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CHDP Provider Information Notice No.: 10-05

TO: ALL CHILD HEALTH AND DISABILITY PREVENTION (CHDP)
PROGRAM PROVIDERS AND MEDI-CAL MANAGED CARE PLANS

SUBJECT: CHDP HEALTH ASSESSMENT GUIDELINES (HAG) REVISIONS:
SECTION 100, PERIODICITY SCHEDULES FOR HEALTH
ASSESSMENT AND DENTAL REFERRAL AND SECTION 703,
TUBERCULIN SKIN TEST

The purpose of this CHDP Provider Information Notice (PIN) No. 10-05 is to distribute the revised sections of the of the CHDP Health Assessment Guidelines (HAG), section 21, formerly section 100, Periodicity Schedules for Health Assessment and Dental Referrals and section 73, formerly section 703, Tuberculosis. The revised section includes the following items:

Section 21 - Periodicity schedules for health assessment and dental referral

- Table 21.1 - Periodicity schedule for health assessment requirements by age groups
- Table 21.2 - Periodicity schedule for dental referral by age

Section 73 – Tuberculosis

- Table 73.1 - Definitions of Positive Tuberculin Skin Test (TST) Results in Children and Adolescents
- Table 73.2 - Pediatric Tuberculosis (TB) Risk Assessment Questionnaire

Both revised sections contain updated recommendations from the American Academy of Pediatrics and the California Department of Public Health Tuberculosis Control Branch. The CMS Branch encourages you to review each section in its entirety.

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The revised sections and tables can be downloaded from the following link:
<http://www.dhcs.ca.gov/services/chdp/Pages/Pub156.aspx>

We hope that this updated information will assist you in providing the highest quality of well-child care to children in your practice. If you have any questions, please contact your local CHDP program.

Original Signed by Harvey Fry for Luis R. Rico

Luis R. Rico, Acting Chief
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Enclosures

PERIODICITY SCHEDULES FOR HEALTH ASSESSMENT AND DENTAL REFERRAL

The Child Health and Disability Prevention (CHDP) Program periodicity schedules for health assessment and dental referral standardize the assessment intervals and promote continuity of care. Refer to Table 21.1 “Periodicity Schedule For Health Assessment Requirements By Age Groups” and Table 21.2 “Periodicity Schedule For Dental Referral By Age”. These schedules reflect the requirements of the California Code of Regulations, Title 17, and Sections 6843, 6846, 6847, and 6848. The frequency of preventive health visits in CHDP differs slightly from the frequency recommended by the American Academy of Pediatrics (AAP)¹.

Every patient encounter offers an opportunity for preventive care. The periodicity schedule becomes a way of tracking and prompting health care providers to practice preventive health care. Each section of the guidelines furnishes information on what should be included in the required health assessments, the rationale for the health assessment, screening requirements considerations for referral, treatment and/or follow up. Other information is included when pertinent to the specific health assessment and helpful to the health care provider.

CHDP reimburses complete health assessments for preventive care performed according to the periodicity schedule. In addition, CHDP reimburses complete health assessments for preventive care which are performed out of periodicity, referred to as Medically Necessary Interperiodic Health Assessments (MNIHA), when any of the following situations exist:

- There is a need for a sports or camp physical examination
- The individual is in foster care or out-of-home placement
- There is a need for a school or preschool entrance examination
- There is a need for providing additional anticipatory guidance to the individual or the parent or legal guardian
- There is a history of perinatal problems
- There is a history of developmental disability

When health assessments are provided outside of the periodicity schedule, the reason must be stated in the Comments/Problems section on the Confidential Screening/Billing Report (PM 160). For further information and instructions, please refer to the CHDP Provider Manual, Health Assessments Section.

Additional services are available for children in need of ongoing treatment, care, or monitoring of a specific disease or previously diagnosed disorder. Diagnosis and treatment services for Medi-Cal eligible children are reimbursable according to the Medi-Cal program of benefits. Diagnosis and treatment services for non Medi-Cal children may be available through the Healthy Families program or the health department in the child’s county of residence. For more information, families may

contact their local CHDP program or the Healthy Families program at 1-800-880-5305.

¹ Hagan JF, Shaw PM, eds. 2008 *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, Third Edition, Elk Grove Village, IL: American Academy of Pediatrics.

Table 21.1 PERIODICITY SCHEDULE FOR HEALTH ASSESSMENT REQUIREMENTS BY AGE GROUPS

Screening Requirement ¹	Age of Person Being Screened														
	< 1 mo	1-2 mos	4 mos	6 mos	9 mos	12 mos	15 mos	18 mos	2 Yr	3 Yr	4-5 Yr	6-8 Yr	9-12 Yr	13-16 Yr	17-20 Yr
Interval Until Next CHDP Exam	1 mo	2 mos	2 mos	3 mos	3 mos	3 mos	3 mos	6 mos	1 yr	1 yr	2 yr	3 yr	4 yr	4 yr	None
History and Physical Examination²	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Dental Assessment ³	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Nutritional Assessment	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Developmental/Behavioral Surveillance	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Developmental Screening ⁴					o			o	o →						
Psychosocial Assessment	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Tobacco Assessment	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Pelvic Exam ⁵														*	*
Measurements															
Head Circumference	•	•	•	•	•	•	•	•							
Height/Length and Weight	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
BMI Percentile									•	•	•	•	•	•	•
Blood Pressure ⁶										•	•	•	•	•	•
Sensory Screening															
Vision ⁷ - Visual Acuity Test										•	•	•	•	•	•
Vision ⁷ - Clinical Observation	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Hearing ⁸ - Audiometric										•	•	•	•	•	•
Hearing ⁸ - Clinical Assessment	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Procedures/Tests															
Hematocrit or Hemoglobin ⁹				*	• →		*	*	•	•	•	*	*	•	*
Blood Lead Risk Assessment/ Anticipatory Guidance ¹⁰				•	•	•	•	•	•	•	•				
Blood Lead Test ¹⁰						•			•	X →					
Anticipatory Guidance	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•

Note: Children coming under care who have not received all the recommended procedures for an earlier age should be brought up-to-date as appropriate.

Other Laboratory Tests
When health history and/or physical examination warrants:
Urine Dipstick or Urinalysis ¹¹
TST ¹² - see Tuberculosis HAG
Sickle Cell
Ova and Parasites
FBG and Total Cholesterol
Papanicolaou (Pap) Smear ¹³
VDRL or RPR ¹⁴
Annually if sexually active; more often as clinically indicated:
Gonorrhea Test ¹⁴
Chlamydia Test ¹⁴
Immunizations¹⁵

Key:
• Required by CHDP one time within the interval given
o Recommended by AAP, Bright Futures but not required by CHDP
* Perform when indicated by risk assessment.
x Perform if no documented lead level at 24 months

1. CHDP intervals are greater than recommended by Bright Futures. Providers may use MNIHA for necessary assessments that fall outside of periodicity such as school, sports or camp physical, foster care or out-of-home placement, or follow-up indicated by findings on a prior health assessment that need monitoring including additional anticipatory guidance, perinatal problems or significant developmental delay.
2. Age appropriate physical examination, including oral examination, is essential with child unclothed, and draped for older child or adolescent.
3. See Dental HAG.
4. Chart indicates ages developmental screening is recommended. For reimbursement information, see CHDP PIN 09-14.
5. Pelvic within 3 years of first sexual intercourse, and at all subsequent health assessments, may be performed as part of MNIHA when clinically indicated by symptoms such as pelvic pain, dysuria, dysmenorrhea. See STI HAG.
6. Blood pressure before 3 years for at risk patients, then at each health assessment and when clinically indicated. See Blood Pressure HAG.
7. See Vision screening HAG.
8. See Hearing Assessment HAG.
9. Hb/Hct starting at 9-12 months, then annually to age 5, then according to periodicity. See Hb/Hct HAG.
10. Test between the ages of 2 and 6 years if no documented lead level at or after 24 months. Test at any age when indicated by risk assessment or if lead risk changes. See Lead HAG.
11. Urinalysis only when clinically indicated. See Urinalysis HAG.
12. Tuberculosis risk factor screen at each visit. TST when indicated. See TB HAG.
13. Pap smear within 3 years of first sexual intercourse and subsequently as clinically indicated.
14. STI testing when risk identified by history/physical. See STI HAG.
15. Provide immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP).

Table 21.2 PERIODICITY SCHEDULE FOR DENTAL REFERRAL BY AGE

Age (Years)	1*	2*	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Interval to Next Referral	1 Yr	1 Yr	1 Yr	1 Yr	1 Yr	1 Yr	1 Yr	1 Yr	1 Yr	1 Yr	1 Yr	1 Yr	1 Yr	1 Yr	1 Yr	1 Yr	1 Yr	1 Yr	1 Yr	1 Yr
Annual Dental Referral	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•

Children of any age **must** be referred to a dentist if a problem is detected or suspected. For children covered by Medi-Cal or temporary Medi-Cal, call Denti-Cal at 1-800-322-6384 or the local CHDP program for assistance in finding a dentist. All others may contact the local CHDP program for help.

* A dental screening/oral assessment is required as part of every CHDP health assessment regardless of age. It is recommended that children be referred to a dentist annually beginning at one (1) year of age. It is mandatory to refer children directly to a dentist annually beginning at three (3) years of age.

Reference: California Code of Regulations, Title 27, Subchapter 13, CHDP, Section 6843 Code of Federal Regulations, Title 42, Section 440.40 (b), Part 441, Subpart B. CHDP Program Letter, 04-13.

TUBERCULOSIS

RATIONALE

Tuberculosis (TB) remains a significant public health problem in California. In 2008, 2,695 cases of TB disease were reported in California; 87 of the reported cases were in children under 5 years of age. While the number and rate of TB cases in this group has not changed significantly since 2005, the rate of decrease has slowed. TB rates among children under 5 years of age are 5-11 times greater among Asian/Pacific Islanders, Hispanics, and Black non-Hispanics compared to White non-Hispanics¹. There is significant regional variation in TB incidence, with the majority of TB cases in large counties and in areas with large immigrant populations.

TB infection may manifest as TB disease or LTBI. Latent tuberculosis infection (LTBI) is a condition in which a person is infected with *M. tuberculosis*, does not currently have active TB disease, but is at risk of progression to active disease. Individuals with LTBI are asymptomatic and not infectious. Identifying children with LTBI in order to intervene with treatment is necessary to prevent future disease. It is also important for case identification, as most children under age five years with LTBI have recently acquired the infection from a person with active TB disease.

The most important steps to reducing the number of children with TB disease are prompt and thorough contact investigation of persons with known or suspected TB and active monitoring of infected contacts until completion of treatment.

The Tuberculosis Control Branch of the California Department of Public Health recommends screening two groups of individuals: (1) those who are at increased risk of contracting TB (as determined by responses to the TB Risk Assessment Questionnaire – see Table 73.2), and (2) those at increased risk of progression from LTBI to active disease based on coexisting medical conditions. The Mantoux Tuberculin Skin Test (TST), or another approved screening test for TB infection, should be used when a child is identified as “at risk” from the TB Risk Assessment Questionnaire.

The Mantoux TST using purified protein derivative is the only standardized method currently approved for identifying children under 17 years of age infected with *M. tuberculosis*. Interferon Gamma Release Assays (IGRAs), such as the *QuantiFERON®-TB Gold* (QFT-G), at present are only approved for testing in those 17 years and older, but may soon be approved for testing younger children.² There are a number of advantages to

1 http://www.cdph.ca.gov/data/statistics/Documents/TB_Report_2008.pdf

2 Mazurek GH, Jereb J, LoBue P, Iademarco MF, Metchock B, Vernon A. Guidelines for Using the QuantiFERON®-TB Gold Test for Detecting Mycobacterium tuberculosis Infection, United States. *MMWR* December 16, 2005 / 54(RR15); 49-55, 2005. (<http://www.cdc.gov/mmwr/PDF/rr/rr5417.pdf>)

IGRA testing. Testing requires a single patient visit to draw a blood sample and does not boost responses measured by subsequent tests, (which can happen with TSTs). In addition, test results can be available within 24 hours, are not subject to reader bias that can occur with TST and are not affected by prior BCG (Bacille Calmette-Guerin) vaccination.³

SCREENING REQUIREMENTS

- Assess all children for risk of exposure to tuberculosis at each health assessment visit. Validated questions for determining risk of LTBI in children in the U.S. may be found in Table 73.2: Pediatric TB Risk Assessment Questionnaire.
- For children who are at increased risk of acquiring LTBI (including those with a positive Risk Assessment Questionnaire and incarcerated adolescents), screen for TB with a TST or IGRA, according to age.
- For children who are more likely to progress to active TB if exposed (children with HIV, organ transplant, TNF-alpha inhibitors, or other condition associated with significant immunosuppression), screen for TB with a TST or IGRA, according to age.
- The *only* contraindication to TST is history of a severe reaction (e.g., necrosis, blistering, anaphylactic shock, or ulcerations) to a previous TST⁴
- Read the skin test 48 to 72 hours after placement and record the results in millimeters (mm) of induration, not erythema. Measure the diameter of the induration transversely to the long axis of the forearm. Trained personnel, not parents, must read the skin test. See Table 73.1.
- If the child fails to return for the scheduled reading:
 1. **Only** a positive reaction may still be measured up to one week after testing.
 2. Repeat the TST if no positive reaction can be measured when the child does return.
- When tuberculosis screening is indicated, the clinician may either place a TST or draw a blood sample for QuantiFERON-TB Gold (QFT-G). Refer to the Medi-Cal Manual for billing procedures.⁵

³ <http://www.cdc.gov/tb/publications/factsheets/testing/QFT.pdf>

⁴ <http://www.cdc.gov/tb/publications/factsheets/testing/skintesting.htm>

⁵ http://files.medi-cal.ca.gov/pubsdoco/publications/Masters-MTP/Part2/pathimmun_m00o03.doc

- Testing for tuberculosis is *not* a universal requirement for school entry in California. California law, however, allows local health departments to require TB testing for school entry based on local epidemiology.⁶ Check with your local health department for the local policy.

Table 73.1 DEFINITIONS OF POSITIVE TST RESULTS IN CHILDREN AND ADOLESCENTS⁷

Reaction Size [*]	Definition of Mantoux skin test (5 TU PPD)
≥ 5 mm induration	POSITIVE WHEN ANY OF THE FOLLOWING ARE PRESENT: Recent contacts with infectious TB cases. HIV infected children and adolescents. Children and adolescents with fibrotic changes on chest radiograph consistent with prior TB. Organ transplant recipients. Children and adolescents who are immuno-suppressed for other reasons.
≥ 10 mm induration	POSITIVE FOR ALL CHILDREN AND ADOLESCENTS: Children or adolescents at increased risk of disseminated disease: <ol style="list-style-type: none"> 1. Those < 4 years of age 2. Those with concomitant medical conditions. Children or adolescents with increased risk of exposure to cases of TB disease: <ol style="list-style-type: none"> 1. Those born in a country with high prevalence of TB cases. 2. Those who travel to a country with a high prevalence of TB cases. 3. Those with parents born in a country with a high prevalence of TB cases. 4. Those who are frequently exposed to adults with risk factors for TB disease.

*Interpretation of the skin test should be made without regard to previous Bacillus of Calmette-Guérin (BCG) vaccine administration.

Note: The Centers for Disease Control and Prevention classification of positive reactions includes a category 15 mm for all other children, (e.g., low risk groups). This classification is not recognized by public health departments in California because PPD cross reactivity to other mycobacterium is low and TB prevalence rates are higher due to a greater number of individuals in high risk groups compared to the rest of the United States. 10 mm is considered positive, except in close contacts, HIV positive individuals, and those with abnormal x-rays, in which 5 mm is positive.

6 California Health and Safety Code. § 121485 - 121520.

7 Modified from American Academy of Pediatrics. *Red Book: 2009 Report of the Committee on Infectious Diseases*. 28th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2009:680-708.

CONSIDERATIONS FOR REFERRAL, TREATMENT, AND/OR FOLLOW-UP

- Refer any child for diagnosis and treatment who has symptoms consistent with active TB disease regardless of the TST results.
- Evaluate all children with positive reactions and provide or refer for a medical evaluation, chest x-ray, and any other laboratory studies needed for the diagnosis of TB disease.
- Report to the local health department any confirmed or suspected case of TB disease within one day of identification (California Code of Regulations, Title 17, Section 2500). Contact your local health department for specific instructions about reporting children with latent TB infection, or converters, and for additional information regarding therapy.
- If TB disease is not found, place children and adolescents under 17 with positive TST on therapy, unless medically contraindicated. A confirmatory QFT-G may be recommended by your local health department to rule out a false positive TST in young adults age 17 – 21. Consult with your local health department TB Control unit for guidance on the most effective treatment regimen. Treatment with isoniazid (INH) has been shown to be very effective in preventing clinical disease in most cases. Efficacy is directly related to the length of treatment and the extent of compliance with the regimen.
- TST negative children less than 5 years of age and any immunosuppressed persons of any age who have been close contacts of persons with infectious TB are candidates for LTBI therapy until a repeat TST is done 8 weeks after the last contact when the TB case was infectious. Exceptions to stopping treatment if the 8 week TST is negative include:
 1. Infants, in whom a negative TST is not reliable until after 6 months of age or
 2. Severely immunosuppressed children, in whom continuation of LTBI treatment for 6-9 months should be considered even if repeat TST is negative.
- Refer all household contacts of persons being treated for active TB disease to the local health department for follow-up or contact tracing.

BACILLUS of CALMETTE-GUÉRIN (BCG) VACCINATION

Many developing countries still use BCG as part of their TB control programs, especially for infants, to prevent the development of disseminated or meningeal disease. There is no reliable way to distinguish tuberculin reactions caused by BCG vaccination from those caused by natural infections. Because many BCG - vaccinated persons come from areas of the world where TB transmission is common, testing for tuberculosis should be done, and positive test results should be interpreted as infection with *M. tuberculosis*.

BASICS OF MANTOUX ADMINISTRATION

The Mantoux tuberculin skin test (TST) is the only test approved for screening children under 17 years of age. The antigen is aspirated into a disposable plastic syringe with a No. 26 gauge, short-bevel needle no more than one (1) hour before use. Purified protein derivative containing five tuberculin units (5 TU) in 0.1 ml is injected intradermally on the volar aspect of the forearm to produce a six to ten mm wheal. The TST may be placed on the same day that an MMR or MMRV vaccine is given. If not placed on the same day, it is recommended that you wait four to six weeks before placing a Mantoux tuberculin skin test.⁸

LOCAL HEALTH DEPARTMENT RESOURCES

Your local health department Tuberculosis Control Program staff are available for consultation on all aspects of TB prevention and treatment, including the training of staff to perform, read, and record TB Mantoux tests. They can provide information about TB trends in your community, provide laboratory services, and assist with arrangements for directly observed therapy (DOT) and the identification and examination of source cases and contacts.

Patient teaching materials are available in English and Spanish from the Centers for Disease Control (CDC) at: <http://www.cdc.gov/tb/publications/factsheets/testing.htm> .

⁸ <http://www.cdc.gov/vaccines/vpd-vac/faqs-nipinfo-general.htm#a6> : Vaccines and PPD Testing.

Table 73.2 PEDIATRIC TB RISK ASSESSMENT QUESTIONNAIRE ⁹

Question*	Follow-up
<p>1. Was your child born outside the United States?</p> <p>If yes, this question should be followed by:</p> <ul style="list-style-type: none"> • Where was your child born? 	<p>If the child was born in Africa, Asia, Latin America, or Eastern Europe, a TST should be placed.</p>
<p>2. Has your child traveled outside the United States?</p> <p>If yes, this question should be followed by:</p> <ul style="list-style-type: none"> • Where did the child travel? • With whom did the child stay? and • How long did the child travel? 	<p>If the child stayed with friends or family members in Africa, Asia, Latin America, or Eastern Europe for 1 week cumulatively, a TST should be placed.</p>
<p>3. Has your child been exposed to anyone with TB disease?</p> <p>If yes, this question should be followed by questions to determine:</p> <ul style="list-style-type: none"> • If the person had TB disease or LTBI, • When the exposure occurred, and • What was the nature of the contact 	<p>If confirmed that the child has been exposed to an individual with suspected or known TB disease, a TST should be placed.</p> <p>If it is determined that a child had contact with an individual with TB disease, notify the local health department per local reporting guidelines.</p>
<p>4. Does your child have close contact with a person who has a positive TB skin test?</p> <p>If yes, this question should be followed by questions to determine:</p> <ul style="list-style-type: none"> • If the person had TB disease or LTBI, • When the exposure occurred, and • What was the nature of the contact 	<p>If confirmed that the child has close contact with an individual with a positive skin test, a TST should be placed.</p>

* Adolescents can be asked these questions directly.

9 Adapted from: *Targeted Tuberculin Skin Testing and Treatment of Latent Tuberculosis Infection in Children and Adolescents*. Pediatric Tuberculosis Collaborative Group. *Pediatrics* 2004;114;1175-1201, p. 1178.