Tips for Improving HEDIS Well-Child Visits and EPSDT Care Measures

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Code and file claims completely and accurately.

Accurate and complete coding of claims is very important. If a service or diagnosis has been performed but not coded correctly, the data may not be captured and accurately reflected in your quality scores.

Use AmeriHealth Caritas Florida's EPSDT Quick Reference Guide for help:
https://amerihealthcaritasfl.com/pdf/provider/forms/provider-epsdt-quick-reference-guide.pdf

- Use correct ICD-10, HCPCS, and procedure codes.
- Use appropriate Z codes associated with EPSDT services.
- Submit claims and encounter data promptly.

If your patient has primary insurance other than Medicaid, it is important that you file a claim with AmeriHealth Caritas Florida as the secondary insurer, so the services performed for that member can be included in your HEDIS Well-Child Visits in the first 30 months of life (W30) and Child and Adolescent Well-Care Visits (WCV) quality scores as well as your EPSDT completion.

Schedule and maximize patient visits.

Provide all needed services while patients are onsite to help keep their care as up to date as possible.

- Use sick visits to complete needed components of well visits: lead screenings, developmental screenings, immunizations, EPSDT screens, and other needed services appropriate to the member's age.
- Use your electronic medical records system to develop standard care templates and standing orders where possible. Use a reminder system to help patients remember to schedule and attend their visits.

Use your member roster.

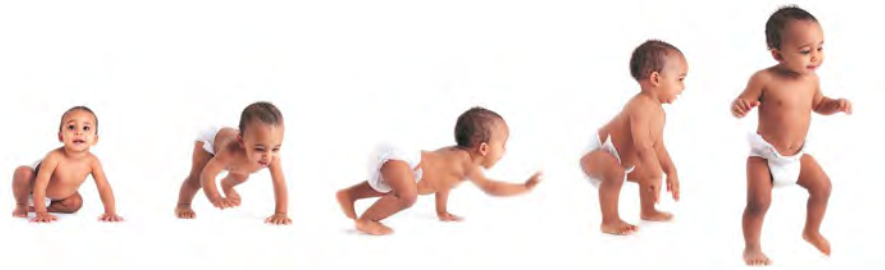
The member roster is an important tool for improving HEDIS W30/WCV and EPSDT scores.

The roster can be accessed through the NaviNet portal:
https://amerihealthcaritasfl.com/provider/resources/navinet.aspx

- Your scores are based on **all members assigned to the practice**.
- Review reports of patients with gaps in care and take steps to address gaps.
- Appoint someone in your office a HEDIS W30/WCV and EPSDT champion.
- Involve the entire practice in checking HEDIS W30/WCV and EPSDT results and setting priorities for improvement.
- Review roster lists and reach out to patients who are new to the practice to set up a new patient appointment.

Make doing the right thing the easy thing.

EPSDT Quick Reference Guide



Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Screens

Under EPSDT, state Medicaid agencies must provide and/or arrange for the promotion of services to eligible children younger than age 21 that include:

- Comprehensive, periodic, preventive health assessments
- All medically necessary immunizations
- Age-appropriate screenings as defined on the state's periodicity schedule
- Additional examinations to treat/address health issues

Treatment for all medically necessary services discovered during an EPSDT screening is also covered.

EPSDT requirements

Under Florida and federal laws, the EPSDT program must provide the following services according to a periodicity schedule developed by the Department of Human Services (DHS) as recommended by the American Academy of Pediatrics:

- A comprehensive health and developmental history, including both physical and mental health development
- A comprehensive unclothed exam
- Appropriate immunizations according to age and health history
- Appropriate laboratory tests, including blood lead-level assessment
- Health education, including anticipatory guidance

For screening eligibility information and services required for a complete EPSDT screen, please consult the EPSDT User Reference Guide and Periodicity Schedule which may be found on our website at **www.amerihealthcaritasfl.com/Providers/Resources/EPSDT**. For a complete EPSDT program description, please consult your AmeriHealth Caritas Florida Provider Manual.

The following diagnosis codes should be used in conjunction with EPSDT claims submitted:

ICD-10	
Z00.00	Encounter for general adult medical examination without abnormal findings
Z00.01	Encounter for general adult medical examination with abnormal findings
Z00.110	Encounter for health examination for newborn under 8 days old
Z00.111	Encounter for health examination for newborn 8 to 28 days old
Z00.121	Encounter for routine child health examination with abnormal findings
Z00.129	Encounter for routine child health examination without abnormal findings
Z38.00	Encounter for single live born infant, delivered vaginally
Z38.01	Encounter for single live born infant, delivered by cesarean
Z38.1	Encounter for single live born infant, born outside hospital
Z38.2	Encounter for single live born infant, unspecified as to place of birth
Z38.30 – Z38.8	Encounter for range of codes for multiple births
Z76.1	Encounter for health supervision and care of a foundling
Z76.2	Encounter for health supervision and care of other healthy infant and child

Important information for Place of Service 21: When billing for newborns in an inpatient setting, please use diagnosis code Z38.00, Z38.01, Z38.1, Z38.2, or Z38.30–Z38.8 in the primary field with Z00.110, Z00.111, Z00.121, Z00.129, Z76.1, or Z76.2 in the secondary field when submitting an EPSDT screen performed in an inpatient hospital setting.

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Submit claim(s) with the following CPT codes for these services:

CPT	
New patient	**Established patient**
99460 Newborn Care (during admission)	99463 Newborn (same day discharge)
99381 Age <1 year	99391 Age <1 year
99382 Age 1–4 years	99392 Age 1–4 years
99383 Age 5–11 years	99393 Age 5–11 years
99384 Age 12–17 years	99394 Age 12–17 years
99385* Age 18–20 years	99395* Age 18–20 years

*requires modifier EP

Maternal depression screens	
96161**	Administration of caregiver-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, per standard instrument.

**96161 is not separately reimbursable but should be billed for encounter purposes with a billed charge of $0.00.

Lead level screening	
Billable service	**CPT code**
Lead screening	83655

EPSDT billing guide				
UB-04	**CMS 1500**	**Item**	**Description**	**C/R†**
18	N/A	Condition codes	Enter the condition code A1 EPSDT.	R
67	21	Diagnosis or nature of illness or injury	When billing for EPSDT screening services, diagnosis codes Z00.110, Z00.111, Z00.121, Z00.129, Z76.1, Z76.2, Z00.00 or Z00.01 (Routine Infant or Child Health Check) must be used in the primary field (21.1) of this block. Additional diagnosis codes should be entered in fields 21.2, 21.3, and 21.4. **An appropriate diagnosis code must be included for each referral.** Immunization V-codes are not required. **Important information for Place of Service 21:** When billing for newborns in an inpatient setting, please use diagnosis code Z38.00, Z38.01, Z38.1, Z38.2, or Z38.30-Z38.8 in the primary field with Z00.110, Z00.111, Z00.121, Z00.129, Z76.1, or Z76.2 in the secondary field when submitting an EPSDT screen performed in an inpatient hospital setting.	R
42	N/A	Revenue code	Enter revenue code 510.	R
44	24D	Procedures, services, or supplies CPT/HCPCS modifier	Populate the first claim line with the age-appropriate E & M codes (along with modifier EP when appropriate) when submitting a "complete" EPSDT visit, as well as any other EPSDT-related services (e.g., immunizations).	R
N/A	24H	EPSDT/family planning	Refer to EPSDT claims table below for screening codes.	R

EPSDT and Family Planning

If an EPSDT referral was given:

- Loop 2300, Segment CRC02 = Y
- Loop 2300, Segment CRC03 = one of the following:
  - AV Available-not used (recipient refused referral)
  - S2 Under treatment
  - ST New service requested
- Loop 2400, Segment SV111 = Y

If the service is an EPSDT service and no follow-up services are required:

- Loop 2300, Segment CRC02 = N
- Loop 2300, Segment CRC03 = NU

†Key: C — Conditional; must be completed if the information applies to the situation or service provided.
R — Required; must be completed for all EPSDT claims.

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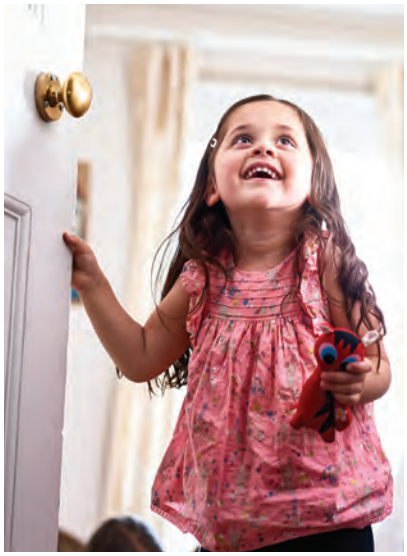
Lead Level Screening

Lead can do great harm, especially to young children. Childhood lead poisoning at low levels can make learning difficult, interfere with growth, harm hearing, and delay development. At high levels, lead can cause coma, convulsions, and even death.



The main source of lead poisoning is lead dust from lead-based paint, which was used in many homes until 1978. Young children are exposed to lead dust in older homes through normal activities such as crawling on the floor and putting their hands, toys, or other objects in their mouths.

Lead can also be found in bare soil, some imported spices, home remedies, and cosmetics.

Lead level screening

Lead poisoning can occur without symptoms. This is very common in children ages 6 months to 6 years. The Centers for Medicare & Medicaid Services (CMS) and the Florida Department of Health have stringent requirements for lead toxicity screening for all Medicaid-eligible children.

- **All** Medicaid-eligible children are considered at risk for lead toxicity and **must** receive blood lead level screening tests for lead poisoning.
- Primary care providers (PCPs) are **required (regardless of responses to the lead screening questions)** to ensure that children are screened for lead toxicity **from 9 months to 18 months old and again from 2 years to 6 years old.**
- Risk questions should be asked at every visit thereafter.

Refer to the Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care periodicity schedule at **https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf**.

The plan recommends that lead screens be done at 9 months old and again before the second birthday, and that risk questions be asked at every visit thereafter.

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As an added incentive to help PCPs comply with these standards, the Plan will reimburse PCPs for blood lead screening services if they are performed in the PCP's office.

Submit claim(s) with the following CPT code for these services:

Billable service	CPT code
Lead screening	83655

Note: This service is covered only when the aforementioned CMS/Florida Department of Health guidelines are followed. Elevated initial blood lead results obtained on capillary screening specimens are presumptive and should be confirmed using a venous specimen.

Providers who participate in our plan have a responsibility to communicate with agencies including, but not limited to, local public health agencies regarding cases involving children with lead poisoning.

The Florida Department of Health provides a toll-free Lead Information Line (**1-850-245-4401**) for questions and also provides electronic materials on lead poisoning and other environmental hazards. You can visit their website at **https://www.floridahealth.gov/environmental-health/lead-poisoning/index.html.**

The Centers for Disease Control and Prevention (CDC) also have resources at **www.cdc.gov/nceh/lead**.

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

Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

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

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

These recommendations represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

Refer to the specific guidance by age as listed in the *Bright Futures Guidelines* (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents.* 4th ed. American Academy of Pediatrics; 2017).

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

The Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care are updated annually.

	INFANCY								EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE										
AGE[1]	**Prenatal**[2]	**Newborn**[3]	**3-5 d**[4]	**By 1 mo**	**2 mo**	**4 mo**	**6 mo**	**9 mo**	**12 mo**	**15 mo**	**18 mo**	**24 mo**	**30 mo**	**3 y**	**4 y**	**5 y**	**6 y**	**7 y**	**8 y**	**9 y**	**10 y**	**11 y**	**12 y**	**13 y**	**14 y**	**15 y**	**16 y**	**17 y**	**18 y**	**19 y**	**20 y**	**21 y**
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																																
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●																				
Weight for Length		●	●	●	●	●	●	●	●	●	●																					
Body Mass Index[5]												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[6]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																																
Vision[7]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	★	●	★	●	★	●	★	★	●	★	★	★	★	★	★
Hearing		●[8]	●[9] →	→	★	★	★	★	★	★	★	★	★	★	●	●	●	★	●	★	●	←	←	●[10] →	→	←	● →	→	←	● →	→	●	→
DEVELOPMENTAL/SOCIAL/BEHAVIORAL/MENTAL HEALTH																																
Maternal Depression Screening[11]				●	●	●	●																									
Developmental Screening[12]								●			●		●																			
Autism Spectrum Disorder Screening[13]											●	●																				
Developmental Surveillance		●	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Behavioral/Social/Emotional Screening[14]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Tobacco, Alcohol, or Drug Use Assessment[15]																					★	★	★	★	★	★	★	★	★	★	★	★
Depression and Suicide Risk Screening[16]																						●	●	●	●	●	●	●	●	●	●	●
PHYSICAL EXAMINATION[17]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[18]																																
Newborn Blood		●[19]	●[20] →	→																												
Newborn Bilirubin[21]		●																														
Critical Congenital Heart Defect[22]		●																														
Immunization[23]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Anemia[24]						★			●	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead[25]							★	★	● or ★[26]		★	● or ★[26]		★	★	★	★																
Tuberculosis[27]				★			★		★			★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia[28]												★			★		★		★	←	● →	★	★	★	★	★	←	←	←	● →	→	★	→
Sexually Transmitted Infections[29]																						★	★	★	★	★	★	★	★	★	★	★	★
HIV[30]																						★	★	★	★	● →	→	→	→	→	→	→	→
Hepatitis B Virus Infection[31]		★ →	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→
Hepatitis C Virus Infection[32]																													● →	→	→	→	→
Sudden Cardiac Arrest/Death[33]																						★ →	→	→	→	→	→	→	→	→	→	→	→
Cervical Dysplasia[34]																																	●
ORAL HEALTH[35]							●[36]	●[36]	★		★	★	★	★	★	★	★																
Fluoride Varnish[37]							←	→	→	→	●	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→
Fluoride Supplementation[38]							★	★	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★						
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per "The Prenatal Visit" (https://doi.org/10.1542/peds.2018-1218).
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" (https://doi.org/10.1542/peds.2011-3552). Newborns discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per "Hospital Stay for Healthy Term Newborn Infants" (https://doi.org/10.1542/peds.2015-0699).
5. Screen, per "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" (https://doi.org/10.1542/peds.2007-2329C).
6. Screening should occur per "Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents" (https://doi.org/10.1542/peds.2017-1904). 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" (https://doi.org/10.1542/peds.2015-3596) and "Procedures for the Evaluation of the Visual System by Pediatricians" (https://doi.org/10.1542/peds.2015-3597).
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" (https://doi.org/10.1542/peds.2007-2333).
9. Verify results as soon as possible, and follow up, as appropriate.
10. Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See "The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies" (https://www.sciencedirect.com/science/article/abs/pii/S1054139X16000483).
11. Screening should occur per "Incorporating Recognition and Management of Perinatal Depression Into Pediatric Practice" (https://doi.org/10.1542/peds.2018-3259).
12. Screening should occur per "Promoting Optimal Development: Identifying Infants and Young Children With Developmental Disorders Through Developmental Surveillance and Screening" (https://doi.org/10.1542/peds.2019-3449).
13. Screening should occur per "Identification, Evaluation, and Management of Children With Autism Spectrum Disorder" (https://doi.org/10.1542/peds.2019-3447).

(continued)

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

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(continued)

14. Screen for behavioral and social-emotional problems per "Promoting Optimal Development: Screening for Behavioral and Emotional Problems" (https://doi.org/10.1542/peds.2014-3716), "Mental Health Competencies for Pediatric Practice" (https://doi.org/10.1542/peds.2019-2757), "Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents With Anxiety Disorders" (https://pubmed.ncbi.nlm.nih.gov/32439401), and "Screening for Anxiety in Adolescent and Adult Women: A Recommendation From the Women's Preventive Services Initiative" (https://pubmed.ncbi.nlm.nih.gov/32510990). The screening should be family centered and may include asking about caregiver emotional and mental health concerns and social determinants of health, racism, poverty, and relational health. See "Poverty and Child Health in the United States" (https://doi.org/10.1542/peds.2016-0339), "The Impact of Racism on Child and Adolescent Health" (https://doi.org/10.1542/peds.2019-1765), and "Preventing Childhood Toxic Stress: Partnering With Families and Communities to Promote Relational Health" (https://doi.org/10.1542/peds.2021-052582).
15. A recommended assessment tool is available at http://crafft.org.
16. Screen adolescents for depression and suicide risk, making every effort to preserve confidentiality of the adolescent. See "Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I. Practice Preparation, Identification, Assessment, and Initial Management" (https://doi.org/10.1542/peds.2017-4081), "Mental Health Competencies for Pediatric Practice" (https://doi.org/10.1542/peds.2019-2757), "Suicide and Suicide Attempts in Adolescents" (https://doi.org/10.1542/peds.2016-1420), and "The 21st Century Cures Act & Adolescent Confidentiality" (https://www.adolescenthealth.org/Advocacy/Advocacy-Activities/2019-(1)/NASPAG-SAHM-Statement.aspx).
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" (https://doi.org/10.1542/peds.2011-0322).
18. These may be modified, depending on entry point into schedule and individual need.
19. Confirm initial screen was accomplished, verify results, and follow up, as appropriate. The Recommended Uniform Screening Panel (https://www.hrsa.gov/advisory-committees/heritable-disorders/rusp/index.html), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (https://www.babysfirsttest.org/) establish the criteria for and coverage of newborn screening procedures and programs.
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" (https://doi.org/10.1542/peds.2009-0329).
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" (https://doi.org/10.1542/peds.2011-3211).
23. Schedules, per the AAP Committee on Infectious Diseases, are available at https://publications.aap.org/redbook/pages/immunization-schedules. Every visit should be an opportunity to update and complete a child's immunizations.
24. Perform risk assessment or screening, as appropriate, per recommendations in the current edition of the AAP *Pediatric Nutrition: Policy of the American Academy of Pediatrics* (Iron chapter).
25. For children at risk of lead exposure, see "Prevention of Childhood Lead Toxicity" (https://doi.org/10.1542/peds.2016-1493) and "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention" (https://www.cdc.gov/nceh/lead/docs/final_document_030712.pdf).
26. Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence areas.
27. Tuberculosis testing per recommendations of the AAP Committee on Infectious Diseases, published in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases.* Testing should be performed on recognition of high-risk factors.
28. See "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).
29. Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases.*
30. Screen adolescents for HIV at least once between the ages of 15 and 21, making every effort to preserve confidentiality of the adolescent, as per "Human Immunodeficiency Virus (HIV) Infection: Screening" (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening); after initial screening, youth at increased risk of HIV infection should be retested annually or more frequently, as per "Adolescents and Young Adults: The Pediatrician's Role in HIV Testing and Pre- and Postexposure HIV Prophylaxis" (https://doi.org/10.1542/peds.2021-055207).
31. Perform a risk assessment for hepatitis B virus (HBV) infection according to recommendations per the USPSTF (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-b-virus-infection-screening) and in the 2021–2024 edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*, making every effort to preserve confidentiality of the patient.
32. All individuals should be screened for hepatitis C virus (HCV) infection according to the USPSTF (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-c-screening) and Centers for Disease Control and Prevention (CDC) recommendations (https://www.cdc.gov/mmwr/volumes/69/rr/rr6902a1.htm) at least once between the ages of 18 and 79. Those at increased risk of HCV infection, including those who are persons with past or current injection drug use, should be tested for HCV infection and reassessed annually.
33. Perform a risk assessment, as appropriate, per "Sudden Death in the Young: Information for the Primary Care Provider" (https://doi.org/10.1542/peds.2021-052044).
34. See USPSTF recommendations (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/cervical-cancer-screening). Indications for pelvic examinations prior to age 21 are noted in "Gynecologic Examination for Adolescents in the Pediatric Office Setting" (https://doi.org/10.1542/peds.2010-1564).
35. Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment (https://www.aap.org/en/patient-care/oral-health/oral-health-practice-tools/) and refer to a dental home. Recommend brushing with fluoride toothpaste in the proper dosage for age. See "Maintaining and Improving the Oral Health of Young Children" (https://doi.org/10.1542/peds.2014-2984).
36. Perform a risk assessment (https://www.aap.org/en/patient-care/oral-health/oral-health-practice-tools/). See "Maintaining and Improving the Oral Health of Young Children" (https://doi.org/10.1542/peds.2014-2984).
37. The USPSTF recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-dental-caries-in-children-younger-than-age-5-years-screening-and-interventions1). Once teeth are present, apply fluoride varnish to all children every 3 to 6 months in the primary care or dental office based on caries risk. Indications for fluoride use are noted in "Fluoride Use in Caries Prevention in the Primary Care Setting" (https://doi.org/10.1542/peds.2020-034637).
38. If primary water source is deficient in fluoride, consider oral fluoride supplementation. See "Fluoride Use in Caries Prevention in the Primary Care Setting" (https://doi.org/10.1542/peds.2020-034637).

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

This schedule reflects changes approved in December 2022 and published in April 2023. For updates and a list of previous changes made, visit www.aap.org/periodicityschedule.

CHANGES MADE IN DECEMBER 2022

HIV

The HIV screening recommendation has been updated to extend the upper age limit from 18 to 21 years (to account for the range in which the screening can take place) to align with recommendations of the US Preventive Services Task Force and AAP policy ("Adolescents and Young Adults: The Pediatrician's Role in HIV Testing and Pre- and Postexposure HIV Prophylaxis").

- Footnote 30 has been updated to read as follows: "Screen adolescents for HIV at least once between the ages of 15 and 21, making every effort to preserve confidentiality of the adolescent, as per 'Human Immunodeficiency Virus (HIV) Infection: Screening' (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening); after initial screening, youth at increased risk of HIV infection should be retested annually or more frequently, as per 'Adolescents and Young Adults: The Pediatrician's Role in HIV Testing and Pre- and Postexposure HIV Prophylaxis' (https://doi.org/10.1542/peds.2021-055207)."

CHANGES MADE IN NOVEMBER 2021

HEPATITIS B VIRUS INFECTION

Assessing risk for HBV infection has been added to occur from newborn to 21 years (to account for the range in which the risk assessment can take place) to be consistent with recommendations of the USPSTF and the 2021–2024 edition of the AAP *Red Book-Report of the Committee on Infectious Diseases*.

- Footnote 31 has been added to read as follows: "Perform a risk assessment for hepatitis B virus (HBV) infection according to recommendations per the USPSTF (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-b-virus-infection-screening) and in the 2021–2024 edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*, making every effort to preserve confidentiality of the patient."

SUDDEN CARDIAC ARREST AND SUDDEN CARDIAC DEATH

Assessing risk for sudden cardiac arrest and sudden cardiac death has been added to occur from 11 to 21 years (to account for the range in which the risk assessment can take place) to be consistent with AAP policy ("Sudden Death in the Young: Information for the Primary Care Provider").

- Footnote 33 has been added to read as follows: "Perform a risk assessment, as appropriate, per 'Sudden Death in the Young: Information for the Primary Care Provider' (https://doi.org/10.1542/peds.2021-052044)."

DEPRESSION AND SUICIDE RISK

Screening for suicide risk has been added to the existing depression screening recommendation to be consistent with the GLAD-PC and AAP policy.

- Footnote 16 has been updated to read as follows: "Screen adolescents for depression and suicide risk, making every effort to preserve confidentiality of the adolescent. See 'Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I. Practice Preparation, Identification, Assessment, and Initial Management' (https://doi.org/10.1542/peds.2017-4081), 'Mental Health Competencies for Pediatric Practice' (https://doi.org/10.1542/peds.2019-2757), 'Suicide and Suicide Attempts in Adolescents' (https://doi.org/10.1542/peds.2016-1420), and 'The 21st Century Cures Act & Adolescent Confidentiality' (https://www.adolescenthealth.org/Advocacy/Advocacy-Activities/2019-(1)/NASPAG-SAHM-Statement.aspx)."

BEHAVIORAL/SOCIAL/EMOTIONAL

The Psychosocial/Behavioral Assessment recommendation has been updated to Behavioral/Social/Emotional Screening (annually from newborn to 21 years) to align with AAP policy, the American College of Obstetricians and Gynecologists (Women's Preventive Services Initiative) recommendations, and the American Academy of Child & Adolescent Psychiatry guidelines.

- Footnote 14 has been updated to read as follows: "Screen for behavioral and social-emotional problems per 'Promoting Optimal Development: Screening for Behavioral and Emotional Problems' (https://doi.org/10.1542/peds.2014-3716), 'Mental Health Competencies for Pediatric Practice' (https://doi.org/10.1542/peds.2019-2757), 'Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents With Anxiety Disorders' (https://pubmed.ncbi.nlm.nih.gov/32439401), and 'Screening for Anxiety in Adolescent and Adult Women: A Recommendation From the Women's Preventive Services Initiative' (https://pubmed.ncbi.nlm.nih.gov/32510990/). The screening should be family centered and may include asking about caregiver emotional and mental health concerns and social determinants of health, racism, poverty, and relational health. See 'Poverty and Child Health in the United States' (https://doi.org/10.1542/peds.2016-0339), 'The Impact of Racism on Child and Adolescent Health' (https://doi.org/10.1542/peds.2019-1765), and 'Preventing Childhood Toxic Stress: Partnering With Families and Communities to Promote Relational Health' (https://doi.org/10.1542/peds.2021-052582)."

FLUORIDE VARNISH

- Footnote 37 has been updated to read as follows: "The USPSTF recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-dental-caries-in-children-younger-than-age-5-years-screening-and-interventions1). Once teeth are present, apply fluoride varnish to all children every 3 to 6 months in the primary care or dental office based on caries risk. Indications for fluoride use are noted in 'Fluoride Use in Caries Prevention in the Primary Care Setting' (https://doi.org/10.1542/peds.2020-034637)."

FLUORIDE SUPPLEMENTATION

- Footnote 38 has been updated to read as follows: "If primary water source is deficient in fluoride, consider oral fluoride supplementation. See 'Fluoride Use in Caries Prevention in the Primary Care Setting' (https://doi.org/10.1542/peds.2020-034637)."

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