430 - EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT SERVICES

EFFECTIVE DATES: 10/01/94, 03/01/19, 02/01/22, 10/01/22, 11/28/23, 10/01/24, 10/01/25, 10/01/26

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I. PURPOSE

This Policy applies to ACC, ACC-RBHA, ALTCS E/PD, DCS CHP (CHP), DES DDD (DDD) Contractors; Fee-For-Service (FFS) Programs including: the American Indian Health Program (AIHP), DES DDD Tribal Health Program (DDD THP), Tribal ALTCS, TRBHA, and all FFS populations, excluding Federal Emergency Services Program (FESP). (For FESP, refer to AMPM Chapter 1100). This Policy establishes requirements for the provision of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

II. DEFINITIONS

Refer to the ~~AHCCCS Contract and Policy Dictionary~~AHCCCS ACOM and AMPM Dictionary[1] for common terms found in this Policy.

For purposes of this Policy, the following terms are defined as:

EARLY	As soon as possible in the child's life, or as soon after the member's eligibility for AHCCCS services has been established.
SCREENING	Regularly scheduled examinations and evaluations of the general physical and behavioral health, growth, development, and nutritional status of infants, children, and adolescents, and the identification of those in need of more definitive evaluation. For the purpose of the AHCCCS Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program, screening and diagnosis are not synonymous.
WELL-CHILD VISIT	A regular or preventative health appointment with the child's doctor or pediatrician. It is used to track the child's growth and development and discuss milestones and concerns.

[1] Updated dictionary name and link.

III. POLICY

The purpose of EPSDT is to ensure the availability and accessibility of health care resources and assist the member/Health Care Decision Maker (HCDM), Designated Representative (DR) in effectively utilizing these resources. Through EPSDT, members receive appropriate preventive, dental, physical health, behavioral health, developmental, and specialty services at specified times and when health problems arise or are suspected so that health problems are averted or diagnosed and treated as early as possible.

The EPSDT program is comprised of screening, diagnostic, and treatment services and provides comprehensive health care through prevention, immunizations, early intervention, diagnosis, medically necessary treatment, and follow-up care of physical and behavioral health conditions. The EPSDT program includes services that correct or ameliorate physical and behavioral conditions and illnesses discovered by the screening process, when those services fall within one of the optional and mandatory ~~categories of "Medical Assistance", as defined in the Medicaid Act.~~ services listed in section 1905(a) of the Social Security Act, regardless whether the services are covered under the state plan[2] Refer to Attachment E (or Contractor/Provider electronic equivalent) for required information related to EPSDT screenings and visits.

Under EPSDT, federal law requires that Title XIX cover all Medicaid-covered services listed in 42 USC 1396d(a) for members under the age of 21 when medically necessary and cost effective and even when the services are not listed as covered services in the AHCCCS State Plan, AHCCCS statutes, rules, or policies. All physical and behavioral health services shall be covered as described within Medicaid covered services listed in 42 USC 1396d(a) if the treatment or service is necessary to "correct or ameliorate" defects or physical and behavioral illnesses or conditions. Although not explicitly covered as part of EPSDT, Long Term Services and Supports (LTSS) must also be considered when needs are identified. Access to LTSS supports the overall health and wellbeing of the EPSDT-eligible member in the least restrictive setting. Medical necessity is determined on a case-by-case basis.

These comprehensive services shall be made available for treatment of all physical and behavioral health conditions, LTSS needs, and illnesses discovered by screening and diagnostic procedures. As outlined in AMPM Exhibit 400-3, the member's health plan of enrollment shall inform EPSDT-eligible members that EPSDT services are available. The Contractor and ~~FFS~~ providers serving FFS members shall provide or arrange for the provision of screening services, to arrange (directly or through referral) for further evaluation and corrective treatment as determined by EPSDT health screenings without delay, and to report EPSDT performance information.

The EPSDT services include, but are not limited to, coverage of: well child visits, inpatient and outpatient hospital services, laboratory and x-ray services, physician services, naturopathic services, nurse practitioner services, medications, dental services, therapy services, behavioral health services, LTSS, medical equipment, medical appliances and medical supplies, orthotics, prosthetic devices, vision services, hearing services, eyeglasses, transportation, family planning services and supplies, women's preventive care services, and maternity services when applicable, as specified in AMPM Chapter 400. EPSDT also includes diagnostic, screening, preventive, and rehabilitative services.

[2] Replaced "Medicaid Act" with the social security act to reflect current terminology.

The EPSDT services do not include services that are experimental, that are solely for cosmetic purposes, or that are not cost effective when compared to other interventions or treatments.

The EPSDT screening services shall be provided in compliance with the periodicity requirements of 42 CFR 441.58. The AHCCCS EPSDT and Dental Periodicity Schedules (Attachment A and AMPM Policy 431, Attachment A) are intended to meet reasonable and prevailing standards of medical and dental practice and specify screening services at each stage of the member's life. The service intervals represent minimum requirements. Any services determined by a Primary Care Provider (PCP) to be medically necessary shall be provided, regardless of the interval. Attachment A is based on recommendations by the Arizona Medical Association and is closely aligned with the guidelines of the American Academy of Pediatrics (AAP).

The EPSDT services focuses on continuum of care by assessing health needs, providing preventive screening, initiating needed referrals, and completing recommended medical treatment and appropriate follow-up.

The EPSDT services include all screenings and services described in this Policy, as well as services specified in Attachment A, and AMPM Policy 431, Attachment A.

A. COVERED SERVICES DURING AN EPSDT VISIT

All applicable Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), and Uniform Billing (UB-04) revenue codes are listed in the AHCCCS Rates and Billing webpage found on the AHCCCS website.

The Providers are required to utilize national coding standards including the use of applicable modifier(s). Refer to the AHCCCS Medical Coding Resources webpage on the AHCCCS website.

The Well-Child visit includes the following:

1. A comprehensive health and developmental history, including growth and developmental screening 42 CFR 441.56(b)(1) which includes physical, nutritional, and behavioral health assessments. Refer to the Centers for Disease Control and Prevention (CDC) website: www.cdc.gov/growthcharts/ for Body Mass Index (BMI) and growth chart resources.

2. Nutritional screening is provided by a PCP.

3. A Nutritional assessment provided by a PCP:
   a. Nutritional assessments are conducted to assist EPSDT-eligible members whose health status may improve with nutritional intervention,
   b. The nutritional assessment is a separately billable service by PCPs who care for EPSDT age members,
   c. AHCCCS covers the assessment of nutritional status provided by the member's PCP as a part of the EPSDT screenings and on an inter-periodic basis, as determined necessary by the member's PCP,
   d. AHCCCS also covers nutritional assessments provided by a registered dietitian when ordered by the member's PCP. This includes EPSDT-eligible members who are underweight or overweight,

e. To initiate the referral for a nutritional assessment or counseling, the PCP shall use the Contractor's referral form in accordance with Contractor protocols. Referral forms are not required for FFS members, and
f. If a member qualifies for nutritional therapy due to a medical condition, the following is covered:
   i. The Contractor ~~or provider serving FFS members~~ [3]shall be responsible for procurement of, and the primary funding source for, medically necessary formula that is exempt from the Special Supplementary Nutrition Program for Women, Infants, and Children (WIC-exempt) ~~and~~
   ~~i.~~ii. The providers serving FFS members shall be responsible for the procurement of medically necessary formula that is exempt from the Special Supplementary Nutrition Program for Women, Infants, and Children (WIC-exempt) and AHCCCS FFS shall be considered the primary funding source, and
   ~~ii.~~iii. For infant formula that is not medically necessary or WIC-exempt, the member should be referred to WIC.

4. Behavioral health screening and services:
   a. The PCPs may provide behavioral health services to EPSDT-eligible members within their scope of practice as specified in AMPM Policy 510,
   b. The American Indian/Alaska Native (AI/AN) members may also receive behavioral health services through an Indian Health Service (IHS) or tribally owned and/or operated 638 facility,
   c. ~~Screenings including~~
      The following screenings are separately billable. As specified in the American Academy of Family Physicians (AAFP) and American Academy of Pediatrics (AAP) Practice guidelines, ~~,~~ ~~and a copy of t~~the completed screening tool or documentation of the tool used, results, follow up action, and referral plan as needed[4] shall be kept in the member's medical record. Refer to the Medical Coding page on the AHCCCS website:
      i. Postpartum depression screening consisting of a standard criterion-referenced screening tool to be performed for screening the mother/parent for signs and symptoms of postpartum depression during the one-, two-, four- and six-month well-child visits. Positive screening results require referral to appropriate case managers and services via the respective health plan,
      ii. Adolescent depression and suicide ~~–~~5 screening consisting of a standard, criterion-referenced screening tool specific for suicide and depression shall be performed at annual well-child visits beginning at 10 years of age. Positive screening results require an appropriate and timely referral for further evaluation and service provision, and
      iii. Adolescent Substance Use Disorder (SUD) screening consisting of a standard criterion-referenced screening tool specific for substance use shall be performed at annual well-child visits beginning at 12 years of age. Positive screening results require an appropriate and timely referral for further evaluation and service provision.

[3] Moved reference to FFS as the FFS provider is not the primary funding source for this service.
[4] Updated documentation requirements for behavioral health screening that aligns with American Academy of Family Physicians (AAFP) and American Academy of Pediatrics (AAP) practice guidelines.
[5] Added depression to adolescent suicide screening for consistency.

5. Developmental Surveillance:
   Developmental surveillance with anticipatory guidance shall be performed with the PCP at each Well-Child visit.

6. Developmental screening:
   a. ~~The~~ Developmental screening is a separately billable service by the PCPs who care for EPSDT age members,
   b. All PCPs who bill for developmental screening shall be trained in the use and scoring of the most up to date developmental screening tools as indicated by the AAP,
   c. Any abnormal developmental screening finding shall result in referrals for appropriate follow-up,
   d. As specified in AMPM Policy 581 and AMPM Policy 320-O, a copy of the completed developmental screening tool shall be kept in the member's medical record,
   e. General Developmental Screening shall occur at nine months, 18 months, and 30 months EPSDT visits. Accepted tools are described in the Centers for Medicare and Medicaid Services (CMS) Core Measure, *Developmental Screening in the First Three Years of Life* and shall be used for screening purposes, and
   f. Autism Spectrum Disorder (ASD) Specific Developmental Screening shall occur at the 18 months and 24 months EPSDT visits. ~~The ASD-specific developmental screening shall occur at the 18 months and 24 months EPSDT visits.~~ Accepted tools are described in the CMS Core Measure, *Developmental Screening in the First Three Years of Life*, and shall be used for screening purposes.

7. A comprehensive unclothed physical examination.

8. Immunizations for members under 21:
   a. AHCCCS covers all vaccines established by the Advisory Committee on Immunization Practices (ACIP) and as recommended by the American Academy of Pediatrics (AAP) vaccine schedule, based on medical necessity as determined by the member's medical provider. Refer to Attachment A and Attachment G,
   b. In addition, healthcare practitioners may administer a vaccine when the immunization is determined to be medically necessary. The determination of medical necessity is based on clinical appropriateness, scientific evidence, and standards of practice, including:
      i. Immunization schedules and published communication from professional medical academic associations including:
         1) American Academy of Pediatrics (AAP),
         2) American College of Obstetricians Gynecologists (ACOG), and
         3) American Academy of Family Physicians (AAFP).
      ii. Evidence-based immunization practice guidelines.
   c. Vaccine counseling is a covered service. This service can be provided in conjunction with:
      i. A preventive health visit (e.g., well-child visit),
      ii. An office visit when another service was provided (e.g., office visit to address diagnosed illness(es), new issues, and/or prescription refills), or
      iii. When vaccine counseling is the sole reason for the office visit. The vaccine counseling is also covered in instances where a vaccine is not administered during the same visit.
   d. Catch-up pediatric vaccinations are covered for members under 21 receiving vaccines at a later age than typically given,

e. All PCPs serving members under the age of 19 years, shall be registered as Vaccines for Children (VFC) providers and VFC vaccines shall be used when administering vaccines,
f. The Providers shall coordinate with the Arizona Department of Health Services (ADHS) for the VFC program in the delivery of immunization services for members under the age of 19, and
g. For immunizations not provided by the VFC program, for members 19 years of age and older, refer to AMPM Policy 310-M.

9. Laboratory tests:
   a. The Laboratory services including anemia testing and diagnostic testing for sickle cell trait (if a child has not been previously tested with sickle cell preparation or a hemoglobin solubility test),
   b. The blood lead screening and testing appropriate to age and risk. The blood lead testing is required for all members at 12 months and 24 months of age. Any member between the ages of 24 months through six years with no record of a previous blood lead test shall receive a blood lead test. The Lead levels may be measured at times other than those specified if thought to be medically indicated by the provider, by responses to a lead poisoning verbal risk assessment, or in response to HCDM/DR concerns. Additional screening for children through six years of age shall be provided utilizing the ~~Arizona Department of Health Services (~~ADHS~~)~~ Parent Questionnaire based on the child's risk as determined by either the member's residential zip code or presence of other known risk-factors, and
   c. Yearly syphilis testing for EPSDT-eligible members who are 15 years of age and older. Testing may be performed for members under the age of 15 at the discretion of the provider, based on risk.

10. Health education, counseling, and chronic disease self-management.

11. Oral health screening:
   a. Appropriate oral health screening intended to identify oral pathology, including tooth decay and/or oral lesions, and the application of fluoride varnish conducted by a physician, physician assistant, or nurse practitioner. Refer to AMPM Policy 431,
   b. Fluoride varnish is limited in a PCPs office to once every three months, during an EPSDT visit for children who have reached six months of age with at least one tooth erupted, with recurrent applications up to five years of age, may be reimbursed according to AHCCCS-approved fee schedules, and
   c. Application of fluoride varnish by the PCP does not take the place of a visit at the dental provider.

12. Vision screenings and services:
   a. Eye examinations as appropriate to age according to the AHCCCS EPSDT periodicity schedule as specified in Attachment A and as medically necessary using standardized visual tools,
   b. Any abnormal screening finding shall result in a referral to an appropriate provider for follow-up,

c. Ocular photo screening with interpretation and report, bilateral is covered for children ages three through six as part of the visit due to challenges with a child's ability to cooperate with traditional chart-based vision screening techniques. Ocular photo screening is limited to a lifetime coverage limit of one,
d. Automated visual screening is for vision screening only, and not recommended for or covered by AHCCCS when used to determine visual acuity for purposes of prescribing glasses or other corrective devices, and
e. Prescriptive lenses and frames are provided to correct or ameliorate defects, physical illness, and conditions discovered by EPSDT screenings or screenings performed through another modality such as Head Start, school, or childcare, subject to medical necessity. Frames for eyeglasses are also covered. As part of EPSDT coverage, eyeglasses and other vision services, including replacement and repair of eyeglasses, for members under the age of 21 years are covered, without restrictions, by AHCCCS to correct or ameliorate conditions discovered during vision screenings.

13. Hearing Screening and Services:
    a. Newborn hearing screening shall be performed per state statute ARS 36-694, and
    b. Medically necessary audiology services to evaluate hearing loss for all members shall be provided on both an inpatient and outpatient basis. Hearing aids are covered only for members under the age of 21 receiving EPSDT services.

14. Tuberculosis (TB) screening:
    Tuberculin skin testing as appropriate to age and risk. Members at increased risk of TB include those who have contact with the following individuals:
    a. Confirmed or suspected as having TB,
    b. In jail or prison during the last five years,
    c. Living in a household with a Human Immunodeficiency Virus (HIV)-infected individual or the child is infected with HIV, and/or
    d. Traveling/immigrating from or having significant contact with individuals indigenous to endemic countries.

B. SICK VISIT PERFORMED IN ADDITION TO A WELL-CHILD VISIT

A "sick visit" can be performed at the same time as a well-child visit if:

1. An abnormality is encountered, or a preexisting problem is addressed in the process of performing an EPSDT service and the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented Evaluation and Management (E/M) service.

2. The "sick visit" is documented on a separate note in the medical record.

The history, exam, and medical decision-making components of the separate "sick visit" already performed during a well-child visit are not to be considered when determining the level of the sick visit.

A minor problem/abnormality that is encountered in the process of performing the preventive medicine E/M service and which does not require additional work and the performance of the key components of a problem-oriented E/M service is included in the well-child visit and should not be billed separately.

C. CONTRACTOR-SPECIFIC REQUIREMENTS

The Contractor shall:

1. Implement processes to ensure age-appropriate screening and care coordination, as specified in Contract, when member needs are identified.

2. Ensure PCPs utilize validated screening tools for all children to assess behavioral health needs, Social Determinants of Health (SDOH), and trauma.

3. Ensure providers utilize accepted, up-to-date developmental screening tools as described in the CMS Core Measure *Developmental Screening in the First Three Years of Life* and complete ongoing training in the use and scoring of these tools, as indicated by the AAP. The Contractor shall monitor providers and implement interventions for non-compliance.

4. Develop policies and procedures to identify the needs of EPSDT age members, inform members of the availability of EPSDT services, coordinate member care, provide care management when medically necessary based on health risk assessment, conduct appropriate follow-up, and ensure members receive timely and appropriate treatment.

5. Develop policies and procedures to monitor, evaluate, and improve EPSDT participation.

6. Ensure members receive required health screenings in compliance with AHCCCS EPSDT and Dental Periodicity Schedules (Attachment A and AMPM Policy 431, Attachment A).

7. Ensure that the Bloodspot Newborn Screening Panel, hearing, congenital heart defect, and, if indicated, bilirubin screening tests are conducted, including initial and secondary screenings, in accordance with 9 AAC 13, Article 2.

8. Ensure that in-office capillary blood draws utilizing validated Clinical Laboratory Improvement Amendments (CLIA) waived testing equipment will be covered for in-network point of care EPSDT visits.

9. Ensure that providers report blood lead levels to ADHS as required under (AAC R9-4-302). The Contractor shall implement protocols for the following:
   a. Care coordination is required for members with blood lead levels above the CDC blood lead reference value (e.g., HCDM, DR, PCP and ADHS) to ensure timely follow-up and retesting,
   b. Care Management and case management are required for all children with blood lead levels above the CDC blood lead reference value. The Care Management and case management shall align with the CDC and ADHS recommended actions based on the member's blood lead level,
   c. Appropriate care coordination for an EPSDT-eligible member who has an elevated blood lead level and is transitioning to or from another AHCCCS health plan, and

d. Referral of members who lose AHCCCS eligibility to low-cost or no-cost follow-up testing and treatment for those members who have a blood lead test result equal to or greater than the current CDC blood lead reference values.

10. Develop, implement, and maintain a process to provide appropriate access to and timeliness of blood lead testing and follow-up care for members who have abnormal blood lead test results.

11. Ensure that:
    a. Each hospital or birthing center screens all newborns using a physiological hearing screening method prior to initial hospital discharge,
    b. Each hospital or birthing center provides outpatient re-screening for infants who were missed or are referred from the initial screening. The outpatient re-screening shall be scheduled at the time of the initial discharge and completed no later than 30 days from birth[6] ~~between two and six weeks of age~~,
    c. When there is an indication that an infant may have a hearing loss in one or both ears[7] or congenital disorder, the family shall be referred to the PCP for appropriate assessment, care coordination and referral(s), ~~and~~
    d. All infants who do not pass the initial hearing screen and the subsequent rescreening shall have appropriate audiologic and medical evaluations to confirm the presence of hearing loss before 3 months of age, and
    ~~d.~~e. All infants with confirmed hearing loss receive services before turning six months of age. Per AAC R9-13-207 the diagnosing audiologist is required to refer to the Arizona Early Intervention Program (AzEIP). The results of all hearing screening and subsequent tests for hearing loss performed on newborns and infants must be reported to the Office of Newborn Screening within seven days of testing.

12. Implement protocols for the care and coordination of members who received TB testing to ensure timely reading of the TB skin test and treatment, if medically necessary.

13. Employ a sufficient number of appropriately qualified local personnel in order to meet the health care needs of members and fulfill Federal and State EPSDT requirements, as well as achieve contractual compliance. This shall include a documented process for ensuring all applicable staff and subcontractors are appropriately trained and kept up to date with the EPSDT program and AHCCCS policies relevant to EPSDT-eligible members.

14. Inform all participating PCPs about EPSDT requirements and monitor compliance with the requirements. ~~–~~This shall include informing PCPs of Federal, State, and AHCCCS policy requirements for EPSDT, and updates of new information as it becomes available and ensuring PCPs providing care to children are trained to use implemented developmental and behavioral health screening tools. This shall also include a process to monitor the utilization of appropriate norm-criterion based referenced and validated developmental and behavioral health screening tools.

[6] Updated to align newborn hearing timelines and follow up expectations with AAC R9-13-207 and national best practices and ensure children with hearing loss receive timely diagnosis and intervention services.

15. Provide EPSDT member outreach, including oral health member outreach as specified in this Policy, AMPM Policy 431, and AMPM Exhibit 400-3. This information shall include:
    a. Develop, implement, and maintain a process to inform members about EPSDT services that align with the enrollment and annual requirements in ACOM Policy 406. This information shall include:
        i. The benefits of preventive health care,
        ii. A description of the services listed in section A (of this Policy), Covered Services During an EPSDT Visit,
        iii. Information on how to obtain these services and assistance with scheduling appointments,
        iv. Availability of case management assistance in coordinating EPSDT covered services,
        v. A statement that there is no copayment or other charge for EPSDT Screening and resultant services as specified in ACOM Policy 431, and
        vi. A statement that assistance with medically necessary transportation as specified in AMPM Policy 310-BB is available to obtain EPSDT services.
    b. Conduct written and other member educational outreach related to immunizations, available community resources (including but not limited to WIC, Arizona Early Intervention Program (AzEIP), Children's Rehabilitative Services (CRS), Behavioral Health, Home Visiting Programs, Head Start/Early Head Start, VFC, and Birth to Five Helpline), lead poisoning prevention (dangers of and sources of lead exposure in Arizona populations, lead poisoning prevention measures and recommended/mandatory testing), age appropriate weight gain, childhood obesity and prevention measures, how to recognize asthma signs and symptoms, reduce triggers, and improve maintenance, age appropriate risk prevention efforts (addressing development, injury and suicide prevention, bullying, violence, drug and alcohol use, social media and sexual behavior), education on importance of utilizing PCP in place of ER visits for non-emergent concerns, recommended periodicity schedule, and other Contractor selected topics at a minimum of once every 12 months. These topics may be addressed separately or combined into one written outreach material; however, each topic shall be covered during the 12-month period. Refer to AMPM Exhibit 400-3, AMPM Policy 431 and ACOM Policy 404 for additional member information requirements,
    c. Develop, implement, and maintain a procedure to notify member/HCDM, DR of visits recommended by the AHCCCS EPSDT and Dental Periodicity Schedules (Attachment A and AMPM Policy 431, Attachment A) including~~. This procedure shall include~~:
        i. ~~Notification to members' HCDM/DR regarding s~~Suggested dates of each well-child visit. If a well-child visit has not taken place, a second written notice shall be sent,
        ii. ~~Notification to members or responsible parties/HCDM, DR regarding s~~Suggested dates of biannual (one-visit every six months) dental visits. If a dental visit has not taken place, a second notice shall be sent,
        iii. ~~Inform members of m~~Medically necessary immunizations according to age and health history,
    d. Refer to AMPM Policy 431 and AMPM Exhibit 400-3 for ~~additional~~ EPSDT oral health member outreach requirements~~, required written notifications, and~~[8]
    ~~e. Processes other than mailings shall be pre-approved by AHCCCS as outlined in ACOM 404.~~
    e. Member outreach shall be pre-approved by AHCCCS and comply with ACOM Policy 404[9],
    f. Provide targeted outreach to those members who did not show for appointments, and

[8] Section revised for clarity and flow.
[9] Added language that member outreach shall comply with ACOM Policy 404.

g. Provide EPSDT information in a culturally competent manner, in accordance with the requirements in ACOM Policy 405 ~~and include oral health member outreach as specified in AMPM Exhibit 400-3 and AMPM Policy 431~~[10].

16. Develop and implement processes to educate, refer, and assist members and their families regarding community health resources, including but not limited to WIC (and ensure medically necessary nutritional supplements are covered), AzEIP, Home Visiting Programs and Head Start as specified in 42 CFR 441.61.

17. Develop and implement processes to ensure the identification of members needing care management services and the availability of care management assistance in coordinating EPSDT covered services.

18. Participate in community and/or quality initiatives, to promote and support best local practices and quality care, within the communities served by the Contractor.

19. Coordinate with other entities when the Contractor determines a member has third party coverage.

20. Develop, implement, and maintain a procedure for ensuring timeliness and care coordination of re-screening and treatment for all conditions identified, including behavioral health services, as a result of examination, screening, and diagnosis. Treatment, if required, shall occur on a timely basis, generally initiating services no longer than 60 days beyond the request for screening services, unless stated otherwise in this Policy.

21. Require and monitor ~~the~~ use of the AHCCCS EPSDT and Dental Periodicity Schedules (Attachment A and AMPM Policy 431, Attachment A) by all contracted providers.

~~21.~~22. Require and monitor use of Attachment E, or a Contractor approved equivalent form inclusive of all components in Attachment E by all contracted providers.[11]

~~22.~~23. Develop and implement a process for monitoring that providers use the most current AHCCCS EPSDT and Dental Periodicity Schedules (Attachment A and AMPM Policy 431, Attachment A) at every EPSDT visit and that all age-appropriate screenings and services are conducted during each visit. The process shall include a description of interventions utilized in the event of provider non-compliance.

~~23.~~24. Develop and implement processes to reduce no-show appointment rates for EPSDT services.

~~24.~~25. Encourage providers to schedule the next EPSDT Screening at the current office visit, particularly for children 30 months of age and younger.

[10] Deleted duplicative statement regarding Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) oral health outreach requirements.
[11] Added requirement to use AHCCCS Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Clinical Sample Templates or an equivalent form approved by the contracted health plan and monitor providers use.

~~25.~~26. Ensure providers enroll and re-enroll annually with the VFC program, in accordance with AHCCCS Contract requirements:

a. The Contractor shall not utilize AHCCCS funding to purchase vaccines covered through the VFC program for members younger than 19 years of age unless otherwise specifically authorized by AHCCCS, and
b. The Contractor shall maintain a documented process to ensure providers document each EPSDT age member's immunizations in the Arizona State Immunization Information System (ASIIS) registry. In addition, the Contractor shall ensure providers maintain the ASIIS immunization records of each EPSDT-eligible member in ASIIS, in accordance with ARS Title 36, Chapter 135. The Contractor is required to monitor provider's compliance with immunization registry reporting requirements and take action to improve reporting when issues are identified.

~~26.~~27. Participate in a review of EPSDT requirements conducted by AHCCCS, including but not limited to: Contractor results of on-site visits to providers and medical record audits.

~~27.~~28. Include language in the PCP contracts that requires the PCPs to:

a. Provide EPSDT services for all assigned members from birth up to 21 years of age. Services shall be provided in accordance with the AHCCCS EPSDT and Dental Periodicity Schedules (Attachment A and AMPM Policy 431, Attachment A),
b. Implement procedures to ensure compliance by PCPs with all EPSDT standards and contract requirements,
c. Implement protocols to ensure that health problems are diagnosed and treated early, before they become more complex and the treatment more costly (including follow-up related to blood lead screening and tuberculosis screening),
d. Have a process and implement protocols for assisting members in navigating the healthcare system, coordinating care and services with the appropriate state agencies, inform members of and ensure members are connected with any other community-based resources and support services that support optimal health outcomes,
e. Refer eligible members to Head Start/Early Head Start and WIC, for WIC approved formula and support services. Ensure that referrals for medically necessary nutritional supplements are made to the Contractor. For more information, refer to EPSDT Service Standards, Nutritional Assessment and Nutritional Therapy of this Policy),
f. Utilize the criteria specified in this policy when requesting medically necessary nutritional supplements,
g. Coordinate with AzEIP to identify children birth up to three years of age with developmental disabilities needing services, including family education and family support needs focusing on each child's natural environment, to optimize child health and development (EPSDT services, as defined in 9 AAC 22, Article 2, shall be provided by the Contractor). Refer to Attachment C[12] and D~~, and~~.
h. ~~Require providers to communicate results of assessments and services provided to AzEIP enrollees within 45 days of the member's AzEIP enrollment. Refer to Attachment C for more information related to the coordination and referral process for early intervention services.~~[13]

[12] Added AMPM Policy 430 Attachment C for reference.
[13] Deleted and referred to the Arizona Early Intervention Program (AzEIP) procedures Attachment C.

~~28.~~29. Coordinate with behavioral health services agencies and providers to ensure continuity of care for members who are receiving or are eligible to receive behavioral health services. Behavioral health services are delivered in accordance with guidelines that incorporate evidence-based "best practices". AHCCCS has implemented 12 Principles to maintain the integrity of the best practices and approaches to providing behavioral health services for children. The Contractor and providers are required to integrate these principles in the provision of behavioral health services for EPSDT age members. Refer to AMPM Exhibit 300-3 and AMPM Policy 580[14].

~~29.~~30. Develop guidelines for use by the PCP in providing the following:

a. Information necessary to obtain Prior Authorization (PA) for commercial oral nutritional supplements,
b. Encouragement and assistance to the HCDM/DR in weaning the member from the necessity for supplemental nutritional feedings when possible, and
c. Education and training, if the member's HCDM/DR elects to prepare the member's food, regarding proper sanitation and temperatures to avoid contamination of foods that are blended or specially prepared for the member.

~~30.~~31. Implement protocols for transitioning a child who is receiving nutritional therapy, to or from another Contractor or another service program (e.g., WIC).

~~31.~~32. Implement a process for verifying medical necessity of nutritional therapy through the receipt of supporting medical documentation dated within three months of the request, prior to giving initial or ongoing authorizations for nutritional therapy. Documentation shall include clinical notes or other supporting documentation from the member's PCP, specialty provider or registered dietitian, including a detailed history and thorough physical assessment that provides evidence of the member meeting all the required criteria, as indicated on Attachment B.

~~32.~~33. Prior to the member's 21st birthday, as specified in AMPM Policy 587 and AMPM Policy 520, ensure that a transition plan is addressed and relevant to the member's needs as identified by their PCP including, but not limited to:

a. Housing and food security,
b. Continuation of health insurance coverage, and
c. Continuous support services for existing physical and behavioral health needs.

~~33.~~34. Develop and implement a written process for medically necessary transportation, to include both emergency and Non-Emergency Medical Transportation (NEMT), as outlined in AMPM Policy 310-BB.

~~34.~~35. Develop and implement a written process to ensure member access to oral interpretation, translation, sign language, disability-related service, and provide auxiliary aids and alternative formats upon request, and at no cost to the member, including translation of documents written in English into the member's preferred language, as specified in ACOM Policy 405.

~~35.~~36. Ensure that Notices of Adverse Benefit Determinations (NABD~~OA~~[15]s), when necessary, are provided to the member/HCDM/DR per the requirements outlined in ACOM Policy 414.

[14] Added AMPM Policy 580 to refer to 12 principles.
[15] Revised to update acronym, changes made throughout Policy.

D. CONTRACTOR-SPECIFIC REQUIREMENTS FOR THE EPSDT PROGRAM PLAN

The Contractor shall have a written EPSDT Program Plan (inclusive of Work Plan and Work Plan Evaluation) that addresses minimum Contractor requirements as specified in Sections A through C in this Policy, as well as the objectives of the Contractor's program that are focused on achieving AHCCCS requirements.

The EPSDT Program Plan shall also incorporate monitoring and evaluation activities for these minimum requirements, as specified in the EPSDT Program Plan checklist found on the AHCCCS Guides and Manuals page. The EPSDT Program Plan shall be submitted as specified in Contract Section F, Attachment F3, Contractor Chart of Deliverables and is subject to AHCCCS approval.

E. PROVIDER REQUIREMENTS

The EPSDT services shall be provided according to community standards of practice in accordance with Section 42 USC 1396d(a) and (r), 1396a(a)(43), 42 CFR 441.50 et seq. and AHCCCS rules and policies including the AHCCCS EPSDT and Dental Periodicity Schedules (Attachment A and AMPM Policy 431, Attachment A).

The Providers shall refer members for follow-up, diagnosis, and treatment. Treatment is to be initiated within 60 days of screening services.

The Providers are required to provide health counseling/education at initial and follow-up visits.

Refer to the specific AHCCCS Contractor for managed care members and to AMPM Policy 820 for Fee-For-Service members, regarding PA requirements.

A PCP referral is not required for naturopathic services.

Additionally, providers shall adhere to the below specific standards and requirements for the following covered services:

1. Breastfeeding Support:
   Per AAP recommendation, the PCPs shall ensure that families receive evidence-based breastfeeding information and support.

2. Immunizations:
   a. For members under the age of 21, immunizations are covered as established by the recommendations of the Advisory Committee on Immunization Practices (ACIP). In addition, immunizations not within or aligned with the ACIP recommendations are covered for members under the age of 21 when, in the provider's medical judgment, compliance with the ACIP recommendations is medically inappropriate. Administration of immunizations not within ACIP recommendations are covered when the health care practitioner determines the immunization to be medically necessary,

b. All immunizations shall be provided according to the American Academy of Pediatrics and/or ACIP recommended Schedule as specified in the CDC recommended vaccine schedules, and when determined to be medically necessary. Refer to Attachment G for the AHCCCS Pediatric routine vaccination schedule. Refer to the CDC website: https://www.cdc.gov/vaccines/hcp/imz-schedules/child-adolescent.html or the AAP website: https://downloads.aap.org/AAP/PDF/AAP-Immunization-Schedule.pdf for additional details on current immunization schedules. The vaccine schedule shall also reflect current state statutes governing school immunization requirements as listed in AAC R9-6-702 Title 9. If appropriate, document in the member's medical record the member/HCDM/DRs decision not to utilize EPSDT services or receive immunizations, and
c. The Providers shall coordinate with the ADHS for the VFC program in the delivery of immunization services for members under the age of 19.

3. Lead Screening:
   a. The ADHS Parent Questionnaire may be utilized to help determine if a lead test should be performed outside of the required testing ages. Screening efforts should focus on ensuring that these children receive blood lead testing,
   b. Anticipatory guidance to provide an environment safe from lead, shall still be included as part of each well-child visit from six months through six years of age, and
   c. A blood lead test result equal to or greater than the current CDC recommended blood lead reference values obtained by capillary specimen or fingerstick shall be confirmed using a venous blood sample.

4. Refer to AMPM Policy 310-DD for information regarding AHCCCS-covered transplants.

5. Metabolic Medical Foods:
   Metabolic formulas and medical foods are covered as specified in ARS 20-2327. If an EPSDT-eligible member has a congenital metabolic disorder identified through the Bloodspot Newborn Screening Panel refer to AMPM Policy 310-GG.

6. Nutritional Therapy:
   a. AHCCCS covers nutritional therapy for EPSDT-eligible members on Enteral Nutrition, Total Parenteral Nutrition (TPN) Therapy, or oral basis when determined medically necessary to provide either complete daily dietary requirements, or to supplement a member's daily nutritional and caloric intake,
   b. A PA is required from the member's Managed Care Contractor or Tribal ALTCS Case Manager or AHCCCS DFSM for FFS members for Commercial Oral Supplemental Nutrition. For FFS members, refer to AMPM Policy 820, and
   c. A PA is not required for members enrolled with a Contractor, if PA has already been obtained for the member receiving nutrition through Enteral Nutrition or TPN Therapy. The Medical necessity for commercial oral nutritional supplements shall be determined on an individual basis by the member's PCP or specialty provider. The PCP or specialty provider shall use the AHCCCS approved form, Attachment B, to obtain authorization from the member's Managed Care Contractor or Tribal ALTCS Case Manager or AHCCCS DFSM for FFS members:

i. Specific criteria shall be met utilizing Attachment B. When assessing the medical necessity of providing commercial oral nutritional supplements. The criteria include:
   1) The member has been diagnosed with a chronic disease or condition,
   2) The member is below the recommended BMI percentile (or weight-for-length percentile for members less than two years of age) for the diagnosis per evidence-based guidance as issued by the AAP, and
   3) There are no alternatives for adequate nutrition.

OR

ii. At least two of the following criteria have been met for the basis of establishing medical necessity:
   1) The member is at or below the 10th percentile for weight-for-length or BMI on the appropriate growth chart for age and gender, as recommended by the CDC, for three months or more,
   2) The member has reached a plateau in growth and/or nutritional status for more than six months, or more than three months if member is an infant less than one year of age,
   3) The member has already demonstrated a medically significant decline in weight within the three-month period prior to the assessment, and
   4) The member is able to consume/eat no more than 25% of his/her nutritional requirements from age-appropriate food sources.

iii. Additionally, the following requirements shall be met:
   1) The member has been evaluated and treated for medical conditions that may cause problems with growth (e.g., feeding problems, behavioral conditions, or psychosocial problems, endocrine, or gastrointestinal problems), and
   2) The member has had a trial of higher caloric foods, blenderized foods, or commonly available products that may be used as dietary supplements for a period of no less than 30 days in duration. If it is determined through clinical documentation and other supporting evidence that a trial of higher caloric foods would be detrimental to the member's overall health, the provider may submit Attachment B, along with supporting documentation demonstrating the risk posed to the member for the Contractor's Medical Director or Designee's consideration in approving the provider's PA request.

iv. The Supporting documentation shall accompany Attachment B. This documentation shall demonstrate that the member meets all of the required criteria and includes:
   1) Initial Requests:
      a) The documentation demonstrating that nutritional counseling has been provided as a part of the health risk assessment and screening services provided to the members by the PCP or specialty provider, or through consultation with a registered dietitian,
      b) The clinical notes or other supporting documentation dated within three months of the request, providing a detailed history and thorough physical assessment demonstrating evidence of member meeting all of the required criteria, as indicated on Attachment B. The physical assessment shall include the member's current/past weight-for-length and BMI percentiles (BMI if member is two years of age or older, otherwise evidence that appropriate growth charts were used for children under age two refer to Attachment B), and

c) The documentation detailing alternatives that were tried in an effort to boost caloric intake and/or change food consistencies that have proven unsuccessful in resolving the nutritional concern identified, as well as member adherence to the prescribed dietary plan/ alternatives attempted.

2) Ongoing Requests:
The Subsequent submissions shall include a clinical note or other supporting documentation dated within three months of the request that includes the members' overall response to supplemental therapy and justification for continued supplement use. This shall include the member's tolerance to formula, recent hospitalizations, current weight-for-length, or BMI percentile (if member is two years of age or older).

v. The Members receiving nutritional therapy shall be physically assessed by the member's PCP, specialty provider, or registered dietitian at least annually. Additionally, documentation demonstrating encouragement and assistance provided to the HCDM/DR in weaning the member from supplemental nutritional feedings should be included, when appropriate. When requesting initial or ongoing PA for commercial oral nutritional supplements, providers shall ensure the following:

1) The Documents are submitted with the completed Attachment B to support all of the necessary requirements for Commercial Oral Nutritional Supplements as detailed above,
2) If the member's HCDM/DR elects to prepare the member's food, education and training regarding proper sanitation and temperatures to avoid contamination of foods that are blended or specially prepared for the member is provided,
3) Ongoing monitoring is conducted to assess member adherence/tolerance to the prescribed nutritional supplement regimen and determine necessary adjustments to the prescribed amount of supplement are appropriate based on the member's weight loss/gain, and
4) The d~~D~~ocumentation demonstrating encouragement and assistance provided to the HCDM/DR in weaning the member from the necessity for supplemental nutritional feedings, when appropriate.

7. Oral Health Services:
As part of the physical examination, the physician, physician assistant, or nurse practitioner shall perform an oral health screening. A screening is intended to identify gross dental or oral lesions but is not a thorough clinical examination and does not involve making a clinical diagnosis resulting in a treatment plan. Referral to a dentist or dental home shall be made as outlined in policy. Refer to AMPM Policy 431, for more details pertaining to covered services, provider, and Contractor requirements.

8. Cochlear and Osseointegrated Implantation:
a. Cochlear implantation: The Cochlear implantation provides an awareness and identification of sounds and facilitates communication for individuals who have profound, sensorineural hearing loss (nerve deafness). Deafness may be prelingual/perilingual or post-lingual. ~~AHCCCS covers medically necessary services for cochlear implantation solely for EPSDT age members.~~ [16]The candidates for cochlear implants shall meet criteria for medical necessity, including but not limited to, the following indications:

[16] Removed as this is no longer the case. AHCCCS now covers cochlear implants for adults over 21 when medically necessary.

i. A diagnosis of either unilateral or bilateral profound sensorineural deafness (using age-appropriate standard testing), with little or no benefit from a hearing (or vibrotactile) aid, as established by audiologic and medical evaluation,
ii. Presence of an accessible cochlear lumen structurally suited to implantation, with no lesions in the auditory nerve and acoustic areas of the central nervous system, as demonstrated by CT scan or other appropriate radiologic evaluation,
iii. No known contraindications to surgery,
iv. Demonstrated age-appropriate cognitive ability to use auditory clues, and
v. The device shall be used in accordance with the Food and Drug Administration (FDA) approved labeling.

b. Coverage of cochlear implantation includes the following treatment and service components:
i. Complete auditory testing and evaluation by an otolaryngologist, speech-language pathologist, or audiologist,
ii. Pre-surgery inpatient/outpatient evaluation by a board-certified otolaryngologist,
iii. Diagnostic procedures and studies, including CT scan or other appropriate radiologic evaluation, for determining candidacy suitability,
iv. Pre-operative psychosocial assessment/evaluation by psychologist or counselor,
v. Prosthetic device for implantation (shall be non-experimental/non-investigational and be Food and Drug Administration approved and used according to labeling instructions),
vi. Surgical implantation and related services,
vii. Post-surgical rehabilitation, education, counseling, and training,
viii. The Equipment maintenance, repair, and replacement of the internal/external components or both if not operating effectively. Examples include but are not limited to: the device is no longer functional, or the used component compromises the member's safety. Documentation which establishes the need to replace components not operating effectively shall be provided at the time prior authorization is sought, and
ix. Cochlear implantation requires PA from the Contractor Medical Director, or from the AHCCCS Medical Director or designee for FFS members.

c. Osseointegrated implants (Bone Anchored Hearing Aid [BAHA]):
AHCCCS coverage of medically necessary services for osseointegrated implantation is limited to EPSDT-eligible members. Osseointegrated implants are devices implanted in the skull that replace the function of the middle ear and provide mechanical energy to the cochlea via a mechanical transducer. These devices are indicated only when hearing aids are medically inappropriate or cannot be utilized due to congenital malformation, chronic disease, severe sensorineural hearing loss, or surgery. Osseointegrated implantation requires PA from the Contractor Medical Director, or from the AHCCCS Medical Director or designee for FFS members. Maintenance of the osseointegrated implants is the same as described above for cochlear implants.

9. Conscious Sedation:
AHCCCS covers conscious sedation for members receiving EPSDT services.

10. Behavioral Health Services:
    AHCCCS requires timeliness of behavioral health services for members eligible for EPSDT services as described in Contract and Policy. The EPSDT behavioral health services include the services listed in 42 USC 1396d(a) necessary to correct or ameliorate mental illnesses and conditions discovered by the screening services whether or not the services are covered under the AHCCCS State Plan Amendment[17].

    For the diagnosis of behavioral health conditions including, but not limited to, Attention Deficit Hyperactivity Disorder (ADHD), depression (including postnatal depression), and/or anxiety disorders, there are clinical guidelines that include assessment tools and algorithms. If allowable within their scope of practice, the clinical guidelines are to be used by PCPs as an aid in treatment decisions.

11. Religious Non-Medical Health Care Institution Services:
    AHCCCS covers religious non-medical health care institution services for members eligible for EPSDT services as specified in AMPM Policy 1210.

12. Care Management Services:
    AHCCCS covers care management services for both physical and behavioral health care, as appropriate for members eligible for EPSDT services. In EPSDT, care management involves identifying the health needs of the member, ensuring necessary referrals are made, maintaining health history, and initiating further evaluation/diagnosis and treatment when necessary.

13. Chiropractic Services:
    AHCCCS covers chiropractic services to members eligible for EPSDT services, when ordered by the member's PCP and approved by the Contractor to ameliorate the member's medical condition.

14. Personal Care Services:
    AHCCCS covers personal care services, as appropriate, for members eligible for EPSDT services.

15. Incontinence Briefs:
    Incontinence briefs, including pull-ups and incontinence pads, are covered in order to prevent skin breakdown and to enable participation in social, community, therapeutic and educational activities under the following circumstances:
    a. The member is over three years and under 21 years of age,
    b. The member is incontinent due to a documented disability that causes incontinence of bowel and/or bladder,
    c. The PCP or attending physician has issued a prescription ordering the incontinence briefs,
    d. Incontinence briefs do not exceed 240 briefs per month unless the prescribing physician presents evidence of medical necessity for more than 240 briefs per month for a member diagnosed with chronic diarrhea or spastic bladder,
    e. The member obtains incontinence briefs from vendors within the Contractor's network, and

[17] Revised to update name.

f. A PA has been obtained as required by AHCCCS, Contractor, or Contractor's designee. The Contractor may require a new PA to be issued no more frequently than every 12 months. A PA for a renewal of an existing prescription may be provided by the physician through telephone contact with the member rather than an in-person physician visit. A PA will be permitted to ascertain that:
   i. The member is over three years and under 21 years of age,
   ii. The member has a disability that causes incontinence of bladder and/or bowel,
   iii. A physician has prescribed incontinence briefs as medically necessary. A physician prescription supporting medical necessity may be required for specialty briefs or for briefs different from the standard briefs supplied by the Contractor, and
   iv. The prescription is for 240 briefs or fewer per month unless evidence of medical necessity for over 240 briefs is provided.

16. Medically Necessary Therapies:
AHCCCS covers medically necessary therapies including physical therapy, occupational therapy, and speech therapy, necessary to correct or ameliorate defects, physical and mental illnesses, and conditions discovered by the screening services. Therapies are covered under both an inpatient and outpatient basis when medically necessary. For EPSDT-eligible members under the age of three years identified by the PCP as needing early intervention services, the Contractor is required to provide services in the natural environment whenever possible. Refer to Attachment C for more information related to the coordination and referral process for early interventions services.

17. Pasteurized Human Donor Milk:
The medically necessary pasteurized human donor milk is a covered service for EPSDT-eligible infants who cannot tolerate or have a medical contraindication to formula use, under the following conditions:
   a. The infant has a medical condition including, but not limited to:
      i. Birth weight of less than 2500 grams,
      ii. Premature birth,
      iii. A congenital or acquired condition that places the infant at high risk for developing Necrotizing Enterocolitis (NEC) or other infections, or
      iv. Other congenital or acquired conditions that place the infant at high risk for serious health complications without the provision of breast milk.
   b. Additionally, the infant is unable to receive maternal breast milk due to a medical condition of either the infant or the birthing parent:
      i. The infant is unable to receive maternal breast milk due to the absence of the birthing parent due to death, adoption, or other severance of parental rights, or
      ii. An appropriate health care provider has determined that the birthing parent should not breastfeed or produce breast milk for their infant due to potential health or safety concerns for either the birthing parent or infant.

The provision of human donor milk is incorporated into the All-Patient Refined Diagnosis Related Groups (APR-DRG) payment for inpatient use and is separately reimbursable for outpatient use.