The EPSDT screen is composed of the following components which must be documented in the medical record:

| COMPONENT | DESCRIPTION |
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| Unclothed physical exam | This is a comprehensive head to toe assessment that must be performed at each screening visit with the child unclothed but suitably draped. It includes the following: Height and weight at each screening visit. Head circumference (up to age two). Plot growth parameters at each visit on an age/sex specific growth and development chart. Blood pressure at age three and yearly thereafter.<br>(included in EPSDT screening fee) |
| Comprehensive Family/Medical/Developmental History | This information must be obtained at the initial screening visit from the parent(s), guardian, or responsible adult who is familiar with the child's history. The history must include an assessment of both physical and mental health development and the history must be updated at each subsequent visit.<br>(included in EPSDT screening fee) |
| Immunization Status | Immunizations and applicable records must be updated according to the current immunization schedule of the Advisory Committee on Immunization Practices (ACIP). A record of past immunization history must be maintained in the child's health record. Immunizations, if needed, should be updated at the time of the screening visit. For additional information about the vaccines please visit the National Immunization Program home page at http://www.cdc.gov/nip (additional reimbursement fee(s) is/are paid by DOM to Medicaid providers enrolled as a Vaccines for Children(VFC) Provider for vaccines covered under the VFC program.) |
| Lead Assessment and Testing | Blood lead levels (BLL's) are done at ages 12 and 24 months. All children ages 24-72 months who have not previously been tested must also receive a blood lead test. Additionally, a verbal lead risk assessment/questionnaire is required at each screening visit from 6 months to 6 years. A lead level is required upon recognition of one or more high risk factors beginning at age six (6) months. An elevated BLL is a blood lead test result equal to or greater than 10 mcg/dl. A BLL test result equal to or greater than 10 mcg/dl obtained by a capillary specimen (finger stick) |

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| | must be confirmed by using a venous blood sample. All venous BLLs greater than or equal to 10mcg/dl must be reported to the MSDH Lead Program at 601-576-7447.<br><br>Providers that utilize an in-house lead analyzer must report all lead results to the Mississippi State Department of Health (MSDH) Lead Program at 601-576-7447. For the Childhood Lead Poisoning Prevention Guidance document visit the MSDH website at http:/www.msdh.state.ms.us.<br>(included in EPSDT screening fee) |
| Urine Screening | Urine dipstick for glucose and protein is done at every screening on every child age 2 to 21 (included in EPSDT screening fee) |
| Sickle Cell Trait Screening | Effective 10/01/1988 sickle cell testing is done at birth at all hospitals. Children born prior to 10/01/1988 should be tested if not previously tested. For more information on genetic screening contact the MSDH Genetic Program at 601-576-7611. |
| Anemia Screening | HCT or HGB from venous blood or finger stick beginning at age 9 months and repeated between 15 months and 4 years; 5 years and 12 years; repeated between 13 years and 20 years. Additional HCT's/HGB's may be done during periodic screens based on the child's need and the physician's judgment. This follows the AAP guidelines. (Included in the EPSDT screening fee.) |
| Serology | RPR is done on all children at age 15 years and every year thereafter and any child that is sexually active regardless of the age. |
| TB Skin Test | TB exposure assessed and TB skin test is done as indicated. (See Provider Policy Manual Section 34.03 for guidelines) |
| Developmental Assessment | A comprehensive developmental history is required to determine the existence of motor, speech, language and physical problems or to detect the presence of any developmental lags. Information must be acquired on the child's usual functioning as reported by the child's parent, teacher, health care professional or other knowledgeable individual. An age appropriate developmental assessment is required at each screening. The assessment should include whether an individual's developmental processes fall within normal |

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| | range of achievement according to age group and cultural background. (included in EPSDT screening fee) |
| Nutritional Assessment/Counseling | A nutritional assessment and counseling is required at each screening visit. Screenings are based on dietary history, physical observation, growth parameters and growth chart, WIC participation, anemia testing, and any other laboratory determinations carried out in the screening process. (included in EPSDT screening fee) |
| Adolescent Counseling<br>(Additional Reimbursement Fee) | Adolescent counseling begins at age 9 years and is done at each screening visit to age 21. It includes discussion with the child regarding reproductive health and explores anatomy and physiology; sexuality/pubertal changes; directed abstinence based sex education; AIDS/STDS. Substance abuse is investigated including alcohol, tobacco and other drugs.<br>Relationships are discussed including relationships with parents, siblings, peers/friends and the presence of physical abuse/neglect. Coping skills reviewed with the child are relaxation techniques, decision making, life planning, and building self esteem. Wellness is also reviewed. The topics that are covered are nutrition, exercise, personal hygiene, dental health, accident prevention, speech and hearing conservation and cancer detection. |
| Vision Testing/Screening<br>(Additional Reimbursement Fee For Objective Testing Only) | A subjective screening for visual problems must be performed on children from birth to age 3 by history and observation. Gross examinations should include ocular motility, alignment, pupil response to light and red reflex. This should be documented as grossly normal or abnormal. Objective testing begins at age 3 to age 21. Visual acuity screening must be performed through the use of the Snellen Test, the Titmus vision test or an equivalent acuity test, in addition to physical inspection. If a child passed the visual acuity test, then administer the plus lens test for hyperopia. The ability of the child to read the 30 foot line or lower with both eyes while looking through these lenses indicates the need for referral. If the child has glasses or contacts, then he/she must be tested wearing his/her glasses or contacts. If he/she does not have them at the exam, then the vision screen must be rescheduled. If a child is uncooperative, perform the subjective assessment. The reason(s) for not being able to perform the test must be documented in the medical record. The vision screening must be billed on the date of the initial screening or periodic screening. |

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| Hearing Testing/Screening (Additional Reimbursement Fee For Objective Testing Only) | The initial hearing screening should be done in the hospital after birth prior to discharge from the newborn nursery.<br><br>See section 25.32 Newborn Hearing Screens of this Provider Policy Manual. A subjective screening for hearing problems must be performed on children from birth to age 3 by history and observation. Suggested measures for providing gross screenings are bells, noisemakers, and verbal stimuli and to observe auditory response and ability to localize the source of sound. From 2 to 3 years of age, continue to test for response to auditory stimuli and observe for child's ability to localize sounds and assess for response to the spoken words or sounds and attempts to imitate words. The development of vocabulary should also be evaluated. This is done in conjunction with the physical examination. Objective testing begins at age 3. Objective hearing screenings are to be performed with the use of an audiometric testing device such as an audiometer or an audioscope.<br><br>If a child fails to respond to the tones in either ear, a complete audiogram must be done. Refer to an audiologist or specialist with a detected hearing loss of 30 decibels at any two frequencies. If a child is uncooperative, do a subjective assessment. The reason(s) for not being able to complete the test must be documented in the medical record. The child should be rescheduled for an appointment to complete the hearing screening. The hearing screening must be billed on the same date of service as the initial or periodic screening. The most generally acceptable frequencies that should be screened are 1000, 2000, 4000 & 6000 or 8000. The screening level acceptable for Medicaid purposes is 30db.<br><br>The audiometric testing device should be calibrated yearly to ensure testing accuracy. A certificate documenting date of calibration is required. |
| Dental Services | Beginning at age 3 the child should be referred to a locally enrolled dentist if the child is not currently under the care of a dentist. The parent(s) or guardian is to be given a list of local dentists who see Medicaid beneficiaries. If there are obvious dental problems prior to this age, the child should be referred to the dentist. A periodic oral examination is recommended once each year. |

Every effort should be made to assure that the required components of an EPSDT screen are accomplished in one visit, and that fragmentation or duplication of screening services is prevented.

Scheduling of initial and periodic screening of EPSDT eligible Medicaid beneficiaries is the responsibility

of the EPSDT screening providers, as well as overall care coordination. EPSDT screening providers can access the Automated Voice Response System (AVRS) to verify the availability of the EPSDT screen at 1-800-884-3222.

Note: To be reimbursed for EPSDT screening the provider must be one of the provider types listed in the provider qualifications section and be enrolled as a Medicaid provider of services. An EPSDT screening agreement must be on file with the Bureau of Maternal and Child Health to provide this service.