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Minnesota Child and Teen Checkups (C&TC) Schedule of Age-Related Screening Standards

C&TC Screening Components by Age C&TC FACT Sheet for each component	Infancy					Early Childhood							Middle Childhood						Adolescence									
	0-1 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
Anticipatory guidance & health education	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Measurements: ■Head circumference	●	●	●	●	●	●	●	●	●																			
■Height and weight	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
■Weight for length percentile*	●	●	●	●	●	●	●	●																				
■Body mass index (BMI) percentile									●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
■Blood pressure											●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Health history, including social determinants of health	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Developmental, social-emotional, mental health: ■Surveillance	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
■Developmental screening					R			R		R	R	→																
■Social-emotional or mental health screening*				R		R		R	R	R	R	R	R	R	R	R	R	R	R	●	●	●	●	●	●	●	●	●
■Autism spectrum disorder screening								R	R																			
■Maternal depression screening	R	R	R	R	→																							
■Tobacco, alcohol or drug use risk assessment																			X	X	X	X	X	X	X	X	X	X
Physical exam: head to toe, including oral exam and sexual development	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Immunizations/review	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Newborn screening follow up: blood spot and critical congenital heart defect	♓	→																										
Laboratory tests/risk assessment: ■Blood lead test					←	●	→	←	●	← If not done at 24 mo			→															
■Hemoglobin/hematocrit					←	●	→												← One time menstruating adolescents →									
■Tuberculosis	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
■Sexually transmitted infection (STI) risk assessment, with lab testing for sexually active youth																			X	X	X	X	X	X	X	X	X	X
■HIV testing for all youth at least one time*																			X	X	X	X	←	●	→		X	X
■Dyslipidemia*									X			X		X		X	←	X	→	←		X	→		←	X	→	
Vision screening: distance (3+years) and near (5+years) acuity*	X	X	X	X	X	X	X	X	X	X	●	●	●	●	●	●	●	●	←	●	→	←	●	→	←	●	→	
Hearing screening: add high frequency screening at 11+ years*	♓	X	X	X	X	X	X	X	X	X	R	●	●	●	●	●	●	●	←	●	→	←	●	→	←	●	→	
Oral Health ■Dental Checkups: Verbal referral to dental provider at eruption of first tooth or no later than 12 months of age				●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
■Fluoride varnish application (FVA) starting at eruption of first tooth*				●	●	●	●	●	●	●	●	●	●															
All C&TC visits require a HIPAA compliant referral condition code: ST, S2, AV or NU	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

KEY: ● Required component for the visit
♓ If no Newborn Screening results on file, or did not pass, follow up appropriately
R Recommended screening for visit
←→ Indicates range to provide component at least one time
X Risk assessment followed by appropriate action
✱ Refer to back side for more information on new requirements

MINNESOTA

Developed jointly by the Minnesota Departments of Human Services and Health

Schedule of Age-Related Screening Standards
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Screening Schedule:

This document (with active links) is available at www.mn.gov/dhs/periodicity-schedule/. This schedule is a minimum standard; more C&TC visits or screenings should be done and billed for as medically necessary. Children in out-of-home placement or foster care should receive C&TC visits at double the frequency listed on the schedule. Refer to AAP Healthy Foster Care America for recommendations.

Refer to the MHCP Provider Manual C&TC section (www.dhs.state.mn.us) for policy, billing and coding information for each component. This manual also addresses screening exceptions if a screening or preventive service is contraindicated or refused.

For each screening component, a C&TC Fact Sheet (www.health.state.mn.us) describes screening requirements, procedures and resources.

Updates to this schedule are based on recommendations from the American Academy of Pediatrics (AAP), Centers for Disease Control and Prevention (CDC), and U.S. Preventive Services Task Force (USPSTF), as well as Minnesota-specific epidemiology for the Medicaid-eligible pediatric population.

Changes on this updated C&TC Periodicity Schedule (compared to 2016):

Frequency of visits increased to align with AAP Bright Futures recommendations. The addition of the 30-month visit provides more opportunity to meet screening recommendations and ensure early identification and treatment of developmental and health issues during a critical period of brain development. After age 6, visit frequency is now annual, instead of biennial. This allows more opportunity for anticipatory guidance, screening and counseling during the pre-teen, adolescent and young adult years. This is a critical time for prevention and early intervention for high risk behaviors, obesity-related conditions and emerging mental health issues.

Weight for length percentile: Assess for every infant up to 2 years old, at which point BMI is assessed instead to monitor growth.

Developmental, social-emotional and mental health: Mental health screening is now required for age 12 and older. The Mental Health Screening C&TC Fact Sheet includes information on recommended screening instruments and referral resources.

Human immunodeficiency virus (HIV) screening: Screen all youth (regardless of reported sexual activity) at least once between 15 and 18 years old, making every effort to preserve the confidentiality of the adolescent. Youth at increased risk of HIV infection should be tested more often.

Dyslipidemia screening: A risk assessment is required for children at the ages indicated on this schedule. For risk assessment guidelines, refer to the Expert Panel on Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents: Summary Report (www.nhlbi.nih.gov). The AAP recommends a routine dyslipidemia screening on all children and youth at 9-11 years and 17-21 years; however, the U.S. Preventive Services Task Force found insufficient evidence for universal screening (Evidence and Rationale page 285 https://brightfutures.aap.org).

Vision screening: Provide distance visual acuity screening beginning at age 3. Add near visual acuity (plus lens) screening beginning at 5 years for children who pass their distance screening and do not already have corrective lenses. Routine vision screening is done with a wall chart with the child at a 10-foot distance. Refer to the Minnesota Department of Health (MDH) Vision Screening website (www.health.state.mn.us) for detailed procedures and recommended equipment for visual acuity screening for recommended wall charts and equipment. Instrument-based vision screening may be used as an alternative to wall charts for children 3-5 years old who are unable or unwilling to cooperate with routine vision screening.

Hearing screening: Screening by pure tone audiometry continues to be recommended at 3 years and required beginning at 4 years. Beginning at 11 years, add 6000 Hz at 20 dB to screen for noise-induced hearing loss. Refer to the MDH Hearing Screening website (www.health.state.mn.us) for detailed procedures and instrument recommendations.

Oral health: Fluoride varnish application (FVA) is now required at every C&TC visit for infants beginning at eruption of first tooth through age 5. Fluoride varnish may also be applied for older children based on risk factors. An oral health risk assessment (www.aap.org) can be used to determine need for oral fluoride supplementation or active referral to a dental provider. Continue to support connection to a dental provider for routine preventive care by making a verbal referral at every C&TC visit beginning at the eruption of the first tooth.

Clarifications:

Health history should include information about social determinants of health.

Tobacco, alcohol or drug use risk assessment replaces the line that previously read “substance use risk assessment.”

HIPAA compliant referral condition code: All necessary diagnostic and therapeutic referrals are part of C&TC standards. This code must be used for all C&TC visits in billing documentation to identify that a C&TC screening has been provided and that appropriate follow-up is taking place. Refer to the MHCP Provider Manual C&TC section (www.dhs.state.mn.us) for more information. If further follow-up, evaluation or treatment of a condition is identified at the C&TC visit, use referral code **ST** (new condition or referral), **S2** (referral for a previously treated condition), or **AV** (parent declines referral). If no condition is identified at the C&TC visit that requires further follow-up, evaluation or treatment, use the referral code **NU** (no referral).