MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

July 13, 2010

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: MARTA E. STAGLIANO, CHIEF, COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1500 – HEALTHY KIDS PROGRAM

BACKGROUND AND EXPLANATION

The use of developmental screening tools during an EPSDT exam is being encouraged by the American Academy of Pediatrics in order to increase the identification of children with developmental disorders. Nevada Medicaid's policy is being updated to reflect reimbursement for developmental screening when a valid, standardized screening tool is used and entered into the child's health care record. All definition numbers were removed for consistency throughout the chapter. Throughout this chapter punctuation and renumbering of some sections were made, but no policy was changed as a result.

These policy changes are effective July 14, 2010.

MATERIAL TRANSMITTED	MATERIAL SUPERCEDED
MTL 26/10 CHAPTER 1500 – HEALTHY KIDS PROGRAM	MTL 23/05, 18/08 CHAPTER 1500 – HEALTHY KIDS PROGRAM

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1503	**Comprehensive Screening Examination**	Added language regarding reimbursement and general information of developmental screenings.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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HEALTHY KIDS PROGRAM

1500 INTRODUCTION

Early and periodic screening, diagnostic and treatment services (EPSDT) are preventive and diagnostic services available to most recipients under age 21. In Nevada, the EPSDT program is known as Healthy Kids. The program is designed to identify medical conditions and to provide medically necessary treatment to correct such conditions. Healthy Kids offers the opportunity for optimum health status for children through regular, preventive health services and the early detection and treatment of disease.

1501 AUTHORITY

Early and periodic screening, diagnostic and treatment services (EPSDT) are a mandatory benefit under the Medicaid program for categorically needy individuals under age 21.

Services available under the Healthy Kids Program are provided as defined in the following:

- Omnibus Budget Reconciliation Act of 1989,
- 42 U. S. C. 1905 (a) and (r);
- 42 U. S. C. 1396 (d) and (r);
- 42 U. S. C. 1902 (a);
- 42 U. S. C. 1903 (i);
- 42 C. F. R., Subpart B, 441.50 – 441.62;
- State Medicaid Manual (Part 5); and
- Nevada Medicaid's State Plan.

1502 DEFINITIONS

DIAGNOSIS

Diagnosis means determination of the nature or cause of physical or mental disease or abnormality through the combined used of health history, physical and developmental examination, and laboratory tests.

EARLY

Early means as soon as possible in the child's life after the child is determined eligible.

HEALTH EDUCATION

Health education means the guidance, including anticipatory, offered to assist in understanding what to expect in terms of a child's development and to provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention.

INTERPERIODIC

Interperiodic means at intervals other than those indicated in the periodicity schedule.

PERIODIC

Periodic means at intervals established for screening by medical, dental, and other health care providers to detect disease or disability that meet reasonable standards of medical practice. The procedures performed and their frequency will depend upon the child's age and health history.

SCREENING

Screening means to examine methodically in order to determine a child's health status and to make appropriate diagnosis and treatment referrals.

TREATMENT

Treatment means medically necessary services or care provided to prevent, correct or improve disease or abnormalities detected by screening and diagnostic procedures.

1503 POLICY

1503.1 PERIODIC SCREENINGS

The Healthy Kids program has established a periodicity schedule for screening, vision, hearing and dental services based upon the American Academy of Pediatrics.

1503.1A COVERAGE AND LIMITATIONS

The Healthy Kids program encourages providers to follow the recommended schedule for developmental screenings offered by the American Academy of Pediatrics. Recipients will be sent letters by the division's QIO-like vendor reminding them to schedule a screening visit on a periodic basis as outlined in Attachment A of this chapter.

Dental services are outlined in Chapter 1000 of the Medicaid Services Manual (MSM). Dental services can occur at intervals outside the established periodicity schedule when indicated as medically necessary to determine the existence of a suspected illness or condition. At a minimum, they must include relief of pain and infection, restoration of teeth, and maintenance of dental health. Generally, dental services must be provided at intervals which meet reasonable standards of medical practice as recognized by medical organizations involved with child health care and should be age appropriate.

Vision services are outlined in Chapter 1100 of the MSM. Vision services can occur at intervals outside the established periodicity schedule when indicated as medically necessary to determine the existence of a suspected illness or condition. At a minimum, services must include diagnosis and treatment for defects in vision, including eye glasses. Generally, vision services must be provided at intervals which meet reasonable standards of medical practice as recognized by medical organizations involved with child health care and should be age appropriate.

Hearing services are outlined in Chapter 1300 of the MSM. Hearing services can occur at intervals outside the established periodicity schedule when indicated as medically necessary to determine the existence of a suspected illness or condition. At a minimum, services must include diagnosis and treatment for defects in hearing, including hearing aids. Generally, hearing services must be provided at intervals which meet reasonable standards of medical practice as recognized by medical organizations involved with child health care and should be age appropriate.

1503.1B PROVIDER RESPONSIBILITY

The provider is expected to follow the periodicity guidelines as recommended when conducting Healthy Kids examinations whenever possible. The provider should offer services as deemed medically appropriate.

1503.2 INTERPERIODIC SCREENINGS

Healthy Kids screening is provided to all eligible persons under the age of 21, which may include medically necessary intervals that are outside an established periodicity schedule, also known as interperiodic screenings.

1503.2A COVERAGE AND LIMITATIONS

DHCFP has identified a periodicity schedule that allows for access to screening, vision, hearing and dental services at intervals which meet reasonable standards of medical practice.

A recipient may request a health care screening or any component of the health screening at any time. Screening services which are medically necessary, such as when a new health problem has occurred or when a previously diagnosed condition has become more severe or changed sufficiently to require a new examination, will be offered, regardless of whether the request falls into the periodicity schedule established by the State.

1503.2B PROVIDER RESPONSIBILITY

The provider should complete screenings according to the periodicity schedule. The provider shall determine whether a screening request is medically necessary when it falls outside the periodicity schedule and will conduct the intervention necessary to address suspected medical problems.

1503.2C RECIPIENT RESPONSIBILITY

The recipient should report all suspected health problems as soon as possible to his/her treating provider.

1503.3 COMPREHENSIVE SCREENING EXAMINATION

A Healthy Kids screening examination must comply with § 1905(r) of the Social Security Act.

1503.3A COVERAGE AND LIMITATIONS

Screening services are designed to evaluate the general physical and mental health, growth, development and nutritional status of infants, children and adolescents. This section describes the components of an exam.

Immunizations and laboratory tests should be billed separately from the screening visit. Objective vision and hearing testing performed during the same visit as the physical examination should not be billed separately. If hearing and vision testing needs to be performed separately from the exam, these procedures should be billed as outlined in applicable MSM chapters.

Nevada Medicaid does not cover "sick kid" visits under the Healthy Kids program. A majority of the screening elements should be completed during a screening appointment to be billed as a Healthy Kids screening. The screening visit should be rescheduled if the child is too ill to complete the examination and should be billed using a routine office visit code.

The following is a description of each of the required age appropriate screening components:

1. COMPREHENSIVE HEALTH AND DEVELOPMENTAL/BEHAVIORAL HISTORY

At the initial screening, the provider must obtain a comprehensive health, developmental/behavioral, mental health and nutritional history from the child's parents or a responsible adult familiar with the child, or directly from an adolescent, when appropriate. This history should be gathered through an interview or questionnaire. A comprehensive initial history includes a review of the:

a. family medical history (health of the parents and current family members, identification of family members with chronic, communicable or hereditary diseases);

b. patient medical history (prenatal problems, neonatal problems, neonatal problems, developmental milestones, serious illnesses, surgeries, hospitalizations, allergies, current health problems and medications);

c. nutritional history;

d. Immunization history;

e. Environmental risk;

f. Family back ground of emotional problems, problems with drinking, or drugs or history of violence or abuse;

g. Patient history of behavioral and/or emotional problems;

h. History of sexual activity, if appropriate; and

i. menstrual and obstetrical history for females, if appropriate.

2. DEVELOPMENTAL/BEHAVIORAL ASSESSMENT

Assessment of developmental and behavioral status should be completed at each visit by observation, interview, history and appropriate physical examination. The developmental

assessment should include a range of activities to determine whether or not the child has reached an appropriate level of development for age.

Nevada Medicaid will reimburse separately for developmental screenings, provided that a valid, standardized developmental screening tool, (i.e. PEDS, Ages and Stages, Early Language Milestone Screen) has been utilized and entered into the child's health care record. Although the American Academy of Pediatrics recommends the use of a standardized screening tool at ages, 9, 18, 30 months, and 3 and 4 years of age, the exact frequency of standardized testing depends on the clinical setting and provider's judgment as to medical necessity. Asking questions about development as part of the general informal developmental survey or history is not a "standardized screening" and is not separately reportable. Providers may be subject to a random audit of records to assure the use of the screening tool. For billing instructions, see the First Health billing manual. https://nevada.fhsc.com/providers/billinginfo.asp.

3. COMPREHENSIVE UNCLOTHED PHYSICAL EXAM

A completed unclothed physical examination must be performed at each screening visit. The examination must be conducted using observation, palpation, auscultation and other appropriate techniques. The examination must include all body parts and systems listed below:

a. Cranium and face;

b. Hair and scalp;

c. Ears;

d. Eyes;

e. Nose;

f. Throat;

g. Mouth and teeth;

h. Neck;

i. Skin and lymph nodes;

j. Chest and back;

k. Abdomen;

l. Genitalia;

m. Musculoskeletal system;

n. Extremities; and

o. Nervous system.

The examination should include screening for congenital abnormalities and responses to voices and other external stimuli.

4. APPROPRIATE IMMUNIZATIONS

The child's immunization status must be reviewed each screening visit. Appropriate immunizations that are due must be administered during the screening visit and according to the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines. This schedule can be found on Attachment B.

Nevada Medicaid cannot reimburse for immunizations (except administration fees) that are available through the state Health Division as part of the Vaccines for Children (VFC) program. Providers are encouraged to enroll with the VFC program which provides the VFC vaccines at no cost to eligible children. Medicaid cannot be billed for the cost of a vaccine obtained through VFC, (even if the provider is not enrolled with VFC) unless there is a documented statewide shortage. To become a VFC provider, please access the website via http://health.nv.gov/.

Nevada Check Up provides the same vaccines through a different funding source, but providers must use the same billing guidelines.

For specific guidelines for the Human Papilloma Virus (HPV) vaccine, please refer to Chapter 1200 – Pharmacy Services.

5. LABORATORY PROCEDURES

Age-appropriate laboratory procedures must be performed at intervals in accordance with the Healthy Kids periodicity schedule. These include blood lead level assessment appropriate to age and risk, urinalysis, Tuberculin Skin Test (TST), Sickle-cell, hemoglobin or hematocrit and other tests and procedures that are age appropriate and medically necessary, such as Pap smears.

6. HEALTH EDUCATION

Health education related to the physical assessment should be provided at each screening visit. It is designed to help children and their parents understand the health status of the child as well as provide information which emphasizes health promotion and preventive strategies. Health education explains the benefits of a healthy lifestyle, prevention of disease and accidents, and normal growth and development, and age appropriate family planning services. (See Section 1503.4A)

Anticipatory guidance should be offered which includes discussion of information on what to expect in the child's current and next developmental phase. It is given in anticipation of health problems or decisions which may occur before the next periodicity visit.

Information should also include a summarization of the results of the screening and laboratory tests, review of the child's health status, and discussion regarding any specific problems detected in the screening.

7. VISION SCREENING

The purpose is to detect potentially blinding diseases and visual impairments, such as congenital abnormalities and malformations, eye diseases, color blindness and refractive errors. The screening should include distance visual acuity, color perception and ocular alignment tests. The vision screening is part of the complete physical examination and should be given by age three.

8. HEARING SCREENING

The purpose is to detect sensorineural and conductive hearing loss, congenital abnormalities, noise-induced hearing loss, central auditory problems, or a history of conditions that may increase the risk for potential hearing loss. The examination must include information about the child's response to voice and other auditory stimuli, speech and language development, and specific factors or health problems that place a child at risk for hearing loss.

9. DENTAL SCREENING

An oral inspection must be performed by the screening provider as part of each physical examination for a child screened at any age. Tooth eruption, caries, bottle tooth decay, developmental anomalies, malocclusion, pathological conditions or dental injuries should be noted. The oral inspection is not a substitute for a complete dental screening examination provided by a dentist. An initial dental referral should be provided on any child age three or older unless it is known that the child is already receiving regular dental care. When the screening indicates a need for dental services at an earlier age, referral

must be made. The importance of regular dental care should be discussed with the family (and the child as appropriate) on each screening visit for children three years and older.

1503.3B PROVIDER RESPONSIBILITY

The provider should assure the above listed elements are included in a screening examination. The provider should seek out and incorporate information regarding the child's usual functioning from parents, teachers, and others familiar with the child when conducting an examination. Medical records should document the assessments and significant positive and negative findings. Discussions with the child and family about the findings should be an integral part of every examination and documented as well. A referral to another Medicaid provider should occur if the provider is unable to perform any screening component.

The screening provider must retain copies of all screening claims and other Medicaid claims as provided by applicable state and federal laws, whichever is longer. Medical records should contain the following information specific to EPSDT screening services:

1. Reason for the visit

2. The date screening services were performed, the specific tests or procedures performed, the results of these tests and the person who provided the service.

3. Documentation of medical contraindication or a written statement from a parent or a guardian on a child screened for whom immunizations were due and not given and attempts the screening provider made to bring the child up-to-date on immunizations.

4. Identification of any screening component not completed, the medical contraindication or other reason why it could not be completed, and attempts the screening provider made to complete the screening.

5. Documentation of a medical contraindication or other reason for delay in vision or hearing screening if not performed on the same day as medical screening

6. Documentation of declination of screening services by the parent

7. Referrals made for diagnosis, treatment or other medically necessary health services for conditions found in the screenings

8. Date the next screening is due

9. Documentation of direct referral for age-appropriate dental services

Providers should submit claims using the established billing codes related to the Healthy Kids Screening examination. These examination codes can be found in Attachment C.

1503.3C RECIPIENT RESPONSIBILITY

The recipient and/or the recipient's parent/legal guardian should supply information as proper to assist in the screening process.

1503.4 FAMILY PLANNING

Family planning services are available to recipients.

1503.4A COVERAGE AND LIMITATIONS

Family planning information should be offered during a Healthy Kids examination as appropriate and requested.

1503.4B PROVIDER RESPONSIBILITY

The provider should request prior authorization when appropriate.

1503.5 DIAGNOSTIC SERVICES

Nevada Medicaid provides diagnostic services as indicated through a Healthy Kids screening.

1503.5A COVERAGE AND LIMITATIONS

Any condition discovered during a screening should be followed up for diagnosis. Prior authorization is not necessary for these diagnostic examinations if they are part of or referred through a Healthy Kids screening. Referrals can include but are not limited to:

1. Vision Services.

2. Dental Services.

3. Hearing Services.

4. Other Necessary Health Care.

1503.5B PROVIDER RESPONSIBILITY

The provider should make referrals for diagnostic testing after discussing the need for such services with the recipient/parent/legal guardian during a post screening interview.

The physician's progress notes should indicate the need for such testing.

A dated written referral must be given to the recipient or parents or forwarded to the referral service provider. The referral must include the following information:

1. The name of the child;

2. The Medicaid ID number of the child;

3. The date of the screening;

4. The abnormality noted;

5. The name, address telephone and fax number of the child's primary physician if different from the screening provider; and

6. The physician to whom the referral applies if known.

The provider should advise recipients of possible resources for obtaining testing as appropriate.

1503.6 TREATMENT

Nevada Medicaid provides for medically necessary treatment as indicated through a Healthy Kids screening and diagnosis.

1503.6A COVERAGE AND LIMITATIONS

Health care and treatment is available to correct or improve defects and physical and mental illnesses or conditions discovered by Healthy Kids screening and diagnostic services. Covered services include all mandatory and optional services that a state can cover under the benefit plan, whether or not such services are covered for adults. The scope of medical services available are described in 42 U.S.C. 1396d(a).

Services that are not medical in nature, including educational interventions are excluded. Treatment must be medically necessary and prior authorized if not typically included in the benefit plan. The QIO-like vendor will review the suggested treatment to ensure it meets with current medical practice standards for the given diagnosis.

When treatment is needed to correct or improve identified conditions, the Division's established requirements for prior authorization apply. See the MSM Chapters related to the requested service to determine if prior authorization is needed before treatment is rendered.

1503.6B PROVIDER RESPONSIBILITY

The provider should discuss the need for treatment services with the recipient/parent/legal guardian during a post referral interview. The physician's progress notes should indicate the need for such treatment.

The provider should request prior authorization when appropriate.

1503.7 CLINICAL STUDIES

Nevada Medicaid covers the routine costs of qualifying phase III and IV clinical trials for children less than 21 years of age. Reasonable and necessary items and services used to diagnose and treat complications arising from participation in phase III and IV clinical trials are covered. These services must be a Nevada Medicaid covered service.

1. Any clinical trial receiving Medicaid coverage of routine costs must meet the following requirements:

    a. The subject or purpose of the trial must be the evaluation of an item or service that is covered by Nevada Medicaid (e.g., physicians' service, durable medical equipment, diagnostic test) and is not excluded from coverage (e.g., cosmetic surgery);

    b. The trial must not be designed exclusively to test toxicity or disease pathophysiology. It must have therapeutic intent;

    c. Trials of therapeutic interventions must enroll patients with diagnosed disease rather than healthy volunteers and;

    d. The clinical trial is approved by one of the following:

        1. National Institute of Health (NIH);

        2. Department of Defense (DOD);

        3. Veteran's Affairs (VA);

        4. Centers for Disease Control (CDC);

        5. Centers for Medicare & Medicaid Services (CMS);

        6. Agency for Healthcare Research & Quality (AHRQ); or

7. National Cancer Institute (NCI).

2. Prior authorization is required. Clinical trials that meet the qualifying coverage criteria will receive Medicaid coverage of routine costs after prior authorization from the QIO-like vendor.

3. Covered Services

   a. Items or services that are typically provided absent a clinical trial (e.g., conventional care);

   b. Items or services required solely for the provision of the investigational item or service (e.g., administration of a non-covered chemotherapeutic agent), the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and

   c. Items or services needed for reasonable and necessary care arising from the provision of an investigational item or service--in particular, for the diagnosis or treatment of complications.

4. Non-Covered Services

   a. Phase I or II clinical trials.

   b. Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient (e.g., monthly CT scans for a condition usually requiring only a single scan).

   c. Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

   d. For items and services, including items and services for which Medicaid reimbursement is not available, Medicaid only covers the treatment of complications arising from the delivery of the non-covered item or service and unrelated reasonable and necessary care. However, if the item or service is not covered by Medicaid and is the focus of a qualifying clinical trial, the routine costs of the clinical trial (as defined above) will be covered by Medicaid but the non-covered item or service, itself, will not.

   NOTE: For policy regarding pharmaceutical clinical studies, please refer to Chapter 1200 – Prescribed Drugs.

1503.8 EXPERIMENTAL TREATMENT

Nevada Medicaid does not cover any item or service that is not medically necessary, unsafe or experimental, or is not generally recognized as an accepted method of medical practice or treatment.

1503.8A COVERAGE AND LIMITATIONS

Nevada Medicaid completes prior authorization on medical services to assure that the care and the services proposed are actually needed, are equally effective, less expensive alternatives have been given consideration, and the proposed service and materials conform to commonly accepted standards. If the services requested fall into the above mentioned categories, they are not reimbursable.

Nevada Medicaid's Quality Improvement Organization Like vendor completes the authorization review.

1503.8B PROVIDER RESPONSIBILITY

Providers should request prior authorization for services which may fall into the above category prior to rendering service.

1503.9 TRANSPORTATION

Assistance with transportation is available to and from a Healthy Kids examination. (Please reference MSM, Chapter 1900)

1503.9A COVERAGE AND LIMITATIONS

Nevada Medicaid pays for transportation in order for a recipient to receive medically necessary care and services. Transportation requires prior authorization in all but emergency situations. The guidelines outline in MSM Chapter 1900, Transportation, should be followed.

1503.10 PREGNANCY RELATED ONLY

The Healthy Kids benefit package is not available to recipients who are eligible solely because of pregnancy.

1503.10A COVERAGE AND LIMITATIONS

A recipient who is less than 21 years old and whose eligibility status is pregnancy related only (P) is not eligible for Healthy Kids. She is eligible for pregnancy related services only, which includes prenatal care, labor and delivery services, and postpartum care for 60 days after the date

of delivery, including the month in which the 60th day falls. The recipient may be eligible for services that relate to conditions that might complicate the pregnancy, but those services cannot be billed as a Healthy Kids service.

1504 HEARINGS

Please reference Nevada Medicaid's Manual Chapter 3100 for Medicaid Recipient Hearing process policy.

1505 REFERENCES AND CROSS REFERENCES

1505.1 POLICY RESOURCES

Please consult other Medicaid Services Manuals which may correlate with chapter 1500, EPSDT.

Chapter 100	Eligibility, Coverage and Limitations
Chapter 600	Physician Services
Chapter 1000	Dental Care
Chapter 1100	Ocular Services
Chapter 1300	DME, Prostheses and Disposable Supplies
Chapter 1900	Medical Transportation Services
Chapter 3100	Medicaid Hearings Procedures
Chapter 3300	Surveillance and Utilization Review Section (SURS)
Chapter 3600	Managed Care Organization

Nevada Check Up Manual

Chapter 1000	Nevada Check Up Program

1505.2 CONTACTS

A. STATE OFFICES

1. Central Office

Nevada Division of Health Care Financing and Policy
Nevada Medicaid Office
1100 E. Williams Street
Carson City, NV 89701
Telephone: (775) 684-3600

2. District Offices

Nevada Division of Health Care Financing and Policy, Medicaid District Offices (DOs) are listed in various Medicaid pamphlets. Local telephone numbers are:

Carson City	(775) 684-3651
Elko	(775) 753-1191
Las Vegas	(702) 668-4200
Reno - Bible Way	(775) 688-2811

B. PROVIDER RELATIONS UNITS

Magellan Medicaid Administration, Inc.
Provider Relations Department
First Health Services Corporation
PO Box 30026
Reno, NV 89520-3026
Toll Free within Nevada (877) NEV-FHSC (638-3472)

C. PRIOR AUTHORIZATION DEPARTMENTS

Magellan Medicaid Administration, Inc.
Nevada Medicaid and Nevada Check Up
HCM
4300 Cox Road
Glen Allen, VA 23060
(800) 525-2395

D. PHARMACY POINT-OF-SALE DEPARTMENT

Magellan Medicaid Administration, Inc.
Nevada Medicaid Paper Claims Processing Unit
PO Box C-85042
Richmond, VA 23261-5042
(800) 884-3238

1505.3 FORMS

CMS (HCFA) 1500 - Health insurance billing form. Forms following the sequence of the CMS (HCFA) 1500 are acceptable. Provider may order this form from a private printer or purchase from:

Government Printing Office
Superintendent of Documents
Room C 836, Building G
Washington, DC 20401

PERIODICITY SCHEDULE

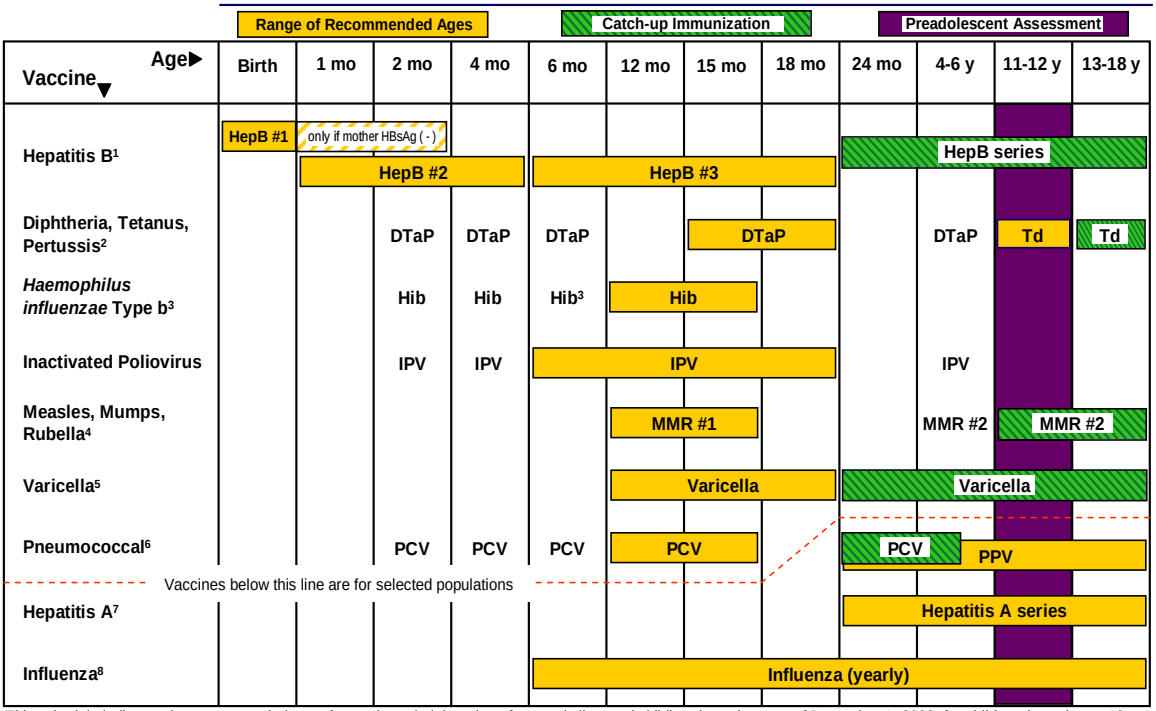
Nevada Medicaid recipients will be sent reminders to schedule screenings at the following intervals.

			Age Range			
Under 1	1-2	3-5	6-9	10-14	15-18	**19-20**
1 month	**12 months**	**3 Years**	**6 Years**	**10 Years**	**16 Years**	**20 Years**
2 months	**15 months**	**4 Years**	**8 Years**	**12 Years**	**18 Years**	
4 months	**18 months**	**5 Years**		**14 Years**		
6 months	**24 months**					
9 months						
5	**4**	**3**	**2**	**3**	**2**	**1**
TOTAL						***20***

IMMUNIZATION SCHEDULE

Each year, CDC's Advisory Committee on Immunization Practices (ACIP) reviews the recommended childhood immunization schedule to ensure it remains current with changes in manufacturers' vaccine formulations, revised recommendations for newly licensed vaccines. The Division will update the posted immunization schedule as appropriate, when the recommendations or changes are made available. The following is the most recent recommendation for immunization coverage.

Recommended Childhood and Adolescent Immunization Schedule — United States, January – June 2004



This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2003, for children through age 18 years. Any dose not given at the recommended age should be given at any subsequent visit when indicated and feasible. Indicates age groups that warrant special effort to administer those vaccines not previously given. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and the vaccine's other components are not contraindicated. Providers should consult the manufacturers' package inserts for detailed recommendations. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form can be found on the Internet: http://www.vaers.org/ or by calling 1-800-822-7967.

1. Hepatitis B (HepB) vaccine. All infants should receive the first dose of hepatitis B vaccine soon after birth and before hospital discharge; the first dose may also be given by age 2 months if the infant's mother is hepatitis B surface antigen (HBsAg) negative. Only monovalent HepB can be used for the birth dose. Monovalent or combination vaccine containing HepB may be used to complete the series. Four doses of vaccine may be administered when a birth dose is given. The second dose should be given at least 4 weeks after the first dose, except for combination vaccines which cannot be administered before age 6 weeks. The third dose should be given at least 16 weeks after the first dose and at least 8 weeks after the second dose. The last dose in the vaccination series (third or fourth dose) should not be administered before age 24 weeks.

Infants born to HBsAg-positive mothers should receive HepB and 0.5 mL of Hepatitis B Immune Globulin (HBIG) within 12 hours of birth at separate sites. The second dose is recommended at age 1 to 2 months. The last dose in the immunization series should not be administered before age 24 weeks. These infants should be tested for HBsAg and antibody to HBsAg (anti-HBs) at age 9 to 15 months.

Infants born to mothers whose HBsAg status is unknown should receive the first dose of the HepB series within 12 hours of birth. Maternal blood should be drawn as soon as possible to determine the mother's HBsAg status; if the HBsAg test is positive, the infant should receive HBIG as soon as possible (no later than age 1 week). The second dose is recommended at age 1 to 2 months. The last dose in the immunization series should not be administered before age 24 weeks.

2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. The fourth dose of DTaP may be administered as early as age 12 months, provided 6 months have elapsed since the third dose and the child is unlikely to return at age 15 to 18 months. The final dose in the series should be given at age ≥4 years. **Tetanus and diphtheria toxoids (Td)** is recommended at age 11 to 12 years if at least 5 years have elapsed since the last dose of tetanus and diphtheria toxoid-containing vaccine. Subsequent routine Td boosters are recommended every 10 years.

3. *Haemophilus influenzae* type b (Hib) conjugate vaccine. Three Hib conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB or ComVax [Merck]) is administered at ages 2 and 4 months, a dose at age 6 months is not required. DTaP/Hib combination products should not be used for primary immunization in infants at ages 2, 4 or 6 months but can be used as boosters following any Hib vaccine. The final dose in the series should be given at age ≥12 months.

4. Measles, mumps, and rubella vaccine (MMR). The second dose of MMR is recommended routinely at age 4 to 6 years but may be administered during any visit, provided at least 4 weeks have elapsed since the first dose and both doses are administered beginning at or after age 12 months. Those who have not previously received the second dose should complete the schedule by the 11- to 12-year-old visit.

5. Varicella vaccine. Varicella vaccine is recommended at any visit at or after age 12 months for susceptible children (i.e., those who lack a reliable history of chickenpox). Susceptible persons age ≥13 years should receive 2 doses, given at least 4 weeks apart.

6. Pneumococcal vaccine. The heptavalent **pneumococcal conjugate vaccine (PCV)** is recommended for all children age 2 to 23 months. It is also recommended for certain children age 24 to 59 months. The final dose in the series should be given at age ≥12 months. **Pneumococcal polysaccharide vaccine (PPV)** is recommended in addition to PCV for certain high-risk groups. See *MMWR* 2000;49(RR-9):1-38.

7. Hepatitis A vaccine. Hepatitis A vaccine is recommended for children and adolescents in selected states and regions and for certain high-risk groups; consult your local public health authority. Children and adolescents in these states, regions, and high-risk groups who have not been immunized against hepatitis A can begin the hepatitis A immunization series during any visit. The 2 doses in the series should be administered at least 6 months apart. See *MMWR* 1999;48(RR-12):1-37.

8. Influenza vaccine. Influenza vaccine is recommended annually for children age ≥6 months with certain risk factors (including but not limited to children with asthma, cardiac disease, sickle cell disease, human immunodeficiency virus infection, and diabetes; and household members of persons in high-risk groups [see *MMWR* 2003;52(RR-8):1-36]) and can be administered to all others wishing to obtain immunity. In addition, healthy children age 6 to 23 months are encouraged to receive influenza vaccine if feasible, because children in this age group are at substantially increased risk of influenza-related hospitalizations. For healthy persons age 5 to 49 years, the intranasally administered live-attenuated influenza vaccine (LAIV) is an acceptable alternative to the intramuscular trivalent inactivated influenza vaccine (TIV). See *MMWR* 2003;52(RR-13):1-8. Children receiving TIV should be administered a dosage appropriate for their age (0.25 mL if age 6 to 35 months or 0.5 mL if age ≥3 years). Children age ≤8 years who are receiving influenza vaccine for the first time should receive 2 doses (separated by at least 4 weeks for TIV and at least 6 weeks for LAIV).

For additional information about vaccines, including precautions and contraindications for immunization and vaccine shortages, please visit the National Immunization Program Web site at www.cdc.gov/nip/ or call the National Immunization Information Hotline at 800-232-2522 (English) or 800-232-0233 (Spanish).

Approved by the Advisory Committee on Immunization Practices (www.cdc.gov/nip/acip), the American Academy of Pediatrics (www.aap.org), and the American Academy of Family Physicians (www.aafp.org).

The following codes should be used when billing for a Healthy Kids screening examination.

CODE	DESCRIPTION
	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, ad the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient
99381	Infant (age under 1 year)
99382	Early childhood (age 1 through 4 years)
99383	Late childhood (age 5 through 11 years)
99384	Adolescent (age 12 through 17 years)
99385	(age 18-20 years)
	Periodic comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, ad the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient
99391	Infant (age under 1 year)
99392	Early childhood (age 1 through 4 years)
99393	Late childhood (age 5 through 11 years)
99394	Adolescent (age 12 through 17 years)
99395	(age 18-20 years)

Providers should refer to HCFA 1500 Billing Guide for additional information regarding other billable codes and procedures.