**Pediatric Preventive Screening**

| Policy Number: AHS – G2042 – Pediatric Preventive Screening | Effective Date: 11/01/2026 |
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POLICY DESCRIPTION | INDICATIONS AND/OR LIMITATIONS OF COVERAGE | TABLE OF TERMINOLOGY | SCIENTIFIC BACKGROUND | GUIDELINES AND RECOMMENDATIONS | APPLICABLE STATE AND FEDERAL REGULATIONS | APPLICABLE CPT/HCPCS PROCEDURE CODES | EVIDENCE-BASED SCIENTIFIC REFERENCES | REVISION HISTORY

## I. Policy Description

Preventive screening is a healthcare service with the goal of illness prevention and health management. According to the American College of Preventive Medicine,[1] "preventive medicine focuses on the health of individuals, communities, and defined populations. Its goal is to protect, promote, and maintain health and well-being and to prevent disease, disability, and death."[1]

Pediatric preventive screening guidelines provide evidence-driven guidance for preventive care screenings and well-child visits. Bright Futures is a "national health promotion and prevention initiative, led by the American Academy of Pediatrics and supported, in part, by the US Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB)."[2]

This policy refers to laboratory-based preventive screening tests performed on individuals newborn through age 18 years, except for newborn screening for genetic disorders. The World Health Organization (WHO) defines an adolescent as any person between the age of 10 and 19.[3]

For guidance on screening for diabetes in the pediatric population, please refer to policy AHS-G2006-Diabetes Mellitus Testing. For guidance on testing for thyroid disease in the pediatric population, please refer to AHS-G2045-Thyroid Disease Testing. For guidance on screening for sexually transmitted infections in the pediatric population, please refer to AHS-G2157-Diagnostic Testing of Common Sexually Transmitted Infections. For guidance on screening for human immunodeficiency virus in the pediatric population, please refer to policy AHS-M2116-Human Immunodeficiency Virus (HIV).

Terms such as male and female are used when necessary to refer to sex assigned at birth.

## II. Indications and/or Limitations of Coverage

Application of coverage criteria is dependent upon an individual's benefit coverage at the time of the request.

1) When it follows all applicable federal and state law recommendations, a newborn screening panel **MEETS COVERAGE CRITERIA**.

2) For all newborns, screening for hyperbilirubinemia **MEETS COVERAGE CRITERIA**.

3) For all newborns, screening for congenital hypothyroidism utilizing serum thyroxine (T4) and/or thyroid-stimulating hormone (TSH) **MEETS COVERAGE CRITERIA**.

4) For all newborns, screening for sickle cell disease **MEETS COVERAGE CRITERIA**.

5) For individuals who have an increased risk for lead exposure (see Note 1), blood lead screening **MEETS COVERAGE CRITERIA** at the following frequencies:
   a) One test per month at six, nine, and twelve months.
   b) One test per year from two years of age to six years of age.

6) Screening for anemia with hemoglobin or hematocrit determination **MEETS COVERAGE CRITERIA** for any of the following situations:
   a) For all individuals who are 12 months of age.
   b) For individuals 4 months and older who are at risk for iron deficiency (see Note 2).

7) For individuals 1 month of age or older who are at increased risk of contracting tuberculosis (see Note 3), tuberculosis screening **MEETS COVERAGE CRITERIA**.

8) Screening for dyslipidemia using a fasting lipid profile or a non-fasting non-HDL-C **MEETS COVERAGE CRITERIA** in any of the following situations:
   a) Annually for children and adolescents who are at increased risk due to personal history or family history (see Note 4).
   b) Once for all children and adolescents during each of the following age periods:
      i) For individuals 9 – 11 years of age.
      ii) For individuals 17 years of age.

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**NOTES:**

**Note 1**: Lead exposure risk factors for children as defined by the CDC: living or spending time in a house or building built before 1978; growing up in a low-income household; being a recent immigrant, refugee or recently adopted from less developed countries; living or spending time with a person who works with lead or has hobbies that expose them to lead.[4]

**Note 2:** Iron deficiency risk factors for children as defined by the AAP: history of prematurity or low birth weight; exposure to lead; exclusive breastfeeding beyond 4 months of age without supplemental iron; weaning to whole milk or complementary foods that do not include iron-fortified cereals or foods naturally rich in iron, feeding problems, poor growth, and inadequate nutrition.[5]

**Note 3:** TB risk factors for children as defined by the AAP: close contact with a person with or suspected to have infectious tuberculosis; radiographic or clinical findings suggestive of TB; HIV infection or considered at risk for HIV infection; being of foreign birth (especially if born in Asia, Africa or Latin America, countries of the former Soviet Union) or is a refugee, or immigrant; contact with HIV infected, homeless, nursing home residents, institutionalized or incarcerated individuals, illicit drug users or migrant farm workers; having a depressed immune system; living or has lived in a "high risk for tuberculosis" area; participating in significant travel to countries with endemic infections.[6,7]

**Note 4**: Dyslipidemia risk factors for children as defined by the AAP: pediatric patient family history includes family members with CVD or dyslipidemia that are ≤55 years of age for men and ≤65 years of age

for women; pediatric patients who have an unknown family history or other CVD risk factors such as being overweight (BMI ≥ 85th percentile, <95th percentile), obesity (BMI ≥ 95th percentile), hypertension (blood pressure ≥ 95th percentile), cigarette smoking, or diabetes mellitus.[8]

## III. Table of Terminology

| Term | Definition |
|---|---|
| AACE | American Association of Clinical Endocrinologists |
| ACE | American College of Endocrinology |
| AAFP | American Academy of Family Physicians |
| AAP | American Academy of Pediatrics |
| ACA | Affordable Care Act |
| ACPM | American College of Preventive Medicine |
| ADA | American Diabetes Association |
| ASH | American Society of Hematology |
| CDC | Centers for Disease Control and Prevention |
| CKD | Chronic kidney disease |
| CLIA '88 | Clinical Laboratory Improvement Amendments of 1988 |
| CMS | Centers for Medicare and Medicaid |
| FDA | Food and Drug Administration |
| G6PD | Glucose 6-phosphate dehydrogenase deficiency |
| HBV | Hepatitis B virus |
| HHS | Health and Human Services |
| HIV | Human immunodeficiency virus |
| HRSA | Health Resources and Services Administration |
| IBD | Inflammatory bowel disease |
| KDIGO | Kidney Disease Improving Global Outcomes |
| LDTs | Laboratory-developed tests |
| LP(a) | Lipoprotein a |
| MCHB | Maternal and Child Health Bureau |
| NASPGHAN | North American Society for Pediatric Gastroenterology, Hepatology & Nutrition NASPGHAN |
| NLA | National Lipid Association |
| NSMBB | Newborn screening and molecular biology branch |
| NSQAP | Newborn screening quality assurance program |
| RUSP | Recommended Uniform Screening Panel |
| TSH | Thyroid stimulating hormone |
| USPSTF | United States Preventive Services Task Force |
| WHO | World Health Organization |

## IV. Scientific Background

The annual "wellness visit" or checkup visit to a primary care provider has been a common component of routine health care for several decades. Providers typically review an individual's personal history and

family history, perform a physical examination, and run a battery of tests during the annual checkup. The types and number of tests performed can vary widely among providers.

Screening (checking for disease when there are no symptoms) can improve the likelihood of early detection and therefore also prognosis.[9] The characteristics of a disease or condition, such as significant effects of an untreated disease, high prevalence in healthy populations, and utility of preclinical detection, can make a condition a good candidate for screening. Newborns and adolescents are more susceptible to certain conditions than adults and, consequently, are recommended for different screenings. For example, infants are typically screened for hyperbilirubinemia, although this condition is not seen as frequently in older children or adults. Schools will often be responsible for the screening of certain conditions, including scoliosis.[10]

Newborn screening is provided to healthy populations to identify newborns that require further testing. Each state handles newborn screening according to predetermined mandates. The United States Secretary of Health and Human Services has established the Recommended Uniform Screening Panel (RUSP) which provides a list of conditions that should be screened, including cystic fibrosis and phenylketonuria. A blood sample is typically taken from the heel of the newborn around the time of hospital discharge.[11] Most of these conditions are identified with tandem mass spectrometry or high pressure liquid chromatography, which are both well-validated.[12]

Screening in children and adolescents is also critical. Some of these screenings may not have apparent benefits for many years or even until adulthood, and the American Academy of Pediatrics (AAP) emphasizes that these preventive screenings have an additive effect.[13] Conditions, such as lead poisoning or significant dyslipidemia, may cause irreversible damage during child development, and as such it is crucial to screen for these conditions. Due to the enormous variation in children and families, the AAP provides many recommendations in the form of a periodicity schedule; this schedule is meant for children "who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in a satisfactory fashion." The AAP notes that developmental, psychosocial, or chronic issues may require additional counseling or treatment visits alongside the preventive care visits.[13]

The Bright Futures initiative was started in 1990 by the Maternal and Child Health Bureau to improve the health of children and prevent disease. The AAP partnered with Bright Futures, and these organizations have now issued joint guidelines and recommendations related to the screening of children and adolescents for common preventable and treatable disorders. The recommendations are age-related and aligned with the standard timing of medical visits for children.[2]

***Clinical Utility and Validity***

The AAP has noted a lack of strong evidence to support pediatric preventive screening for numerous conditions. However, the AAP has emphasized that "lack of evidence does not mean a lack of effectiveness" and has ensured that their recommendations have adequately assessed the benefit of screening against potential harm.[13]

The Centers for Disease Control and Prevention (CDC) estimates that millions of newborn screenings happen every year in the United States.[14] The CDC performed a study assessing the number of conditions diagnosed because of screening newborns and identified approximately 12,500 diagnoses found due to the newborn screening programs, equaling approximately one out of 4000 live births. Severe disorders are identified in approximately 5,000 newborns each year.[15] At the time of the study, the core screening

panels consisted of 29 core conditions. The five most commonly diagnosed conditions were (in order): hearing loss, primary congenital hypothyroidism, cystic fibrosis, sickle cell disease, and medium-chain acyl-CoA dehydrogenase deficiency. The CDC estimated congenital hearing loss to occur in one to three live births out of 1000. Finally, the CDC estimated the cost of the newborn screening program to be about $30 per infant, or $120 million.[15] The CDC has also developed a newborn screening and molecular biology branch (NSMBB) and a newborn screening quality assurance program (NSQAP) that assists in the development of analytical methods to measure substances in dried blood spots. Certified materials for newborn screening tests are also produced by this branch.[16]

## V. Guidelines and Recommendations

**The American Academy of Pediatrics (AAP) and Bright Futures Recommendations for Preventive Pediatric Health Care**

The American Academy of Pediatrics (AAP) (through Bright Futures) recommendations include the following screenings. The Bright Futures/AAP Periodicity Schedule describes the screenings, assessments, physical examinations, procedures, and timing of anticipatory guidance recommended for each age-related visit. Below are the laboratory-related screening recommendations:

- Newborn blood and bilirubin
- Anemia risk assessment at four months, test at 12 months, and further risk assessments at each subsequent visit with appropriate action to follow, if positive.
- Lead screening at six, nine, 12, 18, and 24 months and then once annually from three to six years, if indicated
- Tuberculosis screening at one, six, 12, and 24 months, and then annually thereafter starting at three years old, if indicated
- Dyslipidemia screening at 24 months and then every two years starting at four years old; AAP also recommends screening at least once between ages nine and 11 and between 17 and 21. Annual risk assessments starting at age 12 up to age 16 are recommended, with appropriate action to follow, if positive.
- STI/HIV screening annually starting at 11 years old, with at least one HIV screening between 15 and 2.[17]

Many of these recommendations were based on the USPSTF's recommendations.[13]

For lead poisoning detection, AAP recommend "to do a risk assessment**,** and do a blood lead level test only if the risk assessment comes back positive." The AAP notes that "universal screens or blood lead level tests are not recommended anymore except for high prevalence areas with increased risk factors."[18]

The AAP has also released a policy statement on targeted testing for lead. The AAP recommends targeted testing for lead in immigrant, refugee, or internationally adopted children at time of arrival.[19] This policy statement was reaffirmed in 2021.

The Advisory Committee on Heritable Disorders in Newborns and Children recommendations are included in the Bright Futures' periodicity table. The committee recommends that every newborn screening program include a Recommended Uniform Screening Panel (RUSP) that screens for 36 core disorders and 26 secondary disorders.[20] Required screenings vary by state.

The core disorders are as follows: Propionic Acidemia, Methylmalonic Acidemia, (methylmalonyl-CoA mutase) Methylmalonic Acidemia, (Cobalamin disorders) Isovaleric Acidemia, 3-Methylcrotonyl-CoA Carboxylase Deficiency, 3-Hydroxy-3-Methyglutaric Aciduria, Holocarboxylase Synthase Deficiency, ß-Ketothiolase Deficiency, Glutaric Acidemia Type I, Carnitine Uptake Defect/Carnitine Transport Defect, Medium-chain acyl-CoA dehydrogenase deficiency, Very Long-chain acyl-CoA dehydrogenase deficiency, Long-chain L-3 Hydroxyacyl-CoA Dehydrogenase Deficiency, Trifunctional Protein Deficiency, Argininosuccinic Aciduria, Citrullinemia, Type I, Maple Syrup Urine Disease, Homocystinuria, Classic Phenylketonuria, Tyrosinemia Type I, Primary Congenital Hypothyroidism, Congenital adrenal hyperplasia, S,S Disease (Sickle Cell Anemia), S, βeta-Thalassemia, S,C Disease, Biotinidase Deficiency, Critical Congenital Heart Disease, Cystic Fibrosis, Classic Galactosemia Glycogen Storage Disease Type II (Pompe), Hearing Loss, Severe Combined Immunodeficiencies, Mucopolysaccharidosis Type 1, X-linked adrenoleukodystrophy, Spinal Muscular Atrophy due to homozygous deletion of exon 7 in *SMN*1.[20]

The secondary disorders are as follows: Methylmalonic acidemia with homocystinuria, Malonic acidemia, Isobutyrylglycinuria, 2-Methylbutyrylglycinuria, 3-Methylglutaconic aciduria, 2-Methyl-3-hydroxybutyric aciduria, Short-chain acyl-CoA dehydrogenase deficiency, Medium/short-chain L-3-hydroxyacylCoA dehydrogenase deficiency, Glutaric acidemia type II, Medium-chain ketoacyl-CoA thiolase deficiency, 2,4 Dienoyl-CoA reductase deficiency, Carnitine palmitoyltransferase type I deficiency, Carnitine palmitoyltransferase type II deficiency, Carnitine acylcarnitine translocase deficiency, Argininemia, Citrullinemia type II, Hypermethioninemia, Benign hyperphenylalaninemia, Biopterin defect in cofactor biosynthesis, Biopterin defect in cofactor regeneration, Tyrosinemia, type II, Tyrosinemia, type III, Various other hemoglobinopathies, Galactoepimerase deficiency, Galactokinase deficiency, T-cell related lymphocyte deficiencies.[20]

There is also another category set forth by the RUSP—conditions for which newborn screening is not indicated. These include conditions that do not have adequate testing or did not meet other criteria in the RUSP's review. These conditions are as follows: Krabbe disease, Pompe disease, Lysosomal storage diseases, Creatine transport defect, Fabry disease, X-linked adrenoleukodystrophy, Hurler-Scheie disease, Biliary atresia, Smith-Lemli-Opitz syndrome, Congenital disorder of glycosylation type Ib, Fragile X syndrome, Duchenne and Becker muscular dystrophy, Congenital Cytomegalovirus infection, α1-Antitrypsin deficiency, Carbamylphosphate synthetase deficiency, Adenosine deaminase deficiency, Turner syndrome, Arginine: glycine amidinotransferase deficiency, Neuroblastoma, Diabetes mellitus, insulin dependent, Wilson disease, Guanidinoacetate methyltransferase deficiency, Ornithine transcarbamylase deficiency, Carnitine palmitoyltransferase IB deficiency (muscle), Familial hypercholesterolemia (heterozygote), Congenital Toxoplasmosis, Severe combined immunodeficiency, Neonatal hyperbilirubinemia (Kernicterus), Glucose 6-phosphate dehydrogenase deficiency (G6PD).[21]

"Secondary" disorders refer to a class of conditions that are "part of the differential diagnosis of a core panel condition." The core disorders refer to conditions appropriate for newborn screening; they all "have specific and sensitive screening tests, a sufficiently well understood natural history, and available and efficacious treatments." Although states ultimately decide which conditions to screen for in their newborn screening programs, this list from the Department of Health and Human Services provides some standardization to those programs.[21]

Additionally, The AAP provides guidance on monitoring hemoglobin in children for management purposes. The AAP states: "If a child has mild anemia (Hb level of 10–11 mg/d) and can be closely monitored, an alternative method of diagnosis would be to document a 1 g/dL increase in plasma Hb concentration after 1 month of appropriate iron-replacement therapy, especially if the history indicates

that the diet is likely to be iron deficient. This statement highlights that hemoglobin measurement should be used to monitor response to therapy and guide management decisions, rather than as a screening tool."[5]

**American Association of Clinical Endocrinologists (AACE) and American College of Endocrinology (ACE)**

The 2017 AACE and ACE guidelines for Management of Dyslipidemia and Prevention of Cardiovascular Disease Recommend the following for children:

- "In children at risk for FH (e.g., family history of premature cardiovascular disease or elevated cholesterol), screening should be at three years of age, between nine and 11, and at age 18."[22]
- "Screen adolescents older than 16 years every five years or more frequently if they have ASCVD risk factors, have overweight or obesity, have other elements of the insulin resistance syndrome, or have a family history of premature ASCVD."[22]

**American Diabetes Association (ADA)**

The ADA standards of Medical Care in Diabetes document state the following recommendations for children and adolescents' dyslipidemia testing:

- "Initial lipid profile should be performed soon after diagnosis, preferably after glycemia has improved and age is ≥2 years. If initial LDL cholesterol is ≤100 mg/dL (2.6 mmol/L), subsequent testing should be performed at 9-11 years of age. Initial testing may be done with a nonfasting non-HDL cholesterol level with confirmatory testing with a fasting lipid panel."[23]
- "If LDL cholesterol values are within the accepted risk level (<100 mg/dL [2.6 mmol/L]), a lipid profile repeated every three years is reasonable."[23]

**United States Preventive Services Task Force (USPSTF)**

The USPSTF recommends screening for Hepatitis B virus (HBV) in adolescents and adults who are at an increased risk for infection (Grade B).[24] The USPSTF recommends screening for hepatitis C virus (HCV) infection in adults aged 18 to 79 years (Grade B).[25]

In children and adolescents 20 years or younger, the USPSTF concludes that "the current evidence is insufficient to assess the balance of benefits and harms of screening for lipid disorders in children and adolescents 20 years or younger."[26]

The USPSTF recommends screening for syphilis in adolescents who have ever been sexually active and are at increased risk for syphilis infection. The USPSTF continues to recommend screening for syphilis in nonpregnant persons who are at increased risk for infection.[27]

The USPSTF recommends screening for chlamydia and gonorrhea in all sexually active women ages 24 and under (Grade B).[28]

The USPSTF has stated that there is insufficient evidence to assess the balance of benefits and harms of screening for elevated blood lead levels in asymptomatic children ages 1-5 years.[29]

The USPSTF recommends screening adolescents 15 and older for HIV infection. Adolescents under 15 but who are at increased risk should also be screened (Grade A).[30,31]

The USPSTF has deemed the current evidence insufficient for children ages 6-24 months to be screened for iron deficiency anemia.[32]

The USPSTF recognized the importance of screening for hemoglobinopathies in newborns including sickle cell disease, but will not update this 2007 recommendation.[33]

The USPSTF recognized the importance of screening for congenital hypothyroidism in newborns in 2008, but will not update this recommendation.[34]

The USPSTF recognized the importance of screening for phenylketonuria in newborns, but will not update this 2008 recommendation.[35]

The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for primary hypertension in asymptomatic children and adolescents to prevent subsequent cardiovascular disease. A 2020 recommendation statement by the USPSTF confirmed that the current evidence is insufficient to assess the balance of benefits and harms of screening for high blood pressure in children and adolescents (in general).[36]

**Centers for Disease Control and Prevention**

The CDC acknowledges the Bright Futures and USPSTF recommendations for pediatric preventive screening, including HIV screening.[37] On May 14, 2021, the CDC updated its blood lead reference value (BLRV) from 5 µg/dL to 3.5 µg/dL in response to a recommendation from the Lead Exposure and Prevention Advisory Committee (LEPAC). The BLRV is a metric used to identify children with blood lead levels that are higher than most (97.5th percentile) other children's levels.[38]

The CCD recommends that "all children who are at risk for lead exposure should be tested for lead poisoning" and "blood lead test is the best way to find out if a child has lead poisoning." They note that "Children enrolled in Medicaid are required to get tested for lead at ages 12 and 24 months. They are also required to get tested if they are ages 24–72 months and have no record of ever being tested. For children not enrolled in Medicaid, CDC recommends focusing testing efforts on high-risk neighborhoods and children." Children that are more likely to be exposed to lead include those who: "Live or spend time in a house or building built before 1978. Are from low-income households. Are immigrants, refugees, or recently adopted from less developed countries. Live or spend time with someone who works with lead. Live or spend time with someone has hobbies that expose them to lead."[4]

The CDC recommends healthcare providers use the "Catch-up Immunization schedule" to immunize children who are more than one month behind in immunizations.[39]

**The American Academy of Family Physicians (AAFP)**

The AAFP guidelines recommend various preventive services for children.

For newborns, the AAFP recommends congenital hypothyroidism screening, hearing loss screening, phenylketonuria screening, and sickle cell disease screening. This is closely aligned with USPSTF guidelines.[40]

For sexually active adolescent females, the AAFP recommends gonorrhea and chlamydia infection screening.[40] The AAFP supports the USPSTF recommendation for syphilis screening as listed above.[41]

For children and adolescents at high risk of infection, the AAFP recommends HIV and Hepatitis B screening.[40]

To address and help rectify low-value care practices, Schefft et al. (2019) published on the inception of a series of "do and don't" recommendations in the delivery of healthcare for children and adolescents.[42] These recommendations include a suggestion for laboratory-based screening:

- "Don't routinely screen for hyperlipidemia in children and adolescents."

Turner (2018) confirms that the AAFP "generally adheres to USPSTF recommendations" and references several recommendations about screening from the USPSTF and AAP as listed below. The recommendations included below are only those that are within the scope of this medical policy (laboratory-based preventive screening tests):

Screening Recommendations for Children from Birth to six Years of Age:

- Dyslipidemia screening by a fasting lipid panel received a grade of "insufficient evidence" by the USPSTF. The AAP recommends "risk-based screening at 2, 4, and 6 years of age (SOR C)."
- Iron deficiency screening by complete blood count received a grade of "insufficient evidence" by the USPSTF. The AAP recommends "screen at 12 months; consider supplements for preterm or exclusively breastfed newborns (SOR C)."
- Lead poisoning screening by measuring lead levels. The USPSTF states that there is "insufficient evidence to recommend screening in children 1 to 5 years of age without increased risk (Grade I)." The AAP recommends "screen[ing] high-risk individuals 6 months to 6 years of age (SOR C)."[43]

**National Lipid Association (NLA)**

The guidelines list recommendations for "youth" (<20 years old), stating that "Measurement of Lp(a) may be reasonable with:

- Clinically suspected or genetically confirmed FH.
- Individuals with a family history of first-degree relatives with premature ASCVD (<55 y of age in men, 65 y of age in women)
- An unknown cause of ischemic stroke
- A parent or sibling found to have an elevated Lp(a)."[44]

## VI. Applicable State and Federal Regulations

**Food and Drug Administration (FDA)**

The FDA has approved multiple tests for pediatric preventive screening.

Many labs have developed specific tests that they must validate and perform in house. These laboratory-developed tests (LDTs) are regulated by the Centers for Medicare and Medicaid (CMS) as high-complexity tests under the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88). LDTs are not approved or cleared by the U. S. Food and Drug Administration; however, FDA clearance or approval is not currently required for clinical use.

Although the HHS has created the RUSP to provide some standardization for each state's newborn screening programs, the HHS emphasizes that the conditions screened in each program are ultimately decided by the states.

**Public Health Service Act (PHS Act)**

As per the U.S. Department of Health and Human Services, Section 2713 of the PHS Act "generally requires group health plans and group and individual health insurance issuers that are not grandfathered health plans to provide coverage for recommended preventive services without cost sharing. A complete list of the current recommended preventive services is available at www.healthcare.gov/center/regulations/prevention.html."[45]

**National Association of State Boards of Education (NASBE)**

The NASBE provides information about state mandates for school health screening.[46]

Please note that individual states may provide specific guidelines and recommendations for pediatric preventive screening.

## VII. Applicable CPT/HCPCS Procedure Codes

Procedure codes appearing in medical policy documents are only included as a general reference. This list may not be all inclusive and is subject to updates. In addition, codes listed are not a guarantee of payment.

| CPT | Code Description |
|---|---|
| 80061 | Lipid panel This panel must include the following: Cholesterol, serum, total (82465) Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718) Triglycerides (84478) |
| 82247 | Bilirubin; total |
| 82248 | Bilirubin; direct |
| 82465 | Cholesterol, serum or whole blood, total |
| 83020 | Hemoglobin fractionation and quantitation; electrophoresis (eg, A2, S, C, and/or F) |
| 83021 | Hemoglobin fractionation and quantitation; chromatography (eg, A2, S, C, and/or F) |
| 83655 | Lead |
| 83718 | Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol) |
| 84439 | Thyroxine; free |
| 84443 | Thyroid stimulating hormone (TSH) |
| 84478 | Triglycerides |
| 85014 | Blood count; hematocrit (Hct) |
| 85018 | Blood count; hemoglobin (Hgb) |
| 86480 | Tuberculosis test, cell mediated immunity antigen response measurement; gamma interferon |
| 86481 | Tuberculosis test, cell mediated immunity antigen response measurement; enumeration of gamma interferon-producing T-cells in cell suspension |
| 86580 | Skin test; tuberculosis, intradermal |
| 88720 | Bilirubin, total, transcutaneous |

| | |
|---|---|
| S3620 | Newborn metabolic screening panel, includes test kit, postage and the laboratory tests specified by the state for inclusion in this panel (e.g., galactose; hemoglobin, electrophoresis; hydroxyprogesterone, 17-D; phenylanine (PKU); and thyroxine, total) |

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## VIII. Evidence-based Scientific References


1. ACPM. Preventive Medicine. https://www.theabpm.org/about-us/
2. AAP. Bright Futures. https://brightfutures.aap.org/Pages/default.aspx
3. WHO. Adolescent health. https://www.who.int/topics/adolescent_health/en/
4. CDC. Testing for Lead Poisoning in Children. Updated March 13, 2025. https://www.cdc.gov/lead-prevention/testing/
5. Baker RD, Greer FR, The Committee on N. Diagnosis and Prevention of Iron Deficiency and Iron-Deficiency Anemia in Infants and Young Children (0–3 Years of Age). *Pediatrics*. 2010;126(5):1040-1050. doi:10.1542/peds.2010-2576
6. Nolt D, Starke JR, Committee On Infectious D. Tuberculosis Infection in Children and Adolescents: Testing and Treatment. *Pediatrics*. 2021;148(6):e2021054663. doi:10.1542/peds.2021-054663
7. AAP. Risk Assessment Questionnaire. AAP Tennessee Chapter. 2022. https://tnaap.org/wp-content/uploads/2022/06/RiskAssessQuestions-Rev2leadtbchol.pdf
8. Daniels SR, Greer FR, and the Committee on N. Lipid Screening and Cardiovascular Health in Childhood. *Pediatrics*. 2008;122(1):198-208. doi:10.1542/peds.2008-1349
9. NCI. Screening. https://www.cancer.gov/publications/dictionaries/cancer-terms/def/screening
10. Kelly N. Screening tests in children and adolescents. Updated October 24, 2025. https://www.uptodate.com/contents/screening-tests-in-children-and-adolescents
11. Kemper A. Overview of newborn screening. Updated January 8, 2026. https://www.uptodate.com/contents/newborn-screening
12. HRSA. Newborn Screening: toward a Uniform Screening Panel and System. https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/heritable-disorders/newborn-uniform-screening-panel.pdf
13. AAP. Evidence and Rationale. https://downloads.aap.org/AAP/PDF/Bright%20Futures/BF4_Evidence_Rationale.pdf
14. CDC. About Newborn Screening Laboratories. Updated May 13, 2024. https://www.cdc.gov/newborn-screening/php/about/
15. CDC. CDC Grand Rounds: Newborn screening and improved outcomes. *MMWR Morbidity and mortality weekly report*. Jun 1 2012;61(21):390-3.
16. CDC. Newborn Screening Quality Assurance Program. Updated April 24, 2024. https://www.cdc.gov/laboratory-quality-assurance/php/newborn-screening/
17. AAP. Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule). https://www.aap.org/en/practice-management/care-delivery-approaches/periodicity-schedule/
18. AAP. Detection of Lead Poisoning. https://www.aap.org/en/patient-care/lead-exposure/detection-of-lead-poisoning/
19. AAP. Prevention of Childhood Lead Toxicity. *Pediatrics*. Jul 2016;138(1)doi:10.1542/peds.2016-1493
20. RUSP. Advisory Committee on Heritable Disorders in Newborns and Children. https://www.hrsa.gov/advisory-committees/heritable-disorders/index.html
21. HHS. Recommended Uniform Screening Panel. https://www.hrsa.gov/advisory-committees/heritable-disorders/rusp/index.html

22. Jellinger PS, Handelsman Y, Rosenblit PD, et al. American Association of Clinical Endocrinologists and American College of Endocrinology Guidelines for Management of Dyslipidemia and Prevention of Cardiovascular Disease. *Endocr Pract*. Apr 2017;23(Suppl 2):1-87. doi:10.4158/ep171764.Appgl
23. ADA. Children and Adolescents: Standards of Medical Care in Diabetes−2023. https://diabetesjournals.org/care/article/46/Supplement_1/S230/148046/14-Children-and-Adolescents-Standards-of-Care-in
24. USPSTF. Screening for Hepatitis B Virus Infection in Adolescents and Adults: US Preventive Services Task Force Recommendation Statement. *JAMA*. 2020;324(23):2415-2422. doi:10.1001/jama.2020.22980
25. USPSTF. Hepatitis C Virus Infection in Adolescents and Adults: Screening. Updated March 2, 2020. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-c-screening
26. USPSTF. Lipid Disorders in Children and Adolescents: Screening. *JAMA*. 2023;316(6):625-633. doi:10.1001/jama.2016.9852
27. USPSTF. Syphilis Infection in Nonpregnant Adolescents and Adults: Screening. Updated September 27, 2022. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/syphilis-infection-nonpregnant-adults-adolescents-screening
28. USPSTF. Chlamydia and Gonorrhea: Screening. Updated September 14, 2021. https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/chlamydia-and-gonorrhea-screening
29. Cantor AG, Hendrickson R, Blazina I, Griffin J, Grusing S, McDonagh MS. Screening for Elevated Blood Lead Levels in Childhood and Pregnancy: Updated Evidence Report and Systematic Review for the US Preventive Services Task Force. *Jama*. Apr 16 2019;321(15):1510-1526. doi:10.1001/jama.2019.1004
30. Chou R, Dana T, Grusing S, Bougatsos C. Screening for HIV Infection in Asymptomatic, Nonpregnant Adolescents and Adults: Updated Evidence Report and Systematic Review for the US Preventive Services Task Force. *Jama*. Jun 18 2019;321(23):2337-2348. doi:10.1001/jama.2019.2592
31. USPSTF. Screening for HIV Infection: US Preventive Services Task Force Recommendation Statement. *JAMA*. 2019;321(23):2326-2336. doi:10.1001/jama.2019.6587
32. Siu AL. Screening for Iron Deficiency Anemia in Young Children: USPSTF Recommendation Statement. *Pediatrics*. Oct 2015;136(4):746-52. doi:10.1542/peds.2015-2567
33. USPSTF. Sickle Cell Disease (Hemoglobinopathies) in Newborns: Screening. https://www.uspreventiveservicestaskforce.org/BrowseRec/ReferredTopic/260
34. USPSTF. Congenital Hypothyroidism: Screening. https://www.uspreventiveservicestaskforce.org/BrowseRec/ReferredTopic/230
35. USPSTF. Phenylketonuria in Newborns: Screening. https://www.uspreventiveservicestaskforce.org/BrowseRec/ReferredTopic/252
36. USPSTF. High Blood Pressure in Children and Adolescents: Screening. Updated November 10, 2020. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/blood-pressure-in-children-and-adolescents-hypertension-screening
37. CDC. Preventing HIV. Centers for Disease Control and Prevention. Updated September 26, 2024. https://www.cdc.gov/hiv/prevention/index.html
38. CDC. About the Data: Blood Lead Surveillance. Updated March 7, 2025. https://www.cdc.gov/lead-prevention/php/data/blood-lead-surveillance.html
39. CDC. Healthcare Professionals: Child and Adolescent Immunization Schedule by Age. Updated October 7, 2025. https://www.cdc.gov/vaccines/hcp/imz-schedules/child-adolescent-age.html
40. Lin KW. What to Do at Well-Child Visits: The AAFP's Perspective. *Am Fam Physician*. Mar 15 2015;91(6):362-4.

41. AAFP. Clinical Preventive Service Recommendation: Syphilis. https://www.aafp.org/family-physician/patient-care/clinical-recommendations/all-clinical-recommendations/syphilis.html
42. Schefft M, Schroeder AR, Liu D, Nicklas D, Moher J, Quinonez R. Right Care for Children: Top Five Do's and Don'ts. *Am Fam Physician*. Mar 15 2019;99(6):376-382.
43. Turner K. Well-Child Visits for Infants and Young Children. *Am Fam Physician*. Sep 15 2018;98(6):347-353.
44. Wilson DP, Jacobson TA, Jones PH, et al. Use of Lipoprotein(a) in clinical practice: A biomarker whose time has come. A scientific statement from the National Lipid Association. *J Clin Lipidol*. Sep-Oct 2022;16(5):e77-e95. doi:10.1016/j.jacl.2022.08.007
45. HHS. Affordable Care Act Implementation FAQs (Set 5). https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs5
46. NASBE. Health Policies By State. https://www.nasbe.org/nasbe-redesigns-database-of-state-policies-covering-200-topics-related-to-school-health/

## IX. Revision History

| Revision Date | Summary of Changes |
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| 01/01/2022 | Initial Effective Date |
| 07/19/2022 | Updated background, guidelines, and evidence-based scientific references.<br>Literature review did not necessitate any modification to coverage criteria.<br>The following changes were made for clarity:<br>CC5a: remove all “children”: Ages 12 months to 2 years and<br>CC5b: remove “children”: Ages 6 months to 6 years who are at increased risk for lead exposure, as defined by the AAP (poor, those who are recent immigrants, those in older, poorly maintained housing, those who had a sibling or playmate with an elevated blood lead concentration, those who have parents exposed to lead at work, or those who had lived in or visited a structure that might contain deteriorated, damaged, or recently remodeled lead-painted surfaces).<br>CC7: added “with an individual who”: Tuberculosis screening MEETS COVERAGE CRITERIA for children age 1 month and older who are at increased risk: born in a country other than the U.S., Canada, Australia, New Zealand, or Western Europe, traveled (had contact with resident populations) for longer than 1 week to a country with high risk for tuberculosis, has a family member or contact with an individual who had tuberculosis or a positive tuberculin skin test, or is infected with HIV.<br>Removed codes 86701 and 86702<br>Added code 0257U<br>Revised code disclaimer statement |
| 04/04/2023 | Updated the background, guidelines and recommendations, and evidence-based scientific references. Literature review did not necessitate any modifications to coverage criteria. The following edits were made for clarity:<br>All CC except CC10 were edited for clarity and consistency.<br>CC12 was removed as a CC and is now a note in the Policy Description to see AHS-G2006 for guidance on Hemoglobin A1c screening.<br>CC5.b., CC6.b., CC7, CC8.a., and CC9 all contained a list of high risk situations- these have all been moved into Notes, resulting in Notes 15. |

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| | Removed CPT codes 86592, 86593, 86631, 86632, 86780, 87110, 87270, 87320, 87490, 87491, 87590, 87591, 87810, 87850.<br>Committee approved: 04/04/2023 |
| 06/28/2023 | **Off-Cycle Review: Due to policy reorganization, coverage on screening for Hepatitis B screening (all ages) was moved to G2036-Hepatitis Testing, coverage on screening for chlamydia, gonorrhea, and/or syphilis infection (all ages) was moved to G2157-Diagnostic Testing of Common Sexually Transmitted Infections, and coverage on HIV screening (all ages) was moved to M2116-Human Immunodeficiency Virus.<br>CC8b.ii. previously read: "ii.) 17 – 21 years." Now reads: "ii) For individuals 17 years of age." Coverage of "dyslipidemia using a fasting lipid profile or a non-fasting non-HDLC" for individuals 18 years of age and older is addressed in G2050-Cardiovascular Disease Risk Assessment.<br>**CPT Updates Due to Medical Policy changes:<br>Removed: HIV codes – 86689, 86703, 87390, 87391, 87534, 87535, 87536, 87537, 87538, 87539, 87806, S3645 and Hep B codes – 86704, 86705, 86706, 87320, 87340, 87341, 87516, 87517 removed HIV coverage criteria with reference now to policy G2157 and Hep B coverage criteria with reference now to policy G2036<br>**CPT Updates Due to Coding Enhancement:<br>Removed: 85660 this test is for sickledex and similar solubility assays. Those are not reliable screens in newborns because of hemoglobin F<br>Added: 83020, 83021 these are the correct codes for sickle cell testing<br>Committee approved: 06/28/2023 |
| 09/08/2023 | Added CPT codes 86592, 86593, 86631, 86632, 86780, 87110, 87270, 87320, 87490, 87491, 87590, 87591, 87810, 87850.<br>Committee approved: 09/08/2023 |
| 05/14/2024 | Reviewed and Updated: Updated the background, guidelines and recommendations, and evidence-based scientific references. Literature review did not necessitate any modifications to coverage criteria.<br>Committee approved: 05/14/2024 |
| 05/21/2025 | Reviewed and Updated: Updated background, guidelines, and evidence-based scientific references. Literature review necessitated the following changes in coverage criteria:<br>CC5 edited to reflect that lead screening should be limited to children at an increased risk for lead exposure: "5) For individuals who have an increased risk for lead exposure (see Note 1), blood lead screening MEETS COVERAGE CRITERIA at the following frequencies:<br>a) One test per month at six, nine, and twelve months.<br>b) One test per year from two years of age to six years of age."<br>Added CPT code 86481<br>Removed CPT code 86850, 87555, 87556, 0257U<br>Committee approved: 05/21/2025 |
| 06/17/2026 | CAB Review Q2 2026: Reviewed and Updated: Updated the background, guidelines and recommendations, and evidence-based scientific references. Literature review did not necessitate any modifications to coverage criteria.<br>Committee Approved: 06/17/2026 |