obesity and eating disorders continues to increase, so questions about nutrition are important. Aim to help all adolescents develop healthy eating (and exercise) habits that can be maintained over a lifetime.

Obesity, which greatly increases the likelihood of developing diabetes and heart disease, is now clearly recognized to begin in childhood and adolescence.[18] Sedentary adolescents often snack continually during the time that they spend in front of media devices, compounding their risk. Simple strategies, such as recommending appropriate portion sizes, eliminating sugared soda and fast food, and limiting screen time, can be helpful in improving adolescent eating habits and overall health.[7,19]

Physicians should also attempt to identify adolescents whose eating habits may signal body image or self-esteem problems, psychologic distress, or depression. Frequent dieting, compulsive exercise, and purging are all of concern. At least half of normal-weight young women surveyed in the United States believe they are overweight.[20]

Use this question, for example: "As I ask all my patients—does your weight or body shape cause you any stress? If so, tell me about it." Then follow with specific questions about diet, eating habits, nutritional knowledge and beliefs, and pathologic dieting behaviors. Remember how much eating and exercise behaviors are influenced by genetic inheritance and by behavior modeled in the family or media. In 2010, there were at least 100 easily discoverable pro-anorexia websites encouraging and guiding disordered eating behaviors.[21] Media "apps" for calorie counting are widely available and these can be used to increase health and/or contribute to pathologic behavior.

Remember, of course, to praise good diet and exercise choices whenever you find them.

Looking at peer-related *Activities*

When adolescents or young adults are not at home, in school, or at work, they tend to be with their peers. As a prelude to more sensitive HEEADSSS questions, it is wise to have the patient tell you about what things he or she really enjoys. Adolescents derive much of their identity and self-esteem from peer activities.

Begin by asking: "Tell me what you do with your friends" or "What do you do for fun?" Be concerned about teenagers who cannot readily name friends or describe their activities beyond "hanging out." They may be at higher risk than teenagers who

SCREENING FOR MEDIA USE AND MISUSE

- Improved media access can lead to positive, prosocial outcomes such as empathy, acceptance of diversity, social group acceptability, and respect for the elderly.[a,b] Clinicians are now also faced with identifying how the concerning aspects of the media age—cyberbullying, sexting, driving while texting, online solicitation, Internet addiction (eg, video games), and media-related depression (eg, Facebook depression), to name a few—are affecting virtually every aspect of adolescent patients' psychosocial and physical well-being.
- Adolescents now spend 7 to 11 hours per day with different media, far from the maximum 1 to 2 hours typically recommended.[a] One quarter of teenagers are "cell-mostly" Internet users, stating that they mostly go online from their cell phones.[c] This suggests an unprecedented level of unsupervised Internet access. One-quarter of adolescents experience electronic bullying and one-third text while driving.[d,e] Those bullied online are more likely to report pervasive fear (in multiple environments) than those traditionally bullied.[f] In addition, pornography is available by typing a few key words into a search engine. Failing to identify associated risk behaviors will miss opportunities to improve health outcomes.
- Try to add "media" or "Internet" literacy in discussion with parents and patients. This can include topics such as co-viewing to foster communication and accurate interpretation of content, as well as setting limits (eg, parental controls, time using media, or access to media in one's bedroom).

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talk about specific activities with friends, such as sports, dancing, hobbies, games, or even shopping. Adolescents who say they are "bored all the time" may be depressed.

Ask teenagers about the nature and quantity of their use of television, computers, video games, and mobile media devices. Nearly one-third of high school students surveyed in a large nationwide study played video or computer games for 3 hours or longer on the average school day.[22] You may uncover a lack of parental connection and control, an avoidance of homework or family/peer interaction, or addictive behavior. Seek the specifics when interviewing an adolescent who endorses constant text messaging or social media posting. This behavior may be detrimental (eg, leading to sexting, texting while driving, or media-related depression) and/or it may be protective (as when used to connect with a health peer group that is otherwise unavailable).

On to *Drugs*

The drug history is sensitive. For patients in early adolescence, approach the topic obliquely: "We talked about what you and your friends do to have fun. Do any of your friends use drugs or alcohol (or get drunk or high)?" Young adolescents who would not readily talk about their own drug or alcohol use are often very willing to tell about such behavior by their friends. Next you might ask: "Tell me about a time that you felt pressured by friends to use drugs or alcohol, if any." The answer may lead to a discussion of specific circumstances and types of substances tried.

You may be able to ask older adolescents about drugs more directly. To elicit the most information, you need to know the latest trends of substance use within the patient's specific community. Substances used may include, for example, new synthetic cannabinoids, caffeine-containing energy drinks, anabolic steroids, and prescription medications such as opioids, benzodiazepines, and stimulants.

Also, ask specifically about tobacco and cigarettes, including electronic cigarettes (inhaled doses of nicotine), because many teenagers do not consider chewing tobacco or smoking to be a form of drug use. Be sure to find out whether the adolescent drives while under the influence of drugs or alcohol and/or rides with drivers who are intoxicated.

Explaining harms—without also evaluating readiness to change, acknowledging perceived benefits to substance use, using motivational interviewing techniques, and establishing trust and rapport—will likely not suffice to induce behavioral change. CRAFFT (**C**ar, **R**elax, **A**lone, **F**orget, **F**riends, **T**rouble) is a brief, validated, office-friendly screening test useful in initially assessing the substance-using teenager (Table 5).[23]

The goal of obtaining a drug history is usually to have the adolescent reveal the nature of problematic substance use to his or her parents or guardians (with your facilitation, if the patient desires) so that these caregivers can provide the patient with a more robust support system and foster additional treatment. Alternatively, substance use can remain confidential as long as there is no clear and immediate threat to the patient.

TABLE 5 The CRAFFT questions

Two or more "Yes" answers suggest high risk of a serious substance-use problem or a substance-use disorder.

C	Have you ever ridden in a **Car** driven by someone who was high or had been using drugs or alcohol?
R	Do you ever use alcohol or drugs to **Relax**, feel better about yourself, or fit in?
A	Do you ever use drugs or alcohol when you are **Alone**?
F	Do you **Forget** things you did while using drugs or alcohol?
F	Do your family and **Friends** ever tell you that you should cut down your drinking or drug use?
T	Have you ever gotten into **Trouble** while using drugs or alcohol?

Abbreviation: CRAFFT, Car, Relax, Alone, Forget, Friends, Trouble.
Knight JR, et al.[23]

Sexuality

The sexual history may be the most sensitive part of the interview. It may benefit rapport to seek permission before proceeding: "Do you mind if I ask you a few more personal questions to learn how I can best assist you?" It is also helpful to expressly acknowledge the discomfort most patients feel about discussing this topic. Say, for example: "I know that this may be embarrassing for you, but I ask these questions of all my teenaged patients to make sure I can give my best advice."

Especially with younger adolescents, you might observe: "Tell me about any of your friends who are starting to be in romantic relationships." To older adolescents, simply say: "Tell me about any romantic relationships you've been involved in." The open-endedness of such questions allows adolescents to tell whether they are having relationships with people of the same sex, the opposite sex, or both.

From asking about relationships, it is a short step to asking about sexual relationships: "Since sexual activity can affect your health, please tell me whether any of your relationships involved kissing or touching." If so, inquire about other sexual behaviors. Whether to screen for sexually transmitted infections, pregnancy, abuse, and other sequelae of sexual activity depends on the details.

Ask patients about their knowledge of fertility, contraception, and sexually transmitted infections, given that many teenagers use the Internet and social media as their primary sex educators. You might add: "Many people do not have anyone knowledgeable to talk to about sex. We're always happy to answer any questions you have." And remember, adolescents may forgo contraceptive or reproductive services if they think (rightly or wrongly) that parental notification is mandatory.[12,13]

Do not assume that adolescents who are having sexual experiences are comfortable about it. You may say: "Some of my patients tell me they feel pressured or coerced into having sex. Have you ever felt this way?" Sometimes, you can serve as a trustworthy adult who gives adolescents permission to avoid sexual activity until they are more comfortable with engaging in it. A history of abuse (if any) may not come out in the first interview, but the very fact that you show interest establishes rapport and may lead the patient to reveal the facts at a later time.

In today's Internet-linked world, sexual materials of all kinds are easily available. You may wish to ask teenagers about what sexual information and materials they have accessed online and how much and how often. Again, some experimentation with this is likely normal, but excessive use of such sites or accessing unusual or violent sexual content may

TABLE 6 Patient Health Questionnaire 2

A score of 3 or greater has good sensitivity and specificity for detecting major depression in adolescents.

OVER THE PAST 2 WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING?	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

Richardson LP, et al.[25]

indicate a risky behavior.[7]

Sometimes the greatest impediment to obtaining an adequate sexual history is a physician's own discomfort with sexuality. With practice, these questions become easier to ask without appearing judgmental. You can offer advice and personal opinions, but only if the teenager solicits them and only if you clearly label them as such.

Screening for *Suicide and depression*

Adolescents should be screened for depression when systems are in place to ensure accurate diagnosis, psychotherapy, and follow-up.[24] Teenagers often exhibit depression as boredom, irritability, anxiety, moodiness, sleep disturbance, and social withdrawal. Many are more willing to admit to "stress" than to overt depression or sadness. The Patient Health Questionnaire 2 (PHQ-2), a 2-item survey, may be used as an initial screening tool for depression in adolescents at each visit (Table 6).[25]

When depression seems likely, ask directly and clearly about self-harm. Asking about suicidal behavior does not precipitate or trigger it, and clinicians should not be reluctant to question patients unambiguously: "You've told me that you've been feeling bad lately. Have you felt so bad that you've thought seriously about harming yourself?" Adolescents attempt suicide more often than we realize, so physicians should not be surprised if a teenager has contemplated or even attempted it. Past suicide attempts are a strong risk factor for future attempts and future suicide. The clinical question is: How serious is the ideation, planning, or actual behavior?

Pay attention to sexual orientation. A recent study found that lesbian, gay, and bisexual (LGB) adolescents were more likely than heterosexual teenagers to have attempted suicide in the previous 12 months (21.5% vs 4.2%, respectively).[26] The likelihood of attempting suicide was 20% higher for LGB teenagers in unsupportive environments than in supportive environments. Sexual minority adolescents benefit greatly from clinician-provided support, as well as a safe place for asking questions.

Some adolescents who are not contemplating suicide nevertheless harm themselves. Teenagers who engage in cutting describe it as a mood-stabilizing behavior; in these situations a careful risk assessment is important.

S for *Safety*

Injuries, suicide, and homicide—the major causes of morbidity and mortality in adolescents—are a constant environmental reality for many young people. Antecedents such as bullying, domestic and school violence, gang involvement, sexual abuse, online solicitation, and access to weapons must be identified in the psychosocial history. Family violence, which increases the risk for teenaged violence several-fold, occurs in all social and economic classes, as does dating violence, which is reported by as many as 25% of teenaged and young adult women.[27,28]

Proceed to questions about the threats most prevalent in the patient's community. In some settings, these threats may be school violence and guns; in other settings, these may be sports injuries, sexual violence, or risk taking related to motor vehicles. Then ask about any other threats. Avoid letting assumptions based on the patient's racial, ethnic, or socioeconomic status lead you to skip taking parts of the history.

Find out what strategies the patient uses for self-protection, conflict resolution, and avoidance of violence. (No gangs? How about local bullies? Is there an abusive partner or parent?) Know the school-based and community organizations in your area that offer programs on conflict resolution and violence avoidance so that you can make specialized referrals. Many young people respond to violence with violence because that is all they know from their homes, streets, and media. Before offering concrete solutions, ask adolescents whether they can think of ways to avoid violence using their reported strengths.

Wrapping it up

You may end the psychosocial interview by asking adolescents to tell you in whom they can trust and confide if they have problems. Emphasize that your approach is nonjudgmental and that you welcome future visits. You may say: "I'm here for you, and I want you to feel comfortable confiding in me. If you have something personal to talk about, I'll try to give you my best advice and answer your questions."

Many adolescents do not recognize dangerous behavior patterns as dangerous because they see their activities not as problems but as solutions. Your challenge is to explore these behaviors and the context in which the adolescent lives, and to develop realistic solutions with patient buy-in.[10,11] Depending on the nature of the risk factors identified and the intervention to be established, you can either extend the initial visit or arrange a follow-up.

Finally, by now you may be overwhelmed by the amount of issues to be covered in this interview and wonder how to do this in a limited time. Of course, you cannot cover every aspect in a single visit, but your goal is to establish an effective

relationship in each case and leave the remaining questions for a later visit. You should feel free to add or remove priority questions based on the needs of your patient population. In other words, make HEEADSSS your own.

Try getting into the HEEADSSS of your adolescent patients. Your effort may have a lifelong impact. CP

Dedication

This manuscript is dedicated to the memory of David Rosen, MD, and Eric Cohen, MD, for their significant contributions to previous versions of the HEEADSSS psychosocial history and to the field of adolescent medicine.

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IMPROVING EARLY IDENTIFICATION & TREATMENT OF ADOLESCENT DEPRESSION: CONSIDERATIONS & STRATEGIES FOR HEALTH PLANS

NIHCM FOUNDATION ISSUE BRIEF
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NIHCM FOUNDATION

INTRODUCTION

According to a review by the National Adolescent Health Information Center, the most common mental health disorder among adolescents is depression with over 25 percent of adolescents affected by at least mild symptoms.[1] Mental health problems pose significant financial and social burdens on the individual as well as on families and society. Adolescents with unidentified mental disorders are in poorer physical health and engage in more risky behaviors than their peers, such as unsafe sexual activity, fighting and weapon carrying.[2] These youths are also at the highest risk for committing suicide; studies indicate that 90 percent of teens who die by suicide were suffering from an identifiable mental disorder at their time of death, typically depression.[3] Early identification and treatment can prevent the loss in productivity and high medical costs of depressed individuals, as well as the associated burdens on family members and caregivers.

Unfortunately, depression and other mental disorders often go undiagnosed in adolescence despite the availability of screening tools proven effective in identifying adolescent depression during the primary care visit. With symptoms of nearly three-fourths of all lifetime diagnosable mental health disorders beginning by age 24, it is critical to identify mental health disorders as early in life as possible.[4] The adolescent well-care visit is when most adolescents receive their health care and thus is an opportune time to conduct mental health screenings for this population.

The evidence and support for adolescent mental health screening in primary care is stronger than ever. In light of the benefits associated with early intervention and the existence of effective treatment options, both the Institute of Medicine (IOM) and the United States Preventive Services Task Force (USPSTF) have recently recommended that physicians in primary care settings screen adolescents for major depressive disorder. Easy and accurate screening tools exist, and behavioral health vendors, health plans and primary care providers are working together to implement screening during adolescent primary care visits. Health plans are in a unique position to support the integration of screening into a primary care visit by training physicians to use screening tools, reimbursing them for the time required to conduct a screening, and coordinating referrals for further treatment.

In this issue brief we review the prevalence of adolescent depression, consequences of unidentified depression, costs of screening and treatment, and recommendations and tools for primary care providers to identify and treat adolescent depression. Finally, we share opportunities for health plans to support providers in identifying and treating adolescent depression.

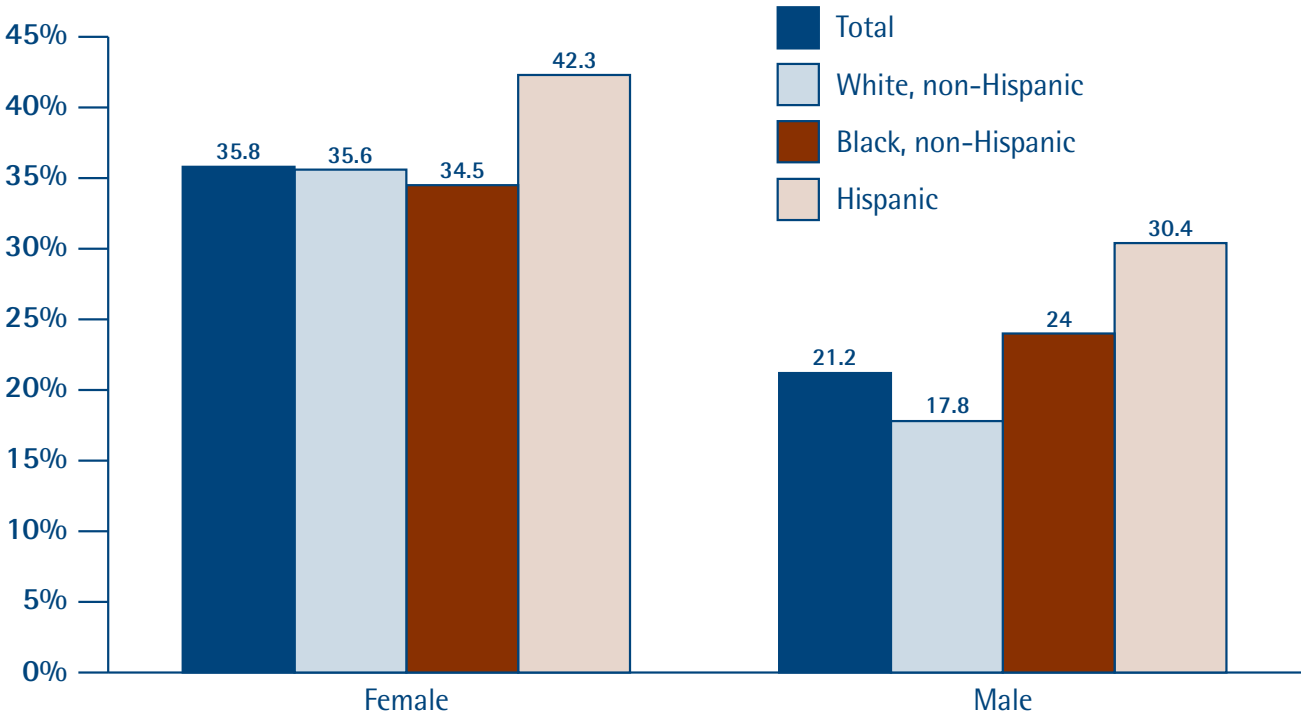
PREVALENCE OF ADOLESCENT DEPRESSION

Depression is one of the most widely reported mental disorders among adolescents. Depression is associated with several risk behaviors and suicide, the third leading cause of mortality for 15 to 24 year olds. As such, it is one of the most studied mental health conditions. Although prevalence statistics vary depending on the population, symptoms or severity examined, it is estimated that over 25 percent of adolescents are affected by at least mild symptoms.[5] In this section we review some of the data most commonly used to describe adolescent depression prevalence.

The Centers for Disease Control and Prevention's (CDC) Youth Risk Behavior Surveillance System (YRBSS) is a national school-based survey that provides one of the broadest measurements of depression in adolescents. The survey asks, "Have you ever felt so sad or hopeless almost everyday for two weeks in a row that you couldn't do some of your usual activities?" Results from the 2007 survey indicate that 36 percent of females and 21 percent of males felt this degree of sadness or hopelessness (**Figure 1**). Hispanic students were more likely to report this level of sadness than their non-Hispanic white or black peers.

There are numerous risk factors for depression including genetic and sociodemographic characteristics. Studies have found that genetic factors, such as parental depression, predict child and adolescent depression.[6] However, environmental influences have also been determined to be significant, along with a combination of environmental and genetic factors. Gender, family structure, parental education and race are also associated with differing levels of risk for depression. The relationship between these characteristics and the prevalence of depression in high school students was examined in a study that utilized AddHealth data, which is the largest, most comprehensive survey of adolescents to date. Severity levels of symptoms were identified as minimal, mild, moderate and severe using the Center for Epidemiological Studies – Depression Scale. Those with moderate and severe symptoms are typically labeled as having depression. This study revealed that in 1995 females were more than twice as likely as males to have depression; depression was almost twice as prevalent in adolescents whose mothers did not graduate from high school than among those with mothers with higher levels of education; and depression was 1.5 times more likely for adolescents living with a single parent than for those living with both parents. This study found that white students were 25 percent more likely to have depression than non-white students.[7]

FIGURE 1: SADNESS OR HOPELESSNESS WHICH PREVENTED USUAL ACTIVITIES BY GENDER AND RACE/ETHNICITY, HIGH SCHOOL STUDENTS, 2007



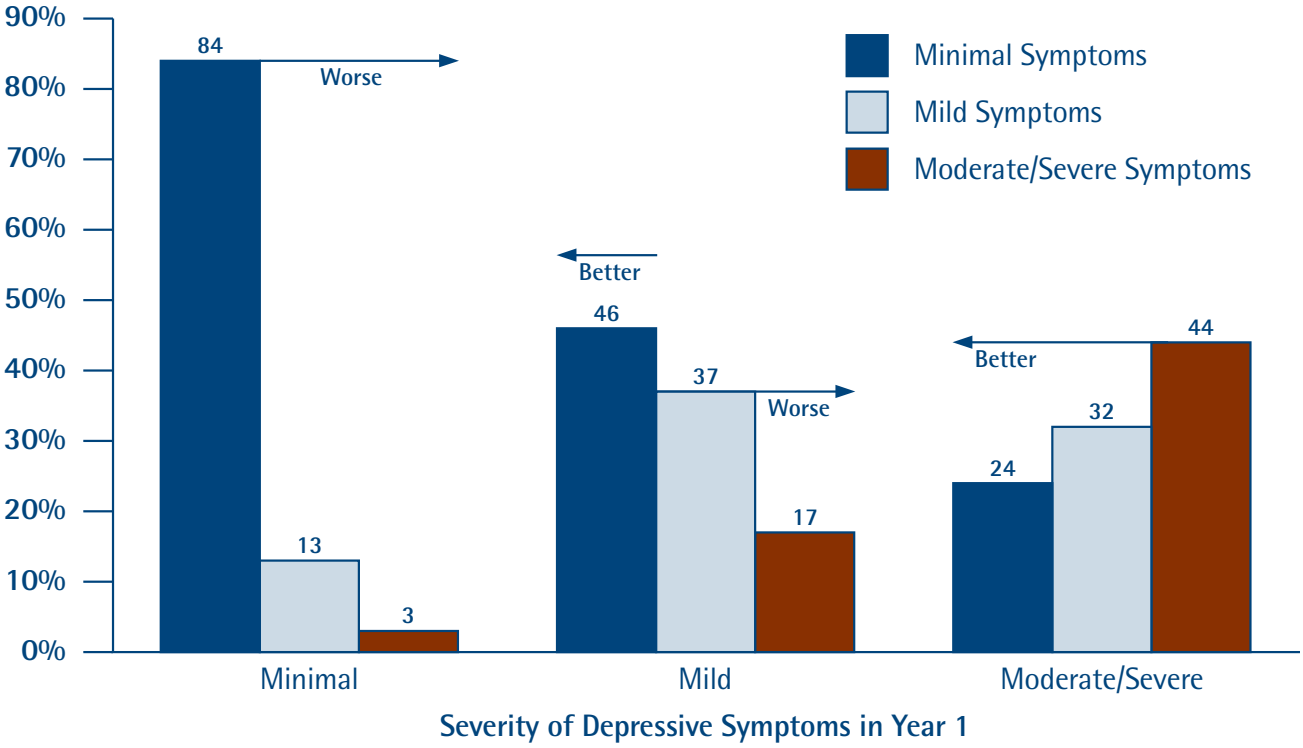
Source: Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance System 2007.

This study also surveyed these students one year later to examine the continuance of depressive symptoms over time. Although depressive symptoms were stable for many, the severity of depression symptoms changed for others and included both improvements and deteriorations in severity (**Figure 2**).

The Substance Abuse and Mental Health Services Administration's (SAMHSA) National Survey on Drug Use and Health (NSDUH) measures the prevalence of major depressive episode (MDE) among youth aged 12 to 17. MDE is diagnosed when a teen experiences a period of two weeks or longer characterized by persistent depressed mood or loss of interest or pleasure and at least four other behavioral symptoms, such as changes in sleep, eating, concentration and self-worth.[8] In 2007 more than 8 percent of adolescents (approximately two million) experienced at least one MDE with females more than twice as likely as males and older adolescents more likely than their younger peers to report MDE (**Figure 3**). Of all adolescents with MDE, females were more likely than males to report severe impairment.[9] Severe impairment is assessed through the Sheehan Disability Scale (SDS) which measures impairment in a person's daily functioning due to MDE. Adolescents aged 12 to 17 are asked to assess (on a 0 to 10 scale) the level of interference caused by MDE to (1) chores at home, (2) school or work, (3) close relationships with family, and (4) social life; ratings of 7 or greater are classified as severe impairment.

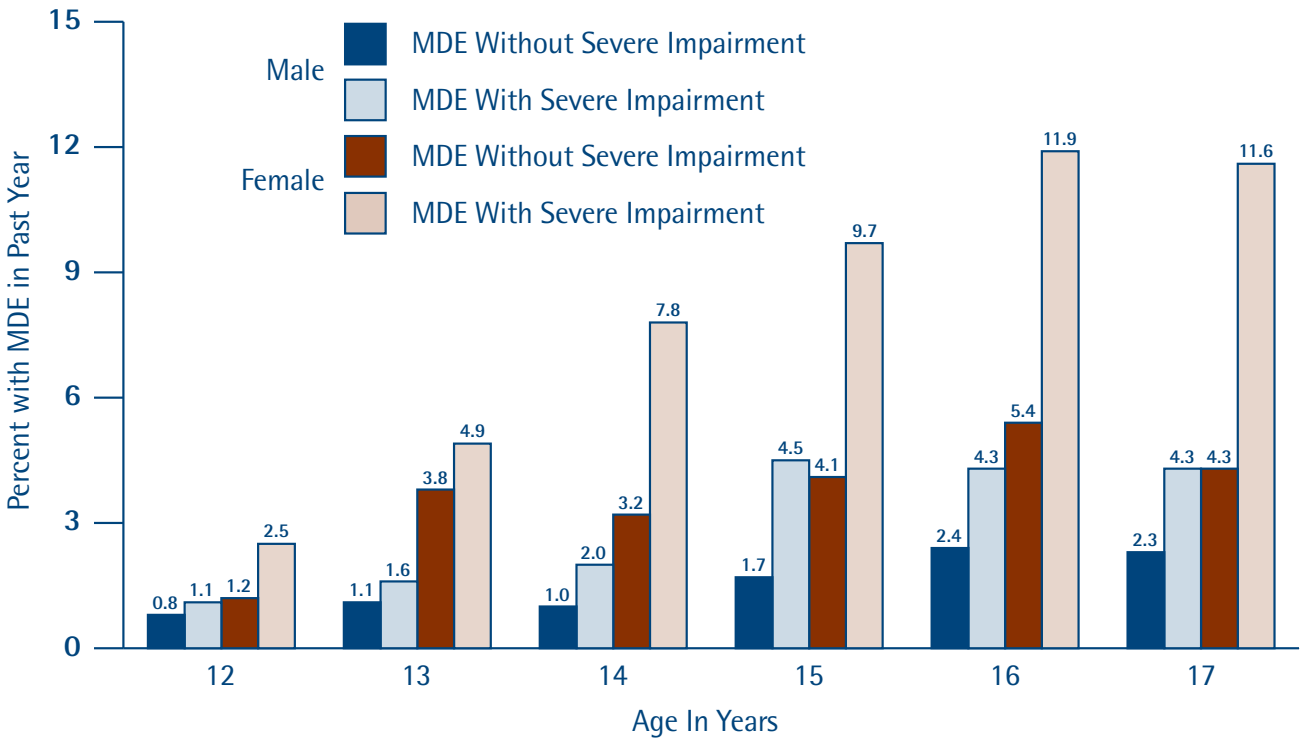
Depression frequently co-occurs with other mental health disorders. The 1990-92 National Comorbidity Survey revealed that 77 percent of 15 to 24 year olds diagnosed with major depression had at least one other psychiatric diagnosis as well. Among those with multiple diagnoses, 40 percent had anxiety disorders, 12 percent had addictive disorders, and 25 percent had conduct disorders.[10] For more than two-thirds of these adolescents and young adults, the diagnosis of major depression occurred after the diagnosis of another psychiatric disorder.

FIGURE 2: SEVERITY OF DEPRESSIVE SYMPTOMS ONE YEAR LATER



Source: AddHealth data in Rushton, Forcier and Schecktman, 2002.

FIGURE 3: MAJOR DEPRESSIVE EPISODE BY SEVERE IMPAIRMENT, AGE AND GENDER, 2007



Source: Substance Abuse and Mental Health Services Administration, Office of Applied Studies. Detailed Tables of 2007 National Survey on Drug Use and Health.

IDENTIFICATION & TREATMENT OF ADOLESCENT DEPRESSION

A lack of identification through screening as well as a lack of treatment among those diagnosed with depression are two well-known issues in the field of adolescent mental health. According to the 2001-2002 National Ambulatory Medical Care Survey (NAMCS) and the National Hospital Ambulatory Medical Care Survey (NHAMCS) which track care given in physician offices, emergency rooms and outpatient departments, physicians reported depression as a diagnosis in 2.8 million adolescent outpatient visits. These visits accounted for 2.9 percent of all outpatient visits by 15 to 17 year olds and 2.0 percent for 11 to 14 year olds. Given the prevalence of depressive symptoms among adolescents, these rates indicate that only a small proportion of the adolescent population is seeking care for depressive symptoms or being screened or diagnosed with depression in the outpatient setting, which is where most adolescents receive care.

A recent study by Ozer et al. examined the rates of provider screening for adolescent depression in California. Using data from the 2003 California Health Interview Survey, they found that just under one-third (31.2 percent) of California adolescents ages 12 to 17 said they had talked to their providers about their emotions or mood. Females were more likely to report being screened for emotional distress than males (37.5 percent versus 25.1 percent, respectively). These screening rates were consistent with a second dataset used in this study from a sample of California pediatric clinics in which 34 percent of teens reported that their doctors discussed their emotions with them (36.4 percent of females and 30.4 percent of males).

Data from SAMHSA's NSDUH indicate only approximately two of every five adolescents who experience MDE receive treatment for depression. Moreover, this rate varies according to gender, geographic region, health insurance coverage and overall health (**Figure 4**). Females, those living in the Northeast, those covered

FIGURE 4: ADOLESCENTS WITH AT LEAST ONE MDE RECEIVING TREATMENT IN THE PAST YEAR, BY DEMOGRAPHIC, GEOGRAPHIC AND HEALTH CHARACTERISTICS, 2007

Characteristic	Percent of Adolescents with MDE in Past Year	Percent of Adolescents with MDE who Received Treatment for Depression
Total	**8.2**	**38.9**
Gender		
Male	4.6	36.7
Female	11.9	39.9
Geographic Region		
Northeast	7.9	46.2
Midwest	8.5	37.9
South	8.0	37.4
West	8.3	37.0
Health Insurance		
Private	8.1	40.6
Medicaid/CHIP	8.2	42.9
Other	9.5	*
None	7.5	17.2
Overall Health		
Excellent	5.4	31.7
Very Good	8.2	38.3
Good	11.3	42.1
Fair/Poor	15.0	50.9

Source: Substance Abuse and Mental Health Services Administration, Office of Applied Studies Detailed Tables of 2007 National Survey on Drug Use and Health.
*Data are suppressed because of low precision.

by health insurance and those in fair or poor health are more likely to receive treatment.

When mental health issues go untreated, they are more likely to result in hospitalization which can be very costly. In 2006 there were 67,404 hospital stays involving a principal diagnosis of affective disorders for children and adolescents aged 10 to 17 (**Figure 5**). These cases accounted for 7.5 percent of all hospital stays for adolescents. Two of every five (42 percent) of these stays were via admissions from the emergency department, indicating a patient in crisis. The mean charge per hospital stay for these adolescents was $13,397, with higher mean charges for younger ages and for Medicaid patients. Total charges for all inpatient care to this population were approximately $903 million in 2006; private payers were charged nearly $374 million. Clearly there are large savings to be had through effective prevention and management of adolescent depression before inpatient care is needed.

The dominant forms of treatment for adolescents with depression are psychotherapy and pharmacotherapy (**Figure 6**). According to the 2007 NSDUH, 94 percent of adolescents treated for MDE saw or spoke with a medical doctor or other professional about depression; of these, 41 percent utilized prescription medication in addition to counseling. Another 6 percent were treated with prescription medication but received no counseling.[14]

FIGURE 5. INPATIENT CARE FOR ADOLESCENTS WITH PRINCIPAL DIAGNOSIS OF AFFECTIVE DISORDERS, 2006

	Inpatient Stays	Percent Admitted through ER	Mean Charge per Stay	Total Charges, All Stays ($ in millions)
All Adolescents (ages 10-17)	67,404	42.0%	$13,397	$903.0
Ages 10-14	28,658	41.3%	$14,596	$418.3
Ages 15-17	38,746	42.5%	$12,509	$484.7
Medicaid	29,329	41.2%	$15,241	$446.9
Privately Insured	31,383	41.9%	$11,903	$373.6
Other Payer	4,441	*	$12,149	$54.0
Uninsured	2,000	59.3%	$11,578	$23.2

Source: Authors' calculations from the Healthcare Cost and Utilization Project (HCUP) Kids' Inpatient Database, Agency for Healthcare Research and Quality. Accessed through HCUPnet at http://hcupnet.ahrq.gov/
*Data are suppressed because of low precision.

ADOLESCENT DEPRESSION & LINK TO SUICIDE RISK

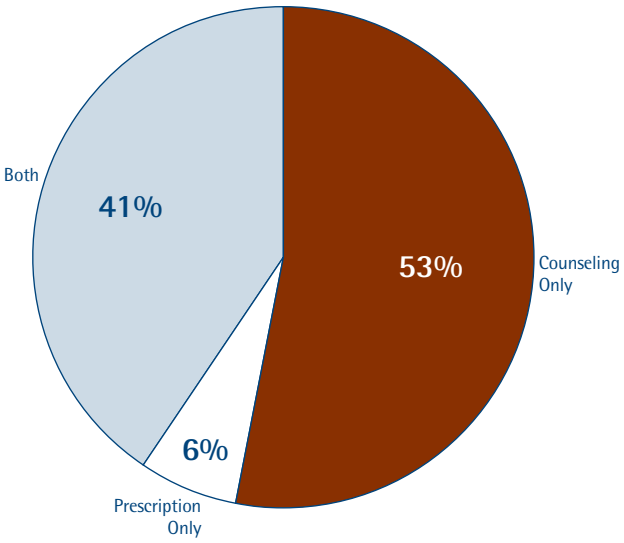
Suicide is the third most common cause of death among adolescents in the U.S. following unintentional injuries and homicides. Suicide accounts for approximately 4,500 deaths a year in youth ages 12 to 24.[15] In 2007 nearly 7 percent of high school students attempted suicide at least once. More than one-third of these students required treatment by a doctor or nurse for an injury, poisoning or overdose resulting from the suicide attempt.[16]

The risk of suicide is greatly increased by depression and other psychological disorders. Some studies indicate that 90 percent of teens who die by suicide were suffering from an identifiable mental disorder at the time of their deaths[17] and approximately 95 percent of all suicides occur among people with a psychological disorder.[18]

Although depression is a major risk factor for suicide, there is concern that antidepressants may increase the risk of suicide, particularly for adolescents. In February 2005 the Food and Drug Administration (FDA) issued a "black box" warning about the increased risk of suicidal thinking and behavior for pediatric patients taking antidepressants. The FDA extended this warning to young adults aged 18 to 24 in 2007.[19] Immediately following these warnings, as expected, there was a dramatic decrease in the utilization of antidepressants.

These FDA warnings have had unintended consequences on depression diagnosis. Research has shown that these black box warnings were followed by declines in depression diagnosis for both youths and adults. In 2007 diagnoses by primary care practitioners of new episodes of depression for children were 44 percent lower than would have been predicted based on historical trends prior to the

FIGURE 6: TREATMENT FOR ADOLESCENT DEPRESSION



Source: SAMHSA Office of Applied Studies, 2007 NSDUH

black box warning. Diagnoses for young adults were 37 percent lower, and diagnoses for adults were 29 percent lower than predicted.[20] While reasons for this decline have not been established and could be the result of fewer people presenting with symptoms during provider visits, the decline may stem from provider reluctance to make a diagnosis and prescribe antidepressants.

A recent study by FDA researchers confirms that the risk of suicidal behavior is greatly increased by the use of antidepressants for people under 25, with no similar increase for those aged 25 to 64. The study did, however, reveal differences in risks associated with the use of specific antidepressants. For example, the risk of suicidal behavior for those taking Zoloft (sertralene) was lower than among those taking a placebo, whereas use of Lexapro and Celexa seemed to increase risk.[21] Thus, the full association between antidepressant use and suicidal behavior remains unclear.

RECOMMENDATIONS AND TOOLS FOR ADOLESCENT DEPRESSION SCREENING

There is strong evidence that a brief standardized depression screening instrument is well-accepted in primary care practice. One study found that using a screening instrument, which took an average of 4.6 minutes for the patient to complete, was met with little resistance by patients and parents and was well perceived and accepted by providers. This finding confirms the recommendations of many respected professional organizations and other institutions that support mental health screening during the primary care visit. **Table 1** reviews the current recommendations specific to screening for adolescent depression.

A multitude of tools exist for primary care providers to screen adolescents for depression during the primary care visit. As part of their recommendation to screen adolescents for major depressive disorder (MDD), the USPSTF concluded that the Patient Health Questionnaire for Adolescents (PHQ-A) and the Beck Depression Inventory-Primary Care Version (BDI-PC) have successfully identified adolescents with MDD in primary care settings.[29] The state of Massachusetts, which recently mandated screening for children and adolescents under age 21 in its Medicaid program (MassHealth), requires that physicians use one of six approved tools when screening for depression in adolescents.[30] Other states may have adopted or recommended other tools for use in screening adolescents for depression. **Table 2** includes descriptions of a variety of screening tools applicable to the adolescent population, including the two instruments recommended by the USPSTF and the six tools approved by MassHealth. See **Appendix One** for more information on how to access these screening tools.

MANAGING & TREATING ADOLESCENT DEPRESSION

Following a diagnosis of depression, there is some evidence that interventions within primary care can lead to improvements in adolescent depression.[38] Primary care providers who offer modest levels of support, such as brief interventions consisting of as few as one to three meetings, can improve adolescent depression.[39] A review of the literature conducted for the USPSTF found that selective serotonin reuptake inhibitors (SSRIs), psychotherapy alone, and treatment that combines psychotherapy with pharmacotherapy have all been proven effective in reducing depressive symptoms among adolescents. However, treatment with SSRIs is

TABLE 1. RECOMMENDATIONS RELATED TO ADOLESCENT DEPRESSION SCREENING

Organization	Recommendation
U.S. Preventive Services Task Force (USPSTF)[23]	Recommends screening of adolescents (12 to 18 years of age) for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up. Risk factors for MDD include parental depression, having co-morbid mental health or chronic medical conditions, or having experienced a major negative life event. Grade B recommendation.[1]
American Academy of Pediatrics (AAP) Bright Futures[24]	Recommends annual confidential screening and referral for emotional and behavioral health problems for adolescent patients.
Institute of Medicine (IOM) "Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities"[25]	Recommends that the Federal government expand prevention and early identification of mental, emotional and behavioral disorders in young people through a national research plan to learn how to implement evidence-based prevention and screening.
American Academy of Pediatrics (AAP)/ American Academy of Child and Adolescent Psychiatry (AACAP) Joint Task Force[26]	Supports the emerging use of standardized screening tools by paying for mental health screening at routine visits and paying for the administration, scoring and interpretation of standardized mental health-assessment instruments.
Society for Adolescent Medicine (SAM)[27]	Supports the availability of a comprehensive range of mental health services and stresses the importance of early identification and appropriate treatment without delay.
Guidelines for Adolescent Depression in Primary Care (GLAD-PC)[28]	1. Patients (aged 10 to 21) with depression risk factors (such as history of previous episodes, family history, other psychiatric disorders, substance abuse, trauma, psychosocial adversity, etc.) should be identified and systematically monitored over time for the development of a depressive disorder. 2. Primary care clinicians should evaluate adolescents at high risk for depression and those who present with emotional problems as the chief complaint. Clinicians should use standardized depression tools to aid in the assessment. 3. Depression assessment should include direct interviews with the patients and families/caregivers and evaluation of functional impairment in different domains and the presence of other existing psychiatric conditions.

TABLE 2. SELECTED SCREENING TOOLS FOR ADOLESCENT DEPRESSION

Screening Tool	Description
BDI®-FastScreen for Medical Patients (previously known as the Beck Depression Inventory-Primary Care version or BDI-PC)[31]	• Used to detect depressive symptoms • Completed by patient • Seven items, takes less than five minutes to complete • USPSTF found this tool to identify MDD accurately among teens aged 12 to 17 in primary care settings
Center for Epidemiologic Study Depression Scale [CES-D][32]	• Measures depressive feelings and behaviors over the past week • Self-report • 20 questions, takes about five minutes to complete
Child Behavior Checklist [CBCL], Youth Self-Report [YSR] and Adult Self-Report [ASR][33]	• The Achenbach System is a set of tools that screens for social, emotional and behavioral status. The various tools cover screening from 1½ years through adulthood. The system also offers the possibility of multi-informant assessment. • The CBCL has two forms: CBCL/1½ -5 years, commonly called the "CBCL preschool" screen; and CBCL/6-18 years, often called the "CBCL school age" screen • The YSR screens from 11 through 18 years • The ASR screens from 18 through 59 years • Forms are completed by parents (CBCL preschool and school-age forms) or by the patient (YSR and ASR) • There are over 100 questions and time for completion varies, but can be up to 20 minutes • Scoring by staff can take several minutes • All are MassHealth Approved Screening Tools
Patient Health Questionnaire for Adolescents [PHQ-A][34]	• Designed to assess anxiety, mood, eating and substance use disorders • To be completed by the adolescent aged 13 to 18 • 83 questions but takes only a few minutes to complete • USPSTF found this tool to identify MDD accurately among teens aged 13 to 18 in primary care settings
Patient Health Questionnaire 9: Depression Screener [PHQ-9][35]	• Screens for depression in young adults 18 years and older • One-page questionnaire that can be completed by the young adult in about five minutes and then quickly scored by staff • Endorsed by TeenScreen, National Center for Mental Health Checkups at Columbia University • MassHealth Approved Screening Tool
Pediatric Symptom Checklist and Pediatric Symptom Checklist-Youth Report (PSC & Y-PSC)[36]	• The PSC is completed by parents of children 4 to 16 years old. • The Y-PSC is completed by youths from 11 to 18+ years of age. • Both versions are 35-item questionnaires that can be completed in about five to 10 minutes, then quickly scored by staff. • Endorsed by TeenScreen National Center for Mental Health Checkups at Columbia University • Both are MassHealth Approved Screening Tools
Strengths and Difficulties Questionnaire [SDQ][37]	• Brief behavioral screening questionnaire • Self-report version to be answered by young people aged 11 to 16 • 25 questions

associated with a small increase in risk for suicidality and should be considered only if clinical monitoring is possible.[40] The USPSTF stresses the importance of screening adolescents for mental disorders only when psychotherapy is available as a treatment option in order to prevent primary care providers from relying on pharmacotherapy alone.

While evidence about the effectiveness of specific interventions in the primary care setting is still limited, the Guidelines for Adolescent Depression in Primary Care (GLAD-PC) have emerged as an important first step in guiding primary care providers as they address adolescent depression. **The GLAD-PC recommendations for initial management of depression are**:[41]

1. Clinicians should educate and counsel families and patients about depression and options for management of the disorder. Clinicians should also discuss limits of confidentiality with the adolescent and family.

2. Clinicians should develop a treatment plan with patients and families and set specific treatment goals in key areas of functioning, including home, peer and school settings.

3. The primary care clinician should establish relevant links/collaboration with mental health resources in the community, which may include patients and families who have dealt with adolescent depression and are willing to serve as resources to other affected adolescents and their families.

4. All management should include the establishment of a safety plan, which includes restricting lethal means, engaging a concerned third party, and developing an emergency communication mechanism should the patient deteriorate, become actively suicidal or dangerous to others, or experience an acute crisis associated with psychosocial stressors, especially during the period of initial treatment when safety concerns are highest.

Primary care practices that identify adolescent depression may benefit from GLAD-PC's recommendations related to treatment and ongoing management. **GLAD-PC's treatment recommendations are**:[42]

1. After initial diagnosis, in cases of mild depression, clinicians should consider a period of active support and monitoring before starting other evidence-based treatment.

2. If a primary care clinician identifies an adolescent with moderate or severe depression or complicating factors/conditions such as coexisting substance abuse or psychosis, consultation with a mental health specialist should be considered. Appropriate roles and responsibilities for ongoing management by the primary care and mental health clinicians should be communicated and agreed upon. The patient and family should be consulted and approve the roles of the primary care and mental health professionals.

3. Primary care clinicians should recommend scientifically tested and proven treatments (i.e., psychotherapies such as cognitive behavioral therapy or interpersonal psychotherapy and/or antidepressant treatment such as SSRIs) whenever possible and appropriate to achieve the goals of the treatment plan.

4. Primary care clinicians should monitor for the emergence of adverse events during antidepressant treatment (SSRIs).

GLAD-PC's recommendations for the ongoing management of adolescent depression in primary care are:[43]

1. Systematic and regular tracking of goals and outcomes from treatment should be performed, including assessment of depressive symptoms and functioning in several key domains: home, school and peer settings.

2. Diagnosis and initial treatment should be reassessed if no improvement is noted after 6 to 8 weeks of treatment. Mental health consultation should be considered.

3. A mental heath consultation should be considered for patients who achieve only partial improvement after primary care diagnostic and therapeutic approaches have been exhausted (including exploration of poor adherence, comorbid disorders, and ongoing conflicts or abuse).

4. Primary care clinicians should actively support depressed adolescents who are referred to mental health providers to ensure adequate management. Primary care clinicians may also consider sharing care with mental health agencies/professionals when possible. Appropriate roles and responsibilities regarding the provision and coordination of care should be communicated and agreed upon by the primary care clinician and mental health specialist.

PREVENTING SUICIDE & MANAGING SUICIDE ATTEMPTS

Suicide ideation and attempts are common among adolescents with depression. GLAD-PC recommends that all providers managing adolescent depression develop an emergency communication plan, establish a safety plan, and obtain information from a third party.[44] This preparation and monitoring are even more critical for youths taking antidepressants given the FDA's black box warning. The frequency of monitoring has been controversial, with the FDA calling for at least weekly face-to-face contact during the first four weeks, followed by biweekly visits for the next four weeks, then a 12 week visit, and as clinically indicated beyond 12 weeks. While no empirical evidence has been found to support weekly face-to-face visits, GLAD-PC recommends that providers develop a regular and frequent monitoring schedule and obtain input from the patient and family to ensure compliance with the monitoring strategy.[45]

In addition to their role in preventing suicide, primary care providers should also be involved in treating an adolescent following a suicide attempt. Prior to discharge from the hospital, a comprehensive treatment plan should be developed that includes specific follow-up care involving both mental health and primary care clinicians. Any medication prescribed following a suicide attempt must be managed and monitored by the prescribing provider to assess continued suicidal risk. Complicating these treatment requirements, adolescents who have attempted suicide are a difficult group to engage after hospitalization, often failing to keep their outpatient appointments.[46] A close relationship between a primary care provider and an adolescent can help facilitate recovery and prevent another suicide attempt.

BARRIERS TO IDENTIFYING & TREATING ADOLECENT DEPRESSION IN PRIMARY CARE

Despite the known benefits of early identification and treatment, as well as the multitude of available screening tools, barriers and challenges to identifying and treating adolescent depression in primary care persist. These challenges include adolescent and parental concerns, organizational and individual physician barriers, workforce shortages, coding and reimbursement limitations in private and public insurance, and a lack of research supporting primary care screening and interventions.

Adolescent and Parental Barriers

The Teen Depression Awareness Project studied the perceived barriers to adolescent depression care as reported by adolescents and their parents. The barriers to care mentioned most often by adolescents and parents were other responsibilities at school, recreational activities, needing to babysit or difficulty getting time off work. Adolescents also mentioned concerns about the perceived stigma of receiving mental health care and feeling uncomfortable talking with anyone about their feelings. Parents and adolescents alike reported access to health care as a barrier, specifically a lack of transportation to a provider's office or inconvenient office hours. Parents also noted concern regarding insurance coverage for depression screening and care.[47]

Organizational and Physician Barriers

In addition to these patient and parent concerns, a survey of pediatric practices found organizational and individual physician barriers prevented providers from diagnosing or intervening when responding about their most recent case of child or adolescent depression. Organizational barriers reported most commonly were inadequate time to obtain patient history and provide counseling and education. Physician barriers to providing depression care were their perceptions of having inadequate training to diagnose, counsel and treat child or adolescent depression. Ambiguity over their level of responsibility for identifying and treating

depression is also a barrier. While nearly all pediatricians felt it was their responsibility to recognize depression in children and adolescents, only about one quarter reported it was their responsibility to treat depression in this age group. The limited use of screening tools among pediatricians also continues to be a barrier. The practices surveyed reported that depression diagnoses among children and adolescents were primarily the result of an expressed parental concern; only 40 percent reported the use of some type of screening questionnaire or tools to identify depression.[48]

Workforce Barriers

Shortages of primary care providers and mental health professionals are also identified as barriers to screening and treating adolescents for depression. The lack of access to primary care providers, especially in rural areas, prevents many adolescents from receiving care. Shortages of mental health professionals, particularly child and adolescent psychiatrists, impede providers from making referrals following a diagnosis. Even when referrals are made, the fact that most are not followed through to completion by the patient or parent represents a further challenge. Providers have expressed reluctance to refer adolescents to community resources, where many services are not evidence-based, there are usually long waiting lists, and patients often find there is a stigma attached to this type of care. Furthermore, few providers and primary care practices are equipped to develop and maintain the linkages with the community resources necessary to provide a continuum of care for adolescents diagnosed with depression.[49]

Coding and Reimbursement Barriers

Financial barriers also restrict the ability of primary care providers to identify and treat adolescent depression. Limits placed on the length of provider visits for reimbursement purposes hinder the ability of providers to address mental health concerns within a primary care visit. Primary care providers are already encouraged and often required to provide a large number of preventive services in their short visit time; screening for depression is another responsibility added to their already constrained time with an adolescent.[50] While screening is generally covered by private insurance, providers and office staff often face difficulties coding for the extended visit time required for screening and further assessment of those who screen positive. Screening primarily occurs during a well visit or sports physical, and most health plans reimburse for only one code associated with these visits. In 2003 the Centers for Medicare and Medicaid Services (CMS) approved two CPT codes — 96110 and 96111 — for developmental and behavioral screening in pediatrics; however these codes are usually rejected when appended to a well visit claim.[51] These codes can be used at a sick visit, but this requires a provider to bring in an adolescent for a separate visit and results in an additional co-payment for the visit.

Mental health carve-outs and their restrictions on recognized providers often prevent primary care providers from billing for mental health services. These plans generally reimburse only mental health professionals for mental health treatment, effectively placing limitations on the amount of treatment that can be provided by primary care setting physicians. Benefit packages also may limit the number of outpatient visits for mental health services, making it extremely difficult for patients to follow through with referrals and treatment. It can also be challenging to use other office staff to administer screenings or otherwise aid in the screening and referral process since non-physician staff are often not reimbursed for their time. The CMS-approved CPT code 96110 includes reimbursement to pay for cost of the screening tool and for non-physician office staff to administer and score the tool, however, as mentioned earlier, it is difficult to use this code in conjunction with a well visit.

There is also a lack of support and reimbursement for collaborative care between primary care providers and mental health professionals, whether through a phone consultation or co-location of mental health services in the primary care practice. Even when primary care and mental health services are co-located, there is often a further barrier of restrictions on billing for same day services.

For adolescents with public insurance, the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program requires screening and testing of all Medicaid children for mental and emotional issues and requires that services be provided if a need is detected.[52]

However, studies have shown that only 60 percent of states reimburse for the use of standardized screening tools and 40 percent of providers report low screening rates and a reluctance to screen.[53]

Research Barriers

While the USPSTF recommendation reviewed the current research and found that certain screening tools were effective in adolescents, this evidence is not as robust as it needs to be. More research is needed to support the widespread use of these and other screening tools and to determine effective interventions to treat depression in the primary care setting. Overall evidence on the cost-effectiveness of depression screening and other preventive interventions in primary care also continues to be limited. One study in the adult population found that primary care depression screening costs an average of $7 per visit but yielded many false positives that resulted in additional burdens to the primary care practice staff and specialty care systems.[54] Screening of adolescents for depression is far from a universal practice for primary care providers, pointing to the need for more research on the cost-effectiveness of screening the adolescent population.

OPPORTUNITIES FOR HEALTH PLANS TO SUPPORT IDENTIFICATION & TREATMENT OF ADOLESCENT DEPRESSION

Opportunities to Support Adolescents, Parents and Primary Care Providers

Health plans can offer support to adolescents, their parents and primary care providers in order to improve the identification and treatment of adolescent depression in the primary care setting. Findings from the Teen Depression Awareness Project suggest that providers can target communications to adolescents and parents to address concerns, needs and priorities for depression care.[55] Health plans can support providers in this effort by arming them with communications tools, such as brochures or other materials, to help them engage adolescents and their parents in this dialogue. Health plans can also target communications directly to adolescents and their parents about the signs of depression and the importance of seeking care.

Provider training and education is another way health plans can help. Such assistance could include resources and support to train providers, other health professionals or office staff to administer screening tools and training and easy access to tools to improve physicians' ability to deliver mental health services to adolescents in the primary care setting, such as those materials developed by the TeenScreen Primary Care Program. Support and training related to managing medication use among adolescents diagnosed with depression is especially critical. To further promote appropriate management and treatment of depression in primary care, health plans can promote the use of the GLAD-PC guidelines.

Opportunities to Reduce Financial Barriers

Reimbursement for the time required to administer a screening tool and further assess adolescents who screen positive during a primary care visit is a vital strategy for improving screening rates. The TeenScreen Primary Care Program has identified a number of codes and combinations of codes that can be used to bill for screening and recommends that providers consult their coding and billing department to determine the best codes to use in their practices.[56] TeenScreen is working with health plans across the country to implement coding for screenings in primary care, help providers understand how to code for mental health checkups, and help with referrals to mental health specialists by giving providers detailed resources and instructions. Several health plans participating in TeenScreen's pilot program have agreed to reimburse for the use of the CPT 91110 code to cover a routine mental health checkup in primary care without a second co-payment. They are also recognizing the use of '25' in the modifier field to allow providers to bill for additional time for further evaluation of an adolescent. Health plans can pilot the TeenScreen Primary Care Program within their network of primary care providers, and providers and plans can obtain implementation materials directly from the program free of charge. See Figure 7 for more information on the TeenScreen Primary Care Program.

Figure 7. TeenScreen National Center for Mental Health Checkups at Columbia University

The TeenScreen National Center for Mental Health Checkups at Columbia University (TeenScreen) is dedicated to early identification of mental illness in adolescents and prevention of teen suicide. The center promotes greater access to youth mental health checkups across the nation and evidence-based screenings provided as part of routine care in adolescent primary care offices, schools and other settings serving youth. TeenScreen was established is 1991 and is at the forefront of the adolescent mental health screening movement. There are currently more than 700 active TeenScreen sites located in 43 states.

Originally focused on partnering with schools, TeenScreen launched a primary care initiative in 2008 that aims to integrate mental health checkups into routine adolescent primary care. TeenScreen Primary Care conducts demonstration projects and research studies in 20 states through partnerships with health plans, hospitals, health centers and medical providers. In working with health and behavioral health plans, TeenScreen reaches out to network primary care providers to encourage their implementation of mental health screening, establishes a coding and reimbursement mechanism for providers and health plans, and develops a facilitated mental health referral system for adolescents identified through screening. The TeenScreen Primary Care Quick Start Guide is a comprehensive resource available for providers to assist with the implementation of mental health checkups in a primary care setting. Other materials available include a Pocket Guide for providers and a Teen Brochure that contains an evidence-based screening questionnaire and information about mental health screening.

By creating reimbursement and referral mechanisms with health plans, TeenScreen is targeting the primary barrier preventing providers from incorporating mental health screenings into routine care. Reimbursement codes and procedures are customized for participating plans, with reimbursement provided for administration and scoring of the questionnaire and/or for physician time for post-screening evaluation. TeenScreen also customizes a referral mechanism for participating health plans to help the primary care provider make a referral to a mental health professional after a positive screen. This process involves providing the primary care provider with a toll-free number for the behavioral health plan that providers and/ or parents can call to obtain a timely appointment with a mental health professional. All calls to the number are answered by a licensed, master's level clinical care manager who conducts a risk rating assessment, determines the appropriate level of care, and assists the family in obtaining a timely appointment with a mental health provider. In the case of an emergency, the clinical care manager will secure and confirm that the patient can be seen immediately by a licensed mental health professional or in a local emergency department. The care manager then follows up within one hour of the appointment to confirm that the patient arrived at the appointment.

TeenScreen partnered with ValueOptions, a behavioral health plan, and is working with two of its managed care organizational partners – EmblemHealth in New York and Kaiser Permanente in southern Colorado. In the spring and summer of 2009, three outreach letters were mailed to approximately 8,000 pediatricians in the EmblemHealth network. As a result of this outreach, screening implementation materials were ordered by 543 providers who have so far requested 68,020 screening questionnaires for their patients. TeenScreen conducted a smaller pilot project with Kaiser Permanente in southern Colorado. Pediatricians and family physicians in Kaiser's network volunteered to participate after an introductory presentation by TeenScreen. Through September 2009, screening implementation materials have been distributed to 41 providers who so far have requested 6,400 screening questionnaires for their patients.[62]

More information on TeenScreen in Primary Care is available at: http://www.teenscreen.org/teenscreen-primary-care.

Reimbursement for non-physician staff to administer screenings and facilitate referrals can also help improve screening rates and alleviate the burden from the primary care provider. Kelleher and Gardner further suggest that innovative financing mechanisms, such as global payment for case management of an adolescent with depression, could also be a useful strategy to ensure appropriate management of depression by the primary care provider.[57]

Opportunities to Support Innovations in Care

Health plans may be able to spur the use of innovations in care for depression in the primary care setting. Kelleher and Gardner suggest that providers could use technology that helps lower the cost of assessment and communication with adolescents to improve early identification of depression.[58] Plans can provide or reimburse for the use of technologies, such as electronic screening tools or email consultations within an electronic medical record. Reimbursing for the use of tele-psychiatry would help providers and adolescents in rural and other areas where access to adolescent psychiatrists is limited. Reimbursement for collaborative care, such as phone consultations between primary care providers and mental health professionals, has the potential to improve care delivery to adolescents. The Massachusetts Child Psychiatry Access Project, described in Figure 8, is an example of how consultation models can increase access to mental health care for children and adolescents who otherwise may have gone without appropriate care.[59] Primary care providers may be more willing to screen when they know they have resources available if they need additional assistance in making a diagnosis or developing a treatment plan.

Pay-for-performance initiatives, proven effective for improving the quality and frequency of screening and treatment for some disease conditions, could be applicable to depression screening. Rosenthal and Frank reviewed the literature on paying for quality and found some research that points to improvements in screening procedures through pay-for-performance initiatives, although the evidence of success in the primary care setting is limited.[60] Plans could explore including depression screening within their pay-for-performance initiatives and offer bonuses to providers who comply with screening guidelines.

Opportunities to Support Additional Research

The successful implementation of any of the above strategies by health plans will likely continue to

Figure 8. Massachusetts Child Psychiatry Access Project (MCPAP)

The Massachusetts Child Psychiatry Access Project (MCPAP) is a statewide project that assists pediatric primary care providers in delivering mental health care to children and adolescents. Providers can access six mental health teams, comprised of child psychiatrists, therapists and a care coordinator. These teams provide phone consultations, diagnostic evaluations and care coordination to find available mental health providers for referrals. They also offer education and training to primary care providers. Since December 2007, Medicaid providers in Massachusetts have been mandated to screen children and adolescents for mental health disorders using MassHealth-approved screening tools. MCPAP teams are available to help primary care physicians utilize standardized behavioral health screening tools in their practices. MCPAP teams can also provide assistance for any clinical questions that arise from performing a depression screening, including how to manage positive screens, make the appropriate diagnosis, coordinate follow-up care and provide information about the availability of behavioral health resources for referral.

MCPAP has interacted with more than 32,000 primary care providers since its inception in 2004, and over 9,000 patients have been reached. Participating providers have reported substantial improvements in their ability to address the mental health needs of their child and adolescent patients. More information on MCPAP is available at: http://www.mcpap.com.

be dependent on the evidence of effectiveness of primary care interventions. Stein, Zitner and Jensen call for additional research to build the evidence base of effective mental health screening tools and interventions in primary care.[61] Plans can support research evaluating the cost-effectiveness of screening and other primary care interventions, which may also lead to better reimbursement in the future for services shown to be cost-effective.

CONCLUSION

Allowing adolescent depression to continue to go undiagnosed has huge consequences for the future health of our nation. The common prevalence of depression among adolescents and the lifelong physical, social and financial consequences of living with untreated depression point to the importance of identifying depression as early as possible. Since health plans largely adhere to the recommendations of the USPSTF for clinical preventive services in making coverage decisions, the recent recommendations from the IOM and USPSTF that primary care physicians screen adolescents for mental health disorders are a positive step toward improved screening rates. The Paul Wellstone and Pete Domenici Mental Health Parity & Addiction Equity Act of 2008 is also expected to have a beneficial impact on coverage and reimbursement for mental health services as health plans begin to address these new parity requirements. The availability of accurate screening tools, combined with these recent recommendations and legislation, point toward increased support for mental health screening in primary care and the potential for screening rates to improve in future years. It will be vital, however, to continue to develop evidence and support for strategies and tools that primary care providers can use to provide effective treatment to adolescents diagnosed with depression. In order to access mental health treatment, adolescents, parents and primary care providers must first overcome the barriers preventing adolescents from being screened for depression and receiving treatment when diagnosed with depression, allowing them access to the most appropriate care. Encouraging screening, providing a billing and reimbursement mechanism, and facilitating referrals to mental health professionals are all strategies that health plans can support in order to have a significant impact on improving early identification and treatment of depression among adolescents.

APPENDIX ONE: HOW TO ACCESS SELECTED SCREENING TOOLS

Screening Tool	Cost	Contact
BDI®-FastScreen for Medical Patients	$105 for complete kit (manual and pad of 50 record forms)	www.beckscales.com
Center for Epidemiologic Study Depression Scale [CES-D]	Free	http://cooccurring.org/public/document/ces-d.pdf http://cooccurring.org/public/document/usingmeasures.pdf
Child Behavior Checklist [CBCL], Youth Self-Report [YSR] and Adult Self-Report [ASR]	• CBCL (includes the YSR) - $395.00 for computer-scored or approximately $300.00 for hand-scored kit • ASR - $245.00 for computer-scored or $230.00 for hand-scored kit	http://www.aseba.org/
Patient Health Questionnaire for Adolescents [PHQ-A] and Patient Health Questionnaire 9: Depression Screener [PHQ-9]	Free	The PHQ-A is a comprehensive screen for a range of mental health disorders. A copy can be obtained by contacting Jeffrey G. Johnson, PhD, Associated Professor of Clinical Psychology, Epidemiology of Mental Disorders, Columbia University at (212) 543-5523 or jgj2@columbia.edu. In order to screen for depression in the primary care setting, TeenScreen has adopted a version of the PHQ-9 modified for adolescents. A copy can also be obtained from TeenScreen. Contact TeenScreen at (212) 265-4426 or through their website at: http://www.teenscreen.org/checkups-in-primary-care
Pediatric Symptom Checklist and Pediatric Symptom Checklist-Youth Report (PSC & Y-PSC)	Free	http://www2.massgeneral.org/allpsych/psc/psc_home.htm
Strengths and Difficulties Questionnaire [SDQ]	Free	http://www.sdqinfo.com/b3.html

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A Survey From Your Healthcare Provider — PSC-Y

Name	Date	ID

	Please mark under the heading that best fits you or circle Yes or No	Never 0	Sometimes 1	Often 2
-	1. Complain of aches or pains			
-	2. Spend more time alone			
-	3. Tire easily, little energy			
●	4. Fidgety, unable to sit still			
-	5. Have trouble with teacher			
-	6. Less interested in school			
●	7. Act as if driven by motor			
●	8. Daydream too much			
●	9. Distract easily			
-	10. Are afraid of new situations			
▲	11. Feel sad, unhappy			
-	12. Are irritable, angry			
▲	13. Feel hopeless			
●	14. Have trouble concentrating			
-	15. Less interested in friends			
■	16. Fight with other children			
-	17. Absent from school			
-	18. School grades dropping			
▲	19. Down on yourself			
-	20. Visit doctor with doctor finding nothing wrong			
-	21. Have trouble sleeping			
▲	22. Worry a lot			
-	23. Want to be with parent more than before			
-	24. Feel that you are bad			
-	25. Take unnecessary risks			
-	26. Get hurt frequently			
▲	27. Seem to be having less fun			
-	28. Act younger than children your age			
■	29. Do not listen to rules			
-	30. Do not show feelings			
■	31. Do not understand other people's feelings			
■	32. Tease others			
■	33. Blame others for your troubles			
■	34. Take things that do not belong to you			
■	35. Refuse to share			
◆	36. During the past three months, have you thought of killing yourself?		Yes	No
◆	37. Have you ever tried to kill yourself?		Yes	No

FOR OFFICE USE ONLY

Plan for Follow-up ☐ Annual screening ☐ Return visit w/ PCP ☐ Referred to counselor
☐ Parent declined ☐ Already in treatment ☐ Referred to other professional

TS _____

Q 36 or Q 37=Y ◆ TS ≥ 30

Source: Pediatric Symptom Checklist – Youth Report (PSC-Y)

Administering, Scoring and Interpreting the PHQ-9 Screening Questionnaire

Administering

- The youth self-report version of the Pediatric Symptom Checklist (PSC-Y) can be used with patients between the ages of 11 and 18 and takes less than five minutes to complete and score.
- The PSC-Y can be administered and scored by a nurse, medical technician, physical assistant, physician or other office staff.
- Patients should be left alone to complete the PSC-Y in a private area, such as an exam room or private area of the waiting room.
- Patients should be informed of their confidentiality rights before the PSC-Y is administered.
- It is recommended that parents are informed that a mental health checkup will be administered as part of the exam.
- The American Academy of Pediatrics and U.S. Preventive Service Task Force recommend that depression screening be conducted annually.

Scoring

- **Each item on the PSC-Y is scored as follows:**
  Never =0
  Sometimes=1
  Often=2
- **To calculate the score, add all of the item scores together:**
  Total Score= _____(range 0-70)
  If items are left blank, they are scored as 0.
  If four or more items are left blank, the questionnaire is considered invalid.
  Note if either suicide question has been endorsed (Questions 36 and 37).
- **Score is positive if: Total Score >/=30**
  OR
  Recent suicidal ideation is reported (Q36)
  OR
  Past suicide attempt is reported (Q37)

Interpreting the Screening Results

- Patients that score positively on their PSC-Y should be evaluated by their primary care provider (PCP) to determine if the symptoms endorsed on the questionnaire are significant, causing impairment and warrant a referral to a mental health specialist or follow-up treatment by the PCP.
- For patients who score negatively on the PSC-Y, it is recommended that the PCP briefly review the symptoms marked as "sometimes" and "often" with the patient.
- The questionnaire indicates only the likelihood that a youth is at risk for a significant mental health problem or suicide; its results are not a diagnosis or a substitute for a clinical evaluation

The symbols on the questionnaire and below represent the different problem areas that are covered on the PSC-Y and lists out the items that correspond with problem areas. Though this does not affect the overall score, the purpose of this breakdown is to help guide the discussion with and evaluation of patients after screening and allows the PCP to focus on the main problem areas identified by the PSC-Y.

Individual Problem Areas (For Interpretation Only)			
Internalizing Problems (i.e. Depression or Anxiety) ▲	**Attention Problems (i.e. ADHD)** ●	**Externalizing Problems (e.g. Conduct Disorder, Oppositional Defiant Disorder** ■	**Suicidality (if either question is endorsed, further assess for suicidal thinking and behavior and depression)** ◆
• Feel sad, unhappy • Worry a lot • Feel hopeless • Seem to be having less fun • Down on yourself	• Fidgety, unable to sit still • Distract easily • Act as if driven by motor • Daydream too much • Have trouble concentrating	• Fight with other children • Tease others • Do not listen to rules • Do not understand other people's feelings • Blame others for your troubles • Take things that do not belong to you	• Recent suicide ideation • Prior suicide attempt
Non-Categorizing Items			
• Complain of aches or pains • Spend more time alone • Tire easily, little energy • Do not show feelings • Have trouble with teacher	• Less interested at school • Are afraid of new situations • Are irritable, angry • Less interested in friends • Absent from school	• School grades dropping • Visit doctor with doctor finding nothing wrong • Have trouble sleeping • Feel that you are bad	• Want to be with parent more than before • Take unnecessary risks • Get hurt frequently • Act younger than children your age

A Survey From Your Healthcare Provider — PHQ-9 Modified for Teens

Name_____ Clinician_____

Medical Record or ID Number_____ Date_____

Instructions: How often have you been bothered by each of the following symptoms during the past two weeks? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.

	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself — or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

10. In the ***past year*** have you felt depressed or sad most days, even if you felt okay sometimes? ☐ Yes ☐ No

11. If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

12. Has there been a time in the past month when you have had serious thoughts about ending your life? ☐ Yes ☐ No

13. Have you ***ever,*** in your ***whole life,*** tried to kill yourself or made a suicide attempt? ☐ Yes ☐ No

FOR OFFICE USE ONLY **Score**_____

Q. 12 and Q. 13 = Y or TS = ≥11

Source: Patient Health Questionnaire Modified for Teens (PHQ-9) (Author: Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues)

PC/PHQ-9 Mod/6.7.11/2000

Administering, Scoring and Interpreting the PHQ-9 Screening Questionnaire

Administering

- The Patient Health Questionnaire Modified for Teens (PHQ-Modified) can be used with patients between the ages of 12 and 18 and takes less than five minutes to complete and score.
- The PHQ-9 Modified can be administered and scored by a nurse, medical technician, physical assistant, physician or other office staff.
- Patients should be left alone to complete the PHQ-9 Modified in a private area, such as an exam room or private area of the waiting room.
- Patients should be informed of their confidentiality rights before the PHQ-9 Modified is administered.
- The American Academy of Pediatrics and U.S. Preventive Service Task Force recommend that depression screening be conducted annually.

Scoring

- **For every X:**
  Not all =0
  Several days=1
  More than half the days=2
  Nearly every day=3
  Add up all "X" ed boxes on the screen
- **Defining a Positive Screen on the PHQ-9 Modified:**
  Total scores >/=11are positive
- **Suicidality:**
  Regardless of the PHQ-9 Modified total score, endorsement of serious suicidal ideation OR past suicide attempt (question 12 and 13 on the screen) should be considered a positive screen.

Interpreting the Screening Results

- Patients that score positively on the questionnaire should be evaluated by their primary care provider (PCP) to determine if the depression symptoms they endorsed on the screen are significant, causing impairment and/or warrant a referral to a mental health specialist or follow-up treatment by the PCP.
- It is recommended that the PCP inquire about suicidal thoughts and previous suicide attempts with all patients that score positive, regardless of how they answered these items on the PHQ-9 Modified.
- For patients who score negative on the PHQ-9 Modified, it is recommended that the PCP briefly review the symptoms marked as "more than half days" and "nearly every day" with the patient.
- The questionnaire indicates only the likelihood that a youth is at risk for depression or suicide; its results are not a diagnosis or a substitute for a clinical evaluation.

Depression Severity

- The overall score on the PHQ-9 Modified provides information about the severity of depression, from minimal depression to severe depression.
- The interview with the patient should focus on their answers to the screen and the specific symptoms with which they are having difficulties.
- Additional questions on the PHQ-9 Modified also explore persistent depressive disorder, impairment of depressive symptoms, recent suicide ideation and previous suicide attempts.
- Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

Source: Patient Health Questionnaire Modified for Teens (PHQ-9) (Author: Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues)

Informed Consent and Agreement to HIV Testing

I understand the following information, which I have read or has been read to me:

- Blood, or another body fluid or tissue sample, will be tested for human immunodeficiency virus (HIV) infection;
- Consent to be tested for HIV, the virus that causes AIDS, should be given FREELY;
- Results of this test, like all medical records, are confidential, but confidentiality cannot be guaranteed; and
- If positive test results become known, an individual may experience discrimination from family or friends and at school or work.

What a NEGATIVE Result Means:

- A negative test means that HIV infection has not been found at the time of the test.

What a POSITIVE Result Means:

- A positive HIV test means that a person is infected with HIV and can transmit the virus by having sex, sharing needles, childbearing (from mother to child), breastfeeding, or donating organs, blood, plasma, tissue, or breast milk.
- A positive HIV test DOES NOT mean a diagnosis of AIDS -- other tests are needed.

What Will Happen if the Test Is Positive:

- A copy of the Department of Health and Mental Hygiene's publication "Information for HIV Infected Persons" will be provided;
- The health department or my doctor will offer advice about services that are available;
- Women who are pregnant or may become pregnant will be told of treatment options which may reduce the risk of transmitting HIV to the unborn child;
- Information will be provided on how to keep from transmitting HIV infection;
- My name will be reported to the health department for tests that indicate HIV infection. This includes, but is not limited to: HIV Antibody (Western blot), HIV Viral Load (RNA or DNA quantification), HIV viral sequencing or HIV p24 antigen tests;
- My name will be reported to the health department if my doctor finds that I have AIDS;
- I will be offered assistance in notifying and referring my partners for services. If I refuse to notify my partners, a doctor may notify them or have a representative of the local health department do so. If a representative of the local health department notifies my partners, my name will not be used. Maryland law requires that when a local health department knows of my partners, it must refer them for care, support, and treatment.

I have been given a chance to have my questions about this test answered.

I hereby agree to be tested for HIV infection.

Print name of individual to be tested in the boxes below:

First Name Middle Init.

Last Name

Signature of Individual to be Tested (or Authorized Substitute) Date

Signature of Counselor or Health Care Provider Date

Consentimiento y autorización para la prueba del VIH

Comprendo la siguiente información que he leído o que me han leido:

- La prueba para detectar la infección por VIH se puede hacer usando una muestra de sangre u otro liquido o tejido corporal;
- El consentimiento para la prueba del VIH, el virus que causa el SIDA, debe darse libremente;
- Como todos los registros de salud, los resultados de esta prueba son confidenciales, pero la confidencialidad no se puede garantizar; y
- Si los resultados positivos de la prueba se divulgaran, la persona pudiera ser objeto de discriminación por parte de su familia o amigos y en la escuela o en el trabajo.

Lo que significa un resultado NEGATIVO:

- Un resultado negativo significa que no se ha encontrado la infección por VIH en el momento de la prueba.

Lo que significa un resultado POSITIVO:

- Un resultado positivo quiere decir que la persona esta infectada con el VIH y puede transmitir el virus por medio de relaciones sexuales, compartiendo agujas, por un embarazo (transmisión de la madre al niño), alimentándolo con lecha materna, o donando órganos, sangre, plasma o leche materna.
- Una prueba positiva NO SIGNIFICA un diagnóstico de SIDA – se requieren otras pruebas.

Qué sucederá si la prueba es positiva:

- Se le dará una copia de la publicación del Departamento de Salud e Higiene Mental titulada “Información para las personas infectadas con VIH”;
- El Departamento de Salud o mi doctor me informarán acerca de los servicios disponibles;
- A las mujeres que están embarazadas o que pueden llegar a estar embarazadas se les informará sobre las opciones de tratamiento que pueden disminuir el riesgo de transmitir la infección al niño que va a nacer;
- Se le dará información sobre cómo evitar la transmisión de la infección;
- Su nombre será reportado al Departamento de Salud junto con los resultados de las pruebas que indican infección con VIH. Estas incluyen pero no están limitadas a: Anticuerpos VIH (Western blot), Carga Viral de VIH (cuantificación de RNA o DNA), secuencia viral de VIH o pruebas de antígeno VIH p24;
- Su nombre será reportado al Departamento de Salud si su doctor encuentra que tiene SIDA;
- El Departamento de Salud o su doctor le ofrecerán ayuda para notificar y referir a sus parejas a servicios médicos. Si rehusa notificar a sus parejas, su doctor puede notificarles directamente o pedir a un representante del Departamento de Salud local que lo haga. Si el personal del Departamento de Salud local notifica a sus parejas, será de forma anónima y no utilizarán su nombre. La ley de Maryland exige que cuando el Departamento de Salud sabe quiénes son sus parejas, los debe referir para cuidado médico, apoyo y tratamiento.

Me han dado la oportunidad de hacer preguntas y obtener respuestas sobre la prueba.

Por la presente autorizo que se me haga la prueba para la infección del VIH.

Escribir el nombre de la persona que se va hacer la prueba con letra de molde:

Primer Nombre — Inicial del Segundo Nombre

Apellido

Firma del cliente (o de la persona autorizada) _____ Fecha _____

Firma del Consejero o del Proveedor de Servicios Médicos _____ Fecha _____

Section 5: Other Child Health-Related Services

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Section 5: Other Child Health-Related Services

A. EXPANDED EPSDT-RELATED SERVICES

Scope of Services

Medicaid participants under 21 years of age are entitled to a broader scope of services than adults are. These services are called expanded EPSDT diagnostic and treatment services. For referral and pre-authorization, contact the participant's Managed Care Organization (MCO) or refer to the MCO Provider Manual regarding the following:

- Vision services including eye glasses[1]
- Nutrition counseling services[1]
- Chiropractic care[1]
- Durable medical equipment and supplies[2]
- Private duty nursing services[3]

Some expanded EPSDT treatment services are not the responsibility of the MCO. Examples of services that are reimbursed through the Medicaid fee-for-service system include:

- Audiology services including hearing aids*[1]
- Occupational therapy[1]
- Physical Therapy[1]
- Speech and language therapy[1]

Inquire about pre-authorization requirements

For information about the above services, to inquire about other medically necessary services, or to obtain authorization for a service when the child is not enrolled in a MCO, contact the following Department of Health and Mental Health (DHMH) Divisions:

[1]**Division of Children's Services** at **410-767-1903**

[2]**Division of Community Support Services** at **410-767-1739**

[3]**Division of Nursing Services** at **410-767-1448** or

For information and pre-authorization for Mental Health Services including Therapeutic Behavioral Services, call **Maryland Public Behavioral Health System** (consumers and providers**)** at **1-800-888-1965**.

Documentation of Referral for Services

When a suspected problem is identified during the child's health care examination, the Primary Care Provider (PCP) may elect to treat the condition if it is within his/her scope of training and expertise. However, if the condition is outside the expertise of the PCP, he/she must complete a referral to a qualified specialist to evaluate, diagnose, and/or treat the condition. When making the referral to the specialist for expanded EPSDT services, include complete name, degree, and nine-digit MA number of the PCP. Use the *Maryland Uniform Consultation Referral Form* (Refer to Section 5, Addendum) as required by regulation to facilitate referrals to specialty providers. Document the referral and include the follow-up summary report from the specialist in the child's medical record.

B. HEALTHCHOICE SELF-REFERRED SERVICES

These services are defined by HealthChoice regulations as services received from a provider outside the Managed Care Organization (MCO) network that **do not require a referral** from the Primary Care Provider (PCP) or pre-authorization from the MCO.[1]The MCO is financially responsible for payment to the out-of-plan providers for the following services:

- Initial medical exam for a child in State-supervised care;
- Emergency services;
- Annual diagnostic and evaluation service for HIV disease;
- Family planning services;
- Newborn's initial medical examination in a hospital;*
- Pregnancy-related services initiated prior to MCO enrollment;
- Renal dialysis provided in a Medicare certified facility;
- School-based health center services including EPSDT preventive services.

**In-plan providers who see newborns should seek reimbursement from the MCO.*

Since 2009, School-Based Health Center (SBHC) providers no longer need a contract with Managed Care Organizations (MCOs) to be reimbursed for Healthy Kids Program preventive care services as long as the SBHC provider is EPSDT certified and complies with the criteria found in the Code of Maryland Regulations (COMAR).[2] If a child or adolescent enrolled in Medicaid receives services in a SBHC, the center is required to send information regarding those services to the primary care provider (PCP) within three (3) business days. The *School-Based Health Center Health Visit Report Form* is used for this purpose (refer to Section 5, Addendum). If a follow-up care with the PCP is required within one (1) week and the health visit report is mailed, the SBHC should also telephone, email, or fax the health visit report to the student's MCO and PCP on the day of the SBHC visit. For assistance or questions regarding EPSDT services at SBHCs, call the **Healthy Kids Program** at **410-767-1836** or (**410-767-1903)**.

[1] See *COMAR 10.09.65.13*

[2] See *COMAR 10.09.68*.

C. CHILDREN IN STATE-SUPERVISED CARE

Who is in State-Supervised care?

Children and adolescents under the care and custody of any state agency, per court order, including the Department of Human Resources (DHR) and the Department of Juvenile Services (DJS) are in State-supervised care. All children in State-supervised care should be enrolled in a Managed Care Organization (MCO).[2] Children newly eligible for Medical Assistance will have fee-for-service coverage until enrolled in a MCO.

Role of the Screening Provider

Children in State-supervised care often need special consideration due to a history of family turmoil and inconsistent medical care. Being removed from his/her home and placed in unfamiliar settings is a stressful life event for a child. Often there are also significant health problems that need immediate attention. Therefore, an initial examination must be completed with care by a Maryland Healthy Kids Program (EPSDT) certified provider preferably prior to or within 24 hours of removal, but no later than 5 days of removal.[3]

If time permits, the comprehensive preventive exam should be completed at the initial visit. In either case, initial or comprehensive, the preventive visit must be completed within 60 days and include all the requirements of the Maryland Healthy Kids Program as specified in the *Maryland Schedule of Preventive Health Care*.[4] Use the *Health Passport Form* provided by the local *Departments of Social Services* to document all health care encounters for children in State-supervised care.[5] The Maryland Healthy Kids Program encounter forms and questionnaires can be used and attached to the Passport when a comprehensive preventive exam is rendered. Refer to *Section 6: Billing and Encounter Data Reporting* for information on billing for services to children in State-supervised care.

Role of DHR and DJS Caseworker

The enrollee's caseworker from DHR or DJS assists the child in accessing needed medical services through the MCO, the Primary Care Provider (PCP), or any other Medicaid provider as appropriate. The caseworker is responsible for ensuring that the initial examination and any follow-up medical services are scheduled according to mandated time frames. The caseworker works with the child's biological parents, caregivers (i.e., foster family, DJS facility), PCP, and

[2] See Department of Human Resource. (2014). Policy #: SSA-CW#14-17.
[3] Ibid.
[4] Ibid.
[5] Ibid.

other community resources to gather needed health history information. **If the child is not already enrolled in Medicaid, it is the caseworker's responsibility to get the child enrolled.**

Role of the MCO

The initial medical examination for children in State-supervised care is a self-referred service. Therefore, if a child is in a MCO, it is the MCO's responsibility to reimburse out-of-network providers for this service within 30 days of rendering service. However, in-network MCO providers other than the child's designated PCP, must obtain MCO authorization before rendering this service. Use the age-appropriate CPT Preventive Medicine Service codes for the initial examination (Refer to Section 6).

To assure continuity and coordination of care, contact the *Special Needs Coordinator* at the child's MCO to assist the DHR case manager with accessing services for the child in State-supervised care (Refer to Section 8). The MCO Special Needs Coordinator expedites any change of network providers upon relocation of the child to a new geographic location. Additionally, the liaison ensures the transfer of the child's medical record to the new PCP. Contact the **Healthy Kids Program at 410-767-1836** with questions about State-supervised care.

D. OTHER PROGRAMS FOR CHILDREN

Rare and Expensive Case-Management Program (REM)

Children under 21 years of age who qualify for enrollment in HealthChoice, and who have certain diseases or medical conditions, may qualify to be enrolled in the *REM Program*.[4] If the child meets the criteria, the family may request enrollment in REM. The Managed Care Organization (MCO) or the Primary Care Provider (PCP) can initiate a referral to the REM program by using the *REM Intake and Referral Form* (Refer Section 5, Addendum). Participation in the REM program is voluntary.

Some examples of diagnoses, which qualify children for the REM Program include spina bifida, cystic fibrosis, hemophilia, congenital anomalies, degenerative disorders, and metabolic and blood disorders. See *Attachment A of the REM Intake and Referral Form* for the current list of diseases and medical conditions (Refer to Section 5, Addendum).

Families electing to have their child enrolled in the REM Program receive services through the Medicaid fee-for-service program rather than through MCOs. Therefore, any Healthy Kids Program certified Medicaid provider could provide preventive care to REM participants. REM participants receive case management services and are eligible for all Medicaid covered services. For questions about referrals, eligibility, grievances, services, and case management call the **REM Program** at **1-800-565-8190**.

Administrative Care Coordination Services

The (ACCU) or Administrative Care Coordination Unit at the Local Health Departments (LHDs) serve as local resources for information and consultation for Medicaid participants to enhance their access to Medicaid services. The LHDs provide linkages to care and care coordination services to "at risk" pregnant or postpartum women, and children to assist participants with access and utilization of the managed care system and other health related services. (**See Sec. 5.5 in this manual). Contact the LHD ACCU for information on available services for prenatal, postpartum and child populations (Refer to Section 8).

Early Intervention Services

The Maryland State Department of Education (MSDE) Early Childhood Intervention and Education (ECIE) includes the *Maryland Infants and Toddlers Program* (MITP)[5] and the *Maryland Preschool Special Education Services*[6] to assist children with disabilities, from birth through five years of age, and their families.

[4] See *https://health.maryland.gov/mmcp/longtermcare/pages/rem-program.aspx*
[5] See *https://marylandpublicschools.org/programs/Pages/Special-Education/MITP/index.aspx*
[6] See *https://marylandpublicschools.org/programs/Pages/Special-Education/MITP/PreschoolServices.aspx*

Maryland Infant and Toddlers Program

The Program provides therapy services and intensive case management for infants and children from birth through 3 years of age who are at-risk of or experiencing developmental delays. There is no financial eligibility requirement. Eligibility is based solely on developmental delay, atypical behavior, or a diagnosed developmental condition. *Maryland's Extended Individualized Family Service Plan* (IFSP) option offers families the choice to remain on an IFSP beyond their child's third birthday, if their child is determined eligible for preschool special education and related services as a child with a disability. The extension of IFSP services beyond the age of three incorporates the strength of the special education/preschool education program with the existing infants and toddlers family-centered model. Obtain more information about services by calling the local *Infants & Toddlers Programs* or the **MSDE Infants & Toddlers Program** at **1800-535-0182** (Refer to Section 8).

Maryland Preschool Special Education Services

The program provides services for children from 3 years through 5 years of age. Maryland Preschool Services include special instruction and related services provided to young children, who qualify under the Individuals with Disabilities Act (IDEA, Part B, section 619). For more information, contact the *Local Child Find* office or the *MSDE Preschool Special Education Services Program* by calling **1-800-535-0182** (Refer to Section 8).

Head Start Program

The Head Start and Early Head Start Programs are federally funded child development programs for children through 4 years of age whose family income is below the federal poverty level. Financial eligibility guidelines for the program are similar to Medical Assistance (MA) and Maryland Children's Health Program (MCHP) income guidelines and therefore, the majority of Head Start children should be enrolled in MA or MCHP. Refer to *Section 1* of the Manual for ways to enroll a child in MA/MCHP. For more information, contact the appropriate *Head Start Grantee Agency* that administers the program in different counties (Refer to Section 8).
The Head Start Program requires a full preventive care visit within 90 days of enrollment following the *Maryland Schedule of Preventive Health Care* (Refer to Section 2). A health coordinator at each local Head Start facility is available to help the family comply with health care recommendations.

E. DENTAL CARE

The *Maryland Healthy Smiles Dental Program*[10] is available for all Maryland Medicaid enrollees under 21 years of age. Pregnant women and adults over 21 years of age in the Rare and Expensive Case Management Program are also eligible to participate in the program and can receive dental care. For the list of available services, refer to the *Maryland Healthy Smiles Dental Program Handbook.*[11] Providers may contact the **Maryland Healthy Smiles Program** at **1-855-934-9812** for questions about dental services and assistance in locating a dentist. Parents or caregivers can self-refer to a dentist, without a referral from the primary care provider.

Since 2015, ***Skygen Dental, Inc.***[12] started coordinating all dental related customer services for Maryland Medicaid participating enrollees. *Skygen Dental, Inc*. is contracted to assist Medicaid enrollees in the Maryland Healthy Smiles Program in locating dental care within a reasonable distance from the enrollees' residence to ensure adequate access to oral health care services. Additionally, *Skygen Dental, Inc*. provides verification of dental benefits and eligibility verification.

Providers may contact the *Office of Oral Health*[13] at **410-767-7915** to assist children not enrolled in the Maryland Healthy Smiles Program and request the *Maryland Oral Health Resource Guide*.[14]

[10] See *https://health.maryland.gov/mmcp/Pages/maryland-healthy-smiles-dental-program.aspx*

[11] To view and print a copy of the handbook, follow the link *https://health.maryland.gov/mmcp/Pages/maryland-healthy-smiles-dental-program.aspx*

[12] See *provider.MDhealthysmiles.com*. Formerly known as Scion Dental

[13] See *https://health.maryland.gov/phpa/oralhealth/pages/home.aspx*

[14] To view the Oral Health Resource Guide, follow the link *https://health.maryland.gov/phpa/oralhealth/Documents/OralHealthResourceGuide.pdf*

F. PUBLIC MENTAL HEALTH SYSTEM (PMHS)

In 2014, the Mental Hygiene Administration and the Alcohol and Drug Abuse Administration merged to become *Behavioral Health Administration* (BHA).[15] The agency, along with 19 local Core Service Agencies delivers a full range of community public mental health services to Medicaid participants in each local jurisdiction of Maryland. In addition, services are also provided to individuals, who because of the severity of their illness and their financial need, qualify to receive state-subsidized services. BHA and the Core Service Agencies are assisted in their responsibility to manage the public mental health services by *Optum Maryland*,[16] an administrative service organization (ASO), which operates under a contract with BHA. The ASO authorizes services, provides utilization management, management information, claims processing, and evaluation services. A Primary Care Provider (PCP) can deliver behavioral health services if the treatment falls within the scope of the provider's practice, training, and expertise.

Maryland Behavioral Health Integration in Pediatric Primary Care (B-HIPP) is a free service for PCPs caring for patients with mental health needs from infancy through the transition to young-adulthood. It provides support to PCP through four main components: telephone consultation, continuing education, resource and referral networking and social work co-location. For more information, refer to BHIPP website at *www.mdbhipp.org at* or call **855-632-4477**.

When a child needs specialty mental health services beyond the scope of primary care, refer them to the **Maryland Public Mental Health System** at **1-800-8881965** (consumers and providers

[15] See *https://health.maryland.gov/bha/Pages/Index.aspx*

[16] See *https://maryland.optum.com/*

Maryland Uniform Consultant Referral Form

School-Based Health Center Health Visit Report Form *Reviewed 2022*

Maryland Infants and Toddlers Program Referral and Feedback Form *Reviewed 2022*

Local Health Services Request Form and Instructions *Reviewed 2022*

REM Referral Form *Reviewed 2022*

Maryland Uniform Consultation Referral Form

Date of Referral:	**Carrier Information:**
Patient Information:	Name:
Name: (Last, First, MI)	Address:
Date of Birth: (MM/DD/YY) / Phone: ( )	Phone Number: ( )
Member #:	Facsimile/Data #: ( )
Site #:	

Primary or Requesting Provider:

Name: (Last, First, MI)		Specialty:
Institution/Group Name:	Provider ID #: 1	Provider ID #: 2 (If Required)
Address: (Street #, City, State, Zip)		
Phone Number: ( )	Facsimile/Data Number: ( )	

Consultant/Facility Provider:

Name: (Last, First, MI)		Specialty:
Institution/Group Name:	Provider ID #: 1	Provider ID #: 2 (If Required)
Address: (Street #, City, State, Zip)		
Phone Number: ( )	Facsimile/Data Number: ( )	

Referral Information:

Reason for Referral:

Brief History, Diagnosis, and Test Results: *(Include ICD-9)*

Services Desired: Provide Care as indicated:	**Place of Service:**
☐ Initial Consultation Only:	☐ Office
☐ Diagnostic Test: (specify) _____	☐ Outpatient Medical/Surgical Center *
☐ Consultation With Specific Procedures: (specify) _____	☐ Radiology ☐ Laboratory
_____	☐ Inpatient Hospital *
☐ Specific Treatment: _____	☐ Extended Care Facility *
☐ Global OB Care & Delivery	☐ Other: (Explain)
☐ Other: (Explain)	* (Specific Facility Must be Named.)

Number of Visits: _____ . If Blank, 1 Visit is Assumed.	**Authorization #:** (If Required)	Referral is Valid Until: (Date) _____ . (See Carrier Instructions)

Signature: (Individual Completing This Form)	**Authorizing Signature:** (If Required)

Referral certification is not a guarantee of payment. Payment of benefits is subject to a member's eligibility on the date that the service is rendered and to any other contractual provisions of the plan / carrier.

White: Carrier; Yellow: Primary or Requesting Provider; Pink: Consultant/Facility Provider; Goldenrod: Patient

See Carrier/Plan Manual for Specific Instructions.

SCHOOL-BASED HEALTH CENTER HEALTH VISIT REPORT FORM

☐ **Well child exam only (see attached physical exam form)**

SBHC Name & Address: **SBHC Provider Number:** **Contact Name:** **Telephone:** **Fax:**	**MCO Name & Address:** **Contact Name:** **Telephone:** **Fax:** **Date Faxed:**	
Student Name: **DOB:** **MA Number:** **SS Number:**	**Date of Visit:** **Type of Visit:** ☐ **Acute/Urgent** ☐ **Follow Up** ☐ **Health Maintenance**	**ICD-10 Codes**
Provider Name/Title:		**CPT Codes**
T: P: RR: BP: PF: PaO2: Hgt: Wgt: BMI: Rapid Strep Test: - Hgb: BGL: U/A:	**Drug Allergy:** ☐ **NKDA**	
	Current Medications:	**Immunization review:** ☐ **UTD** **Given today:** **Needs:**

Age: **Chief Complaint:**
HPI:

Past Medical History: ☐ **Unremarkable** ☐ **See health history** ☐ **Pertinent:**

Physical Findings:

General: ☐ Alert/NAD
☐ Pertinent:

Head: ☐ Normal
☐ Pertinent:

Ears: ☐ TMs: pearly, + landmarks , + light reflex
☐ Cerumen removed curette/lavage
☐ Pertinent:

Eyes: ☐ PERRLA, sclerae clear, no discharge/crusting
☐ Pertinent:

Nose: ☐ Turbinates: pink, without swelling
☐ Pertinent:

Mouth: ☐ Pharynx without erythema, swelling, or exudate
☐ Normal dentition without caries
☐ Pertinent:

Neck: ☐ Full ROM. No tenderness
☐ Pertinent:

Lymph Nodes: ☐ No lymphadenopathy
☐ Pertinent:

Cardiac: ☐ RRR, normal S1 S2, no murmur
☐ Pertinent:

Lungs: ☐ CTA bilaterally, no retractions, wheezes, rales, ronchi
☐ Pertinent:

Abdomen: ☐ Soft, non-tender, no HSM, no masses,
☐ Bowel sounds present
☐ Pertinent:

Genitalia: ☐ Normal female/normal male Tanner Stage
☐ Pertinent:

Extremities: ☐ FROM
☐ Pertinent:

Neurologic: ☐ Grossly intact
☐ Pertinent:

Skin: ☐ Intact, no rashes
☐ Pertinent:

ASSESSMENT: **PLAN:**

Rx Ordered:

Labs Ordered:

Radiology Services Ordered:

PCP F/U Required:
☐ **Yes** ☐ **No**

Provider Signature: _____

MDH 2020 **For MCO formulary info, find MCO website at:**https://mmcp.health.maryland.gov/healthchoice/pages/home.aspx

Maryland Infants and Toddlers Program Referral and Feedback Form

Please complete this form for each child you refer for early intervention. Diagnosis of a specific condition or disorder is not necessary for referral.

SECTION 1 – To be completed by Physician/Health Care Provider/Referring Agency

Parent/Child Contact Information:

Child Name: _____

Date of Birth: ____/____/____ Child Age in Months: _____ Gender: M / F

Home Address: _____

City: _____ State: **Maryland** Zip Code: _____

Parent/Guardian: _____ Relationship to Child: _____

Primary Language: _____ Home Phone: _____ Other Phone: _____

Reason(s) for Referral to Early Intervention: *Please check all that apply.*

☐ Identified condition or diagnosis (e.g., spina bifida, Down syndrome, Birthweight <1200g): _____

☐ Suspected developmental delay or concern *(Please circle areas of concern)*:

Motor/Physical Cognitive Social/Emotional Speech/Language Behavior Other: _____

☐ Failed Standardized Developmental Screening Tool *(Please indicate screen used and attach screen results)*:

☐ Ages and Stages PEDS Other: _____

☐ At Risk/High Probability Factor *(Describe)*: _____

☐ Other *(Describe)*: _____

Referral Source Contact Information:

Person Making Referral: _____ Date of Referral: ____/____/____

Address: _____ City/State: _____ Zip: _____

Office Phone: _____ Office Fax: _____ E-mail _____

SECTION 2 – To be completed by the Parent/Guardian

Parent/Guardian Consent to Release Information:

I, _____ *(print name of parent or guardian)*, give my permission for my pediatric health care provider (listed above) and the Maryland Infants and Toddlers Program to share and communicate any and all pertinent information regarding my child *(print child's name)* _____.

Parent/Guardian Signature: _____ **Date:** ____/____/____

SECTION 3 – To be completed by Local Early Intervention System (local Infants and Toddlers Program) and returned to the Referral Source (e.g., physician)

Date Referral Received: ____/____/____ Attempts to Contact Unsuccessful:

Name of Assigned Service Coordinator: _____

Office Phone: _____ Office Fax: _____ E-mail: _____

Eligible for Early Intervention Services? Yes No

Initial Results of IFSP *(Attach IFSP Part II, Section A)*:

Areas of Development to be Addressed:

☐ Cognitive ☐ Expressive Language ☐ Receptive Language ☐ Social-Emotional

☐ Adaptive/Self-Help ☐ Gross Motor ☐ Fine Motor

Initial Services to be Provided:

☐ Special Instruction ☐ Speech/Language Therapy ☐ Occupational Therapy ☐ Physical Therapy

Form adapted from The American Academy of Pediatrics Policy Statement: Role of the Medical Home in Family-Centered Early Intervention Services. Early Intervention Referral Form. Pediatrics 2007; 120; 1153-1158.

Date: / / To: Attention: Address: City/State/Zip: Phone:

HealthChoice
LOCAL HEALTH SERVICES REQUEST FORM

Client Information	
Client Name: Address: City/State/Zip: Phone: County: DOB: / / SS#: - - Sex: ☐M ☐F Hispanic: ☐Y ☐N MA#: Private Ins.: ☐ No ☐Yes Martial Status: ☐Single ☐Married ☐Unknown If Interpreter is needed specific language:	Race: ☐African-American/Black ☐Alaskan Native ☐American Native ☐Asian ☐Native Hawaiian ☐Pacific Islander ☐White ☐More than one race ☐Unknown Caregiver/Emergency Contact: Relationship: Phone:
FOLLOW-UP FOR: (Check all that apply) ☐Child under 2 years of age ☐Child 2 – 21 years of age ☐Child with special health care needs ☐ Pregnant EDD: ____ / ____ / ____ ☐Adults with disability(mental, physical, or developmental) ☐Substance use care needed ☐Homeless (at-risk)	RELATED TO: (Check all that apply) ☐Missed appointments: ___ #missed ☐Adherence to plan of care ☐Immunization delay ☐Preventable hospitalization ☐Transportation ☐Other:
Diagnosis:	
Comments:	

MCO:	Date Received: / /
Document Outreach: # Letter(s) _____ # Phone Call(s) _____ # Face to Face _____	☐Unable to Locate ☐Contact Date: / / ☐Advised ☐Refused
Comments:	
Contact Person: Phone: Fax:	Provider Name: Provider Phone:

Local Health Department (County)	Date Received: / /
Document Outreach: # Letter(s) _____ # Phone Call(s) _____ # Face to Face _____	☐No Action (returned) Reason for return:
Contact Person: Contact Phone:	Disposition: ☐Contact Complete: Date: / / ☐Unable to Locate: Date: / / ☐Referred to: Date: / /
Comments:	

LOCAL HEALTH SERVICES REQUEST FORM

INSTRUCTIONS FOR USE:

1.) **Purpose:** This form is to be used by PMP/ MCO to refer clients in need of outreach and health-related services to the LHD-ACCU.
2.) **To:** Fill in the appropriate local health department based on the client's county of residence.
3.) **From:** Indicate the referral source including, mailing address, contact name, phone number, and fax number.
4.) **Client Name:** Provide demographic information, MA number, last known address and phone number.
5.) **Follow-up:** Indicate the population category (FOR) and the reason for the request (Related To) Please add additional information or comments, that may assist the LHD to outreach member.

MCO Section:
Indicate type and number of outreach attempts; forward top copy to LHD-ACCU. Please indicate provider name and phone number. Please add additional information/comments that may assist the LHD to outreach member.

LHD Section:
Indicate action taken and return the appropriate copy to the MCO/Provider.

SEND REFERRALS TO:

Allegany Co. Hlth. Dept.- ACCU
12501 Willowbrook Rd. S.E. (301) 759-5094
Cumberland, MD 21502 (fax) 301-777-2401

Anne Arundel Co. Hlth. Dept. - ACCU
3 Harry S. Truman Pkwy. HD #8 (410) 222-7541
Annapolis, MD 21401 (fax) 410-222-4150

Baltimore Co. Hlth. Dept. - ACCU
6401 York Rd., Third Floor (410) 887-8741
Baltimore, MD 21212 (fax) 410-828-8346

Calvert Co. Hlth. Dept. - ACCU
975 Solomons Island Rd. North, (410) 535-5400
Prince Frederick, MD 20678 (fax) 410-535-1955

Caroline Co. Hlth. Dept. - ACCU
403 S. Seventh Street (410) 479-8189
Denton, MD 21629 (fax) 410-479-4871

Carroll Co. Hlth.Dept. - ACCU
290 S. Center Street (410) 876-4941
Westminster, MD 21157 (fax) 410-876-4959

Cecil Co. Hlth. Dept. - ACCU
401 Bow Street (410) 996-5145
Elkton, MD 21921 (fax) 410-996-0072

Charles Co. Hlth. Dept. - ACCU
4545 Crain Hwy. (301) 609-6803
White Plains, MD 20695 (fax) 301-934-7048

Dorchester Co. Hlth. Dept. - ACCU
3 Cedar Street (V. Areska) (410) 228-3223
Cambridge, MD 21613 (fax) 410-228-8976

Frederick Co. Hlth. Dept. - ACCU
350 Montevue Lane (301) 600-8888
Frederick, MD 21702 (fax) 301-600-3302

Garrett Co. Hlth. Dept. - ACCU
1025 Memorial Dr. (301) 334-7770
Oakland, MD 21550 (fax) 301-334-7771

Harford Co. Hlth. Dept. - ACCU
Div. of Care Coordination (410) 942-7999
2015 Pulaski Hgwy. Suite E (fax) 410-272-5467
Havre de Grace, MD 21078

Howard Co. Hlth. Dept. - ACCU
8930 Stanford Blvd (410) 313-7323
Columbia, MD 21045 (fax) 410-313-5838

Kent Co. Hlth. Dept. -ACCU
125 S. Lynchburg St. (410) 778-7035
Chestertown, MD 21620 (fax) 410-778-7019

Montgomery Co. Hlth. Dept - ACCU
1401 Rockville Pike, Suite 2400 (240) 777-1635
Rockville, MD 20852 (fax) 240-777-4645

Prince Georges' Co. Hlth. Dept.- ACCU
9314 Piscataway Road 301-856-9550
Clinton, MD 20735 (fax) 301-856-9628

Queen Anne's Co. Hlth. Dept.- ACCU
206 N. Commerce S treet (443) 262-4481
Centreville, MD 21617 (fax) 443-262-9357

St. Mary's Co. Hlth. Dept.- ACCU
21580 Peabody Street (301) 475-9431
Leonardtown, MD 20650-0316 (fax) 301-475-4350

Somerset Co. Hlth. Dept.- ACCU
8920 Sign Post Road (443) 523-1740
Westover, MD 21871 (fax) 410-651-2572

Talbot Co. Hlth. Dept.- ACCU
100 S. Hanson Street (410) 819-5654
Easton, MD 21601-0480 (fax) 410-819-5683

Washington Co. Hlth. Dept. - ACCU
1302 Pennsylvania Avenue (240) 313-3229
Hagerstown, MD 21742 (fax) 240-313-3222

Wicomico Co. Hlth. Dept.- ACCU
Carroll Street (Mat./Child Hlth) (410) 543-6942)
Salisbury, MD 21801 (fax) 410-543-6568

Worcester Co. Hlth. Dept.-ACCU
9730 Healthway Dr (410) 629-0164
Berlin, MD 21811 (fax) 410-629-0185

Baltimore City
Healthcare Access Maryland (410) 649-0500 x 0032
1 North Charles Street #800 (fax) 410-649-0528
Baltimore, MD 21202

DHMH 4582 rev. 5/14
1-800-456-8900

MDH 4582 (ACCU)
04/20/EPSDT rev.

INSTRUCTIONS FOR COMPLETING THE REM INTAKE/REFERRAL FORM

PLEASE COMPLETE ALL REQUESTED INFORMATION

Page 1 –

Referral Source:
Referral source name, address, telephone number and fax number.

Patient Information:
Patient's first name, middle initial and last name. Patient's Medical Assistance (MA) number.
Patient's complete address, including apartment number, if applicable.
Patient's date of birth, telephone number(s), Sex, and Social Security Number.

Managed Care Organization (MCO) Information. This should include the name of the MCO, the name of a contact person and telephone number at the MCO, if known.

Patient Contact Information:
The person identified may be the patient (if an adult), the parent, guardian, caregiver, significant other etc. Please include the contact person's complete address, telephone number(s) and their relationship to the patient.

Referring Provider (Physicians, Nurse Practitioner, Physician Assistant) Information:
Provide the name of the referring provider. Include the provider's specialty, license number, and telephone number. The referring provider's signature is **required**. Include information about any consulting physicians with their specialties, telephone numbers, and license numbers, if known.

PAGE 2 – Complete patient's name and date of birth at the top of page 2.

Clinical Information:
Provide the primary and secondary diagnoses including the ICD-10 codes. These are necessary to verify eligibility for REM enrollment.

Supporting Information:
This section will require specific information pertaining to each REM diagnosis. The history and physical sections should be completed. Please refer to the guidelines listed on the REM disease list for the recommended medical documentation for each REM eligible diagnosis. Please contact the REM Intake Unit at 1-800-565-8190 if you have any questions.

PLEASE NOTE:
A physician's signature is required at the bottom of page 2. Please fax this completed form and all supporting clinical information to the REM Intake Unit at 410-333-5426.

Or mail to:
Maryland Department of Health
REM Intake Unit
201 W. Preston Street, Room 210
Baltimore, Maryland 21201-2399

For questions, please call the REM Intake Unit at 1-800-565-8190.

Packet revised 5/20/19

For more information, visit the REM website at
https://health.maryland.gov/mmcp/longtermcare/pages/rem-program.aspx

Intake & Referral Form

Rare and Expensive Case Management

Questions - Call 1-800-565-8190

Fax (410) 333-5426

Mail or Fax To:

REM Intake Unit
Maryland Department of Health (MDH)
201 W. Preston Street, Room 210
Baltimore, Maryland 21201

MDH USE ONLY	
CM Agency:	
Date Assigned:	☐ Incomplete ☐ Complete
Screener/Date	Date Received:
County	
Date File Complete:	☐ Approved ☐ Denied Decision Date:

Referral Source:	
Address:	
Phone ( )	Fax ( )

PATIENT INFORMATION

Patient Name				MA #:
Address				Home Phone ( )
Apt. #		DOB:		Work Phone ( )
City	State	Zip	Sex: **M** **F**	SSN:

MCO	Contact Person
	Phone ( )

Patient Contact		Contact Phone ( )	
Address		Relationship to Patient	
Apt. #	City	State	Zip Code

Referring Physician	**Signature:**	Date:
Name	Phone ( )	
Specialty	License #	
PCP		
Name	Phone ( )	
Specialty	License #	
Consulting Physician		
Name	Phone ( )	
Specialty	License #	

REM Intake & Referral Form

Patient Name: _____ **DOB:** _____

CLINICAL INFORMATION			
REM Qualifying Diagnosis		**Additional Diagnosis**	
ICD-10 Code		ICD-10 Code	
	1		1
	2		2
	3		3
	4		4

SUPPORTING INFORMATION (ATTACH COPIES)	
History	
Physical	
Laboratory/Pathology	
Radiology	
Consultations	
Comments	
MD Signature	**Date**

Section 6: Billing and Encounter Data Reporting

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Section 6: Billing and Encounter Data Reporting

A. INTRODUCTION

This section explains the use of the *State of Maryland Eligibility Verification System (EVS)* and briefly summarizes the billing for services provided to MCO recipients, including newborn care. Although the section provides resource information on relevant MCO billing instructions, it is not intended to supplant the MCO's billing instructions. MCO specific billing instructions can be found on each MCO's web site or in their manual.

Included in this section is also billing information about fluoride varnish application, Vaccines for Children program, and other services specific to child's health that should be billed to Medicaid Fee-for-Service (FFS). In addition, the section instructs providers how to bill using the CMS-1500 Claim Form or 837P electronic format.

B. ELIGIBILITY VERIFICATION

When a child presents with a specific MCO card, use the instructions on that card for eligibility verification or consult the MCO Provider Manual. If the MCO says the child is not eligible, check the EVS, because the child may be eligible for services in the Fee-for- Service (FFS) system. EVS is a system available to providers to allow verification of Maryland Medicaid recipient's eligibility status.

EVS/Interactive Voice Response (EVS/IVR)

EVS/IVR is a telephone-inquiry system that is available 24 hours a day, 7 days a week. The system verifies whether a patient is enrolled in one of the State Medical Care Programs on the day you call. EVS can verify past dates of eligibility for services rendered up to 1 year ago. EVS provides the eligibility category of the recipient and, if he/she is enrolled in a MCO, it gives the name and phone number of the recipient's MCO and the option to transfer the call. The message does not state the primary care provider (PCP). This information is available from the respective MCO.

In order to use the EVS, the practice must have:

- A touch tone phone
- Provider's MA number and NPI number,
- Recipient's MA number and Name Code or Social Security Number (SSN) and Name Code
- The EVS telephone number: **1-866-710-1447**.

For current eligibility, enter the 9-digit provider number and press the pound (#) button. If the EVS replies without an error, enter the recipient's 11-digit number and the 2-digit name code. The name code is the first two characters of the recipient's last name converted into numeric touch-tone numbers. Press the pound (#) button once and carefully listen to the entire message. Enter another number immediately after the EVS message to determine the MA eligibility of another recipient, or press # to end the call.

For past eligibility up to one year after the service was rendered, enter the date of service after the recipient MA number, last name code, and press the pound (#) button. The date of service must contain six (6) digits; for example, 1/1/15 would be 010115 #. EVS will respond with eligibility information for the Date of Service requested or an error message if incorrect information has been entered. If you enter the date incorrectly, EVS re- prompts you to reenter only the date.

If only the Social Security number is available, at the recipient number cue press "0" and press the pound (#) button. The EVS will reply, "Enter Social Security Number and Name Code." By

using a recipient SSN and Name Code, you may search current eligibility or optionally search past eligibility up to 1 year. To search past eligibility, follow the Name Code data entry with the Date of Service. If you have entered a valid SSN, which is on file, and the recipient is currently eligible for Medical Assistance, EVS will provide you with a current eligibility status and the valid Recipient MA Number. You should record the Recipient Number that the system provides. If the SSN is not on file, recipient eligibility cannot be verified until the MA number is obtained.

The message for individuals not enrolled in a MCO is "State or federally eligible," or it will list the specific program, such as Family Planning.

Most Common Eligibility Status Messages:

- Eligible for date of service;
- Not eligible for date of service;
- Recipient has other health insurance. Policy number(s): Phone number: The insurance company listed should be billed prior to State Medicaid. For further information, call 410-767-1773.
- Recipient is in HealthChoice. MCO name: MCO phone number:
- Recipient is in the Rare and Expensive Case Management Program (REM). All services for REM are reimbursed on a FFS basis. Contact the REM program at 1800-565-8190.
- Medicare is primary payer. Providers may not balance bill recipients.
- Valid card number: <Card #>. A duplicate MA card has been issued and the previous card is no longer valid.

For further assistance, call **Provider Relations Division** at **410-767-5503** or **1-800-445- 1159.**

Web-based EVS

For providers enrolled in *eMedicaid*, *WebEVS*, a web-based eligibility application, is now available at *https://www.emdhealthchoice.org*. The provider must be enrolled in *eMedicaid* in order to access the web EVS system.

Authorized Users can:

- Verify recipient eligibility;
- Check if the recipient is enrolled at MCO or has other third party insurance;
- Verify current date of service and past eligibility up to 1 year;
- View archived Remittance Advice for up to two years;
- Access Remittance Advice on Monday of each week.

For additional information view the Maryland/Medicaid's Electronic Provider Revalidation & Enrollment Portal (*ePREP) at eprep.health.maryland.gov* website, or contact **410-767-5340 or 1-844-4MD-PROV (1-844-463-7768)** for provider application support.

C. GENERAL RULES FOR MEDICAL ASSITANCE BILLING

Filling Statues for Billing

The following statutes must be followed for timely billing:

- MCO claims must be received within 12 months from the date of service;
- Fee-For-Service (FFS) claims must be received within 12 months of the date of service;

Please Note: A Remittance Advice, Medicare/Third-party Explanation of Benefits (EOB), IMA-81 (letter of retro-eligibility) and/or a returned date-stamped claim from the program are the **only** documents that will be accepted as proof of timely filing.

Please bill promptly. Claims received after the deadlines will be denied. If the recipient is enrolled in an MCO on the date of service, the MCO must be billed directly.

Paper Claims

If a provider is submitting paper claims, he/she must use a CMS-1500 form version 02-12, in accordance with Federal mandate. Claims can be submitted in any quantity and at any time within the filing time limitation. Once Medical Assistance receives a claim, it may take 30 business days to process. Invoices are processed on a weekly basis. Payments are issued weekly and mailed to provider's "pay-to" address. **Medicaid will accept paper claims only on the revised Form 1500, version 02-12. Providers cannot report both ICD-9-CM and ICD-10-CM codes on the same claim form.** For those services rendered to recipients **not** enrolled in an MCO, mail FFS claims to the following address:

Claims Processing
Maryland Department of Health and Mental Hygiene
P.O Box 1935
Baltimore, MD 21203-1935

For MCO Claims: Paper claims for students enrolled in HealthChoice must be submitted to the appropriate MCO. Once an MCO receives a claim, they are required to process claims within 30 calendar days (or pay interest).

Electronic Claims

If a provider chooses to submit claims electronically, HIPAA regulations require providers to complete electronic transactions using ANSI ASC X12N 837P, version 5010A. **Before** submitting electronic claims directly or through a billing service, a provider must have a signed *Submitter Identification Form* and *Trading Partner Agreement* on file. Providers must also undergo testing before transmitting such claims. Electronic claims are generally paid within two weeks of submission.

Testing information can be found on the MDH website at the following link: *http://www.health.maryland.gov/hipaa/Pages/testinstruct.aspx*

If you have any questions regarding HIPAA testing, please send an email to: mailto: mdh.hipaaedtest@maryland.gov

Companion guides to assist providers for electronic transactions can be found on the MDH website: *http://health.maryland.gov/hipaa/Pages/transandcodesets.aspx*.

For MCO Claims: Providers should contact individual MCOs if interested in billing electronically. MCOs are not required to accept electronic claims. Each MCO may require separate testing.

Healthy Kids/EPSDT Exceptions for Third Party Billing

When participants have both Medicaid and other insurance coverage, the provider must bill the other insurance first. However, States are required to exempt certain Healthy Kids/ EPSDT services from this rule.
For preventive services, you may submit the following codes directly to the appropriate MCO (or Medical Assistance, if appropriate) even if the child is covered by other third-party insurance:

- Preventive Medical Services (99381-99385, 99391-99395)
- Immunizations
- Developmental Tests (96110, 96111)
- Objective Hearing Tests (92551)
- Objective Vision Tests (99173)

The Medical Assistance Program or the MCO will handle recoveries from other insurances for these services. When the patient has Medical Assistance and other third party insurance, do not bill the patient for any co-pay or deductible associated with other insurance policies.

Only the services/codes listed above are exempt. Other EPSDT components, such as laboratory tests and other primary care services, must first be submitted to the other insurer prior to billing Medical Assistance of the MCO.

D. BILLING FOR FLUORIDE VARNISH APPLICATION AS PART OF THE EPSDT PREVENTIVE CARE VISIT

Note: All billing for application of fluoride varnish, whether the recipient is with a MCO or Medicaid Fee for Service (FFS), must be submitted to SKYGEN USA, LLC formally *Scion Dental, Inc.*[7].

In order to be reimbursed by Maryland Medicaid for the fluoride varnish application, EPSDT certified and licensed medical providers, nurse practitioners and physician assistants must:

- Be enrolled in Maryland's Medical Assistance Program (Medicaid) and have an active Medicaid number with a registered NPI number
- Render services within a practice (solo or group) that has an active Medicaid number with a registered NPI number
- Be EPSDT certified by the Maryland Healthy Kids Program
- Complete the State approved fluoride varnish training program

Reimbursement for Fluoride Varnish Application

All claims for reimbursement for fluoride varnish applications by a Maryland EPSDT provider must be made to SKYGEN USA, LLC whether the child is enrolled in a MCO or Medicaid FFS. D1206 must be billed in conjunction with an office well-child visit procedure code. Oral health screening is part of the well-child visit and cannot be billed separately.
For the specific fluoride varnish application CDP code, see the Table below.

Table 1: Fluoride Varnish Application CDT Code

Procedure	CDT Code
Topical Fluoride Varnish	D1206

For More Information:

- For a more detailed description of billing for fluoride varnish application, or for additional information, refer to the ***MDH Office of Oral Health*** website at *http://www.mchoralhealth.org/flvarish/* or contact the Office**:**
  - By phone at 410 767-3081
  - By e-mail: *health.maryland.gov/oral-health*
- For provider support and information, contact ***Scion Dental*** at **1- 844-275-8753.**

[7] See *provider.MDhealthysmiles.com.*

E. BILLING FOR VACCINES FOR CHILDREN PROGRAM

Providers must use vaccines provided by the *Vaccines for Children (VFC) Program*[8] for patients from birth to the 19th birthday. At present, the State reimburses the provider for administrative costs associated with administering VFC vaccines. The provider should bill the "usual and customary" charge for administration of each vaccine to the State. You should use the appropriate CPT code for the vaccine/toxoid or immune globulin in conjunction with the modifier – SE (State and/or Federally-funded programs/services). You will not be reimbursed for vaccine administration unless the modifier – SE is added to the end of the appropriate CPT vaccine code.

For VFC immunization administration codes, see the Table below:

Table 2: VFC Program CPT Codes

Vaccine	CPT-MOD
Influenza virus, quadrivalent (IIV4), split virus, preservative free, for IM use	90630-SE
Hepatitis A, pediatric/adolescent (2 dose)	90633-SE
Hemophilus influenza b, HbOC conjugate (Hib)	90645-SE
Hemophilus influenza b, PRP-OMP conjugate (Hib)	90647-SE
Hemophilus influenza b, PRP-T conjugate (Hib)	90648-SE
Human Papilloma virus (HPV) vaccine, types 6,11,16,18,31,33,45,52,58 nonavalent, (3 dose) for ID use	90651-SE
Influenza virus, split virus, preservative free, 6-35 months	90655-SE
Influenza virus, split, preservative free, > 2 yrs	90656-SE
Influenza virus, split virus, 6-35 months	90657-SE
Influenza virus, split virus, 3-18 years	90658-SE
Influenza virus, live, intranasal	90660-SE
Pneumococcal conjugate, 13 valent	90670-SE
Rotavirus, pentavalent, live, oral (3 dose)	90680-SE
Rotavirus, monovalent, live, 6-32 weeks	90681-SE
Diptheria, tetanus toxoids, acellular pertussis and polio virus, inactivated, 5th dose, 4-6 years (DTaP- IPV)	90696-SE

[8] See http://www.marylandvfc.org/

Table 2: VFC Program CPT Codes	
Vaccine	**CPT-MOD**
Diptheria, tetanus toxoids, acellular pertussis, haemophilus influenza type b, poliovirus, 2-59 months (DTaP-Hib-IPV)	90698-SE
Diphtheria, tetanus toxoids and acellular pertussis, < 7 years (DTaP)	90700-SE
Diphtheria and tetanus toxoids, < 7 years(DT)	90702-SE
Measles, mumps and rubella virus, live (MMR)	90707-SE
Measles, mumps, rubella and varicella (MMRV)	90710-SE
Poliovirus, inactivated (IPV)	90713-SE
Tetanus and diphtheria toxoids, 7-18 years (Td)	90714-SE
Tetanus diphtheria toxoids and acellular Pertussis (Tdap) 7-18 years	90715-SE
Varicella virus live	90716-SE
Diphtheria, tetanus toxoids, acellular pertussis and Hepatitis B and poliovirus (DTaP-HepB-IPV)	90723-SE
Pneumococcal polysaccharide, 23-valent, 2-18 yrs	90732-SE
Meningococcal conjugate, tetravalent	90734-SE
Hepatitis B, adolescent (2 dose)	90743-SE
Hepatitis B, pediatric/adolescent (3 dose)	90744-SE

For vaccines not included in the VFC Program, but considered medically necessary vaccines (e.g., flu vaccines for high-risk patients), and for patients 19-20 years of age**,** Medicaid will reimburse providers for the acquisition cost of vaccines purchased by the provider. Managed Care Organizations (MCOs) are also required to cover such vaccines. Use the CPT codes with no modifier for the applicable immunizations administered to the Medicaid recipient. A separate administration fee is **not paid** for provider stock used for MA patients.

Students who are behind on their immunizations can be scheduled for additional inter- periodic preventive visits to “catch up” on their vaccinations using the appropriate Evaluation and Management (E&M) CPT code based on “complexity” and time with a V20, ICD-9 diagnosis code. However, a visit for the sole purpose of providing a vaccine with no other service rendered **may not be billed.**

Section 6: Billing and Encounter Data Reporting

Contact your VFC provider at the *VFC Contact Center* using one of the phone numbers listed on the ***Vaccines for Children*** website at the following link: *http://www.marylandvfc.org* (Refer to Section 7, Appendix III), to find answers to questions regarding enrolling in the VFC Program, ordering vaccines and vaccine administration. You can also e-mail VFC at: mdh.IZinfo@maryland.gov.

List of Vaccines for Children/VFC Contact Phone Numbers:

Baltimore City & County, Harford, and Howard: (410) 274-6240

Frederick, Montgomery, and Prince George's: (410) 299-5647

All remaining Maryland counties: (410) 404-4128.

Contact the Healthy **Kids Program at 410-767-1836** with questions about vaccine reimbursement.

F. BILLING FOR SERVICES TO CHILDREN IN STATE-SUPERVISED CARE

A child in State-supervised care is a child in the care and custody of a State agency as a result of a court order or voluntary placement agreement, including by not limited to children that are:

- Under the supervision of the Department of Juvenile Services
- In kinship or foster care under the Department of Human Resources
- In residential treatment centers or psychiatric hospitals for the first 30 days after admission.

All children in State supervised care can be enrolled in a Managed Care Organization (MCO).[9] Children newly eligible for Medical Assistance will have Fee-for-Service (FFS) coverage until enrolled in a MCO. An initial examination must be completed with care by a Maryland Healthy Kids Program (EPSDT) certified provider preferably prior to or within 24 hours of removal, but no later than 5 days of removal.[10]

If the child already has Medicaid and is enrolled in a MCO, bill the MCO for the initial examination. The child's MCO is required to permit a self-referral of a child in State- supervised care for an initial examination and is obligated to pay for all portions of the examination to out-of-network providers except for the mental health screen within 30 days of rendering service. However, in-network MCO providers other than the child's designated Primary Care Provider (PCP) must obtain MCO authorization before rendering this service.

If the child has Medicaid, but is not in a MCO, bill FFS Medicaid for the initial examination. If Department of Human Resources has not yet issued a MA number for the child, work with the caseworker to obtain the number and then bill FFS Medicaid.

Eligible providers should bill using the age-appropriate preventive CPT code with **modifier-32** (Mandated Services) for the initial examination and any other procedures provided during this visit. When this modifier is used, MCOs will be obligated to pay for all portions of the EPSDT examination. Providers should use modifier "32" for initial visits only. Refer to the Table on the next page to bill for age appropriated preventative CPT codes in conjunction with modifier "32".

[9] See Department of Human Resource. (2014). Policy #: SSA-CW#14-17.

[10] *Ibid.*

Table 3: Preventive Medicine CPT Codes with 32 Modifier		
Procedure	**CPT Code**	**Modifier**
Comprehensive Preventive Medicine (New Patient)		
New patient 0 – 11 months	99381	32
New patient 1 – 4 years	99382	32
New patient 5 – 11 years	99383	32
New patient 12 – 17 years	99384	32
New patient 18 – 39 years	99385	32
Comprehensive Preventive Medicine (Established Patient)		
Established patient 0 – 11 months	99391	32
Established patient 1 – 4 years	99392	32
Established patient 5 – 11 years	99393	32
Established patient 12 – 17 years	99394	32
Established patient 18 – 39 years	99395	32

Contact the staff specialist for **Children's Services** for additional information at **410- 767-1836.**

G. BILLING FOR SERVICES TO CHILDREN IN MANAGED CARE ORGANIZATIONS (MCOs)

Most children are enrolled in MCOs and therefore providers must be familiar with the specific instructions for billing and reporting encounters for each MCO. Please refer to each MCO's Provider Manual.

Recipients must obtain all services except services excluded through their MCO. The recipient's Primary Care Provider (PCP) will give referrals for specialty care.

Suggested Checklist for Billing MCO

1. Verify through the EVS and the applicable MCO that the child is enrolled with HealthChoice and with your practice.
2. Use the Current Procedural Terminology (CPT) Preventive Medical Services codes.
3. Submit encounter data (for capitation reporting or claim submission) to the respective MCO. Follow the MCO's instructions found in the applicable MCO Provider Manual.
4. For Children in State-supervised care, the MCOs must pay the initial exam as a self-referred service. **Use codes 99381–99385** for full screen. Follow the respective MCO directions for submitting vaccine claim information.
5. Follow the directions from each MCO concerning CPT codes for VFC vaccine administration. **All PCPs participating with MCOs who serve patients younger than 19 years of age must enroll with the Vaccines for Children (VFC) Program.**
6. For provider-purchased vaccine stock administered to patients 19-20 years of age, bill the MCOs by submitting the vaccine-specific CPT code following the MCO directions. Since Vaccines for Children (VFC) program does not cover patients 19 years of age and older, the MCO is responsible for reimbursement of vaccines administered to this age group and reimbursement is generally at acquisition costs.
7. The MCO is also responsible for all medically necessary vaccines for patients not covered by the VFC Program. For example, vaccine such as Synagis is not currently included in the VFC Program and therefore providers should bill the MCO.
8. If you are not part of an MCO and a recipient identified by EVS as an MCO recipient sees services from you for which an MCO is responsible, you may contact the MCO to determine if it will approve payment for rendered services. Otherwise, the MCO has no obligation to reimburse you. If the recipient-required services are emergency services, you may provide the appropriate services and expect to be reimbursed by the MCO by billing the MCO directly. If you provided non-emergency services without MCO authorization, Medical Assistance will not reimburse you.

Section 6: Billing and Encounter Data Reporting

Newborn Billing Information

Medical Assistance will automatically cover all infants born to women with MA coverage on the date of delivery through their first birthday. The Program, however, cannot issue the newborn's card until the hospital or Department of Social Services' worker notifies Maryland Department of Health (MDH)\ formerly DHMH. MDH will enroll the newborn upon receipt of the Hospital Report of Newborn form (DHMH-1184). Since 2012, MDH enrolls newborns online via the Program's *eMedicaid* application (1184 process). For detailed instructions, refer to *1184 New Born Processing-eMedicaid Manual*.[11] The 1184 process serves to initiate the child's temporary MA number and notify the appropriate MCO of the newborn's enrollment.

For all mothers with MA at the time of delivery, the newborn's **temporary MA number** is the same as the mother's number except for the last two digits. The last two digits are 01 for the first baby and consecutively increasing numbers for subsequent children. The permanent number and card will be issued after the local Health Department or Department of Social Services completes the transaction, usually within 4 weeks.

Infants born to mothers enrolled in a MCO will be enrolled in the mother's MCO. To assure coordination of care, a *Newborn Coordinator* is assigned to each MCO to handle newborn assignment in the MCOs (Refer to Section 8).

If the mother does not have MA at the time of delivery, an application can be completed in the hospital and sent to Medical Assistance for eligibility determination. If the newborn is determined eligible, coverage starts on the first day of the month on which the application was submitted.

Do not bill Medical Assistance for services to newborns using the mother's number. If the mother was eligible, use the temporary newborn MA number that has been assign. **Contact the Newborn Coordinator of the mother's MCO for problems encountered with newborn MA numbers or eligibility**. If you are unable to determine the mother's MCO, or the mother was not enrolled in Medicaid at the time of delivery, call the ***Health Choice Hot Line*** **at 1-800-456-8900** for assistance. A *Provider Action Grid* is included to assist providers with issues that may arise in the newborn period (Refer to Section 1, Addendum).

Providers should bill MA directly for children who are not enrolled with an MCO. If you provide any health care services to a recipient enrolled in an MCO, you must seek reimbursement from the MCO. For example, if an out-of-plan provider renders the initial medical examination of a newborn in the hospital, because the MCO does not arrange for a network provider, the MCO must reimburse this service as a self-referral service at no less than the Medicaid rate. **Use CPT Code 99460** (eff. 1/1/09).

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[11] See https://health.maryland.gov/mmcp/docs/1184%20E-Medicaid%20Manual%20New%20Born%20Processing.PDF

H. BILLING FOR SERVICES TO CHILDREN NOT IN A MCO (FEE-FOR-SERVICE)

Providers will find that most children are enrolled in a Managed Care Organization (MCO). However, if the patient is not in a MCO, bill the Medical Assistance/Medicaid Fee-For-Service (FFS) Program. To participate in the Medicaid Program, apply online at *eprep.health.maryland.gov* (contact # 1-844-463-7768).

All rendering providers, solo practices and group practices must have a **National Provider Identifier (NPI),** a 10-digit, numeric identifier that does not expire or change. NPI is a HIPAA mandate requiring a standard unique identifier for health care providers. It is administered by the Centers for Medicare and Medicaid Services (CMS). Additional information on NPI can be obtained from the CMS website at: *https://nppes.cms.hhs.gov/#/*. **Providers must use the NPI on all electronic transactions. When a provider bills on paper, the NPI number and the provider's 9-digit Medicaid provider number will be required in order to be reimbursed appropriately.**

Providers should apply online for NPIs through the National Plan and Provider Enumeration System (NPPES) at *nppes.cms.hhs.gov/NPPES/Welcome*. A paper application is available at: *http://www.cms.gov/Medicare/CMS-Forms/CMS- Forms/downloads/cms10114.pdf .* Submit completed, signed paper copies of the NPI Application/Update Form **(CMS- 10114)** to the NPI Enumerator at the address below:

NPI Enumerator
P.O. Box 6059
Fargo, ND 58108-6059
1-800-465-3203
customerservice@npienumerator.com

All rendering providers, solo practices and group practices must also have a valid Medical Assistance (MA) provider number. For assistance or to determine the status of the MA number or application, call **Provider Enrollment Support** at **410-767-5340.**

Follow the general billing practices noted in the *Physicians' Services Provider Fee Manual* and the most current *Physicians' Services Provider Fee Schedule.* Contact the **Provider Relations Unit at 410-767-5503 or 1-800-445-1159** to request these materials or access information on the following MDH webpage: *https;//mmcp.health.maryland.gov/Pages/Provider-Information.aspx*.

Always refer to your copy of the *Current Procedural Terminology (CPT*) edition published yearly by the *American Medical Association* to verify current codes. For more information on AMA products, please call **1-800-621-8335** or visit: *http://www.ama-*

assn.org/ama/pub/physician-resources/solutions-managing-your- practice/coding-billing-insurance/cpt.page.

Preventive Medicine Services Codes

The EPSDT program uses the following Preventive Medicine (full screening) CPT codes for billing well-child care.

- New Patient/Full Screening: 99381 – 99385 – A full screening includes a health and developmental history, unclothed physical exam, appropriate laboratory tests, immunizations, and health education/anticipatory guidance. Note: A newborn infant history and examination completed in a hospital should be billed using CPT newborn care code 99460.

- Established Patient/Full Screening: 99391–99395 – A full periodic screening is completed on an established patient at subsequent intervals according to the age intervals on the *Maryland Healthy Kids Preventive Care Schedule* (Refer to Section 2).

Preventive Medicine CPT codes are also used to report a full EPSDT screening provided in a hospital outpatient department setting (when the physician's services are not included in the cost-based hospital rate) and for patients who are in the care and custody of a State agency pursuant to a court order or a voluntary placement agreement.

See the Table below for specific codes. For fee schedule, refer to the most current *Medicaid Provider Fee Schedule Manual* at: *https://health.maryland.gov/mmcp/pages/provider-information.aspx*

Table 4: Preventive Medicine CPT Codes	
Procedure	**CPT Code**
Comprehensive Preventive Medicine (New Patient)	
New patient 0 – 11 months	99381
New patient 1 – 4 years	99382
New patient 5 – 11 years	99383
New patient 12 – 17 years	99384
New patient 18 – 39 years	99385
Comprehensive Preventive Medicine (Established Patient)	
Established patient 0 – 12 months	99391
Established patient 1 – 4 years	99392
Established patient 5 – 11 years	99393
Established patient 12 – 17 years	99394

If a child presents for a problem-oriented visit and the child is due for a preventive visit, it is recommended that the provider complete the Healthy Kids preventive care in addition to rendering care for the presenting problem, and use the appropriate CPT preventive code. However, providers cannot bill for a "problem-oriented" and preventive visit for the same child, on the same day. If only "problem-oriented" care is rendered, use the appropriate Evaluation and Management (E&M) CPT codes for time and level of complexity.

Under certain situations, a preventive exam and another E&M service may be payable on the same day. In this case, providers should select the most appropriate single E&M service based on all services provided. If an abnormality is encountered or a preexisting problem is addressed in the process of performing a preventative E&M service, and if the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented E&M service, then the appropriate office/outpatient code should also be reported. Insignificant or trivial abnormality should not be reported.

Modifier-25 should be added to the office/outpatient code to indicate that a significant, separately identifiable E&M service was provided by the same physician on the same day as the preventive medicine service. The appropriate preventive medicine service is additionally reported.

Oral health assessment by the Primary Care Provider (PCP) is included in the preventive code as part of the Healthy Kids preventive care examination. Dentists, however, should consult SKYGEN USA, LLC, formally ***Scion Dental, Inc***.[12] at **1- 844-275-8753** regarding coding for dental services.

[12] See *provider.MDhealthysmiles.com*.

Objective Hearing and Vision Tests, Substance Use, and Developmental Screening

Objective hearing and vision tests can be billed in addition to the preventive screen. Providers can also bill separately for developmental screening with an approved or recommended standardized, validated general developmental screening tool (Refer to Section 3, Addendum) during either a preventive or episodic visit using CPT code 96110 (see below). CPT 96111 should be used for a longer, more comprehensive developmental evaluation performed by a physician or other specially trained professional.

See the Table below for specific codes. For fee schedule, refer to the most current *Medicaid Provider Fee Schedule Manual* at: ***https://health.maryland.gov/mmcp/pages/provider-information.aspx*** .

Table 5: Objective Hearing & Vision Tests, Substance Use and Development Screening CPT Codes

Procedure	CPT Code
Hearing/screening test, pure air only	92551
Visual screening test	99173
Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes and up to 10 minutes	99406
Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	99407
Alcohol and/or substance (other than tobacco) use disorder screening, self-administered	W7000[1, 9]
Alcohol and/or substance (other than tobacco) use disorder screening; provider-administered structured screening(e.g., AUDIT, DAST)	W7010[1]
Alcohol and/or substance (other than tobacco) use disorder intervention; greater than 3 minutes up to 10 minutes (CRAFFT, CAGE-AID)	W7020[1]
Alcohol and/or substance (other than tobacco) use disorder intervention; greater than 10 minutes up to 20 minutes (CRAFFT, CAGE-AID)	W7021[1]
Alcohol and /or substance (other than tobacco) use disorder intervention; greater than 20 minutes (CRAFFT, CAGE-AID)	99409[2]
Developmental screening:(e.g., Ages and Stages Questionnaire, Pediatric Evaluation of Developmental Status) with Interpretation and Report*	96110[2,3,4]
Autism screening: Modified Autism Checklist in Toddlers, Revised with Follow-up (MCHAT-R/F)	96110[2,3,4]
Mental health/behavioral assessment: (e.g., Pediatric Symptom Checklist (PSY-Y), Strengths and Difficulties Questionnaire (SDQ, Ages and Stages Questionnaire-Social Emotional (ASQ-SE)	96127[5,6,7]

Table 5: Objective Hearing & Vision Tests, Substance Use and Development Screening CPT Codes	
Procedure	**CPT Code**
Early Childhood Screening Assessment	
Depression screening	96127[5,6,7]
Post-partum depression screening (Patient Health Questionnaire-9 (PHQ-9), Edinburgh Postnatal Depression Scale (EPDS))	96161[8]

[1]The Department will pay a provider for a maximum of one screening and four (4) interventions annually per recipient ages 12-20. Providers cannot bill more than one screening code on the same claim for the same patient on the same day. However, if a screening and intervention are completed on the same day, they may be billed on the same claim. If a self-screen and a provider screen are performed in the same day, Maryland Medical Assistance will pay whichever is billed first. Providers do not need to bill for a significant, separately identifiable E&M service on the same day as performing an intervention service.

[2] A standardized, validated tool must be used.

[3]For FFS patients: Providers may bill a maximum of two (2) units of CPT 96110 on the same date of service when a screening tool for autism or a social-emotional screening (e.g., ASQ-SE) is administered in addition to a general developmental screening tool.

[4]For MCO patients: If providers bill for more than one unit of services, they must use modifier "59" following the CPT code. Modifier 59 is used to identify procedures/services, other than E&M services, that are not normally reported together, but are appropriate under the circumstance.

[5]The assessment may be billed only when a standardized screening tool is used and results documented.

[6]A maximum of two units of 96127 will be reimbursed per visit.

[7]96127 may be combined with other screening codes (ex. W7000) for a maximum of 2 units of screening per visit.

[8]96161 will be reimbursed up to four units total per child through age 12 months. Zero units will be reimbursed age 13 months or older. This service should be billed using the child's MA number.

[9]A maximum of one unit of W7000 will be reimbursed annually for recipients age 11 and up.

*Documentation for developmental screening should include:

- Any parental concerns about the child's development,
- The name of screening tool used,
- The screening tool results, reviewing all major areas of development,
- An overall result of the development assessment for age (e.g., normal, abnormal, needs further evaluation), and
- A plan for referral or further evaluation when indicated.

For more detailed information about pediatric screening/assessment in Healthy Kids Preventive Health Schedule, please check *Table 6.1* on pp. 147-148.

For other pediatric mental health screening/assessments, check *Table 6.2* on p. 149.

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Table 6. 1. Pediatric Screening/Assessments in Healthy Kids Preventive Health Schedule

	Recommendation from Healthy Kids Preventive Health Schedule	Examples of Acceptable Standardized Tools	Billing Guidelines	Limitations
Post-partum depression screening	Screening recommended at 1, 2, 4 and 6-month well child checks. Providers may "pre-screen" with PHQ-2 to determine if a longer standardized screening tool is needed. **PHQ-2 may not be billed.**	• Patient Health Questionnaire-9 (PHQ-9) • Edinburgh Postnatal Depression Scale (EPDS)	**96161**: Caregiver-focused health risk assessment **may be billed only when a standardized screening tool is used.** Billing should occur under child's MA number	**96161 will be reimbursed up to 4 units total per child through age 12 months.** 0 units will be reimbursed age 13 months and older.
Developmental screening	Surveillance recommended at every well child visit; use of standardized screening tool required for all children at 9, 18 and 24 months (and whenever concern).	• Ages and Stages Questionnaires (ASQ) • Parents' Evaluation of Developmental Status (PEDS)	**96110**: Developmental screening **may be billed only when a standardized screening tool is used and results documented**	**96110 will be reimbursed up to 8 units total per child through age 5 years.** 0 units will be reimbursed age 6 years and older. A maximum of 2 units of 96110 will be reimbursed per visit when both a general developmental screen and an autism screen are conducted; OR 96110 may be combined with other screening codes when appropriate (ex. 96127) for a maximum of 2 units of screening reimbursed per visit
Autism screening	Surveillance recommended at every well child visit; use of standardized screening tool required for all children at 18 and 24 months (and whenever concern).	• Modified Autism Checklist in Toddlers, Revised with Follow-up (MCHAT-R/F): 16-30 months	**96110**: Developmental screening **may be billed only when a standardized screening tool is used and results documented**	**96110 will be reimbursed up to 8 units total per child through age 5 years.** 0 units will be reimbursed age 6 years and older. A maximum of 2 units of 96110 will be reimbursed per visit; OR 96110 may be combined with other screening codes (ex. 96127) for a maximum of 2 units of screening per visit

Section 6: Billing and Encounter Data Reporting

	Recommendation from Healthy Kids Preventive Health Schedule	Examples of Acceptable Standardized Tools	Billing Guidelines	Limitations
Mental health/ behavioral assessment	Annually beginning at 3 years of age. Use of standardized screening tool is recommended.	• Pediatric Symptom Checklist (PSC-Y) • Strengths and Difficulties Questionnaire (SDQ) • Ages and Stages Questionnaire – Social Emotional (ASQ-SE) • Early Childhood Screening Assessment	**96127**: Brief emotional/ behavioral assessment **may be billed only when a standardized screening tool is used and results documented**	A maximum of 2 units of 96127 will be reimbursed per visit; OR 96127 may be combined with other screening codes (ex. 96110) for a maximum of 2 units of screening per visit
Depression screening	Screening recommended annually beginning at 11 years of age.	• PHQ-9 Modified for Teens • Pediatric Symptom Checklist (PSC-Y) • Center for Epidemiological Studies Depression Scale for Children (CES-DC) • Beck Depression Inventory (BDI)	**96127:** Brief emotional/ behavioral assessment **may be billed only when a standardized screening tool is used and results documented.** **NOTE: PHQ-2 may not be billed.**	A maximum of 2 units of 96127 will be reimbursed per visit; OR 96127 may be combined with other screening codes (ex. W7000) for a maximum of 2 units of screening per visit
Substance use assessment	Annually beginning at 11 years of age; use of brief screening tool is recommended. Positive screens should be followed by brief intervention and referral for treatment when indicated (SBIRT: Screening, Brief Intervention, and Referral to Treatment)	• CRAFFT • CAGE-AID	**W7000:** Alcohol and/or substance use disorder screening **may be billed only when a standardized screening tool is used and results documented.** W7020: Intervention; > 3 minutes up to 10 minutes W7021: Intervention; >10 minutes up to 20 minutes W7022: Intervention; >20 minutes	A maximum of 1 unit of W7000 will be reimbursed annually for recipients age 11 and up W7000 may be combined with other screening codes (ex. 96127) for a maximum of 2 units of screening per visit A maximum 4 interventions will be reimbursed annually per recipient age 11 and up

Table 6. 2. Other Pediatric Mental Health Screening/Assessments

	Recommendation	Examples of Acceptable Standardized Tools	Billing Guidelines	Limitations
ADHD Assessment	AAP clinical policy recommends use of ADHD-focused parent and teacher ratings scales as a component of screening/diagnosis when there is concern	• Vanderbilt ADHD Diagnostic Rating Scales – Parent and Teacher • Conners-3 Ratings Scales • ADHD Rating Scale-5 for Children and Adolescents	**96127**: Brief emotional/ behavioral assessment **may be billed only when a standardized screening tool is used and results documented.**	A maximum of 2 units of 96127 will be reimbursed per visit
Other disorder-focused mental health screening/ assessment	Disorder-focused mental health screening and assessment tools may be used when there is a specific concern, ex. anxiety	• Screen for Childhood Anxiety Related Disorders (SCARED) • Spence Children's Anxiety Scale	**96127**: Brief emotional/ behavioral assessment **may be billed only when a standardized screening tool is used and results documented.**	A maximum of 2 units of 96127 will be reimbursed per visit
ADHD Assessment	AAP clinical policy recommends use of ADHD-focused parent and teacher ratings scales as a component of screening/diagnosis when there is concern	• Vanderbilt ADHD Diagnostic Rating Scales – Parent and Teacher • Conners-3 Ratings Scales • ADHD Rating Scale-5 for Children and Adolescents	**96127**: Brief emotional/ behavioral assessment **may be billed only when a standardized screening tool is used and results documented.**	A maximum of 2 units of 96127 will be reimbursed per visit
Other disorder-focused mental health screening/ assessment	Disorder-focused mental health screening and assessment tools may be used when there is a specific concern, ex. anxiety	• Screen for Childhood Anxiety Related Disorders (SCARED) • Spence Children's Anxiety Scale	**96127**: Brief emotional/ behavioral assessment **may be billed only when a standardized screening tool is used and results documented.**	A maximum of 2 units of 96127 will be reimbursed per visit

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Please check the following links to publicly available screening tools:

PSC and PCS-Y*:* *https://mmcp.health.maryland.gov/epsdt/healthykids/Documents/PSC-Y%20Teen%20Screen.pdf* or
https://www.brightfutures.org/mentalhealth/pdf/professionals/ped_sympton_chklst.pdf
Strengths and Difficulties Questionnaire: *http://www.sdqinfo.org/py/sdqinfo/b0.py*
Early Childhood Screening Assessment – Tool: *http://www2.tulane.edu/som/tecc/upload/ECSA-Screen.pdf*
Early Childhood Screening Assessment – Scoring Guide:
http://www2.tulane.edu/som/tecc/upload/ECSA-at-a-glance.pdf
PHQ2: *http://www.cqaimh.org/pdf/tool_phq2.pdf*
PHQ: 9 - Modified for Teens:
https://mmcp.dhmh.maryland.gov/epsdt/healthykids/AppendixSection4/PHQ-9%20Modified.pdf
or
https://www.aacap.org/App_Themes/AACAP/docs/member_resources/toolbox_for_clinical_practice_and_outcomes/symptoms/GLAD-PC_PHQ-9.pdf
Center for Epidemiological Studies Depression Scale for Children (CES-DC):
https://www.brightfutures.org/mentalhealth/pdf/professionals/bridges/ces_dc.pdf CRAFFT
Screening Tool: self-administered:
https://mmcp.dhmh.maryland.gov/epsdt/healthykids/Appendix2Risks%20Assessment%20Forms/CRAFFT%20Adolescent%20Substance%20Abuse%20Assessment%20%20Form-English.pdf or
http://www.ceasar-boston.org/CRAFFT/selfCRAFFT.php
CRAFFT Screening Tool: clinician administered: *http://www.ceasar-boston.org/CRAFFT/screenCRAFFT.php*
CAGE-AID: *http://www.integration.samhsa.gov/images/res/CAGEAID.pdf*
AUDIT (Alcohol Use Disorders Identification Test):
http://pubs.niaaa.nih.gov/publication/aduit.htm DAST-
A (Drug Abuse Screening Test - Adolescent):
http://www.nationaldrugsscreening.com/testing
Vanderbilt Assessment Scales*:* *http://www.nichq.org/childrens-health/adhd/resources/vanderbilt-assessment-scales*
SCARED*:* *http://www.pediatricbipolar.pitt.edu/resources/instruments*
Spence Children's Anxiety Scale: *http://www.scaswebsite.com/1_1_.html*

Laboratory Services

All providers billing for any laboratory service(s) must be CLIA certified and approved by the Maryland Laboratory Administration, if located in Maryland. Contact the **Division of Hospital and Physician Services at 410-767-1462** for information regarding CLIA certification. Interpretation of laboratory results, or the taking of specimens other than blood, is considered part of the office visit and may not be billed as a separate procedure. Specimen collection for Pap smears and PKU (Phenylketonuria) for infants is not billable by a physician

See the Table below for specific laboratory services CPT codes frequently billed in addition to the Healthy Kids preventive code. For fee schedule, refer to the most current *Medicaid Provider Fee Schedule Manual:* ***https://health.maryland.gov/mmcp/pages/provider-information.aspx***

Table 6: Laboratory Services CPT Codes

Procedure	CPT Code
Venipuncture under 3 yrs, physician skill (e.g., blood lead)	36406
Venipuncture, physician skill, child 3 yrs and over (e.g., blood lead)	36410
Venipuncture, non-physician skill, all ages	36415
Capillary blood specimen collection, finger, heel, earstick (e.g. PKU, blood lead filter paper, hematocrit)	36416
Urinalysis/microscopy	81000
Urine Microscopy	81015
Urine Dipstick	81005
Urine Culture (Female Only)	87086
Hematocrit (spun)	85013
Hemoglobin	85018
PPD – Mantoux	86580

Evaluation and Management Office Visits (E&M) Codes

Generally, CPT descriptions for E&M services indicate "per day" and only one E&M service may be reported per date of service. Modifier - 21 for prolonged E&M service is informational only and does not affect payment. Providers cannot bill for a "problem- oriented" and preventive visit for the same child, on the same day. The comprehensive nature of the preventive medicine services codes (99381-99394), however, reflects an age and gender appropriate history/exam and is not synonymous with the "comprehensive" examination required in E&M codes (99201-99215). Under certain situations, a preventive exam and another E&M service may be payable on the same day. Modifier-25 should be added to the office/outpatient code to indicate that the same physician provided significant, separately identifiable E&M services on the same day as the preventive medicine services. The applicable preventative medicine service is additionally reported.

See specific E&M codes in Table 7 below. For fee schedule, see the most current *Medicaid Provider Fee Schedule Manual* at: ***https://health.maryland.gov/mmcp/pages/provider-information.aspx***

Table 7: Evaluation & Management Office Visit Codes

Procedure	CPT Code
New patient (10 minutes)	99201
New patient (20 minutes)	99202
New patient (30 minutes)	99203
New patient (45 minutes)	99204
New patient (60 minutes)	99205
Established patient (5 minutes)[1]	99211
Established patient (10 minutes)	99212
Established patient (15 minutes)	99213
Established patient (25 minutes)	99214
Established patient (40 minutes)	99215

[1] E&M "that may not require the presence of a physician"

I. CMS-1500 BILLING INSTRUCTIONS

When filing a paper claim, providers must use original CMS-1500 forms available from the **Government Printing Office** at **202-512-1800**, the American Medical Association, and major medical-oriented printing firms.

See the following website for more information:
http://www.cms.hhs.gov/electronicbillingeditrans/16_1500.asp

Blocks that refer to third party payers must be completed only if there is a third party payer other than Medicare or Medicaid. The Medical Assistance Program is by law the **"payer of last resort."** If a patient is covered by other insurance or third party benefits such as Worker's Compensation, CHAMPUS or Blue Cross/Blue Shield, the provider must first bill the other insurance company before Medical Assistance will pay the claim. Exceptions include claims for well child care and immunization, which can be billed without first billing the other third party insurer.

Proper Submission of the CMS 1500 Billing Form

The following table provides information on how to complete the required blocks on the CMS-1500 form. Please note that for the Medical Assistance claims processing, the top right side of the CMS-1500 must be blank. Notes, comments, addresses, or any other notations in this area of the form will result in the claim being returned unprocessed.

Block 1 – Show all type(s) of health insurance applicable to this claim by checking the appropriate box(es)

Block 1a – INSURED'S ID NUMBER

1. When billing a Managed Care Organization (MCO), enter the participant's unique MCO number. Please note that all MCOs have unique MCO numbers for their clients. If there is no unique MCO number for a particular participant, enter the participant's MA number in this box. At this point of time, MedStar Family Choice, United Healthcare, and Priority Partners are the only MCOs that have unique numbers. If you do not have the patient's unique number, call the MCO and get that number. All other MCOs accept the students MA number in this block.

2. When billing DHMH for a Fee-For-Service participant, no number is required in this box.

Block 2 – PATIENT'S NAME – (Last Name, First Name, and Middle Initial) – Enter the patient's name as it appears on the Medical Assistance card.

Block 3 – PATIENT'S BIRTH DATE/SEX – Enter the patient's date of birth and sex (Optional).

Block 4 – INSURED'S NAME – Enter name (Last Name, First Name, and Middle Initial) – If the patient has other third party insurance, enter the name of the person in whose name the third party coverage is listed (*No entry required when billing for a patient without third-party insurance*).

Block 5 –PATIENT'S ADDRESS – Enter the patient's complete mailing address with zip code and telephone number (Optional).

Block 6 – PATIENT'S RELATIONSHIP TO INSURED – Enter the appropriate relationship only when there is third party health insurance besides Medicare and Medicaid (*No entry required when billing for a patient without third-party insurance*).

Block 7 – INSURED'S ADDRESS – When there is third party health insurance coverage besides Medicare and Medicaid, enter the insured's address and telephone number (*No entry required when billing for a patient without third-party insurance*).

Block 8 – RESERVED FOR NUCC USE.

Block 9 – OTHER INSURED'S NAME – No entry required.

Block 9a – OTHER INSURED'S POLICY OR GROUP NUMBER – Enter the patient's ***eleven digit Maryland medical assistance number*** exactly as it appears on the Medical Assistance card. Check for transposition of numbers. The MA number must appear here regardless of whether or not a patient has other insurance. A patient's Medicaid eligibility should be verified on *each* date of service, *prior* to rendering service, by calling the EVS. EVS is operational 24 hours a day, 365 days a year at the following number: **1866-710-1447** or online at *http://www.emdhealthchoice.org*.

Block 9b – RESERVED FOR NUCC USE – No entry required.

Block 9c – RESERVED FOR NUCC USE – No entry required**.**

Block 9d – INSURANCE PLAN OR PROGRAM NAME – Enter the insured's group name and group number if the patient has health insurance besides Medicare/Medicaid (*No entry required when billing for a patient without third-party insurance).*

Block 10a thru 10c (Block 10d only for abortion-related billing) – IS PATIENT'S CONDITION RELATED TO – Check "Yes" or "No" to indicate whether employment, auto liability or other accident involvement applies to one or more of the services described in Item 24, if this information is known. If not known, leave blank.

Block 11 – INSURED'S POLICY GROUP OR FECA NUMBER – If the patient has **other third-party insurance and the claim has been rejected by that insurance, enter the appropriate rejection code listed below:** For information regarding participant's coverage, contact Third Party Liability Unit at **410-767-1765**.

Code	Rejection Reasons
K	Services Not Covered
L	Coverage Lapsed
M	Coverage Not in Effect on Service Date
N	Individual Not Covered
Q	Claim Not Filed Timely (Required documentation, e.g., a copy of rejection from the insurance company)
R	No Response from Carrier Within 120 Days of Claim Submission (Requires documentation e.g., statement indicating a claim submission, but to response)
S	Other Rejection Reasons Not Defined Above (Requires documentation e.g., a statement on the claim indicating that payment was applied to the deductible)

For information regarding participant's coverage, contact Third Party Liability Unit at **410-767-1765**.

Blocks 11a – INSURED'S DATE OF BIRTH – (*No entry required when billing for a patient without third-party insurance).*

Block 11c – EMPLOYER'S NAME OR SCHOOL NAME – (*No entry required when billing for a patient without third-party insurance).*

Block 11c – INSURANCE PLAN OR PROGRAM NAME – (*No entry required when billing for a patient without third-party insurance).*

BLOCK 11d – IS THERE ANOTHER BENEFIT PLAN? – *(No entry required when billing for a patient that doesn't have another third party insurance in addition to the one already described in 11 above).*

Block 12 – PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE – If the provider already has an authorized signature on file for the patient, this section should read "Signature on File" and include the billing date.

Block 13 – INSURED'S OR AUTHORIZED PERSON'S SIGNATURE – If the provider already has an authorized signature on file for the patient, the section should read "Signature of File" and include the billing date. (*No entry required when billing for a FFS client or a client without third party insurance*.)

Block 14 – DATE OF CURRENT ILLNES, OR INJURY OR PREGNANCY

Block 15 – IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS (OTHER DATE)

Block 16 – DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION – No entry required.

Block 17 – NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

Note: Completion of 17-17b is only required for Lab and Other Diagnostic Services.

Block 17 should be completed in cases where there is a referring physician**.** Completion is optional if a valid Medical Assistance individual practitioner identification number is entered in Block #17a. To complete, enter the full name of the ordering practitioner. Do not submit an invoice unless there is an order on file that verifies the identity of the ordering practitioner. **–** No entry required.

Block 17a (gray shaded area) – ID OF REFERRING PHYSICAIN – Enter the ID Qualifier **– 1D (Medicaid Provider Number)** followed by the provider's 9-digit Medicaid Provider Number. **–** No entry required.

Block 17b – Enter the NPI of the referring, ordering, or supervising provider listed in Block 17.

Block 18 – HOSPITALIZATION DATES RELATED TO CURRENT SERVICES – No entry required.

Block 19 – ADDITIONAL CLAIM INFORMATION

Block 20 – OUTSIDE LAB – Check "no"

Block 21 – DIAGNOSIS OR NATURE OF THE ILLNESS OR INJURY –
Enter the 3, 4, or 5 alpha/numeric code from the ICD-9/ICD-10 related to the procedures, or services, listed in Block #24d. List the primary diagnosis on Line 1 and secondary diagnosis on Line 2. Additional diagnoses are optional and may be listed on Lines 3 and 4.

Note: Do not report ICD-10 codes for claims with dates of service prior to October 1, 2015. The Program will accept either ICD-9 or ICD-10 codes depending upon the dates of service on the revised form. REMINDER: ICD-9 and ICD-10 codes cannot be reported on the same claim form, ***providers must bill on separate claims and they cannot be combined****.*

REMINDER: ICD-9 and ICD-10 codes **cannot** be reported on the same claim form.

Block 22 – MEDICAID RESUBMISSION – No entry required.

Block 23 – PRIOR AUTHORIZATION NUMBER – For those services that require preauthorization, a preauthorization number **must** be obtained and entered in this Block.

Block 24 (gray shaded area) - NATIONAL DRUG CODE (NDC) – Report the NDC/quantity when billing for drugs using the J-code HCPCS. Allow for the entry of 61 characters from the beginning of 24A to the end of 24G. Begin by entering the qualifier **N4** and then the 11-digit NDC number. It may be necessary to pad NDC numbers with left-adjusted zeroes in order to report eleven digits (5-4-2). Without skipping a space or adding hyphens, enter the unit of measurement qualifier followed by the numeric quantity administered to the patient. Below are the measurement qualifiers when reporting NDC units:

Measurement Qualifiers
F2 International Unit
GR Gram
ML Milliliter
UN Units (EA/Each)
ME Milligram

Example: NDC/Quantity Reporting
24A DATE(S) OF SERVICE D. PROCEDURES, SERVICES G. DAYS OR UNITS
FROM: TO: CPT/HCPCS
MM DD YY MM DD YY
N400009737604ML1 (SHADED AREA)
01 01 08 01 01 08 J1055

More than one NDC can be reported in the shaded lines of Box 24. Skip three spaces after the first NDC/Quantity has been reported and enter the next NDC qualifier, NDC number, unit qualifier and quantity. This may be necessary when multiple vials of the same drug are administered with different dosages and NDC's.

Block 24a – DATE OF SERVICE – Enter each separate dates of service as a **six (6) digit numeric date (e.g. 03/31/14) under the "FROM" heading.** Leave the space under the "TO" heading blank. Each date of service on which a service was rendered must be listed on a separate line. **Ranges of dates are not accepted on this form.** If more than one type of billable service was rendered on a given day, each service should be billed on a separate line. Thus, one date of service may be used on more than one line.

Block 24b. – PLACE OF SERVICE – Enter 11 for Doctor's Office visits.

Block 24c. – EMG – No entry required.

Block 24d. – PROCEDURES, SERVICES OR SUPPLIES – List the appropriate five (5) character procedure code. The Physician Fee Schedule can be found at https://mmcp.health.maryland.gov/Pages/Provider-Information-aspx.

Block 24e. – DIAGNOSIS POINTER – Enter a single or combination of diagnosis from Block #21 above for each line on the invoice.

Note: the Program only recognizes up to eight (8) pointers, A-H.

Block 24f. – CHARGES – Enter the usual and customary charges. Do not enter the Maryland Medicaid maximum fee unless that is your usual and customary charge. If there is more than one unit of service on a line, the charge for that line should be the total of all units.

Block 24g. – DAYS OR UNITS OF SERVICE – Enter the total number of units or service for each procedure. Multiple, identical services rendered on different days should be billed on separate lines.

Block 24h. – EPSDT FAMILY PLAN – No entry required.

Block 24i. – ID. QUAL. – Enter the ID Qualifier **1D (Medicaid Provider Number)**

Block 24j. (gray shaded area) RENDERING PROVIDER ID # – Enter the 9-digit MA provider number of the practitioner rendering the service. In some instances, the rendering number may be the same as the payee provider number in Block #33. Enter the rendering provider's NPI in the unshaded area.

Block 25 – FEDERAL TAX ID NUMBER

Block 26 – PATIENT'S ACCOUNT NUMBER – An alphabetic, alpha-numeric, or numeric patient account identifier (up to 13 characters) used by the provider's office can be entered. If recipient's MA number is incorrect, this number will be recorded on the Remittance Advice

Block 27 – ACCEPT ASSIGNMENT? – For payment of Medicare coinsurance and/or deductibles, this Block must be checked "Yes". Providers agree to accept Medicare and/or Medicaid assignment as a condition of participation.

Note: Regulations state that providers shall accept payment by the Program as payment in full for covered services rendered and make no additional charge to any participant for covered services.

Block 28 – **TOTAL CHARGE –** Enter the sum of the charges shown on all lines of Block 24f.

Block 29 – AMOUNT PAID – Enter the amount of any collections received from any third party payer, **EXCEPT Medicare**. If the recipient has third party insurance and the claim has been rejected, the appropriate rejection code shall be placed in Block # 11.

Block 30 – RESERVED FOR NUCC USE – No entry required.

Block 31 – SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS – Please write "Signature on File" and include the date of submission. ***Note: The date of submission must be in Block 31 in order for the claim to be reimbursed.***

Block 32 –SERVICE FACILITY LOCATION INFORMATION – Complete only if billing for medical laboratory services referred to another laboratory or the facility where trauma services were rendered. Enter the name and address of facility.

Block 32a – **NPI** – Enter facility's NPI number.

Block 32b (gray shaded area) – Enter the ID Qualifier **1D (Medicaid Provider Number)** followed by the facility's 9-digit Maryland Medicaid provider number.

Note: The Program will not pay a referring laboratory for medical laboratory services referred to a reference laboratory that is not enrolled. The referring laboratory also agrees not to bill the recipient for medical laboratory services referred to a nonparticipating reference laboratory.

Block 33 – BILLING PROVIDER INFO & PH # – Enter the name, complete street address, city, state, and zip code of the provider. This should be address to which claims may be returned. The nine (9) digit Maryland Medical Assistance provider number to which payment is to be made must be entered in the lower right hand section of this block. Errors in this area are likely to result in denied or misdirected payment.

Block 33a – NPI – Enter the NPI number of the billing provider in Block # 33. Errors or omissions of this number will result in non-payment of claims.

Block 33b (gray shaded area) – Enter the ID Qualifier 1D (Medicaid Provider Number) followed by the shaded area) 9-digit MA provider number of the provider in Block #33. Errors or omissions of this number will result in non-payment of claims.

Note: It is the provider's responsibility to promptly report all name changes, addresses, correspondence addresses, practice locations, tax identification number certification to the MDH's/ Maryland Medicaid's Electronic Provider Revalidation & Enrollment Portal (ePREP) at: eprep.health.maryland.gov ***contact #: 1-844-4MD-PROV or 1-844-463-7768.***

Rejected Claims

Rejected claims will be listed on your Remittance Advice (RA) along with an Explanation of Benefits (EOB) code that provides the precise reason a specific claim was denied. EOB codes are very specific to individual claims and provide you with detailed information about the claim. There are several reasons a claim may be rejected:

Data was incorrectly keyed or was unreadable on the claim

- Typing or printing clearly will help to avoid errors when a claim is scanned. When a claim is denied, always compare data from the RA with the file copy of your claim. If the claim was denied because of a keying or scanning error, resubmit the claim with the corrected data.

The claim is a duplicate, has previously been paid or should be paid by another party

- Verify that you have not previously submitted the claim;
- If the program determines that an enrollee has third party coverage that should be billed first, the claim will be denied. Submit the claim to the third party payer first; and
- If an enrollee has coverage through a HealthChoice MCO, you must bill that organization for services rendered.

For MCO Rejected Claims: The information above is true for claims submitted to Medical Assistance; each MCO sets its own rules for rejection of claims and provides varying information on the EOB (see MCO manuals for further information).

Adjustment Request

If you have been paid incorrectly for a claim **or** received payment from a third party after Medical Assistance has made payment, you **must** complete and submit an Adjustment Request Form (DHMH 4518A) to correct the payment. If an incorrect payment was due to an error made by Medical Assistance, or an incorrect number of units were inadvertently billed, complete an Adjustment Request Form following the directions on the back of the form. Additionally, please be aware that provider's charges may differ from reimbursement rates, and reimbursement rates may vary depending on the insurer.

When completing the Adjustment Request Form, bill for the entire amount(s) due, rather than any unpaid amounts or units.

Example: You submitted and received payment for three units, but should have billed five units. **Do not** bill for the remaining two units, bill for the **entire** five units.
Total Refunds – If you receive an incorrect payment, return the check issued by the Medical Assistance Program only when every claim payment listed on the Remittance Advice (RA) is incorrect (e.g., none of the enrollees listed are your patients). When this occurs, send a copy of the RA and the check with a complete Adjustment Request Form to the address on the bottom of the form.

Partial Refunds – If you receive a RA that lists correct and incorrect payment, do not return the Medical Assistance Program check. Deposit the check and file an Adjustment Request Form for those claims paid incorrectly.

NOTE: For overpayments or refunds, the provider may issue and submit one check to cover more than one Adjustment Request Form.

Before mailing Adjustment Request Forms, be sure to attach any supporting documentation such as RAs and CMS-1500 claim forms. Adjustment Request Forms should be mailed to:

Medical Assistance Adjustment Unit
Box 13045
Baltimore, MD 21203

Section 7: Preventive Care Forms

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PREVENTIVE CARE FORMS

A. Age-Specific Encounter Forms *Reviewed 2022*

B. Immunization forms *Reviewed 2022*

C. Medical and Family History Form-English and Spanish *Reviewed 2022*

D. Objective Hearing and Vision Form *Reviewed 2022*

Section 7: Preventive Care Forms

For all age-specific Encounter Forms, please visit the Healthy Kids website at https://health.maryland.gov/mmcp/epsdt/healthykids/Pages/Encounter-Forms.aspx. See example Encounter Form below:

PEDIATRIC VISIT 0 to 1 MONTH DATE OF SERVICE_____

NAME_____ M / F DATE OF BIRTH_____ AGE_____

WEIGHT_____/_____% HEIGHT_____/_____% HC_____/_____% TEMP_____

HISTORY:
Family health history documented & updated?_____
Perinatal history documented & updated?_____
Concerns: _____

PSYCHOSOCIAL ASSESSMENT:
Sleep: **Child care:**
Maternal Depression Screen? Yes / No
Referral or Support? Yes/No (circle)

Recent changes in family: *(circle all that apply)*
New members, separation, chronic illness, death, recent move, loss of job, other_____

Environment: Smokers in home? Yes / No

Violence Assessment:
History of injuries, accidents? Yes / No
Evidence of neglect or abuse? Yes / No
Risk Assessment: TB Positive or Negative (circle)

PHYSICAL EXAMINATION (unclothed)

Wnl	Abn	*(describe abnormalities)*
☐	☐	Appearance/Interaction
☐	☐	Growth
		_____
☐	☐	Skin/Umbilicus
		_____
☐	☐	Head/Face/Fontanelles
☐	☐	Eyes/Red reflex/Cover test
☐	☐	Ears
☐	☐	Nose
☐	☐	Mouth/Gums
		_____
☐	☐	Neck/Nodes
☐	☐	Lungs
		_____
☐	☐	Heart/Pulses
☐	☐	Chest/Breasts
		_____
☐	☐	Abdomen
☐	☐	Genitals/Circumcision
		_____
☐	☐	Extremities/Hips/Feet
☐	☐	Neuro/Reflexes/Tone
		_____
☐	☐	Vision *(gross assessment)*
☐	☐	Hearing *(gross assessment)*

_____

NUTRITIONAL ASSESSMENT:
Breast/bottle: Amount & frequency _____

Bowel/bladder: Number of wet_____, dry_____ in 24 hours?
Number BM's in 24 hours? _____

Education: Hold to feed ☐ Use of pacifier ☐
If breast fed, Vitamin D ☐ Feed on demand ☐ Growth spurts ☐

DEVELOPMENTAL SURVEILLANCE: *(**O**bserved or **R**eported)*
Social: Regards face ☐ Alert ☐ Social smile ☐

Fine Motor: Follows 90 degrees ☐ Grasps ☐

Language: Coos ☐ Laughs ☐

Gross Motor: Head steady when sitting ☐ Hand brought to mouth ☐

ANTICIPATORY GUIDANCE:
Social: Time out for parent ☐ Parental adjustment ☐
Sibling rivalry ☐

Parenting: Respond to cry ☐ Trust-building ☐ Holding, comfort ☐

Play and communication: Crying is communication ☐
Voices, mobiles, music, pictures ☐

Health: Diaper/skin care ☐ Bathing & washing hair ☐
Sneezing, hiccoughs, soft spot ☐
Taking baby's temperature ☐ Second hand smoke ☐

Injury prevention: Rear facing/rear riding infant car seat ☐
Sleep on back ☐ Smoke detector/escape plan ☐ Hot water set at 120° ☐
Choking/suffocation ☐ Poison control # ☐ Fall prevention (heights) ☐
Hot liquids ☐ Firearms (owner risk/safe storage) ☐ Water safety (tub) ☐
Don't leave unattended ☐

PLANS/ORDERS/REFERRALS
1. Immunizations ordered ☐ _____
2. Second metabolic screen ☐ _____
3. Follow-up newborn hearing screen ☐ _____
4. Next preventive appointment ☐ _____
5. Referrals for identified problems? *(specify)*_____

_____
_____
_____
_____
_____

Signatures: _____

https://mmcp.health.maryland.gov/epsdt/Pages/Home.aspx ***Maryland Healthy Kids Program*** 2020

Section 7.0 Immunization Forms

7.1 **Maryland Immunization Certification Form**
https://mmcp.health.maryland.gov/epsdt/healthykids/Appendix3Section7/Maryland-Immunization-Certification-Form.pdf

7.2 **Immunization Schedule**
https://health.maryland.gov/phpa/OIDEOR/IMMUN/Shared%20Documents/Current_Recommended_Childhood-Adolescent_Immunization_Schedule_Final.pdf

7.3 **Combination Vaccine Schedule**
https://health.maryland.gov/mmcp/epsdt/healthykids/Appendix3Section7/Combination-VaccineSchedule2017.pdf

7.4 **Parental Delegation Form**
https://health.maryland.gov/mmcp/epsdt/healthykids/Appendix3Section7/Parental-Delegation-Form.pdf

7.5 **VFC Vaccine Inventory Form**
https://mmcp.health.maryland.gov/epsdt/healthykids/Appendix3Section7/VFC-Provider-Inventory-2015.pdf **- According to VFC, they no longer use this form Providers must order through Immunet 7.3.5**

7.6 **VFC Log**
https://mmcp.health.maryland.gov/epsdt/healthykids/Appendix3Section7/VFC-Patient-Log_July-2013.pdf

7.7 **Patient Eligibility Screening Record According to VFC**
https://mmcp.health.maryland.gov/epsdt/healthykids/Appendix3Section7/VFC-Eligibility-Screening-Rec ord_Mar-2015.pdf

7.8 **VFC Program Contact Center**
https://www.marylandvfc.org/

7.9 **VFC Vaccine Administration Record**
https://health.maryland.gov/mmcp/epsdt/healthykids/Appendix3Section7/Vax-Admin-Record-July-2017.pdf

7.10 Maryland Department of Health Immunization Certificate (896)
https://health.maryland.gov/phpa/OIDEOR/IMMUN/Shared%20Documents/MDH_896_form.pdf

7.11 **New Online VFC Vaccine Return and Wastage Form**
https://www.marylandvfc.org/maryland-vfc-vaccine-return-and-wastage-form/

7.12 New Temperature Log for Refrigerator Celsius
https://www.marylandvfc.org/wp-content/uploads/2018/04/p3037c_updated.pdf

7.13 **New Temperature Log for Refrigerator Fahrenheit**
https://www.marylandvfc.org/wp-content/uploads/2018/04/p3037c_updated.pdf

7.14 **Temperature Log for Freezer- Celsius**
https://phpa.health.maryland.gov/OIDEOR/IMMUN/Shared%20Documents/p3038c_updated.pdf

7.15 **Temperature Log for Freezer –Fahrenheit**
https://phpa.health.maryland.gov/OIDEOR/IMMUN/Shared%20Documents/p3038f_updated.pdf

Maryland Healthy Kids Program
Medical/Family History Questionnaire

Patient Name:	Date of Birth:	Sex: (circle) Male Female
Form Completed By: / Today's Date	Relationship:	

PREGNANCY AND BIRTH HISTORY

Name of Hospital: _____
Illnesses during pregnancy? No ☐ Yes ☐
Medications during pregnancy? No ☐ Yes ☐
Alcohol/Drug Abuse? No ☐ Yes ☐
Problems at birth? No ☐ Yes ☐
Describe: _____
Type of delivery? ☐ Vaginal ☐ C-section
Birth Weight_____Discharge Weight_____
Did baby receive Hepatitis B vaccine? No ☐ Yes ☐
Date of Hepatitis B immunization:_____
Newborn Hearing Screen? No ☐ Yes ☐

PSYCHOSOCIAL HISTORY

Who lives in household?_____
_____
How many?_____
☐ Rent? ☐ Own? ☐ Shelter?
Who cares for child?_____
Date of Birth? Mother_____
Father_____
Are parents working? Mother No ☐ Yes ☐
Father No ☐ Yes ☐
Foster Care? _____Dates:_____
Other Languages?_____

FAMILY HISTORY

Has anyone in the family (parents, grand-parents, aunts/uncles, sisters/brothers) had:

			Who?
Allergies (List) _____	No ☐	Yes ☐	_____
_____			
Asthma	No ☐	Yes ☐	_____
TB/Lung Disease	No ☐	Yes ☐	_____
HIV/AIDS	No ☐	Yes ☐	_____
Suicide Attempts	No ☐	Yes ☐	_____
Heart Disease	No ☐	Yes ☐	_____
High Blood Pressure/Stroke	No ☐	Yes ☐	_____
High Cholesterol	No ☐	Yes ☐	_____
Blood Disorders/Sickle Cell	No ☐	Yes ☐	_____
Diabetes	No ☐	Yes ☐	_____
Seizures	No ☐	Yes ☐	_____
Mental Illness	No ☐	Yes ☐	_____
Cancer	No ☐	Yes ☐	_____
Birth Defects	No ☐	Yes ☐	_____
Hearing Loss	No ☐	Yes ☐	_____
Speech Problems	No ☐	Yes ☐	_____
Kidney Disease	No ☐	Yes ☐	_____
Alcohol/Drug Abuse	No ☐	Yes ☐	_____
Hepatitis/Liver Disease			
Thyroid Disease	No ☐	Yes ☐	_____
Learning Problems/Attention	No ☐	Yes ☐	_____
Deficit Disorder	No ☐	Yes ☐	_____
Family Violence	No ☐	Yes ☐	_____

Other: _____
_____

MEDICAL HISTORY

Has your child ever had:

Allergies (List) _____	No ☐	Yes ☐
_____		
Asthma	No ☐	Yes ☐
Chicken Pox (Year) ___	No ☐	Yes ☐
Frequent Ear Infections	No ☐	Yes ☐
Vision/Hearing Problems	No ☐	Yes ☐
Skin Problems/Eczema	No ☐	Yes ☐
TB/Lung Disease	No ☐	Yes ☐
Seizures/Epilepsy	No ☐	Yes ☐
High Blood Pressure	No ☐	Yes ☐
Heart Defects/Disease	No ☐	Yes ☐
Liver Disease/Hepatitis	No ☐	Yes ☐
Diabetes	No ☐	Yes ☐
Kidney Disease/Bladder Infections	No ☐	Yes ☐
Physical or Learning Disabilities	No ☐	Yes ☐
Bleeding Disorders/Hemophilia	No ☐	Yes ☐
Sexually Transmitted Diseases	No ☐	Yes ☐
Emotional or Behavioral Problems	No ☐	Yes ☐
Depression/Suicidal Thoughts	No ☐	Yes ☐
Hospitalizations/Surgeries	No ☐	Yes ☐
Physical/Emotional/ Sexual Abuse	No ☐	Yes ☐
Bone or Joint Injuries	No ☐	Yes ☐
Obesity/Eating Disorders	No ☐	Yes ☐
Other: _____	No ☐	Yes ☐
_____		

Current Medication(s): (*List*) _____
_____

Reviewed by:	Date of Review:

OBJECTIVE HEARING AND VISION TESTING
MARYLAND HEALTHY KIDS PROGRAM

Child's Name:_____ Date of Birth_____

Objective Vision Testing recommended at ages 3 to 6, 8, 10, 12, 15, and 18 years

Date of Service: _____

Screened by: _____

Ages 3 – 6

Visual Acuity R _____ L _____

Muscle Balance:
Near R _____ L _____
Far R _____ L _____

Vision Fusion:
Pass _____ Fail _____

Color Screens (optional):
Pass _____ Fail _____

Comments: _____

_____

Date of Service: _____

Screened by: _____

Ages 8 – 20

Visual Acuity R _____ L _____

Muscle Balance:
Near R _____ L _____
Far R _____ L _____

Hyperopia:
Pass _____ Fail _____

Pass _____ Fail _____

Comments: _____

_____

……

Objective Hearing Testing recommended at ages 3 to 6, 8, 10, 12, 15, and 18 years

Date of Service: _____

Screened by: _____

HZ	1000	2000	4000
Rt. ___db	_____	_____	_____
Lt. ___db	_____	_____	_____

Comments: _____

_____

Date of Service: _____

Screened by: _____

HZ	1000	2000	4000
Rt. ___db	_____	_____	_____
Lt. ___db	_____	_____	_____

Comments: _____

_____

Section 8.0 Telephone Directories

Healthy Kids Program Consultants ***Reviewed 2022***

Local Departments of Social Services ***Reviewed 2022***

Local Domestic Violence Directory ***Reviewed 2022***

Local Health Departments Administrative Care Coordinators Units ***Reviewed 2022***

Local Health Departments MD Children's Health Programs ***Reviewed 2022***

Local Health Departments Nursing Lead Contacts ***Reviewed 2022***

Local Health Departments TB Control Coordinators ***Reviewed 2022***

Local Protective Services ***Reviewed 2022***

Maryland Head Start Centers ***Reviewed 2022***

Maryland Health Connection Connector Entities ***Reviewed 2022***

Maryland Local WIC Agencies ***Reviewed 2022***

Maryland VFC Center ***Reviewed 2022***

Medicaid Administrative and Billing Contacts ***Reviewed 2022***

Medicaid HealthChoice Managed Care Organizations Resource List ***Reviewed 2022***

Medicaid Health Choice Managed Care Organizations Pharmacy Benefits Managers ***Reviewed 2022***

Medicaid Transportation Grant Program Local Managers ***Reviewed 2022***

MSDE Local Child Find Programs ***Reviewed 2022***

MSDE Local Infants & Toddlers Programs ***Reviewed 2022***

REM Program ***Reviewed 2022***

Section 8.0 Telephone Directories

8.1 Healthy Kids Consultants
https://health.maryland.gov/mmcp/epsdt/healthykids/Pages/epsdt_consult.aspx

8.2 Local Departments of Social Services
https://health.maryland.gov/mmcp/epsdt/healthykids/Section%208/Local-Departments-of-Social-Services.pdf

8.3 Local Domestic Violence Directory
https://health.maryland.gov/mmcp/epsdt/healthykids/Section%208/Domestic-Violence-Directory.pdf

8.4 Local Health Departments Administrative Care Coordination Units
https://health.maryland.gov/mmcp/epsdt/healthykids/Documents/Local%20Health%20Departments%20Administrative%20Care%20Coordination%20Units.pdf

8.5 Local Health Departments Children's Health Program
https://health.maryland.gov/mmcp/epsdt/healthykids/Section%208/MCHP-Contact-List.pdf

8.6 Lead Program Nursing Contacts at Local Health Departments
https://mde.maryland.gov/programs/Land/Documents/LeadFactSheets/LeadfsHealthDeptNursingContacts.pdf

8.7 Local Health Departments TB Control Coordinators
https://health.maryland.gov/mmcp/epsdt/healthykids/Section%208/Local-TB-Units.pdf

8.8 Local Protective Services
https://health.maryland.gov/mmcp/epsdt/healthykids/Section%208/Local-Protective-Services.pdf

8.9 Maryland Head Start
https://health.maryland.gov/mmcp/epsdt/healthykids/Section%208/Maryland-Head-Start.pdf

8.10 Maryland Health Connection Connector Entities
https://health.maryland.gov/mmcp/epsdt/healthykids/Section%208/Maryland-Health-Connection-Connector-Entities.pdf

8.11 Maryland Local WIC Agencies
https://health.maryland.gov/mmcp/epsdt/healthykids/Section%208/Local-WIC-Contacts.pdf

8.12 Maryland VFC Contact Center https://www.marylandvfc.org/

8.13 Medicaid Administration and Billing Contacts
https://health.maryland.gov/mmcp/epsdt/healthykids/Section%208/Medicaid-Administration-Contacts.pdf

8.14 Newborn Coordinators Action Grid
https://health.maryland.gov/mmcp/docs/ProviderActionGrid.pdf