

Hawaii Early And Periodic, Screening, Diagnosis, and Treatment (EPSDT) Exam

Please COMPLETELY fill in this form by supplying the requested information and filling in the appropriate **O**

PATIENT INFORMATION

Screen Date (MMDDYY)	Indicate the EPSDT periodic screening age being reported	Sex																																														
	<table border="1" style="width: 100%; text-align: center; font-size: 8px;"> <tr> <td>14 d</td><td>30 d</td><td>2 m</td><td>4 m</td><td>6 m</td><td>9 m</td><td>12 m</td><td>15 m</td><td>18 m</td><td>2 y</td><td>3 y</td><td>4 y</td><td>5 y</td><td>6 y</td><td>8 y</td><td>10 y</td><td>12 y</td><td>14 y</td><td>16 y</td><td>18 y</td><td>20 y</td><td>M</td><td>F</td> </tr> <tr> <td><input type="radio"/></td><td><input type="radio"/></td> </tr> </table>	14 d	30 d	2 m	4 m	6 m	9 m	12 m	15 m	18 m	2 y	3 y	4 y	5 y	6 y	8 y	10 y	12 y	14 y	16 y	18 y	20 y	M	F	<input type="radio"/>																							
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Name (Last, First, Middle Initial)	Medicaid/QUEST ID	Birthdate (MMDDYY)
	0 0	

MEASUREMENTS

For infants, head circumference and weight for length should be assessed and documented in the Medical record.

Blood Pressure	Height (In)	Weight (Lbs)	BMI #	BMI %	BMI Reference – For Information Only			
					<table border="1" style="width: 100%; text-align: center; font-size: 8px;"> <tr> <td>Normal < 85%</td> <td>Overweight 85%-94%</td> <td>Obese ≥95%</td> </tr> </table>	Normal < 85%	Overweight 85%-94%	Obese ≥95%
Normal < 85%	Overweight 85%-94%	Obese ≥95%						

IMMUNIZATIONS GIVEN TODAY AND STATUS

HepB	<input type="radio"/>	PCV	<input type="radio"/>	MMR	<input type="radio"/>	Tdap	<input type="radio"/>	Immunization(s) Not Given				
DTaP	<input type="radio"/>	Rotav	<input type="radio"/>	Varicella	<input type="radio"/>	MCV4/MPSV4	<input type="radio"/>	Immunizations up to date				<input type="radio"/>
IPV	<input type="radio"/>	Influenza	<input type="radio"/>	HepA	<input type="radio"/>	HPV	<input type="radio"/>	Catch Up Scheduled				<input type="radio"/>
Hib	<input type="radio"/>	Other (List)					<input type="radio"/>	Refused (List)				<input type="radio"/>

Comments:	Contraindicated (List)	<input type="radio"/>
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SCREENING DONE TODAY

	Normal	Abnormal		Done
Vision Screening: Snellen, Allen, Tumbling Es, LEA Symbols 3y, 4y, 5y, 6y, 8y, 10y, 12y, 14y-16y, 18y	<input type="radio"/>	<input type="radio"/>	Blood Lead Level 9 - 12m, 2y (2 levels required by 2 years)	<input type="radio"/>
Hearing Screening: Audiometry (20-25 db screen) 4y, 5y, 6y, 8y, 10y	<input type="radio"/>	<input type="radio"/>	Hgb/Hct 9m – 12m, Females-12y – 14y	<input type="radio"/>
Developmental Screening *(see back) 9m, 18m, 24m - 36m (3 screenings required by 36 months)	PEDS: ≥ 2 predictive concerns = Abnormal ASQ: ≥ 1 domain falling below normal cut-offs = Abnormal Other (list)		Comments for screenings not done:	Y N
Autism Screening *(see back) 18m, 24m Fail = Abnormal	CHAT M-CHAT Other (list)		Has the child seen a dentist within the past year?	<input type="radio"/>

As part of surveillance per the AAP/Bright Futures recommended periodicity (see back), the following should be done and documented in the medical record: TB risk assessments, lead risk assessment, psychosocial/behavioral assessments, and for adolescents- alcohol/drug use assessment, and as appropriate - dyslipidemia, STI, and cervical dysplasia screening.

REFERRALS MADE TODAY

By leaving this section blank, I am confirming that there are no referral needs.

Already referred or receiving state or specialty services.	<input type="radio"/>	H-KISS	<input type="radio"/>	PHN	<input type="radio"/>	CAMHD	<input type="radio"/>	WIC	<input type="radio"/>
Patient/parent refused.	<input type="radio"/>	PT/OT/Speech/Audiology	<input type="radio"/>	DOE	<input type="radio"/>	DDD	<input type="radio"/>	Child Welfare	<input type="radio"/>
Behavioral Health/Substance Abuse (List name & specialty)	<input type="radio"/>	Nutrition/Exercise (List name & specialty)							<input type="radio"/>
Medical/Surgical/Developmental (List name & specialty)	<input type="radio"/>	Other(s) (List name & specialty)							<input type="radio"/>

CARE COORDINATION ASSISTANCE NEEDED

Please call patient's Health Plan for Care Coordination assistance if needed.

No Care Coordination Needed	<input type="radio"/>	Managing medical condition and/or medications	<input type="radio"/>	Obtaining foreign/sign language translation	<input type="radio"/>	Obtaining dental care (If yes, call CCMC)	<input type="radio"/>	Scheduling/Keeping appointments	<input type="radio"/>
Arranging transportation	<input type="radio"/>	Coordinating multiple appointments	<input type="radio"/>	Family needs assistance in following the POC	<input type="radio"/>	Obtaining specialty services	<input type="radio"/>	Other	<input type="radio"/>

If assistance is needed, please provide parent's/ caregiver's telephone no. The health plan will call to facilitate coordination.

List additional information or other assistance needed:

Phone Numbers	Aloha Care	808-973-1650 (Oahu) 1-800-434-1002 (Toll Free)	Kaiser QUEST	808-432-5330 (Oahu) 1-800-651-2237 (Toll Free)	CCMC Dental Resource	808-486-8030 (Oahu) 1-866-486-8030 (Toll Free)
	HMSA QUEST	808-948-6486 (Oahu) 1-800-440-0640 (Toll Free)	Ohana Health Plan	1-888-846-4262	Evercare	1-888-980-8728

PROVIDER STATEMENT: A complete EPSDT exam also includes a history (initial or interval), a physical exam, age appropriate surveillance and anticipatory guidance. By signing below, I confirm that these were performed and documented in the patient's medical record.

Provider Name (Print)	Signature	NPI #

For additional forms, contact ACS at 808-952-5570 (Oahu) or 800-235-4378 (Toll Free).

GENERAL INSTRUCTIONS FOR DHS 8015
Submit this form with your CMS 1500 claim form.

The following instructions detailing the completion of the Hawaii EPSDT DHS 8015 form can also be found on the Med-QUEST Division's website, www.med-quest.us, and in the Hawaii State Medicaid Provider Manual.

Complete the form using either **black** or **blue** ink. When indicated, fill in circles. **Do not** (✓) check, (x) cross, or (/) line through the circles.

Section: Patient Information

1. Fill in date of screening visit (date should match date of service on CMS 1500 Claim form)
2. If the age of the patient on the date of the exam is **NOT** at the specific age listed in the column, indicate the EPSDT periodic screening age being reported. Usually, this is the age range immediately below the age of the child. E.g. If the child is 8 months and the child has not had a 6 month EPSDT exam, select 6 months. If the child is 8 months and has had a 6 month exam, an interperiodic exam can be done, with a 9 month EPSDT exam scheduled for a later date. If the child is 8 months but almost 9 months, and has had a 6 month exam, a 9 month EPSDT exam can be selected with subsequent visits prior to the 12 month visit billed as interperiodic exams.

Section: Measurements

1. Record height and weight in English using pounds and inches.
2. Calculate BMI and BMI% for children age **2 – 20 y/o**, using the CDC website BMI calculator (<http://apps.nccd.cdc.gov/dnpabmi/>).

Section: Immunizations Given Today

1. Fill in the circle(s) next to all of the immunizations given at visit. Indicate if immunizations are up to date, if catch-up is scheduled, if immunizations were refused, or if immunizations were contraindicated. This section should **NOT** be left blank.

Section: Screening Done Today

1. Record the results of the vision screening by filling in the appropriate circle. Use one or more of the listed validated vision screening tools.
2. Record the results of the audiometry testing by filling in the appropriate circle. A diagnostic audiologic assessment should also follow any positive hearing screens of newborns and children less than 4 years.
3. Record the results of the developmental screening, if done, by filling in the appropriate circle. It is recommended that either the PEDS or ASQ screening tool be used. Another validated screening tool recommended by the AAP may be used. A list of these may be found in the latest AAP policy on 'Identifying Infants and Young Children with Developmental Disorders in the Medical Home' (Table 1- General Developmental Screening Tools) that can be accessed through <http://aappolicy.aappublications.org/cgi/content/full/pediatrics;118/1/405>
4. Record the results of the autism screening, if done, by filling in the appropriate circle. It is recommended that either the CHAT or M-CHAT screening tool be used. Another validated screening tool recommended by the AAP may be used. A list of these may be found in the latest AAP policy on 'Identifying Infants and Young Children with Developmental Disorders in the Medical Home' (Table 1- Autism Screening Tools) that can be accessed through <http://aappolicy.aappublications.org/cgi/content/full/pediatrics;118/1/405>
5. Fill in the circle if a blood lead level was ordered. Blood lead levels are required at 9 – 12 months and 2 years of age. A blood lead level should be done at 3 – 6 years of age if a level has never been done or risk level changes.
6. Fill in the circle if an Hgb/Hct blood level was ordered. Follow EPSDT's recommended age(s) as listed.
7. Indicate if the child has seen a dentist. Y or N should be selected.
8. If no screenings were done, leave the section blank.

Section: Referrals Made Today (Leave the section blank if no referrals were made during this visit)

1. Fill in the appropriate circle(s).
2. List the program(s) and/or specialty(ies) as indicated. For medical/developmental specialties, please note the specialty and agency or individual to whom the referral was made.
3. If referrals are made, please list a current phone number for parental contact under the Care Coordination section, so that the health plan can follow-up on the referral.

****Note:** If specific services or programs are not known, refer patient to H-KISS, a DOH central referral agency for developmental early intervention services. If child is school age, refer to DOE. A referral may be made even prior to establishing a diagnosis.

Section: Care Coordination Assistance Needed

1. Fill in the appropriate circle(s) next to the assistance needed for the patient. If no care coordination is needed, indicate this by selecting 'no care coordination needed'.
2. Record the patient's/parent's/caregiver's contact phone number if assistance is needed. Refer patient/parent/caregiver to appropriate Health Plan if preferred.

Section: Provider Statement

1. To be considered complete, the provider signature **MUST** be filled out along with the provider's NPI #.

Surveillance, risk assessment, and anticipatory guidance should follow the AAP/Bright Futures recommended periodicity schedule and guidelines.

The AAP/Bright Futures periodicity schedule and guidelines can be found at http://brightfutures.aap.org/3rd_Edition_Guidelines_and_Pocket_Guide.html

Tuberculin Skin Test (TST) Risk Assessment & Recommendations for Infants, Children, and Adolescents (<http://aapredbook.aappublications.org>)

(Bacille Calmette-Guérin immunization is not a contraindication to a TST.) (HIV = Human Immunodeficiency Virus; LTBI = Latent Tuberculosis Infection)

Children for whom immediate TST is indicated (Beginning as early as 3 months of age):

- Contacts of people with confirmed or suspected contagious tuberculosis (contact investigation)
- Children with radiographic or clinical findings suggesting tuberculosis disease
- Children immigrating from countries with endemic infection (eg, Asia, Middle East, Africa, Latin America, countries of the former Soviet Union) including international adoptees
- Children with travel histories to countries with endemic infection and substantial contact with indigenous people from such countries (If the child is well, the TST should be delayed for up to 10 weeks after return.)

Children who should have annual TST:

- Children infected with HIV
- Incarcerated adolescents

Children at increased risk of progression of LTBI to tuberculosis disease: Children with other medical conditions, including diabetes mellitus, chronic renal failure, malnutrition, and congenital or acquired immunodeficiencies deserve special consideration. Without recent exposure, these people are not at increased risk of acquiring tuberculosis infection. Underlying immune deficiencies associated with these conditions theoretically would enhance the possibility for progression to severe disease. Initial histories of potential exposure to tuberculosis should be included for all of these patients. If these histories or local epidemiologic factors suggest a possibility of exposure, immediate and periodic TST should be considered. An initial TST should be performed before initiation of immunosuppressive therapy, including prolonged steroid administration, use of tumor necrosis factor-alpha antagonists, or immunosuppressive therapy in any child requiring these treatments.