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2008 Pediatric and Adolescent Preventive Schedule: Ages 0 through 18 years

Physical Exam	Age Range	Comments	References *Note: The specific references are listed in their entirety on page 8 of this guideline.*
Well Child Exam :	Newborn, 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months 2 to 18 years annually	These guidelines apply to healthy children. Children with medical conditions may require additional follow-up.	1. AAP 2000 2. Expert consensus opinion of the 2004 Preventive Health QI Committee
- Weight **-Height** **-BMI**	All well child visits All well child visits All well child visits beginning at 2yr.	Calculate and plot BMI once a year in all children and adolescents (2-20 years). **Children with a BMI in the 95% percentile** would have two (2) additional preventive health office follow-up visits specifically for obesity per year and a blood pressure taken two (2) nutritional counseling visits specifically for obesity per year and one (1) set of recommended laboratory studies (lipid profile, hemoglobin A1c, AST, ALT and fasting glucose)	1. AAP (2000) Updated 2003 2. AAFP (2002) Updated 2005 3. USPSTF (1996) Updated 2004 4. CDC (2004)
-Head Circumference	All well child visits from newborn to 24 months of age	**Children with a BMI in the 85% percentile** would have one (1) additional preventive health follow-up office visit specifically for obesity per year and no additional laboratory studies.	1. AAP (2000) Updated 2005
- Blood Pressure	All well child visits starting at age 3 years.		1. AAP (2000) Updated 2005 2. USPSTF(1996) Updated 2004
- Vision Screening (integral to physical exam) **Assessment :** **-Distance Visual Acuity** **-Ocular Alignment** **-Ocular Media Clarity**	3year, 4 year, 5 year, 6 year, 8 year, 10 year, 12 year,15 year and when indicated.	If patient is uncooperative, re-screen within 6 months. *This is not an optical exam. Optical exams require additional vision benefits.	1. AAP (2000) Updated 2005 2. USPSTF(1996) Updated 2004

Physical Exam	Age Range	Comments	References *Note: The specific references are listed in their entirety on page 8 of this guideline.*
-Hearing Screening	Newborn, 4 years, 5 years, 6 years, 8 years, 10 years, 12 years, 15 years, and when indicated	Children identified at risk for hearing loss should be objectively screened annually. AAP recommends objective screening for all newborns. US Preventive Services Task Force concludes that the evidence is insufficient to recommend for or against routine screening of newborns for hearing loss during the postpartum hospitalization.	1. AAP (2000) Updated 2005 2. USPSTF(2001) Updated 2004

History/ Developmental and Safety Assessment	Age Range	Comments	References
Anticipatory Guidance/ Psychosocial Screening/Sexual History & Reproductive Guidance	At office visits	Anticipatory Guidance/Psychosocial Screening: Age appropriate discussions include but not limited to substance abuse, drinking and driving/riding with someone who is under the influence of alcohol and or other abusive substances, tobacco use and second hand smoke exposure, promote smoke-free household nutrition/exercise, initial dental exam at age three, oral fluoride supplementation at currently recommended doses to preschool children older than 6 months of age whose primary water source is deficient in fluoride, child abuse / domestic violence and maintain adequate calcium intake to prevent osteoporosis. Reaffirm adequate intake of Vitamin D recommend supplement of 200 IU per day for • All breastfed infants unless weaned to at least 500ml /d of formula. • All nonbreastfed infants who are ingesting less than 500ml/d of formula • Children/adolescent who do not get regular sunlight exposure, do not ingest at least 500 ml/d of Vit D fortified milk or do not take a daily vitamin supplement containing at least 200 IU of Vit D. Routine Iron Supplementation for children who are at increased risk for iron deficiency anemia: • Preterm and low birth weight infants • Infants whose principal dietary intake is unfortified cow's milk • Certain medical conditions Anticipatory Guidance Sexual History & Reproductive Guidance: Age appropriate discussions to include but not limited to normal growth, development and maturation, the benefits of healthy lifestyle behaviors and choices, health education related to sexual choices including abstinence/birth control/safe sex/STDs, and dietary folic acid (0.4mg/day) for females of reproductive age.	1. AAP (2000) Updated 2006 2. AAFP (2001) Updated 2005 3. USPSTF (1996) Updated 2006 4. AAPD (2003) 5. ACOG (2006)
Safety Issues	At office visits	Safety Issues – age appropriate discussions include: Traffic Safety; bicycle safety, car seats, motorcycle helmet use, seatbelts, ATVs ,teenage driving, pickup truck bed riding Burn Prevention; hot water temperature, milk and formula heating, smoke detectors, electrical outlets, grills, irons, ovens , fires Fall Prevention; window and stairway gates/guards, falls, Choking Prevention; choking/suffocation, Drowning Prevention; water safety, buckets, bathtubs, lifejackets, diving Firearm Safety; in home firearms, storage Sports Safety; protective equipment, conditioning	1. AAP (2000) Updated 2003 2. AAFP (1996) Updated 2005 3. USPSTF (1996) updated 2004 4. Pediatrics 2007

History/ Developmental and Safety Assessment	Age Range	Comments	References
		Safe Sleep Environment; sleep position Poison Prevention; phone number for poison control center. Instructions on how to call for help local emergency services, CPR Sun exposure (tanning beds), depression/suicide, occupational hazards, school hazards, recreational hazards, body piercing, tattoos, and other high risk behaviors such as cutting behavior, and the choking game. Syrup of ipecac is no longer to be used routinely as a home treatment strategy.	
Development/ Behavioral Assessment	All well child visits Formal screening for Autism at 9months,12 months, 15months, 18 months and 24 months	Use M-CHAT Assessment (Available at www.aap.org)	1. AAP (2000) Updated 2007 2. USPSTF(2001) Updated 2004

Laboratory Screening	Age Range	Comments	References
Hereditary/ Metabolic Screening	• Newborn to 1 month	Hemoglobinopathy, PKU, Thyroid, Galactosemia, according to Pennsylvania State law. Supplemental Screening—Determine if done in the hospital. If not, offer by one month.	1. AAP (2000) Updated 2003 2. AAFP (2001) Updated 2005 3. USPSTF (1996) Updated 2004
Lead Screening	• 9 months or older when indicated by risk based tool.	The AAP recommends that in addition to risk-based lead screening health care practitioners reference any relevant guidance from a city or state health department about lead screening in children. Please refer to any state specific recommendations and mandates. The USPSTF recommends against routine screening for elevated blood lead levels in asymptomatic children aged 1 to 5 years who are at average risk. **Note:** The Commonwealth of Pennsylvania promotes the universal screening of all children ages one and two and children ages three through six without a confirmed prior lead blood test. West Virginia state Medicaid program recommends lead screening in children between 9-12 months of age, repeated 1-2 years later.	1. AAP (2005) 2. USPSTF (1996)Updated 2006 3. Pennsylvania Department of Health, PA Lead Elimination Plan (6/28/2005)
Hematocrit or Hemoglobin	• Once from 9 to 12 months • Annually for females during adolescence • When indicated	US Preventive Services Task Force recommends screening for high-risks infants but concludes that there is insufficient evidence to recommend for or against routine screening asymptomatic persons. All menstruating adolescents should be screened annually.	1. AAP (2000) Updated 2003 2. USPSTF(1996) Updated 2004
Urinalysis	• Once at 5 years of age	Dipstick. Microscopic not required.	1. AAP (2000) Updated 2003
Tuberculosis	• 12 months to 18 years when indicated	A Mantoux should be done upon recognition of high risk factors. Community and personal risk factors should determine frequency. Tine test use is discouraged.	1. AAP (2000) Updated 2003 2. USPSTF (1996) Updated 2004
Cholesterol Screening	• 24 months to 18 years when indicated	If family history cannot be obtained and other high risk factors are present, screening should be done at the discretion of the physician.	1. AAP (2000) Updated 2003
Chlamydia/ Gonorrhea and other STD Screening	<u>Chlamydia:</u> Routine screening for all sexually active non-pregnant young women aged 24 and younger and for older non-pregnant women who are at risk. <u>Gonorrhea:</u> • Screening females at high risk of	Options for Chlamydia screening include: • Amplified DNA – urine • Urethral probe • Cervical probe	1. AAP (2000) Updated 2003 2. USPSTF (1996) Updated 2007 3. AAFP (1996) Updated 2005 4. CDC 2006

Laboratory Screening	Age Range	Comments	References
	infection Human immunodeficiency virus (HIV) Screen all adolescents at increased risk for HIV infection. <u>Other STD screening</u>: • Risk-based screening recommended for all sexually active males and females.	The CDC recommends routine voluntary HIV screening for all persons 13-18 years old in health care settings not based on risk; however the USPSTF concluded there is insufficient evidence to recommend either for or against routinely screening for HIV adolescents and adults who are not at an increased risk for infection.	
Papanicolaou Test (Pap Smear)	• When indicated	Strongly recommended for females who have been sexually active and have a cervix. Screening should begin 3 years after the start of sexual activity, and should be done at least every 3 years. The USPSTF concludes that the evidence is insufficient to recommend for or against new technologies (such as liquid based technology) in place of conventional Pap tests. The USPSTF concludes that the evidence is insufficient to recommend for or against *human papillomavirus* (HPV) testing as a primary screening test for cervical cancer.	1. AAP (2000) Updated 2003 2. USPSTF (1996) Updated 2004 3. ACOG (2000) Updated 2003 4. AAFP 2005
Genetic Risk Assessment and BRCA Mutation Testing for Breast and Ovarian cancer Susceptibility	Women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes be referred for genetic counseling and evaluation for BRCA testing. Any one of the following indicates a risk of having a BRCA mutation: • Personal and/or family history of breast cancer diagnosed under the age of 50. • Personal and/or family history of ovarian cancer at any age. • Women of Ashkenazi Jewish ancestry diagnosed with breast cancer or ovarian cancer at any age, regardless of family history. • Personal and/or family		1. USPSTF (2005) 2. AMA 2006

Laboratory Screening	Age Range	Comments	References
	history of male breast cancer. • Affected relatives with a known BRCA1 or BRCA2 mutation. • Bilateral breast cancer, especially if diagnosed at an early age. • Breast cancer and ovarian cancer in the same person.		

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References:

1. www.cdc.gov/nip/recs/child-schedule.htm CDC (September 2006)
2. www.aafp.org/exam.xml AAFP (2005)
3. www.accessexcellence.org/WN/SUA05/dna_test_chlamydia.html *DNA Test for Chlamydia*, January 28, 1995.
4. www.health.state.mn.us/divs/fh/mch/webcourse/intro/comp12.html *Tuberculosis Screening Fact Sheet*, Minnesota Department of Health, March 2002
5. American Academy of Pediatrics. *Don't Treat Swallowed Poison With Syrup of Ipecac Says AAP*. November 3, 2003.
6. www.cdc.gov/nccdphp/dnpa/bmi/ *BMI: Body Mass Index*. April 17, 2003.
7. www.aap.org/family/parents/immunize.htm AAP (2001)
8. US Preventive Services Task Force. *Guide to Clinical Preventive Services.* 2nd ed. Washington, DC: US Department of Health and Human Services; 1996.
9. http://www.ahrq.gov/clinic/uspstfix.htm. US Preventive Services Task Force. Washington, DC: US Department of Health and Human Services; 2005.
10. American Academy of Pediatrics, Committee on Practice and Ambulatory Medicine. Recommendations for pediatric preventive health care. www.aap.org. 2000.
11. American Academy of Family Physicians. *Summary of Policy Recommendations for Periodic Health Examination*. Kansas City, MO: American Academy of Family Physicians; 2004.
12. American College of Obstetricians and Gynecologists. *Cervical Cancer Screening: Testing Can Start Later and Occur Less Often Under New ACOG Recommendations*. July 31, 2003.
13. American College of Obstetricians and Gynecologists. *Primary and Preventive Care: Periodic Assessments.* Washington, DC: 2000.
14. American College of Obstetricians and Gynecologists. *ACOG Clarifies Recommendations on Cervical Cancer Screening in Adolescents.* September 30, 2004. http://www.acog.org/from_home/publications/press_releases/nr09-30-04-1.cfm?printerFr.
15. http://www.dsf.health.state.pa.us/health/CWP/view.asp?A=179&QUESTION_ID=240544 PA Dept of Health Lead Elimination Plan
16. Pediatrics 2007 Jan;119 (1):202-6

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Some flexibility in specific cases will require deviations from guideline recommendations. All providers are responsible for individualizing recommendations to the specific clinical characteristics of each patient.

Please refer your Highmark patient to Blues On Call℠ (1-888-BLUE-428) or our Website at www.highmark.com, for health education services.
Highmark Healthy High Five: www.highmarkhealthyhigh5.org
KidShape® is a family-based weight-management program for overweight children, 6-14 years of age. To learn more about KidShape® and the Western PA locations that currently deliver the program call 1-800-879-2217.
SPARK (Sports Play and Active Recreation for Kids) is a nationally researched physical activity after-school program designed to meet activity recommendations for children ages 5 -14. To learn more about SPARK and these locations go to www.paspark.org or 1-800-652-9420.
Personal Nutrition Coaching is individual nutrition coaching by a registered dietitian to address weight management, heart health, or diabetes. An individualized plan is created that can be easily integrated into the individual's lifestyle. (7 sessions). The parent or main caregiver must accompany the child or adolescent during the coaching sessions.
Refer your Highmark patients to the Depression Management Program at 1-800-596-9443 (Option 1) for continued support in the management of your patients with a depression diagnosis.
Reference behavioral health benefits, levels of care available to members, or care or case management services at 1-800-485-2889 (Option 1).
Access components of the Behavioral Health Toolkit via Navinet. Select: Resource Center/Clinical Reference Materials/Quality Management Resource Binder or fax your toolkit Order Form to Behavioral Health Toolkit Contact @ 412-544-2619.

As with any insurance, members are eligible for services only as long as they are active members of the plan and the services are covered benefits of their group contract.

Physicians are encouraged to reference the Highmark Drug Formulary when selecting prescription drug therapy for eligible members, which may be found at http://highmark.formularies.com/.
Members with a Select (formerly the Highmark Closed Formulary) benefit do not have coverage for nonformulary drugs. When selecting prescription drug therapy for eligible Medicare Advantage members, please consider referencing the Highmark Medicare-Approved Formulary which may be found at http://highmark.medicare-approvedformularies.com.

If appropriate, consider prescribing medications included in the formulary to avoid noncovered expenses for your patient. Physicians may request to have a nonformulary drug covered for an individual patient. Evidence to support the ineffectiveness of formulary alternatives for the particular patient's condition or a reasonable expectation of adverse reactions from the use of formulary products must be submitted for a request to be considered.

Instructions and the request form for this process are located on the Provider Resource Center under "Provider Forms".