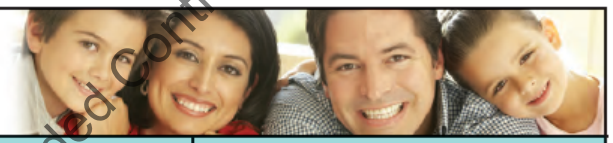
DOCUMENT HISTORY

STATUS	DOCUMENT REVISION	EFFECTIVE DATE	DESCRIPTION
Baseline	1.0	7/1/2023	Initial version, EOHHS Medicaid Managed Care Manual Chapter 2.3, EPSDT Periodicity Schedule
Revision			

EPSDT

RHODE ISLAND MEDICAID EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT



Key: • To be performed ★ Risk Assessment to be performed, with appropriate action to follow, if positive ←→ Perform within indicated time frame		Infancy							Early Childhood							Middle Childhood						Adolescence									
	Prenatal	Newborn	3-5 days	By 1 Mo	2 Mo	4 Mo	6 Mo	9 Mo	12 Mo	15 Mo	18 Mo	24 Mo	30 Mo	3 Yrs	4 Yrs	5 Yrs	6 Yrs	7 Yrs	8 Yrs	9 Yrs	10 Yrs	11 Yrs	12 Yrs	13 Yrs	14 Yrs	15 Yrs	16 Yrs	17 Yrs	18 Yrs	19 Yrs	20 Yrs
History																															
Initial/Interval (1)	• (2)	• (3)	• (4)	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Measurements																															
Length/Height and Weight		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Head Circumference		•	•	•	•	•	•	•	•	•	•	•																			
Weight for Length		•	•	•	•	•	•	•	•	•	•																				
Body Mass Index (5)												•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Blood Pressure (6)		★	★	★	★	★	★	★	★	★	★	★	★	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Sensory Screening																															
Vision (7)		★	★	★	★	★	★	★	★	★	★	★	★	•	•	•	•	★	•	★	•	★	•	★	★	•	★	★	★	★	★
Hearing		• (8)	• (9)	←→		★	★	★	★	★	★	★	★	★	•	•	•	★	•	★	•	←→		• (10)	←→	←→	•	←→		←→	•
Developmental/Behavioral Health																															
Developmental Screening (11)								•			•		•																		
Autism Spectrum Disorder Screening (12)											•	•																			
Developmental Surveillance		•	•	•	•	•	•		•	•		•		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Psychosocial/Behavioral Assessment (13)		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Tobacco, Alcohol and Drug Use Assessment (14)																						★	★	★	★	★	★	★	★	★	★
Depression Screening (15)																							•	•	•	•	•	•	•	•	•
Maternal Depression Screening (16)				•	•	•	•																								
Physical Examination																															
Physical Examination (17)		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Procedures (18)																															
Newborn Blood		• (19)	• (20)	←→																											
Newborn Bilirubin (21)		•																													
Critical Congenital Heart Defect (22)		•																													
Immunizations (23)		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Anemia (24)						★			•	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead (25)							★	★	• or ★ (26)		★	• or ★ (26)		★	★	★	★														
Tuberculosis (27)				★			★		★			★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia (28)												★			★		★		★	←→	•	←→	★	★	★	★	★	←→			•
Sexually Transmitted Infections (29)																						★	★	★	★	★	★	★	★	★	★
HIV (30)																						★	★	★	★	←→	•	←→		★	★
Other																															
Oral Health (31)							★	★	• or ★		• or ★	• or ★	• or ★	•			•														
Anticipatory Guidance (32)	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Transition to Adult Services (33)																								←→	←→	←→	←→	←→	←→	←→	←→

Rhode Island requires that all children, prior to school entry, receive vision and lead screenings and be up to date on immunizations. See schedule for recommendation in each area.
Please see dental schedule for the recommendations for pediatric oral health care.

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1 If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up-to-date at the earliest possible time.

2 A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per "The Prenatal Visit" (http://pediatrics.aappublications.org/ content/124/4/1227.full).

3 Newborns should have an evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).

4 Newborns should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding newborns should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in "Breastfeeding and the Use of Human Milk" (http://pediatrics.aappublications.org/content/129/3/e827.full). Newborns discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per "Hospital Stay for Healthy Term Newborns" (http://pediatrics.aappublications.org/content/125/2/405.full).

5 Screen, per "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" (http://pediatrics.aappublications.org/content/120/ Supplement_4/S164.full).

6 Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.

7 A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3-year-olds. Instrument-based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/e20153596) and "Procedures for the Evaluation of the Visual System by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/e20153597), but is not currently EPSDT requirement due to cost of device.

8 Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (http://pediatrics.aappublications.org/content/120/4/898.full).

9 Verify results as soon as possible, and follow up, as appropriate.

10 Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See "The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies" (http://www.jahonline.org/article/S1054-139X(16)00048-3/fulltext).

11 See "Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening" (http://pediatrics.aappublications.org/content/118/1/405.full).

12 Screening should occur per "Identification and Evaluation of Children With Autism Spectrum Disorders" (http://pediatrics.aappublications.org/content/120/5/1183.full)

13 This assessment should be family centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health. See "Promoting Optimal Development: Screening for Behavioral and Emotional Problems" (http://pediatrics.aappublications.org/content/135/2/384) and "Poverty and Child Health in the United States" (http://pediatrics.aappublications.org/content/137/4/e20160339).

14 A recommended assessment tool is available at http://www.ceasar-boston.org/CRAFFT/index.php.

15 Recommended screening using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit and at https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf.

16 Screening should occur per "Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice" (http://pediatrics.aappublications.org/content/126/5/1032).

17 At each visit, age-appropriate physical examination is essential, with infant totally unclothed and older children undressed and suitably draped. See "Use of Chaperones During the Physical Examination of the Pediatric Patient" (http://pediatrics.aappublications.org/content/127/5/991.full).

18 These may be modified, depending on entry point into schedule and individual need.

19 Confirm initial screen was accomplished, verify results, and follow up, as appropriate. The Recommended Uniform Newborn Screening Panel (http://www.hrsa.gov/advisorycommittees/mchbadvisory/ heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (http://genes-r-us.uthscsa.edu/sites/genes-r-us/files/nbsdisorders.pdf) establish the criteria for and coverage of newborn screening procedures and programs. If indicated, need for repeat screening and follow-up is communicated to PCP by the RI Newborn Screening Program. For results or to confirm screening refer to KIDSNET or call the Program Coordinator at 401-921-7619.

20 Verify results as soon as possible, and follow up, as appropriate.

21 Confirm initial screening was accomplished, verify results, and follow up, as appropriate. See "Hyperbilirubinemia in the Newborn Infant ≥35 Weeks' Gestation: An Update With Clarifications" (http://pediatrics.aappublications.org/content/124/4/1193).

22 Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per "Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease" (http://pediatrics.aappublications.org/content/129/1/190.full)

23 Schedules, per the AAP Committee on Infectious Diseases, are available at https://redbook.solutions.aap.org/ss/resources.aspx. Every visit should be an opportunity to update and complete a child's immunizations.

24 See "Diagnosis and Prevention of Iron Deficiency and Iron-Deficiency Anemia in Infants and Young Children (0–3 Years of Age)" (http://pediatrics.aappublications.org/content/126/5/1040.full).

25 For children at risk of lead exposure, see "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention" (http://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf). RI State Law requires lead screening at a minimum between 9 and 15 months of age, and again 12 months later, between 21 and 36 months of age. See the Department of Health website at http://www.health.ri.gov/publications/brochures/provider/LeadScreeningAndReferralInterventionProcess.pdf for more detail.

26 Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence areas.

27 Tuberculosis testing per recommendations of the AAP Committee on Infectious Diseases, published in the current edition of the AAP Red Book: Report of the Committee on Infectious Diseases. Testing should be performed on recognition of high-risk factors.

28 See "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).

29 Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the AAP Red Book: Report of the Committee on Infectious Diseases.

30 Adolescents should be screened for HIV according to the USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspshivi.htm) once between the ages of 15 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.

31 Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment (https://www.aap.org/RiskAssessmentTool) and refer to a dental home. Inform parents of Rite Smiles Program http://www.eohhs.ri.gov/Consumer/DentalServices/ChildrenYoungAdults.aspx as needed. Recommend brushing with fluoride toothpaste in the proper dosage for age. See "Maintaining and Improving the Oral Health of Young Children" (http://pediatrics.aappublications.org/content/134/6/1224). See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspsdnch.htm). Once teeth are present, fluoride varnish may be applied to all children every 3–6 months in the primary care or dental office. Indications for fluoride use are noted in "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626). If primary water source is deficient in fluoride, consider oral supplementation. For those at risk, the PCP should consider application of fluoride varnish for caries prevention (http://pediatrics.aappublications.org/content/134/3/626). See also guidance for health care providers at https://www.teethfirstri.org/health-care-providers.

32 Anticipatory Guidance refers to age-appropriate guidance to parents, children, and adolescents on: injury and illness prevention, developmental surveillance and milestones, sexuality, substance abuse, etc.

33 Transition refers to equipping the adolescent and family for the transfer from pediatric to adult health care by age 22. See the RI Department of Health website located at www.health.ri.gov for healthcare transition resources.