

**CHAPTER 1241. EARLY AND PERIODIC SCREENING
DIAGNOSIS AND TREATMENT PROGRAM**

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Authority

The provisions of this Chapter 1241 issued under sections 403, 451 and 509 of the Public Welfare Code (62 P.S. §§ 403, 451 and 509), unless otherwise noted.

Source

The provisions of this Chapter 1241 adopted December 6, 1980, effective December 1, 1980, 10 Pa.B. 4611, unless otherwise noted.

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Cross References

This chapter cited in 55 Pa. Code § 1101.31 (relating to scope); and 55 Pa. Code § 1101.95 (relating to conflicts between general and specific provisions).

GENERAL PROVISIONS**§ 1241.1. Policy.**

The MA Program provides payment for EPSDT services rendered to eligible recipients by practitioners enrolled as providers under the program. Payment for EPSDT services is subject to this chapter, Chapter 1101 (relating to the general provisions) and the limitations established in Chapter 1150 (relating to MA Program payment policies) and the MA Program fee schedule.

Source

The provisions of this § 1241.1 adopted December 6, 1980, effective December 1, 1980, 10 Pa.B. 4611; amended December 23, 1983, effective January 1, 1983, 13 Pa.B. 3932; amended September 30, 1988, effective October 1, 1988, 18 Pa.B. 4418. Immediately preceding text appears at serial page (117502).

§ 1241.2. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

Administrative contractor—A nonprofit organization engaged in health care management that has contracted with the Department to be responsible for the coordination of existing, and the development of new screening resources to serve the eligible population in assigned geographical areas. The administrative contractor shall be accountable to the Department for the quality of services rendered and for fulfilling other responsibilities specified in this chapter.

EPSDT Program—Early and Periodic Screening, Diagnosis and Treatment Program.

Eligible Child—An individual 20 years of age or younger who is eligible for a Public Assistance cash grant or Supplemental Security Income (SSI) or an individual 20 years of age or younger who does not receive a cash grant and whose annual income and resources do not exceed certain limits based on family size.

Screening—The direct provision of testing and evaluation services provided by certified EPSDT screening providers for eligible children in order to ascertain diseases or abnormalities requiring diagnosis and treatment.

Screening provider—A licensed physician, a group of licensed physicians or an appropriate agency such as a hospital, health center or health department which uses the services of licensed physicians. The provider shall be able to provide either directly or through referral facets of general pediatric services to MA and non-MA children.

Source

The provisions of this § 1241.2 adopted December 6, 1980, effective December 1, 1980, 10 Pa.B. 4611.

SCOPE OF BENEFITS

§ 1241.21. Scope of benefits for the categorically needy.

Categorically needy recipients under age 21 are eligible for EPSDT screening services listed in Appendix A (relating to screening services required examinations and diagnostic tests) in addition to the services for which they are ordinarily eligible as categorically needy recipients. Categorically needy individuals screened under this chapter are also eligible for hearing aids and eyeglasses.

Source

The provisions of this § 1241.21 adopted December 6, 1980, effective December 1, 1980, 10 Pa.B. 4611.

§ 1241.22. Scope of benefits for medically needy.

Medically needy recipients under age 21 are eligible for EPSDT screening services listed in Appendix A (relating to screening services required examinations and diagnostic tests) in addition to the services for which they are ordinarily eligible as medically needy recipients. Medically needy recipients screened under this chapter are also eligible for hearing aids, eyeglasses and dentists' services.

Source

The provisions of this § 1241.22 adopted December 6, 1980, effective December 1, 1980, 10 Pa.B. 4611.

§ 1241.23. Scope of benefits for State Blind Pension recipients.

State Blind Pension recipients are not eligible for EPSDT services.

Source

The provisions of this § 1241.23 adopted December 6, 1980, effective December 1, 1980, 10 Pa.B. 4611.

PROVIDER PARTICIPATION

§ 1241.41. Participation requirements.

In addition to the participation requirements established in Chapter 1101 (relating to general provisions), screening providers are required, as a condition of participation, to have a written agreement with the Department as to the screening services to be provided and the rate of payment. Screening providers shall also have a current MA outpatient provider agreement and be certified as a screening provider by the Office of MA.

Source

The provisions of this § 1241.41 adopted December 6, 1980, effective December 1, 1980, 10 Pa.B. 4611.

§ 1241.42. Ongoing responsibilities of providers.

In addition to the ongoing responsibilities of providers established in Chapter 1101 (relating to general provisions), screening providers shall be responsible for the following:

(1) If the screening provider is not licensed or equipped to render the necessary treatment or further diagnosis, the screening provider shall refer the individual to an appropriate enrolled practitioner or facility, or to the CAO for supportive help in locating an appropriate provider.

(2) Immunizations shall be updated and recorded during EPSDT screening. The physician's records shall show as much immunization history as can be provided by the physician and the parents. Standard immunization guidelines, and amendments thereof, will be issued and published by the Department through a Class II Bulletin based on recommendations of recognized medical and dental organizations involved in child health care.

Authority

The provisions of this § 1241.42 amended sections 403(a) and (b) and 443.3(1) and (2) of the Public Welfare Code (62 P. S. §§ 403(a) and (b) and 443.3(1) and (2)).

Source

The provisions of this § 1241.42 adopted December 6, 1980, effective December 1, 1980, 10 Pa.B. 4611; amended May 25, 1990, effective May 26, 1990, 20 Pa.B. 2751. Immediately preceding text appears at serial page (117504).

PAYMENT FOR EPSDT SCREENING**§ 1241.51. General payment policy.**

The Department will make all payments to the participating screening provider.

Source

The provisions of this § 1241.51 adopted December 6, 1980, effective December 1, 1980, 10 Pa.B. 4611.

§ 1241.53. Limitations on payment.

(a) Payment for screening will be made no more frequently than specified in the MA Program fee schedule:

(b) The Department will make payment for immunizations approved by the Federal Drug Administration (FDA), when used as approved by the FDA, and as listed in the Department's pricing service.

Authority

The provisions of this § 1241.53 amended under sections 403(a) and (b) and 443.3(1) and (2) of the Public Welfare Code (62 P. S. §§ 403(a) and (b) and 443.3(1) and (2)).

Source

The provisions of this § 1241.53 adopted December 6, 1980, effective December 1, 1980, 10 Pa.B. 4611; amended May 25, 1990, effective May 26, 1990 and apply retroactively to December 1, 1988, 20 Pa.B. 2751. Immediately preceding text appears at serial pages (117504) to (117505).

§ 1241.54. Noncompensable services and items.

- (a) Payment will not be made for the following:
 - (1) Screens that do not include the appropriate tests in Appendix A (relating to screening services required examinations and diagnostic tests).
 - (2) General health care provided during an EPSDT screening examination visit.
 - (3) A medical examination performed on the same day as the screen.
 - (4) Invoices not submitted to the billing contractor within 30 days of the screening examination. Invoices received after 30 days will be returned.
 - (5) Laboratory tests that are included in the screening fee.
- (b) The following services and items are noncompensable for medically needy screened individuals:
 - (1) Medical equipment and supplies, with the exception of hearing aids and eyeglasses.
 - (2) Prostheses.
 - (3) Appliances.
 - (4) Orthoses.
 - (5) Pharmaceutical services as specified in Chapter 1121 (relating to pharmaceutical services).

Source

The provisions of this § 1241.54 adopted December 6, 1980, effective December 1, 1980, 10 Pa.B. 4611.

UTILIZATION CONTROL

§ 1241.71. Scope of claims review procedures.

Claims submitted for payment under the MA Program are subject to the utilization review procedures established in Chapter 1101 (relating to general provisions).

Source

The provisions of this § 1241.71 adopted December 6, 1980, effective December 1, 1980, 10 Pa.B. 4611.

ADMINISTRATIVE SANCTIONS**§ 1241.81. Provider misutilization.**

Providers determined to have billed for services inconsistent with MA Program regulations, to have provided services outside the scope of customary standards of practice, or to have otherwise violated the standards set forth in the provider agreement, are subject to the sanctions described in Chapter 1101 (relating to general provisions).

Source

The provisions of this § 1241.81 adopted December 6, 1980, effective December 1, 1980, 10 Pa.B. 4611.

**APPENDIX A
SCREENING SERVICES REQUIRED EXAMINATIONS AND
DIAGNOSTIC TESTS**

The screening of an eligible MA recipient shall include the following examinations, evaluations and appropriate diagnostic tests as specified per age group.

- (1) *Individuals—Birth Through 18 Months*
 - (i) Taking a health history from the parent or guardian.
 - (ii) Unclothed physical examination.
 - (iii) Developmental Appraisal—Denver or equivalent.
 - (iv) Growth Measurements.
 - (v) Metabolic Screening—PKU when appropriate.
 - (vi) Anemia Screening—Hemoglobin and/or Hematocrit when appropriate.
 - (vii) Lead Poisoning Evaluation when appropriate.
 - (viii) Sickle Cell Anemia Evaluation when appropriate.
 - (ix) Tuberculosis Testing when appropriate.
 - (x) Assessing and updating appropriate immunizations.
- (2) *Individuals—19 Months Through Age 20*
 - (i) Taking of a health history from the parent.
 - (ii) Unclothed physical examination, including Tanner Score and blood pressure.
 - (iii) Developmental Appraisal.
 - (iv) Vision Test.
 - (v) Hearing Test.
 - (vi) Dental Examination.
 - (vii) Urine Screen for bacteria, sugar, albumin.
 - (viii) Malnutrition Evaluation.
 - (ix) Tuberculosis Testing when appropriate.
 - (x) Iron Anemia—Hemoglobin and Hematocrit when appropriate.
 - (xi) Lead Poisoning Evaluation when appropriate.

- (xii) Sickle Cell Anemia Evaluation when appropriate.
- (xiii) Assessing and updating appropriate immunizations when required.

APPENDIX B. [Reserved]

Source

The provisions of this Appendix B reserved May 25, 1990, effective May 26, 1990, 20 Pa.B. 2751. Immediately preceding text appears at serial pages (124152) and (117509).

APPENDIX C. [Reserved]

Source

The provisions of this Appendix C reserved December 23, 1983, effective January 1, 1983, 13 Pa.B. 3932. Immediately preceding text appears at serial page (58168).

**APPENDIX D. EPSDT IMMUNIZATION GUIDELINES—
STATEMENT OF POLICY**

**Recommended Childhood Immunization Schedule
United States, January—December 1997**

Vaccines¹ are listed under the routinely recommended ages. **Bars** indicate range of acceptable ages for vaccination. **Shaded bars** indicate catch-up vaccination: at 11-12 years of age, Hepatitis B vaccine should be administered to children not previously vaccinated, and Varicella Virus vaccine should be administered to unvaccinated children who lack a reliable history of chickenpox.

Age ► Vaccine ▼	Birth	1 mo	2 mos	4 mos	6 mos	12 mos	15 mos	18 mos	4-6 yrs	11-12 yrs	14-16 yrs	
Hepatitis B ^{2,3}	Hep B-1											
		Hep B-2			Hep B-3					Hep B ³		
	Diphtheria, Tetanus, Pertussis ⁴		DTaP or DTP	DTaP or DTP	DTaP or DTP		DTaP or DPT ⁴			DTaP or DTP	Td	
			Hib Polio ⁶	Hib Polio	Hib ⁵	Hib ⁵			Polio		MMR ⁷ OR MMR ⁷	
						Polio ⁵						
		MMR										
Varicella ⁸					Var				Var ⁸			

Approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).

¹ This schedule indicates the recommended age for routine administration of currently licensed childhood vaccines. Some combination vaccines are available and may be used whenever administration of all components of the vaccine is indicated. Providers should consult the manufacturers' package inserts for detailed recommendations.

² *Infants born to HBsAg-negative mothers* should receive 2.5 µg of Merck vaccine (Recombivax HB®) or 10 µg of SmithKline Beecham (SB) vaccine (Engerix-B®). The 2nd dose should be administered \geq 1 mo after 1st dose.

Infants born to HBsAg-positive mothers should receive 0.5 mL hepatitis B immune globulin (HBIG) within 12 hrs of birth, and either 5 µg of Merck vaccine (Recombivax HB®) or 10 µg of SB vaccine (Engerix-B®) at a separate site. The 2nd dose is recommended at 1-2 mos of age and the 3rd dose at 6 mos of age.

Infants born to mothers whose HbsAg status is unknown should receive either 5 µg of Merck vaccine (Recombivax HB®) or 10 µg of SB vaccine (Engerix-B®) within 12 hrs of birth. The 2nd dose of vaccine is recommended at 1 mo of age and the 3rd dose at 6 mos of age. Blood should be drawn at the time of delivery to determine the mother's HBsAG status; if it is positive, the infant should receive HBIG as soon as possible (no later than 1 wk of age). The dosage and timing of subsequent vaccine doses should be based upon the mother's HBsAg status.

³ Children and adolescents who have not been vaccinated against hepatitis B in infancy may begin the series during any childhood visit. Those who have not previously received 3 doses of hepatitis B vaccine should initiate or complete the series during the 11-12 year-old visit. The 2nd dose should be administered at least 1 mo after the 1st dose, and the 3rd dose should be administered at least 4 mos after the 1st dose, and at least 2 mos after the 2nd dose.

⁴ DTaP (diphtheria and tetanus toxoids and acellular pertussis vaccine) is the preferred vaccine for all doses in the vaccination series, including completion of the series in children who have received \geq 1 dose of whole-cell DTP vaccine. Whole-cell DTP is an acceptable alternative to DTaP. The 4th dose of DTaP may be administered as early as 12 mos of age, provided 6 mos have elapsed since the 3rd dose, and if the child is considered unlikely to return at 15-18 mos of age. Td (tetanus and diphtheria toxoids, adsorbed, for adult use) is recommended at 11-12 yrs of age if at least 5 yrs have elapsed since the last dose of DTP, DTaP or DT. Subsequent routine Td boosters are recommended every 10 yrs.

⁵ Three H. influenzae type b (Hib) conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB® [Merck]) is administered at 2 and 4 mos of age, a dose at 6 mos is not required. After completing the primary series, any Hib conjugate vaccine may be used as a booster.

⁶ Two poliovirus vaccines are currently licensed in the US: inactivated poliovirus vaccine (IPV) and oral poliovirus vaccine (OPV). The following schedules are all acceptable by the ACIP, the AAP and the AAFP, and parents and providers may choose among them:

1. IPV at 2 and 4 mos; OPV at 12-18 mos and 4-6 yrs
2. IPV at 2, 4, 12-18 mos, and 4-6 yrs
3. OPV at 2, 4, 6-18 mos, and 4-6 yrs

The ACIP routinely recommends schedule 1. IPV is the only poliovirus vaccine recommended for immunocompromised persons and their household contacts.

⁷ The 2nd dose of MMR is routinely recommended at 4-6 yrs of age or at 11-12 yrs of age, but may be administered during any visit, provided at least 1 mo has elapsed since receipt of the 1st dose, and that both doses are administered at or after 12 mos of age.

⁸ Susceptible children may receive Varicella vaccine (Var) during any visit after the 1st birthday, and unvaccinated persons who lack a reliable history of chickenpox should be vaccinated during the 11-12 year-old visit. Susceptible persons \geq 13 yrs of age should receive 2 doses, at least 1 mo apart.

Source

The provisions of this Appendix D adopted May 25, 1990, effective May 26, 1990, 20 Pa.B. 2791; amended January 11, 1991, effective January 18, 1991, 21 Pa.B. 165; amended September 27, 1991, effective September 28, 1991, 21 Pa.B. 4429; amended December 4, 1992, effective December 11, 1992, 22 Pa.B. 5785; amended August 1, 1997, effective August 2, 1997, 27 Pa.B. 3818. Immediately preceding text appears at serial pages (177234) to (177236) and (188507).

Cross References

This appendix cited in 55 Pa. Code § 1221.51 (relating to general payment policy).

**APPENDIX E. GUIDELINES ON CHILDHOOD LEAD
POISONING PREVENTION**

Childhood Lead Poisoning Prevention Questionnaire

Does your child live in or regularly visit a house, a day-care center or a nursery school that was built before 1960 and has peeling or chipping paint?

Does your child live in a home built before 1960 that is being remodeled or renovated?

Does your child live near a heavily traveled major highway where soil and dust may be contaminated with lead?

Have any of your children or their playmates had lead poisoning?

Do you give your child any home or folk remedies which may contain lead?

Does your child often come in contact with an adult who works with lead—in construction, welding, plumbing, pottery or other trades?

Does your child live near a lead smelter, a battery-recycling plant or other industrial sites likely to release lead?

Does your home plumbing have lead pipes or copper with lead solder joints?

Under recent Federal clarification, a child, whose parent has answered “yes” to one or more of the risk assessment questions, is determined to be at high risk. A child, whose parent has answered “no” to all questions, is determined to be at low risk. We believe that most MA eligible children will be at high risk for lead poisoning. The EP test is not effective and is no longer acceptable as a screening test for lead poisoning. The use of the blood lead test is now required when screening Medicaid-eligible children for lead toxicity, whether they are determined high risk or low risk.

Screening Schedule

I. For children 6 to 36 months of age who are at LOW risk for HIGH dose lead exposure by questionnaire: an initial blood lead (PbB) test at 12 months of age and as follows:

A. If PbB test result: <10 ug/dL, retest at 24 months.

B. If PbB test result: 10-14 ug/dL, retest every 3 to 4 months. After 2 consecutive measurements are <10 ug/dL or three are ≤15 ug/dL, retest child in 1 year.

C. If PbB test result ≥15 ug/dL, case manage and retest every 3 to 4 months.

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II. For children 6 to 36 months of age who are at HIGH risk for HIGH dose exposure by questionnaire an initial PbB test at 6 months of age and as follows:

A. If PbB test result is <10 ug/dL, rescreen every 6 months. After 2 subsequent consecutive measurements are <10 ug/dL or three are ≤ 15 ug/dL, testing frequency can be decreased to once a year.

B. If PbB test result 10-14 ug/dL, rescreen child every 3 to 4 months. After 2 subsequent consecutive measurements <10 ug/dL or three are ≤ 15 ug/dL, testing frequency can be decreased to once a year.

III. For children 36 to 72 months of age:

As for younger children, a questionnaire should be used at each routine office visit of children from 36 to 72 months of age. Any child at HIGH risk by questionnaire who has not been previously tested should be tested. All children who have had venous blood lead tests ≥ 15 ug/dL or who are at risk by questionnaire should be screened at least once a year until their sixth birthday (age 72 months) or later, if indicated (e.g. developmentally delayed with pica). Children should also be screened any time history suggests exposure has increased.

*Follow up for all Children 6 to 72 months
at PbB Levels >15 ug/dL*

A. If PbB 10-14 rescreen in 3-4 months or more often is indicated, provide family with education and nutritional counseling, and take a detailed environmental history to identify any obvious sources or pathways of lead exposure. It is unlikely that there is a single predominant source of lead exposure for most of these children, thus, a full home inspection is not recommended. It is prudent, however, to try to decrease exposure to lead with some simple interventions.

B. If PbB 15-19 ug/dL: same as preceding, plus discuss interventions to reduce PbB levels. If the PbB persists at this level, environmental investigation and abatement.

C. If PbB 20-44 ug/dL: same as for all of the preceding, plus venous confirmation, medical evaluation and follow-up.

D. If 45-69 ug/dL: same as for all of the preceding, plus URGENT medical and environmental follow-up.

E. If ≥ 70 ug/dL (VENOUS) or symptomatic lead poisoning a MEDICAL EMERGENCY, requiring immediate inpatient chelation therapy plus the same as for all preceding.

Elevated PbB results obtained on capillary screening specimens are presumptive and must be confirmed using venous PbB as follows: less than 10 ug/dL not applicable; 10-14 ug/dL not applicable; 15-19 ug/dL within 1 month; 20-44 ug/dL within 1 week; 45-69 ug/dL within 48 hours; greater than or equal to 70 ug/dL immediately.

The Department currently reimburses for blood lead testing through distinct procedure codes listed on the MA Fee Schedule and as a component of the Early and Periodic Screening, Diagnosis and Treatment Program.

NOTE: For a free copy of the October 1991 CDC Statement contact the Pennsylvania Department of Health, Childhood Lead Poisoning Prevention Program at (717) 783-8451.

Source

The provisions of this Appendix E adopted August 27, 1993, effective August 28, 1993, 23 Pa.B. 4119; amended April 15, 1994, effective upon publication and apply retroactively to December 23, 1993, 24 Pa.B. 1973. Immediately preceding text appears at serial pages (184971) to (184972) and (181903).

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