



Child and Teen Checkups (C&TC) Screening Components Standards and Guidelines



For Provider Documentation

Child and Teen Checkups (C&TC) Early and Periodic Screening Diagnosis and Treatment (EPSDT) Program

Child and Teen Checkups (C&TC) is the name for Minnesota's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. C&TC is a comprehensive child health program provided to children and teens from newborn through the age of 20 who are enrolled in Medical Assistance (MA) or MinnesotaCare.

The purpose of this document, "C&TC Screening Component Standards and Guidelines for Provider Documentation," is to identify the required standards for C&TC components and the personnel qualified to perform them and to offer guidelines to assist providers with C&TC documentation. The documentation guidelines can be used to review current clinic forms to determine if the forms contain the required documentation for a complete C&TC. Clinics can use this information to revise their forms as necessary. The set of age-related C&TC Documentation Forms (DHS-4813B-R) http://www.dhs.state.mn.us/id_028848, can serve as examples.

The C&TC Documentation Forms were created by a C&TC Documentation Template Workgroup consisting of the Minnesota Departments of Health (MDH) and Human Services (DHS), physicians, coding/billing representatives, clinic quality improvement staff and representatives from health plans and public health. These C&TC Documentation Forms are available to clinics and providers as a resource. Providers use of the C&TC Documentation Forms is encouraged but not mandatory.

The main role of the C&TC Documentation Forms is to identify all required components and provide ease of chart documentation. Additional documentation will be found in other chart areas such as the complete immunization record, lab reports and growth grids. The C&TC Documentation Forms can provide links to these other documentation areas.

Clinic staff who are evaluating or developing their own forms should review specific details about C&TC requirements contained under "C&TC Screening Component Standards and Guidelines" <http://edocs.dhs.state.mn.us/lfservlet/Legacy/DHS-4813A-ENG>. All these documents can be found in the C&TC Provider Guide DHS-4212: C&TC Provider Guide <http://edocs.dhs.state.mn.us/lfservlet/legacy/DHS-4212-ENG>. If incorporating billing information into the form, be sure to review CPT Code definitions. It is the clinic's responsibility to ensure that their documentation forms and process follow the CPT and coding and billing documentation guidelines.

Clinic documentation forms for C&TC can be age-specific or "one size fits all." However, the C&TC Documentation Template Workgroup strongly recommends that age-specific forms be used. For documentation samples, please refer to the C&TC Documentation Forms, created by the workgroup.

If a clinic uses dictation rather than a documentation form, the dictation must address all C&TC components. The C&TC Periodicity Schedule (Schedule of Age-Related Screening Standards) <http://edocs.dhs.state.mn.us/lfservlet/Legacy/DHS-3379-ENG> or a recommended C&TC Documentation Form could be used to prompt dictation.

Other resources include:

- C&TC Web Site for Providers: <http://www.dhs.state.mn.us/CTCProvider>
- MDH Web Site for Providers: <http://www.health.state.mn.us/divs/fh/mch>
- FACT Sheets
- C&TC Contact Resource Lists.

Component standards	Personnel qualified	Documentation suggestions
<p>Anticipatory Guidance and Health Education:</p> <p>Anticipatory guidance and health education concerning the child’s health must be provided as a part of every C&TC screening. The physical, developmental and social-emotional/mental health and other C&TC components give the initial context for providing health education at the C&TC screening. The dental screening also provides an additional opportunity for anticipatory guidance and health education.</p> <p>Anticipatory guidance or health education is to assist the child, parent or guardian in understanding the expected growth and development of the child and to give child, parent or guardian age-appropriate information about the benefits of healthy lifestyles and practices that promote injury and disease prevention. Health questions and concerns of the child, parent or guardian must be addressed.</p>	<p>Physician</p> <p>Nurse Practitioner</p> <p>Physician Assistant</p> <p>Or R.N. with adequate training</p>	<p>Show documentation that age-appropriate anticipatory guidance and health education were given.</p> <p>Consider using:</p> <ul style="list-style-type: none"> ▪ a list of age-appropriate anticipatory guidance topics which could be checked off or circled for quick documentation. Allow space for brief note. ▪ an age-appropriate anticipatory check off guidance box and allow space to write in discussion topics or a box to check for “see dictation notes”. <p>■ For examples, please refer to the C&TC Documentation Forms. http://www.dhs.state.mn.us/id_028848</p> <p>■ Additional Information: C&TC Component FACT Sheets can be found at: FACT Sheets</p>

Component standards	Personnel qualified	Documentation suggestions
<p>Physical Growth and Measurements:</p> <ul style="list-style-type: none"> ▪ A child's height/length and weight must be measured and the results plotted, as appropriate, on a standardized growth grid based on data from the Centers for Disease Control and Prevention (CDC). ▪ Body Mass Index (BMI): BMI should be calculated and documented at each C&TC visit beginning at age 2 as recommended by CDC and the American Academy of Pediatrics (AAP). BMI percentile should be documented based on CDC growth charts. ▪ The head circumference of a child from birth to 24 months of age or a child whose growth in head circumference appears to deviate from the norm must be measured and plotted on a standardized growth grid based on CDC data. ▪ Blood pressure must be measured starting at three years of age. ▪ Children determined to have nutritional risks or fall outside the normal range for BMI must be referred, as appropriate, for further clinical assessment, nutritional counseling or be referred to a nutritional program such as Women, Infants, and Children (WIC); the Minnesota Food Assistance Program (MFAP), the Food Support Program, Mothers and children (MAC) or Head Start. 	<p>Anyone with adequate training (i.e., Nursing Assistant, Certified Medical Assistant, or R.N.)</p>	<p>Record numerical values for height, weight, BMI and BMI percentile, head circumference (up to 24 months) and blood pressure (beginning at age 3 years).</p> <p>Growth information should be plotted on standardized growth grids based on CDC data as appropriate.</p> <p>■ For examples, please refer to the C&TC Documentation Forms. http://www.dhs.state.mn.us/id_028848</p> <p>■ Additional Information: CDC growth charts can be found at: www.cdc.gov/growthcharts C&TC Component FACT Sheets can be found at: FACT Sheets</p>

Component standards	Personnel qualified	Documentation suggestions
<p>Health, Developmental and Social-Emotional/Mental Health History:</p> <p>A history of a child’s health, development and social-emotional/mental health must be obtained from the child, parent of the child, or an adult who is familiar with the child’s health history. The history must include, but is not limited to:</p> <ul style="list-style-type: none"> ▪ A complete medical history (see documentation column to right) ▪ Identification of social-emotional/mental health status/needs/risks ▪ Information on sexual development/maturation ▪ Lead and tuberculosis risks and exposure ▪ Nutrition intake (see below) ▪ Chemical use/abuse/risks <p>The Health history should be updated at each subsequent visit.</p> <p>Nutrition: A child must receive screening of nutritional status through questions about dietary practices to identify unusual, deficient or excessive eating habits, dietary quality and quantity, meal patterns etc. A child must be referred to the Special Supplemental Food Program for Women, Infants, and Children (WIC) for eligibility determination. When the nutritional screening and the screening of a child’s physical growth indicates a nutritional risk condition, the child must be referred for further assessment, receive nutritional counseling, and be referred to a nutrition program such as WIC, MAC, the Minnesota Food Assistance Program (MFAP) and the Food Support Program.</p>	<p>Physician</p> <p>Nurse Practitioner</p> <p>Physician Assistant</p> <p>Or R.N. with adequate training</p>	<p>Document health, developmental and social-emotional/mental health history. Record normal/abnormal findings.</p> <p>Consider including:</p> <ul style="list-style-type: none"> ▪ identifying information ▪ social history information ▪ past medical history (immunizations, hospitalizations, surgeries, illness, accidents, TB risks, medications, allergies, operations, lead exposure, etc.) ▪ family health history ▪ medications ▪ present health status of the child ▪ complete review of systems ▪ health maintenance, including, but not limited to: <ul style="list-style-type: none"> • safety • development • nutrition • discipline • social-emotional/mental health needs • activities/recreation • chemical/tobacco use • sexuality <p>Topics will vary if age-specific forms are used.</p> <p>▪ For examples, please refer to the C&TC Documentation Forms. http://www.dhs.state.mn.us/id_028848</p> <p>▪ Additional Information: C&TC Component FACT Sheets can be found at: FACT Sheets</p>

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<p>Developmental and Social-Emotional/Mental Health</p> <p>Developmental and social-emotional/mental health surveillance of the child is required at every screening. To do this, the provider must use a combination of information obtained during the health history, developmental and social-emotional/mental health screening as well as standardized tool if used, and clinical observation to determine the child’s developmental and social-emotional/mental health status and need for further assessment and referral.</p> <p>Although there are many screening tools available for developmental screening and social-emotional/mental health screening, at this time, there isn’t a tool which screens for both. For information on the recommended tools, click on the MDH web site link for Developmental and Social-Emotional/Mental Health listed under Additional Information in the lower right column.</p> <p>Development: It is recommended as best practice that a standardized tool be used for children under 6 years.</p> <p>For children under 6 years of age, developmental screening includes:</p> <ul style="list-style-type: none"> ▪ Social and self help skills ▪ Cognitive development ▪ Fine/gross motor development ▪ Language and speech development. <p>For children over 6 years of age, developmental screening may include:</p> <ul style="list-style-type: none"> ▪ Motor skills development ▪ Language ▪ Cognitive development ▪ Vocational skills ▪ Attention skills ▪ Social/relationship skills ▪ Identifying the presence of learning disabilities. <p>Social-Emotional/Mental Health: It is recommended as best practice that a standardized mental health tool be used for screening children of all ages.</p> <p>Standardized tools used must be culturally sensitive; have norms for the age-range tested; have written procedures for administration, scoring and interpretation; and be statistically reliable and valid.</p>	<p>Physician</p> <p>Nurse Practitioner</p> <p>Physician Assistant</p> <p>Or R.N.</p> <p>Certified Medical Assistant or screener with adequate training</p>	<p>For children under 6 years of age, document normal/abnormal findings in the areas of:</p> <ul style="list-style-type: none"> ▪ Social and self help skills ▪ Cognitive development ▪ Fine and gross motor development ▪ Language and speech development. <p>For children over 6 years of age, document normal/abnormal findings in the suggested areas of:</p> <ul style="list-style-type: none"> ▪ Motor skills development ▪ Language ▪ Cognitive development ▪ Vocational skills ▪ Attention skills ▪ Social/relationship skills. <p>If standardized tools are used for developmental and social-emotional/mental health screening, document the types of tools used and the results.</p> <p>■ For examples, please refer to the C&TC Documentation Forms http://www.dhs.state.mn.us/id_028848</p> <p>■ Additional Information: C&TC Component FACT Sheets can be found at: FACT Sheets</p> <p>Developmental and Social-Emotional/Mental Health Screening: Information about the recommended standardized tools for development and Social-Emotional/Mental health screening for C&TC can be found on the MDH Web site at: http://www.health.state.mn.us/divs/fh/mch/mch-pro3.html</p>

Component standards	Personnel qualified	Documentation suggestions
<p>Physical Exam:</p> <p>Unclothed and completed according to medically accepted procedures include:</p> <ul style="list-style-type: none"> ▪ Pulse, respiration ▪ Head, eyes, ears, nose, mouth/oral, pharynx ▪ Neck, chest, heart, lungs ▪ Abdomen, spine ▪ Extremities, joints, muscle tone, skin ▪ Neurological condition ▪ Genitals/sexual development: A child must be evaluated to determine whether the child’s sexual development is consistent with the child’s chronological age. When indicated, a female must receive a breast examination and pelvic examination and a male must receive a testicular examination. If it is in the best interests of the child, counseling on normal sexual development; information on birth control and sexually transmitted infections; and prescriptions and tests must be offered to the child as appropriate based on age and sexual activity. If it is in the best interest of the child, a screening provider may refer the child to other resources for counseling or to another provider for a pelvic examination. ▪ An oral examination of a child’s mouth must be performed to detect deterioration of hard tissue and inflammation or swelling of soft tissue. Counseling about the systemic use of fluoride must be given to a child or parent of the child when fluoride is not available through the community water supply or school programs. ▪ Because dental caries (tooth decay) is the most prevalent chronic disease in the US, it is recommended that infants and young children receiving C&TC/EPSTDT screenings receive fluoride varnish applications at 3-6 month intervals. ▪ Because dental caries can occur in children as young as 12 months of age, it is recommended that they begin receiving fluoride varnish applications at 12 months of age or when the first tooth erupts. ▪ By providing prevention education and fluoride varnish applications as part of the C&TC visit, providers can help reduce the risk of dental decay for young children. The application of fluoride varnish can be performed by primary care providers and other appropriately trained primary care clinic staff. 	<p>Those qualified to complete the physical exam component are physicians, physician assistants and nurse practitioners.</p> <p>Also, licensed school nurses, certified public health nurses and registered nurses who have completed the C&TC Screening Component Training currently provided by MDH and are providing the service in a public health clinic, community health clinic (as defined in Minnesota rules, Part 9505.0255), Head Start or school.</p>	<p>Document normal/abnormal findings of the physical exam.</p> <ul style="list-style-type: none"> ▪ Consider a box to check off normal/abnormal findings for each physical exam component and some space allowed for brief notes or a box to check for “see dictation”. ▪ Document refusal of any portion of the physical exam <p>■ For examples, please refer to the C&TC Documentation Forms. http://www.dhs.state.mn.us/id_028848</p> <p>■ Additional Information: C&TC Component FACT Sheets can be found at: FACT Sheets</p> <p>On-line training of how to apply fluoride varnish can be found at: http://meded1.ahc.umn.edu/fluoridevarnish/</p>

Component standards	Personnel qualified	Documentation suggestions
<p>Physical Exam continued:</p> <p>Note: primary care providers will be reimbursed for fluoride varnish application in addition to regular C&TC payment. Information on billing for fluoride varnish applications can be found in the Minnesota Health Care Programs Provider Manual, Chapter 9, Children’s Services:</p> <p>Note: The reason for the exception which allows school nurses, PHNs and RNs to perform C&TC exams in specified settings is to provide greater access to C&TC services in areas where providers are limited or non-existent or the child does not have a medical home. This exception does not include RNs in clinics where there are physicians, physician assistants and nurse practitioners able to offer these services.</p> <p>C&TC’s which occur in non-traditional settings should always promote a medical home and the family should be connected as soon as possible with a full service clinic.</p> <p>When a C&TC is performed elsewhere than the child’s medical home, the screening results information should be sent on to the child’s regular clinic. This will keep both the regular provider informed and help reduce duplication of services.</p>		

Component standards	Personnel qualified	Documentation suggestions
<p>Immunization Review and Administration:</p> <p>The immunization status of a child must be reviewed and compared to the current Recommended Childhood and Adolescent Immunization Schedule of the federal Advisory Committee on Immunization Practices (ACIP), which is provided by the Centers for Disease Control and Prevention (CDC) and which includes current recommendations for vaccine administration, schedules of periodicity, appropriate dosage and contraindications. The Minnesota Department of Health (MDH) Recommended Childhood Immunization Schedule, which is revised annually, may be used as it incorporates the ACIP schedule.</p> <p>If it is determined that one or more immunizations on the schedule are needed and are appropriate to be administered, they must be offered and given to the child upon request if accepted by the parent or child.</p> <p>C&TC providers must use vaccine available through the Minnesota Vaccine For Children Program (MNVFC)</p> <p>Providers are responsible for keeping a current copy of the MDH Recommended Childhood Immunization Schedule.</p>	<p>Physician</p> <p>Nurse Practitioner</p> <p>Physician Assistant</p> <p>Nurse</p> <p>Certified Medical Assistant</p>	<p>Document that immunizations were reviewed and which immunizations were given. If immunizations were due but not given, document reasons why. Also include plan for catch up.</p> <p>Consider boxes on the documentation form or template to check for:</p> <ul style="list-style-type: none"> ▪ “immunizations reviewed” ▪ “child current” or “up-to-date” and ▪ “Immunizations given” <p>It is not necessary to have a complete record of immunizations on the documentation form. If desired, the form could have boxes to check for the different immunizations given that day or all immunization information could be kept in a separate immunization file. The documentation form could reference where the immunization can be found in the chart.</p> <hr/> <p>■ For examples, please refer to the C&TC Documentation Forms. http://www.dhs.state.mn.us/id_028848</p> <hr/> <p>■ Additional Information: C&TC Component FACT Sheets can be found at: FACT Sheets</p> <p>For a current copy of the MDH Recommended Childhood Immunization Schedule, MNVFC Program information and other immunization-related information, call 651-201-5503 or toll free at: 1-800-657-3970 or visit the Website at: www.health.state.mn.us/immunize</p>

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<p>Vision:</p> <p>Children birth through two years must be subjectively monitored for vision concerns. Children must be screened for family history of early onset vision problems and ocular abnormalities, as well as maternal and neonatal infection. A child must be observed for proper eye alignment, pupillary reflex, the presence of nystagmus, and muscle balance, which includes an examination for esotropia, exotropia, phorias, and extraocular movements. The external parts of a child's eyes must be examined, including: the lids, conjunctiva, cornea, iris and pupils. Until visual acuity can be obtained, observe the child's eyes for ability to track, pupillary response to light, and retinal reflex symmetry. The child, parent or guardian must be asked if there are concerns about the child's vision. When indicated, the child must receive a referral for age-appropriate diagnostic vision tests.</p> <p>Children age three and older, in addition to the above, must be objectively screened for visual acuity using current standardized testing methods such as Lea, HOTV, Snellen or Sloan charts.</p> <p>When indicated, the child must receive a referral for age-appropriate diagnostic vision tests. At the 16 and 20 year checkups, acuity testing is not required, however, subjective screening should be done and if no acuity testing occurred at the previous checkup, consider performing visual acuity testing.</p>	<p>Physician</p> <p>Nurse Practitioner</p> <p>Physician Assistant</p> <p>Or R.N. with adequate training</p> <p>An adequately trained individual (i.e., trained Nursing Assistant, Certified Medical Assistant or Paraprofessional)</p>	<p>Document normal/abnormal vision findings.</p> <p>Document result of visual acuity for children 3 years and older. If visual acuity testing is not done document reason.</p> <hr/> <p>■ For examples, please refer to the C&TC Documentation Forms.</p> <p>http://www.dhs.state.mn.us/id_028848</p> <hr/> <p>■ Additional Information:</p> <p>C&TC Component FACT Sheets can be found at: FACT Sheets</p> <p>Refer to the MDH Vision Screening Web page for the new 2006 vision screening guidelines and related information at: http://www.health.state.mn.us/divs/fh/mch/hlth-vis/vision.html</p>

Component standards	Personnel qualified	Documentation suggestions
<p>Hearing:</p> <p>Subjective Methods Children of all age groups must be subjectively monitored for hearing concerns. The child, parent or guardian must be asked if there are concerns about the child’s hearing. Children must be screened for a family history of permanent childhood hearing disability or loss, child delay of language acquisition or history of hearing, speech, language and/or developmental delay, the ability to determine the direction of a sound, and a child history of other risk indicators for hearing loss, such as recurrent or persistent otitis media with effusion.</p> <p>When indicated by subjective methods, the child must receive age-appropriate objective hearing screening or a referral for objective screening.</p> <p>Objective Methods Puretone audiometric screening is the gold standard for children of all ages when developmentally appropriate.</p> <ul style="list-style-type: none"> ▪ Birth through two years: Newborn hearing screening is recommended for all newborns using Automated Auditory Brainstem Response (AABR) or Oto-Acoustic Emission (OAE) technology by one month of age, diagnosis of hearing loss by 3 months and enrollment into early intervention by 6 months. If an infant did not receive a newborn hearing screen in the hospital, it is recommended that the AABR or OAE be performed on an outpatient basis. If an infant or toddler exhibits risk factors or there is parental concern, the child should receive objective screening or be referred for objective screening. ▪ Three years: At the 3 year visit, it is recommended that puretone audiometric screening is performed. If the child is unable to complete testing, attempt to rescreen within 6 months. If the child is unable to complete testing and there are risk factors or parental concern identified in the subjective screening, refer the child to an audiologist. ▪ Children age four and older: In addition to the subjective screening, ages four and older must receive an objective puretone audiometric screening using current testing methods. At the 16 and 20 year checkups, objective screening is not required, however, if no objective screening occurred at the previous checkup, consider performing puretone audiometric screening. <p>When indicated by objective methods, the child must receive a referral to an audiologist for age-appropriate diagnostic hearing tests.</p>	<p>An adequately trained individual</p> <p>(i.e. Nursing Assistant, Certified Medical Assistant, Paraprofessional)</p>	<p>Document newborn hearing screening results when available.</p> <p>Document normal/abnormal hearing findings and risk factors present.</p> <p>For children 3 - 4 years and older, document result of pure tone audiometric testing. If puretone audiometry is not done, document reason.</p> <hr/> <p>■ For examples, please refer to the C&TC Documentation Forms. http://www.dhs.state.mn.us/id_028848</p> <hr/> <p>■ Additional Information: C&TC Component FACT Sheets can be found at: FACT Sheets Refer to the MDH Hearing Manual at: Hearing Screening Guidelines</p>

Component standards	Personnel qualified	Documentation suggestions										
<p>Laboratory tests:</p> <p>Laboratory tests must be completed in accordance with the C&TC Schedule of Age-Related Screening Standards and the following guidelines. (See Web site link under “Documentation Suggestions, far right.)</p> <p>Lead:</p> <p>Children enrolled in Medical Assistance and MinnesotaCare Programs are considered at risk for lead exposure.</p> <p>Routine Screen:</p> <p>Child health care providers must use a blood lead test to screen children at one and two years of age, and children up to six years of age who have not previously been screened. A child should be tested for lead whenever the history indicates that there are risk factors for lead poisoning.</p> <p>Either capillary or venous blood may be used as the specimen for the direct blood lead test. When the result of the capillary blood lead test is greater than or equal to 10 micrograms lead per deciliter of blood (10 ug/dL) the child must be referred for a venous blood lead test. A child with a venous blood lead level greater than or equal to 10 ug/dL must be referred for diagnosis and treatment.</p> <p>Follow-up Care:</p> <table border="1" data-bbox="121 865 1073 1133"> <thead> <tr> <th data-bbox="121 865 594 951">If result of capillary screening test (µg/dL) is:</th> <th data-bbox="594 865 1073 951">Perform diagnostic test on venous blood within:</th> </tr> </thead> <tbody> <tr> <td data-bbox="121 951 594 995">10 – 14.9</td> <td data-bbox="594 951 1073 995">3 months</td> </tr> <tr> <td data-bbox="121 995 594 1039">15 – 44.9</td> <td data-bbox="594 995 1073 1039">1 week</td> </tr> <tr> <td data-bbox="121 1039 594 1083">45 – 59.9</td> <td data-bbox="594 1039 1073 1083">48 hours</td> </tr> <tr> <td data-bbox="121 1083 594 1133">≥ 60</td> <td data-bbox="594 1083 1073 1133">Immediately (as an emergency lab test)</td> </tr> </tbody> </table> <p>Laboratories performing blood lead analysis are required to report all results to the Minnesota Department of Health.</p> <p>Periodic Evaluation:</p> <p>In order to monitor a change in the child’s status, administer the following questions annually to the parent or guardian of all children three to six years of age whose previous test results were less than 10 ug/dL. Screen the child with a blood lead test if the answer to any of the following questions is “Yes” or “Don’t Know” or if parent or guardian expresses concern.</p>	If result of capillary screening test (µg/dL) is:	Perform diagnostic test on venous blood within:	10 – 14.9	3 months	15 – 44.9	1 week	45 – 59.9	48 hours	≥ 60	Immediately (as an emergency lab test)	<p>Physician</p> <p>Nurse Practitioner</p> <p>Physician Assistant</p> <p>Nurse</p> <p>Certified Medical Assistant</p> <p>Lab Technician</p> <p>Nurse Midwife</p>	<p>Document lab tests ordered.</p> <p>It is not necessary to have a complete record of lab test results on documentation form. Lab test results may be found elsewhere in the chart. Form could indicate where this information can be found.</p> <p>Consider using checklist of most commonly ordered lab tests.</p> <hr/> <p>■ For examples, please refer to the C&TC Documentation Forms.</p> <p>http://www.dhs.state.mn.us/id_028848</p> <hr/> <p>■ Additional Information:</p> <p>C&TC Component FACT Sheets can be found at:</p> <p>FACT Sheets</p> <p>C&TC Periodicity Schedule (Schedule of Age-Related Screening Standards)</p> <p>MDH C&TC On-line Training Web page:</p> <p>http://health.state.mn.us/divs/fh/mch/Webcourse/lead/guidelines6.cfm</p>
If result of capillary screening test (µg/dL) is:	Perform diagnostic test on venous blood within:											
10 – 14.9	3 months											
15 – 44.9	1 week											
45 – 59.9	48 hours											
≥ 60	Immediately (as an emergency lab test)											

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<p>Laboratory tests continued:</p> <p>Since the child's last blood lead test:</p> <ul style="list-style-type: none"> ▪ Does the child have a playmate, housemate, or sibling who has recently been diagnosed with an elevated blood lead? ▪ Has the child moved to or started regularly visiting a home, childcare, or other building built before 1950? ▪ Has there been any repair, remodeling, or damage (such as water damage or chipped paint) to a home, childcare, or other building built before 1978 that the child lives in or regularly visits? <p>Urine:</p> <p>Test urine for the presence of abnormalities such as glucose, ketones, protein, leukocytes in sexually active male and female adolescents, and other abnormalities. A baseline screening between 3-5 years is optional. One dipstick screening or equivalent is required between the ages of 12-20 years of age.</p> <p>Microhematocrit or hemoglobin:</p> <p>Use either a microhematocrit determination or a hemoglobin concentration test for anemia.</p> <p>Newborn Screening:</p> <p>All newborn infants are required to be tested for heritable and congenital disorders such as fatty acid oxidation, organic acid and endocrine disorders; hemoglobinopathies; and others according to Minnesota Statutes 144.125 and rules prescribed by the commissioner of health. If the tests identify heritable and congenital disorders, the child must be referred for genetic counseling.</p> <p>Tuberculosis:</p> <p>A medically appropriate Tuberculosis test must be administered yearly to a child whose health history indicates ongoing exposure to tuberculosis unless the child has previously tested positive. A child who tests positive must be referred for diagnosis and treatment.</p> <p>Other laboratory tests: Other laboratory tests such as those for cervical cancer, sexually transmitted infections, cholesterol screening, pregnancy, and parasites must be performed when indicated by a child's medical or family history.</p>		<ul style="list-style-type: none"> ▪ For more information about lead risks, exposure, and testing please visit the MDH lead Web page: www.health.state.mn.us/divs/eh/lead ▪ For more detailed information, see the MDH Newborn Screening Web site: www.health.state.mn.us/newbornscreening

Component standards	Personnel qualified	Documentation suggestions
<p>Dental Checkup:</p> <p>Verbally refer the child for preventive dental health care beginning at age three, or earlier if indicated, for preventive dental checkups.</p> <p>Children need regular preventive dental/oral health care, sometimes beginning as early as 1 year of age. The oral examination performed as part of the physical exam and the health history information gathered from the parent or guardian during the screening will help determine whether a child needs an early dental referral.</p> <p>It is important for C&TC providers to talk to the child, parent or guardian about good dental health and getting regular preventive dental health care.</p> <ul style="list-style-type: none"> ▪ Because dental caries (tooth decay) is the most prevalent, chronic disease in the US, it is recommended that infants and young children receiving C&TC screenings receive fluoride varnish applications at 3-6 month intervals. ▪ Because dental caries can occur in children as young as 12 months of age, it is recommended that they begin receiving fluoride varnish applications at 12 months of age or when the first tooth erupts. ▪ By providing prevention education and fluoride varnish applications as part of the C&TC visit, providers can help reduce the risk of dental decay for young children. The application of fluoride varnish can be performed by primary care providers and other appropriately trained primary care clinic staff. ▪ Note: primary care providers will be reimbursed for fluoride varnish application in addition to regular C&TC payment. Information on billing for fluoride varnish applications can be found in the Minnesota Health Care Programs Provider Manual, Chapter 9, Children’s Services. <p>A verbal referral for regular preventive dental care should be given at each subsequent C&TC visit.</p>	<p>Anyone with adequate training</p>	<p>Document verbal dental referrals for preventive care.</p> <p>Include a box to check that a dental referral was made at age 3 or earlier if appropriate and thereafter at each C&TC visit.</p> <hr/> <p>■ For examples, please refer to the C&TC Documentation Forms. http://www.dhs.state.mn.us/id_028848</p> <hr/> <p>■ Additional Information: C&TC Component FACT Sheets can be found at: FACT Sheets</p>

Referrals	Suggestions for documentation
<p>When problems are identified and referrals for additional follow-up, evaluation, diagnosis and/or treatment are made to other providers/clinics, agencies or back to self, documentation is required.</p>	<p>Document any referrals made. Designate area on form to document referrals.</p>
<p>Whenever a child needs to be seen again by the screening provider or another provider for any follow-up as a result of a C&TC screening, it is considered a “C&TC referral” and the appropriate C&TC referral code must be used when billing. Please refer to the Billing section of the C&TC Provider Guide for information on the C&TC referral codes (link to far right).</p>	<p>■ For examples, please refer to the C&TC Documentation Forms. http://www.dhs.state.mn.us/id_028848</p> <p>■ Additional Information: C&TC Provider Guide can be found at: http://edocs.dhs.state.mn.us/lfservers/legacy/DHS-4212-ENG</p>

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