I. PURPOSE:
To define the expected standards of outpatient care for well children, from infancy to young adulthood, who are covered by any of the Denver Health Medical Plans (DHMP).
This guideline encompasses adolescent preventive health as a component of the well child care visits to promote continuity of care and to meet national preventive care standards. Regular (at least annual) contact with a health care provider not only manages physical health but provides an opportunity for education, risk assessment, and promotion/reinforcement of healthy choices. Early, periodic, screening, diagnostic and treatment (EPSDT) is key to ensuring that children and youth receive appropriate preventive, dental, mental health, developmental and specialty services. The well child visit and adolescent preventive health is most effective when a team approach is used to develop optimum physical, emotional and developmental health/needs of the member. Providers should utilize clinical judgment based on the needs of the individual patient.

II. POPULATION:
2 weeks of life through 21 years of age. To align with Denver Health Ambulatory Care Services (ACS), this guideline includes patients from newborn through 20 years of age.

III. GUIDELINE:
The information and recommendations for pediatric and adolescent preventive healthcare contained herein align with the Colorado Department of Health Care Policy and Financing (HCPF) program requirements for EPSDT. See sections below for additional detail.

A. Well Child Care (WCC) visit Periodicity:
   Periodic Health Evaluation and Recommended Screening: [See Visit Schedule immediately below, page 2]
   1. Initial/Interval History and Physical Exam
      a. Visits to include an age-appropriate history and physical exam.
      b. WCC measurements:
         • Height and weight every WCC, and every visit ≥ 3 years of age
         • OFC (head circumference) every WCC ≤ 2 years of age
         • Blood pressure every WCC ≥ 3 years of age (at younger ages if indicated)
         • Body Mass Index every WCC ≥ 2 years of age
      c. Assessment of Medication and Herbal Remedies
      d. Sensory Screening - Hearing
         • All newborns in nursery or refer to audiology at first WCC during infancy
         • Initiate formal screening at 4 years of age and perform annually at each subsequent WCC through 10 years of age.
         • Screen at 20d
         • Screen the following frequencies: 500, 1000, 2000, 4000 Hz routinely

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• Screen once between age 11 and 14 years, once between 15 and 17 and once between 18 and 21. This should include 6,000 and 8,000 Hz.

Sensory Screening - Vision (see also DH Pediatric Visual Acuity Screening Guidelines)
• Attempt to initiate standard screening method at 3 years of age and perform at each subsequent WCC.

PERIODIC HEALTH EVALUATION VISIT SCHEDULE:

<table>
<thead>
<tr>
<th>0-1 Years (Infancy)</th>
<th>1-4 Years (Early Childhood)</th>
<th>5-21 Years (middle Childhood-Young Adult)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages 1-2 weeks and 1(Breast Fed Infants), 2, 4, 6, 9, and 12 months</td>
<td>Ages 15, 18, and 24 months, 30 months (prn) and at 3 and 4 years</td>
<td>Annually</td>
</tr>
</tbody>
</table>

2. Age-Appropriate Developmental Assessment, Patient Education, and Anticipatory Guidance:
   a. Preschool Development/Behavioral Screening: (physical and mental)
      • Recognized questionnaire should be administered and documented in the medical record, at each WCC between 9 months of age and 48 months of age. Within Denver Health the Ages and Stages Questionnaire (ASQ) is utilized with the score documented in the Electronic Health Record, EHR.
        ➢ Minimum expectations (see CP-23.004 Pediatric Development Screening A for details of screening and referral process) for example:
          o One (1) ASQ by 15 months of age
          o Two (2) ASQs by 24 months of age
          o Three (3) ASQs by 36 months of age

   b. Physical: Gross/fine motor and sexual development [See Physical Activity Table below, page 5]


   d. Language: expression, comprehension, and articulation

   e. Social: Assessment of social integration and peer relations, including school performance and family issue. Social Skills, child temperament
      • Ask about educational/day-care arrangements for infants, toddlers and preschoolers, and school and activities for older children
      • Sexual Activity History
        ➢ Annually after 11 years of age as appropriate based on development
      • Tobacco Exposure, Use and Education [See Tobacco Table below, page 7]

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Assessment at every visit (patient and parent), with education at every WCC (and as needed)

- Child Abuse Assessment – at clinician’s discretion [See Family Violence/Abuse Table below, page 8]
- Domestic Violence/Home Safety Assessment – at clinician’s discretion
- Mental Health Needs Assessment
  - Adolescents
    - Assessment of possible school/learning, behavioral, legal, emotional, family/friends or sexual behavior concerns/problems
    - Completion of self-administered Risk Assessment such as "Adolescent Health History" annually
    - For high risk adolescents, administer PHQ-9 (or similar) to screen for depression (all adolescents if adequate follow-up can be identified). The score is documented in the EHR.


  - Nutrition, Physical Activity, Dental, Injury, Behavior and Development Counseling [See Diet/Nutrition Table below, page 11]
    - Reach Out and Read: Guidance on language stimulation (with provision of new book) at every WCC from 6 months of age to 5 years of age
  - Age appropriate per WCC and "Bright Futures" forms (<12 years of age)
  - Condom instruction
    - Assess need at every adolescent visit

- Behavioral Health
  - At age 0-6 months, ask about parental postpartum depression or history of prenatal depression
  - Adolescent Psychosocial/Behavioral Assessment
    - Behavioral/Social/Emotional Screening (annually from newborn to 21 years years of age
    - Refer to primary care provider or mental health professional for those with a positive screening
    - Assess age-appropriate behavioral health, including aggression, depression, anxiety, and risk-taking behavior
    - Utilize behavioral health screening tools as appropriate

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g. Oral Health and Screening
   • The DH "Dental Home" is a combination of oral health care provided by primary care providers and Dentists
   • Assessment of oral health and dental preventive counseling at every WCC
   • Application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption. 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 up to 5 years of age
   • Referral to Dentist by 1 year of age or first tooth eruption for all children

3. Laboratory Screening
   a. Anemia
      • screen all children at 12-15 months of age and repeat if risk factors are present
      • Consider screening at 9 months of age for high risk infants (e.g., on whole milk, very low birth weight)
   b. Lead
      • Complete risk assessment at 6 months and again at 9 months
      • Perform on all children at 12-23 months of age WCC
      • Obtain on children 3-6 years of age if not previously screened
   c. Sexually Transmitted Infection (STI) screening
      >>> Annually after 11 years of age as appropriate based on development” Consider universal urine GC/chlamydia in teens greater than or equal to 13 years at physicals.
      >>> Increase frequency if new partners, unprotected intercourse, or “test of cure”
      >>> Other screenings as indicated (HIV and RPR if GC is positive, or if two (2) or more partners in past six (6) months, history of STI; intercourse in exchange for money, drugs or housing; anal intercourse; intravenous drug abuse)
      >>> HIV screening recommended at 17 years of age
      • Pap/HPV screening: As long as the patient is not immunocompromised (HIV infection, etc.), cervical cytology screening should be avoided under 21 years of age
   d. New Immigrant or Refugee check/perform laboratory testing per current CDC recommendations.

4. Family planning counseling
   a. Pediatric visits
      • Parental education as appropriate
   b. Adolescents

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### Cognitive, Language, and Social Development:

<table>
<thead>
<tr>
<th>0-1 Years (Infancy)</th>
<th>1-4 Years (Early Childhood)</th>
<th>5-10 Years (Middle Childhood)</th>
<th>11-21 Years (Adolescence)</th>
</tr>
</thead>
</table>
| • Ages and Stages Questionnaire (ASQ) should be administered at each WCC between 9-48 months of age:  
  - Complete at least 1 ASQ by 15 months of age                                     | • ASQ should be administered at each WCC between 9-48 months of age: Goals for ASQ completion  
  - 1 completed by 15 months                                                       | • Counsel that unstructured play is essential to the cognitive, physical, social, and emotional well-being development of children and adolescents  
  - Review the importance of cognitive development by exposing children to language through talking, singing, and reading aloud | • Complete an adolescent psychosocial/behavioral assessment at every well child visit ≥ 11 years  
  - Encourage adolescents to maintain a balance of participation in extracurricular activities with demands of academics and/or work  
  - Assess and screen for school concerns, signs of learning disorders, and social-adjustment concerns  
  - Assess possible behavioral, legal, emotional, family/friends or sexual behavior concerns or problems  
  - For high risk adolescents, administer PHQ-4 to screen for depression (all adolescents if appropriate follow-up can be identified)  
  - Screen those age 11 years and older for sexual activity history as appropriate based on development |
| • Review opportunities for cognitive growth and language development through talking, singing, and reading aloud and developing baby’s fine (e.g. play with toys or food) and gross (e.g. tummy time, practice walking) motor skills  
  • Counsel on avoiding background TV or related media                                | • Counsel that unstructured play is essential to the cognitive, physical, social, and emotional well-being development of children and adolescents  
  - Review the importance of cognitive development by exposing children to language through talking, singing, and reading aloud | • Complete an adolescent psychosocial/behavioral assessment at every well child visit ≥ 11 years  
  - Encourage adolescents to maintain a balance of participation in extracurricular activities with demands of academics and/or work  
  - Assess and screen for school concerns, signs of learning disorders, and social-adjustment concerns  
  - Assess possible behavioral, legal, emotional, family/friends or sexual behavior concerns or problems  
  - For high risk adolescents, administer PHQ-4 to screen for depression (all adolescents if appropriate follow-up can be identified)  
  - Screen those age 11 years and older for sexual activity history as appropriate based on development |

### Tobacco:

<table>
<thead>
<tr>
<th>0-4 Years</th>
<th>5-10 Years</th>
<th>11-21 Years</th>
</tr>
</thead>
</table>
| • Counsel parents who smoke on the potentially harmful effects of smoking on fetal and child health and on maintaining a smoke-free home. Refer parents to their PCP, QuitLine or to another smoking cessation program for help  
  • Counsel patients not to begin using                                      | • Counsel parents who smoke on the potentially harmful effects of smoking on fetal and child health and on maintaining a smoke-free home. Refer parents to their PCP, QuitLine or to another smoking cessation program for help  
  • Counsel patients not to begin using                                      | • Counsel parents who smoke on the potentially harmful effects of smoking on fetal and child health and on maintaining a smoke-free home. Refer parents to their PCP, QuitLine or to another smoking cessation program for help quitting  
  • Counsel patients not to begin using                                      |
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### Sun Safety:

<table>
<thead>
<tr>
<th>0-10 Years (Early Childhood-Middle Childhood)</th>
<th>11-21 Years (Adolescence-Young Adult)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Advise that infants 6 months of age and younger should be kept out of direct sunlight</td>
<td>• Encourage limiting time in the sun during peak hours and use of sunscreen, clothing, and hats to prevent sun exposure</td>
</tr>
<tr>
<td>• Encourage limiting time in the sun during peak hours</td>
<td>• Educate about skin cancer</td>
</tr>
<tr>
<td>• Encourage use of sunscreen, clothing, and hats to</td>
<td>• Discourage use of indoor tanning</td>
</tr>
</tbody>
</table>

### Family Violence/Abuse:

<table>
<thead>
<tr>
<th>0-21 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Screen for signs of family violence, including: facial/body bruising; depression; anxiety; failure to keep medical appointments; reluctance to answer questions about discipline in the home; or frequent office visits for complaints not supported by medical evaluation of the child</td>
</tr>
<tr>
<td>• Screen for signs of child physical and/or sexual abuse</td>
</tr>
<tr>
<td>• Counsel about safe relationships with adults, including no secrets, touching private parts or being asked to touch others private parts</td>
</tr>
<tr>
<td>• For adolescents, counsel on safe and appropriate dating and relationships as well as strategies for avoiding or resolving conflicts with friends and peers</td>
</tr>
<tr>
<td>• Ask about relationships with peers and bullying</td>
</tr>
<tr>
<td>• Assessment at every visit (patient and parent) with education at every well child check (and as needed) regarding: child abuse assessment and domestic violence/home safety assessment</td>
</tr>
</tbody>
</table>

### Tobacco Use:

#### 0-4 Years
- QuitLine or to another smoking cessation program for help quitting

#### 5-10 Years
- Tobacco products, including e-cigarettes
  - Provide interventions, such as education and brief counseling to prevent initiation of smoking

#### 11-21 Years
- or any other substances such as e-cigarettes, smokeless tobacco, cigars, herbal substances
  - Advise tobacco users to quit, especially patients who are pregnant
  - Assess readiness to quit
  - Assist tobacco users in quitting, especially patients who are pregnant. Provide brief counseling and refer to QuitLine or a smoking cessation program (patients under 18 will need consent from guardian to enroll)
  - Arrange follow-up
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GENERAL COUNSELING AND GUIDANCE- SOCIAL AND EMOTIONAL WELL-BEING

Electronic Media Exposure:

<table>
<thead>
<tr>
<th>0-1 Years (Infancy)</th>
<th>1-4 Years (Early Childhood)</th>
<th>5-21 Years (Middle Childhood-Young Adult)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discourage screen time except supervised video chats</td>
<td>Discourage screen time for children less than 2 years, and limit screen time to 1 hour per day for 2-4 year olds</td>
<td>Ask about frequency of age-appropriate screen time, including TV, computer, and mobile electronic devices (handheld video games, cell phones, etc.) being viewed</td>
</tr>
<tr>
<td></td>
<td>Ask about frequency of age-appropriate screen time, including TV, computer, and mobile electronic devices (handheld video games, cell phones, etc.) being viewed</td>
<td>Counsel on impact of screen time as a risk factor for low school performance, overweight, and violent behavior</td>
</tr>
<tr>
<td></td>
<td>Counsel on monitoring material being viewed</td>
<td>Counsel on monitoring material being viewed</td>
</tr>
<tr>
<td></td>
<td>Discourage placement of computer and TV in bedroom</td>
<td>Encourage discussions on internet safety (behavior or social media, cyber bullying, etc.)</td>
</tr>
<tr>
<td></td>
<td>Counsel on impact of screen time as a risk factor for becoming overweight, low school performance, and violent behavior</td>
<td>Place consistent limits on time spent using media, and they types of media. Ensure that media does not take the place of adequate sleep, physical activity, and other behaviors essential to health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Designate media-free times together, such as dinner or driving, as well as media-free locations at home, such as bedrooms</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discourage placement of computer and TV in bedroom</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discuss limits on text messaging and cell phone use, such as, no phone in bedroom near bedtime</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Encourage shutting down electronic devices before bedtime</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discourage listening to loud-frequency sound on earphones</td>
</tr>
</tbody>
</table>

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**Diet/Nutrition:**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Dietary Habits and Recommendations</th>
</tr>
</thead>
</table>
| **0-1 Years** | • Ask about dietary habits including food insecurity  
  • Promote breastfeeding as best form of infant nutrition for first 4-6 months  
  • Recommend breastfeeding for at least 1 year if possible and counsel breast milk as sole source of nutrition  
  • Counsel for breastfed infants to receive 400 IU of oral vitamin D drops daily beginning soon after birth and continuing until the daily consumption of fortified formula or milk is 500mL (16oz/2cups)  
  • Infants weaned before 12 months should receive iron fortified infant formula  
  • Cow's milk can be given to children at 1 year of age  
  • Counsel not to restrict fat or cholesterol  
  • Refer eligible families to WIC or SNAP programs for help with supplemental nutritional or other needs |
| **1-10 Years** | • Ask about dietary habits, including food insecurity  
  • Counsel about the benefits of a healthy diet, ways to achieve a healthy diet, and safe weight management  
  • A healthy diet:  
    o Emphasizes fruits and vegetables; whole grains; low-fat dairy; lean proteins, nuts and legumes  
    o Limits red meat, saturated and trans fat, and food and beverages with added sugar  
    o Follows appropriate portion size  
  • Refer eligible families to WIC or SNAP programs for help with supplemental nutritional or other needs |
| **11-21 Years** | • Ask annually about dietary habits, including food insecurity  
  • Counsel about the benefits of a healthy diet, ways to achieve a healthy diet, and safe weight management  
  • A healthy diet:  
  o Emphasizes fruits and vegetables; whole grains; low-fat dairy; lean proteins, nuts and legumes  
  o Limits red meat, saturated and trans fat, and food and beverages with added sugar  
  o Follows appropriate portion size  
  • Screen for eating disorders by asking about body image and dieting patterns  
  • Counsel to maintain adequate calcium and vitamin D intake  
  • Counsel against sugar-sweetened and caffeinated drinks  
  • Advise patients at risk of becoming pregnant to take a multivitamin containing 0.4mg folate  
  • Refer eligible families to WIC or SNAP programs for help with supplemental nutritional or other needs |

**B. EPSDT Services**

1. EPSDT is key to ensuring that children and youth receive appropriate preventive, dental, mental health, developmental and specialty services.
   a. **Early:** Assessing and identifying problems early  
   b. **Periodic:** Checking children's health at periodic, age-appropriate intervals

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c. **Screening**: Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems

d. **Diagnostic**: Performing diagnostic tests to follow up when a risk is identified, and

e. **Treatment**: Control, correct or ameliorate health problems found.

f. EPSDT is made up of the following screening, diagnostic, and treatment services:

2. **Screening Services**
   a. Comprehensive health and developmental history
   b. Comprehensive unclothed physical exam
   c. Appropriate immunizations (according to the Advisory Committee on Immunization Practices)
   d. Laboratory tests (including lead toxicity testing)
   e. Health Education (anticipatory guidance including child development, healthy lifestyles, and accident and disease prevention)

3. **Vision Services**
   a. At a minimum, diagnosis and treatment for defects in vision, including eyeglasses.

4. **Dental Services**
   a. At a minimum, dental services include relief of pain and infections, restoration of teeth, and maintenance of dental health, including examinations, cleanings and fluoride treatments.

5. **Hearing Services**
   a. At a minimum, diagnosis and treatment for defects in hearing, including hearing aids.

6. **Other Necessary Health Care Services**
   a. Additional health care services that are coverable under the Federal Medicaid program and found to be medically necessary to treat, correct or ameliorate illnesses and conditions discovered regardless of whether the service is covered in a state’s Medicaid plan.

7. **Diagnostic Services**
   a. When a screening indicates the need for further evaluation, diagnostic services must be provided.

8. **Treatment**
   a. Necessary health care services must be made available for treatment of all physical and mental illnesses or conditions discovered by any screening and diagnostic procedures.

9. **Lead Screening**

C. **EPSDT Wrap-Around Services**

1. Wrap-Around Benefits are additional treatments or services that are not part of the Denver Health Medicaid Choice covered benefits, but are covered by Medicaid and payable by the State’s fiscal agent when medically necessary. It is the providers’ responsibility to make a referral to another provider or Healthy Communities. Providers can obtain assistance with Wrap-Around services from the ACS RN Care

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Copanionator and should contact them with any questions. See Section VII for tracking requirements associated with Wrap-Around benefits.

a. Wrap-Around Benefits associated with EPSDT:
   b. Hearing devices and auditory training
   c. Dental/hygienist care and treatment
   d. Orthodontia for severe, handicapping malocclusions
   e. Transportation for non-emergency medical, dental, or behavioral/mental health care
   f. Family planning with a non DH provider such as Planned Parenthood
   g. Hospice services
   h. Skilled nursing facility care
   i. Intestinal transplants
   j. Private duty nursing
   k. Expanded benefits; benefits that the state chooses to provide a child that are above and beyond the EPSDT benefit package. Examples are: chiropractic care and extraordinary home care.

D. EPSDT Supporting Services and Programs
   1. Healthy Communities is a comprehensive community-based outreach program designed to assist families, children, and pregnant women to find appropriate services. Healthy Communities can help provide or arrange for the provision of screening services for all children; arrange (through referral) for corrective treatment as determined by child health screenings; missed appointment follow-up; and refer for transportation assistance. Providers can also contact Healthy Communities to obtain assistance with EPSDT related Wrap-Around services, or may refer members to Healthy Communities for any questions related to EPSDT related Wrap-Around services.

   EPIC: AMB REF TO PEDIATRIC CARE COORDINATION (EPSDT) [REF430] Phone: (303) 602-6770

   2. For Denver Health Medical Plan (DHMP) members, contact Member Services for questions regarding Care Management or to refer a child for Care Management Services. Phone: (303) 602-2140

   3. The EPSDT Outreach Coordinator for the State is available to help providers and families of Medicaid children (ages 0 through 20) by helping families complete paperwork for Medicaid and CHP+; guiding families to appropriately use Medicaid benefits; assisting with finding a Medicaid dentist; assisting with coordination of transportation through the local Health and Human services department. Contact: Gina Robinson Phone: (303) 866-6167

E. Medical Necessity for EPSDT Services
   1. Medical Necessity is defined as:
      a. A service that is found to be equally effective treatment among other less conservative or more costly treatment options.

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b. Meets one of the following criteria:
   i. The service is expected to prevent or diagnose the onset of an illness, condition, or
doability.
   ii. The service is expected to cure, correct, or reduce the physical, mental, cognitive, or
developmental effects of an illness, injury, or disability.
   iii. The service is expected to reduce or ameliorate the pain and suffering caused by an
illness, injury, or disability.
   iv. The service is expected to assist the individual to achieve or maintain maximum
functional capacity in performing activities of daily living.

c. May be a course of treatment that includes observation or no treatment at all.

2. Medical Necessity does not include:
   a. Experimental or investigational treatments;
   b. Services or items not generally accepted as effective; and/or not within the normal course and
duration of treatment; or
   c. Services for caregiver or providers convenience.

F. EPSDT Provider Responsibility
1. Provide health screening services, including immunizations; according to EPSDT guidelines and
periodicity schedule (see Section I above).
2. Promptly diagnose, treat or provide referral for problems identified during the screening process.
   a. If a provider is not licensed or equipped to render necessary treatment, the provider is
responsible to make a referral to another provider, make a referral to Healthy Communities,
and/or make a referral to the UM case managers to assist with a referral (see Section IV above).
3. Utilize the Colorado PAR Provider Portal for wrap-around services available through Colorado Health First
for delivery of medically necessary services to EPSDT-eligible members.

G. Tracking of EPSDT-required Services
1. Initiation of treatment, if required, must occur within an outer limit of six months after a referral has been
placed. To ensure the delivery of EPSDT-required services, the following tools should be utilized as needed:
   a. EPIC Reports
   b. ACS Data and Analytics Reports
   c. Colorado PAR Provider Portal Reports

IV. EXTERNAL REFERENCES/TOOLS:
American Academy of Pediatrics Bright Futures Guidelines: http://brightfutures.aap.org

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either to replace a clinicians judgment or to establish a protocol for all patients with a particular condition.
AAP Committee on Infectious Diseases Red Book: http://aapredbook.aappublications.org/
Colorado Department of Health Care Policy and Financing

V. ATTACHMENTS:
American Academy of Pediatrics: Bright Futures/AAP periodicity schedule 2022

VI. REFERENCES:
2. American Academy of Pediatrics: Bright Futures/AAP periodicity schedule July 2022
6. Fluoride Use in Caries Prevention in the Primary Care Setting
7. Promoting Optimal Development: Screening for Behavioral and Emotional Problems’, ‘Mental Health Competencies for Pediatric Practice’, ‘Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents With Anxiety Disorders’, and ‘Screening for Anxiety in Adolescent and Adult Women: A Recommendation From the Women’s Preventive Services Initiative’

Signature: Christine Seals Messersmith MD
Email: christine.seals@dhha.org

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"Well Child and Adolescent Health Guideline 2022 - Needs signature" History

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