430 EARLY PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES

REVISION DATE: 10/1/2019
REFERENCES: 42 CFR 441.58, 42 CFR 441.56(B)(1), 441.50; 42 U.S.C. 1396d(a) and (r), 1396a (a) (43); A.R.S. § 36-135; A.A.C. R9-13-201 et seq, A.A.C. R9-4-302, A.A.C. R9-22-201 et seq; Division Medical Policy 310-P; AMPM Exhibits 400-1, 400-2B, 400-3, 430-1, 430-2, 430-3, 430-4, and 431-1; AMPM Appendices A, B, E, and F; AMPM Chapter 800
DELIVERABLES: Children's Provider Case Manager Caseload Inventories and Ratios

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is a comprehensive child health program of prevention, treatment, correction, and improvement of physical and behavioral/mental health conditions for members eligible for ALTCS and Targeted Support Coordination under 21 years of age. The purpose of EPSDT is to ensure the availability and accessibility of health care resources, and to assist members in effectively using these resources. EPSDT services provide comprehensive health care through primary prevention, early intervention, diagnosis, medically necessary treatment, and follow-up care of physical and behavioral health conditions for members under 21 years of age.

EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary, mandatory, and optional services listed in federal law 42 U.S.C. 1396d (a) to correct or ameliorate defects and physical and behavioral/mental illnesses and conditions identified in an EPSDT screening, whether or not the services are covered under the AHCCCS State Plan. All members age out of Oral Health & EPSDT services at age 21. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness, do not apply to EPSDT services.

A well child visit is synonymous with an EPSDT visit. EPSDT services include all screenings and services described in this Policy and as referenced in AHCCCS EPSDT Periodicity Schedule (AMPM Exhibit 430-1) and AHCCCS Dental Periodicity Schedule (AMPM Exhibit 431-1) located in the AHCCCS Medical Policy Manual.

The Division has adopted Appendix B, EPSDT Standards and Tracking Forms in the AHCCCS Medical Policy Manual, which are to be used by providers to document all age-specific, required information related to EPSDT screenings and visits.

Providers must use the EPSDT Tracking Forms referenced above or electronic equivalent that includes all components found in the hard copy form, at every EPSDT visit.

The Medicaid Act defines EPSDT services to include screening services, vision services, dental services, hearing services and "*such other necessary health care, diagnostic services, treatment and other measures described in 42 U.S.C. 1396d (a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the (AHCCCS) State Plan.*" This means that EPSDT covered services include services that correct or ameliorate physical and mental defects, 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 covered under EPSDT include all 29 categories of services in the Federal Law, even when they are not listed as covered services in the

AHCCCS State Plan, statutes, rules, or policies, as long as the services are medically necessary and cost effective.

EPSDT includes, but is not limited to, coverage of:

A. Inpatient and outpatient hospital services

B. Laboratory and x-ray services

C. Physician and nurse practitioner services

D. Medications and medical supplies

E. Dental services

F. Therapy services

G. Behavioral health services

H. Orthotics and prosthetic devices

I. Eyeglasses

J. Transportation

K. Family planning services

L. Diagnostic, screening, preventive, and rehabilitative services.

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.

EPSDT screening services are provided in compliance with the periodicity requirements of 42 CFR 441.58. The Administrative Services Subcontractor (AdSS) must ensure members receive required health screenings in compliance with the AHCCCS EPSDT Periodicity Schedule and the AHCCCS Dental Periodicity Schedule, which are intended to meet reasonable and prevailing standards of medical and dental practice and specify screening services at each stage of the child's life; see AHCCCS EPSDT Periodicity Schedule (AMPM Exhibit 430-1) and AHCCCS Dental Periodicity Schedule (AMPM Exhibit 431-1). The service intervals are minimum requirements, and any services determined by a Primary Care Provider (PCP) to be medically necessary must be provided, regardless of the interval. The requirements and reporting forms for an EPSDT screening service are described in this Policy. EPSDT focuses on continuum of care by: assessing health needs, providing preventive screening, initiating needed referrals, and completing recommended medical treatment and appropriate follow-up.

A. EPSDT Definitions

Early - in the case of a child already enrolled with an AdSS or AHCCCS Contractor, as early as possible in the child's life, or in other cases, as soon after the member's eligibility for services has been established.

Periodic - at intervals established by AHCCCS for screening to assure that a condition, illness, or injury is not incipient or present.

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 EPSDT program, screening and diagnosis are not synonymous.

Diagnostic - determination of the nature or cause of a condition, illness, or injury through the combined use of health history, physical, developmental, and psychological examination, laboratory tests, and X-rays, when appropriate.

Treatment - any of the 29 mandatory or optional services described in 42 U.S.C. 1396d(a), even if the service is not covered under the (AHCCCS) State Plan, when necessary to correct or ameliorate defects and physical and mental illnesses and conditions detected by screening or diagnostic procedures.

B. Covered Services During an EPSDT Visit

Comprehensive periodic screenings must be performed by a clinician, according to the timeframes identified in the AHCCCS EPSDT Periodicity Schedule and the AHCCCS Dental Periodicity Schedule, and inter-periodic screenings, as appropriate, for each member. All covered services during an EPSDT visit are provided by the AdSS,

The AdSS must:

1. Implement processes to ensure age-appropriate screening and care coordination when member needs are identified.

2. Ensure providers use the-approved standard developmental screening tools and complete training in the use of these tools, as indicated by the American Academy of Pediatrics.

3. Monitor providers and implement interventions for non-compliance.

4. Ensure that the Bloodspot Newborn Screening Panel and hearing tests are conducted, including initial and secondary screenings, in accordance with Arizona Administrative Code (A.A.C.) R9-13-201 et seq.

The AHCCCS EPSDT Periodicity Schedule is based on recommendations by the Arizona Medical Association and is closely aligned with the guidelines of the American Academy of Pediatrics. The service intervals are minimum requirements. Any services determined by a PCP to be medically necessary must be provided, regardless of the interval.

EPSDT visits are all-inclusive visits. The payment for the EPSDT visit is intended to cover all elements outlined in the AHCCCS EPSDT Periodicity Schedule. Exceptions to payments are noted in each of the paragraphs below. Only services specifically identified below as a separately billable service may be billed separately or in addition to the EPSDT visit.

EPSDT visits must include:

1. A comprehensive health and developmental history, including growth and development screening [42 CFR 441.56(B)(1)] that includes physical, nutritional, and behavioral health assessments

   Refer to the Centers for Disease Control and Prevention website for Body Mass Index (BMI) and growth chart resources.

2. Nutritional Assessment provided by a PCP

   Nutritional assessments are conducted to assist EPSDT members whose health status may improve with nutritional intervention. Payment for the assessment of nutritional status provided by the member's PCP is part of the EPSDT screening specified in the AHCCCS EPSDT Periodicity Schedule, and on an inter-periodic basis as determined necessary by the member's PCP. Payment for nutritional assessments are included in the EPSDT visit and are not a separately billable service.

3. Behavioral Health Screening and Services provided by a PCP

   The Division covers behavioral health services for members eligible for EPSDT. EPSDT behavioral health services include the services listed in 42 U.S.C. 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. PCPs may treat Attention Deficit Hyperactivity Disorder (ADHD), depression and anxiety.

   All other behavioral health conditions must be referred to the entity for which the member is assigned for behavioral health services. American Indian members may receive behavioral health services through an Indian Health Service or Tribal operated 638 facility, regardless of AdSS enrollment. PCPs that prescribe medications to treat ADHD, depression, or anxiety disorders must complete an annual assessment of the member's behavioral health condition and treatment plan. Payment for behavioral health screenings and assessments are part of an EPSDT visit and not separately billable services.

   Note: CPT code 96101 PSYCHOLOGICAL TESTING (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology) is not a separately billable service. The code may be billed on the claim to indicate the service was performed, but payment will be included in the fee paid for the EPSDT visit.

4. Developmental Screening Tools used by a PCP

   AHCCCS-approved developmental screening tools should be used for developmental screening by all participating PCPs who care for EPSDT-age members. PCPs must be trained in the use and scoring of the developmental screening tools, as indicated by the American Academy of Pediatrics. A list of available training resources may be found in the Arizona Department of Health Services website at www.azdhs.gov/clinicians/training-opportunities/developmental/index.php). The developmental screening should be completed for EPSDT members from birth through three years of age during the nine-month, 18-month, and 24-month EPSDT visits. A copy of the screening tool must be kept in the medical record. Use of AHCCCS approved developmental screening tools may be billed separately using CPT-4 code 96110 (Developmental screening, with interpretation and report, per standardized instrumentation) for the nine-month, 18-month and-24 month visit when the developmental screening tool is used. A developmental screening CPT code (with EP modifier) must be listed in addition to the preventive medicine CPT codes. Other CPT-4 codes, such as 96111 – Developmental Testing (includes assessment of motor, language, social, adaptive) are not considered screening tools and are not separately billable. To receive the developmental screening tool payment, the modifier EP must be added to the 96110. For claims to be eligible for payment of code 96110; the provider must have satisfied the training requirements, the claim must be a 9, 18, or 24-month EPSDT visit, and an AHCCCS approved developmental screening tool must have been completed.

   Approved developmental screening tools include:

   a. The Parent's Evaluation of Developmental Status (PEDS) tool which may be obtained from www.pedstest.com or www.forepath.org

   b. Ages and Stages Questionnaire (ASQ) tool, which may be obtained from www.agesandstages.com

   c. The Modified Checklist for Autism in Toddlers (MCHAT) may be used only as a screening tool by a PCP, for members 16-30 months of age, to screen for autism when medically indicated. Copies of the completed tools must be retained in the medical record.

5. A comprehensive unclothed physical examination

6. Appropriate immunizations according to age and health history (administration of the immunizations may be billed in addition to the EPSDT visit using the CPT-4 code appropriate for the immunization with an SL modifier)

   Combination vaccines are paid as one vaccine. Providers must be registered as Vaccines for Children (VFC) providers and VFC vaccines must be used.

7. Laboratory tests, including blood lead screening assessment and blood lead testing appropriate to age and risk, 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)

   EPSDT covers blood lead screening. Required blood lead screening for children under six year of age is based on the child's risk as determined by either the member's residential zip code or presence of other known risk-factors, as specified in the Arizona Department of Health Services Targeted Lead Screening Plan for the Prevention of Childhood Lead Poisoning. For more information refer to *Blood Lead Screening* section in this policy for more information.

   Payment for laboratory services that are not separately billable and part of the payment made for the EPSDT visit include but are not limited to: CPT Codes 99000, 36415, 36416, 36400, 36406, and 36410. In addition, payment for all laboratory services must be in accordance with limitations or exclusions specified in contract.

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

   These are not separately billable services, and they are part of the EPSDT visit payment.

9. 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's assistant, or nurse practitioner

   Application of fluoride varnish may be billed separately from the EPSDT visit, using CPT Code 99188. Fluoride varnish is limited in a PCP's office to once every six 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 two years of age.

10. Appropriate vision, hearing, and speech screenings

    These screenings are covered during an EPSDT visit.

    EPSDT covers eye examinations as appropriate to age according to the AHCCCS EPSDT Periodicity Schedule and as medically necessary using standardized visual tools. Payment for vision and hearing exams, (including, but not limited to CPT codes 92015, 92081, 92285, 92551, 92552, 92553, 92567, 92568, 92285, 92286, 92587, 92588, 95930, and 99173) or any other procedure that may be interpreted as fulfilling the vision and hearing requirements provided in a PCP's office during an EPSDT visit, are part of the EPSDT visit and are not a separately billable services.

    Ocular photo screening with interpretation and report, bilateral (CPT code 99177) is covered for children age three to five as part of the EPSDT visit due

to challenges with a child's ability to cooperate with traditional vision screening techniques. Ocular photo screening is limited to a lifetime coverage limit of one. This procedure, although completed during the EPSDT visit, is a separately billable service.

Note: Automated visual screening, described by CPT code 99177, is not recommended for or covered by the Division when used to determine visual acuity for purposes of prescribing glasses or other corrective devices.

Vision CPT codes with the EP modifier must be listed on the claim form in addition to the preventive medicine CPT codes for visit screening assessment. With the exception of CPT code 99177, no additional reimbursement is allowed for these codes.

Hearing CPT codes with the EP modifier must be listed on the claim form, in addition to the preventive medicine CPT codes, for a periodic hearing screening assessment. With the exception of CPT code 99177, no additional reimbursement is allowed for these codes.

The AdSS must ensure:

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 babies who were missed or are referred from the initial screening. Outpatient re-screening must be scheduled at the time of the initial discharge and completed between two and six weeks of age.

c. When there is an indication that a newborn or infant may have a hearing loss or congenital disorder, the family must be referred to the PCP for appropriate assessment, care coordination and referral(s).

d. All infants with confirmed hearing loss receive services before turning six months of age.

11. Tuberculin skin testing, as appropriate to age and risk

Children at increased risk of tuberculosis (TB) include those who have contact with persons who have been:

a. Confirmed or suspected as having TB

b. In jail or prison during the last five years

c. Living in a household with an HIV-infected person or the child is infected with HIV

d. Traveling/emigrating from, or having significant contact with persons indigenous to, endemic countries.

C. EPSDT Service Standards

EPSDT services must be provided according to community standards of practice and the AHCCCS EPSDT and Dental Periodicity Schedules. The AHCCCS EPSDT Tracking Forms must be used to document services provided and be in compliance with Division standards. The tracking forms must be signed by the clinician who performs the screening. The AdSS must monitor PCPs' use of and submission of EPSDT Tracking Forms, whether hard copy or electronic, to the AdSS Maternal and Child Health Unit.

All EPSDT services are provided by the AdSS. EPSDT providers must adhere to the following specific standards and requirements:

1. **Immunizations** - EPSDT covers all child and adolescent immunizations, as specified in the Centers for Disease Control and Prevention (CDC) recommended childhood immunization schedules. All appropriate immunizations must be provided to establish, and maintain, up-to-date immunization status for each EPSDT age member. (Refer to the CDC website for current immunization schedules.)

   The Division covers the human papilloma virus (HPV) vaccine for female and male EPSDT members age 11 to 21 years of age. The Division will cover members nine and 10 years of age, if the member is deemed to be in a high-risk situation. For adult immunizations, refer to Chapter 310-M, *Immunizations* in this Policy Manual. Providers must coordinate with the Arizona Department of Health Services (ADHS) Vaccines for Children (VFC) program in the delivery of immunization services. Immunizations must be provided according to the Advisory Committee on Immunization Practices Recommended Schedule. (Refer to the CDC website.) The AdSS must ensure providers enroll and re-enroll annually with the VFC program, in accordance with contract requirements. The AdSS must not use funding from the Division to purchase vaccines covered through the VFC program for members younger than 19 years of age.

   The AdSS must ensure providers:

   a. Document each EPSDT-age member's immunizations in the Arizona State Immunization Information System (ASIIS) registry.

   b. Maintain the ASIIS immunization records of each EPSDT member in ASIIS, in accordance with A.R.S. § 36-135.

   The AdSS must monitor provider's compliance with immunization registry reporting requirements and take action to improve reporting when issues are identified.

2. **Eye Examinations and Prescriptive Lenses** - EPSDT covers eye examinations as appropriate to age, according to the AHCCCS EPSDT Periodicity Schedule, and as medically necessary using standardized visual tools. Vision exams provided in a PCP's office during an EPSDT visit are not a separately billable service. Prescriptive lenses and frames are provided to correct or ameliorate defects, physical illness, and conditions discovered by EPSDT screenings, subject to medical necessity. Frames for eyeglasses are also covered.

3. **Blood Lead Screening** - EPSDT covers blood lead screening. Required blood lead screening for children under six year of age is based on the child's risk as determined by either the member's residential zip code or presence of other known risk-factors, as specified in the Arizona Department of Health Services Targeted Lead Screening Plan for the Prevention of Childhood Lead Poisoning.

    a. Children living in a targeted high-risk zip code: All children living in a high risk zip code as identified by the Arizona Department of Health Services Targeted Lead Screening Plan for the Prevention of Childhood Lead Poisoning must have a blood lead test at 12 and 24 months of age. Children between 36 and 72 months of age must receive a screening blood lead test, if they have not been previously screened for lead poisoning.

    b. Children living outside of the targeted high-risk zip codes: Children living in Arizona, but not in a targeted high-risk zip code must receive an individual risk assessment according to the AHCCCS periodicity schedule (when the child is 6, 9, 12, 18, and 24 months of age and then annually through age 6 years), with appropriate follow-up action taken for those children who are determined to be at high risk based on criteria included within the Arizona Department of Health Services Targeted Lead Screening Plan for the Prevention of Childhood Lead Poisoning.

    A blood lead test result, equal to or greater than 10 micrograms of lead per deciliter of whole blood obtained by capillary specimen or finger stick, must be confirmed using a venous blood sample. A verbal blood lead screening risk assessment must be completed at each EPSDT visit for children six through 72 months of age (six years of age) to assist in determining risk.

    The AdSS must ensure that providers report blood lead levels equal to or greater than ten micrograms of lead per deciliter of whole blood to ADHS (A.A.C. R9-4-302).

    The AdSS must implement protocols for:

    a. Care coordination for members with elevated blood lead levels (parents, PCP and ADHS) to ensure timely follow-up and retesting

b. Appropriate care coordination for an EPSDT child, who has an elevated blood lead level and is transitioning to or from another AdSS

c. Referral of members who lose AHCCCS or Division eligibility to low-cost or no-cost follow-up testing and treatment for those members that have a blood lead test result equal to or greater than ten micrograms of lead per deciliter of whole blood

Refer to Chapter 500, *Care Coordination Requirements* in this Policy Manual for more information related to transitioning members.

4. **Organ and Tissue Transplantation Services** - Refer to Policy 310-DD, Covered Transplants and Related Immunosuppressant in this Policy Manual and Attachment A, Extended Eligibility Process-Procedure for Covered Solid Organ and Tissue Transplants in the AHCCCS Medical Policy Manual for a discussion of covered transplantations.

5. **Tuberculosis (TB) Screening** - EPSDT covers TB screening. The AdSS must implement protocols for care and coordination of members who received TB testing to ensure timely reading of the TB skin test and treatment, if medically necessary.

6. **Nutritional Assessment and Nutritional Therapy**

a. Nutritional Assessments

Nutritional assessments are conducted to assist EPSDT members whose health status may improve with nutritional intervention. The Division covers the assessment of nutritional status provided by the member's PCP as a part of the EPSDT screenings, as specified in the AHCCCS EPSDT Periodicity Schedule and on an inter-periodic basis, as determined necessary by the member's PCP. The Division 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.

To initiate the referral for a nutritional assessment, the PCP must use the AdSS referral form in accordance with AdSS protocols.

If a member qualifies for nutritional therapy due to a medical condition (as described in the Nutritional Therapy section below), the AdSS is the primary payor for:

i. Infant formulas above the amount provided through the WIC program or formula types deemed medically necessary that are not provided through the Women, Infants and Children (WIC) program

Note: This does not include formulas outside of those offered through the WIC program that are not medically

necessary, such as formula types selected based on brand preference.

For members, under the age of five, requiring formula types deemed medically necessary that are not provided through the WIC program, the AHCCCS Certificate of Medical Necessity for Commercial Oral Nutritional Supplements (AMPM Exhibit 430-2) must be submitted directly to the member's AdSS, as WIC is a secondary payor of specialty exempt formulas.

For members who are infants (0-1 year), requiring infant formulas above the amount provided through the WIC program, the AHCCCS Certificate of Medical Necessity for Commercial Oral Nutritional Supplements (AMPM Exhibit 430-2) must be submitted directly to the member's AdSS for the amount of formula that exceeds that provided through the WIC program.

Note: WIC is a secondary payor of infant formulas above the amount provided through the WIC program.

ii. Medical foods

iii. Parenteral feedings

iv. Enteral feedings.

If a member has a congenital metabolic disorder identified through the Bloodspot Newborn Screening Panel (such as Phenylketonuria, Homocystinuria, Maple Syrup Urine Disease, or Galactosemia), refer to Chapter 320-H, Metabolic Medical Food in this Policy Manual.

b. Nutritional Therapy:

The Division covers nutritional therapy for EPSDT-eligible members on an enteral, parenteral, 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. The AdSS is the primary payor for parenteral and enteral feedings, unless nutritional therapy is covered by a member's primary insurance.

i. Enteral nutritional therapy: Provides liquid nourishment directly to the digestive tract of a member who cannot ingest an appropriate amount of calories to maintain an acceptable nutritional status. Enteral nutrition is commonly provided by Jejunostomy tube (J-tube), Gastrostomy Tube (G-tube) or Nasogastric (N/G) tube. Refer to the specific AdSS for managed care members and the Division's AIHP (Fee-For-Service) regarding Prior Approval (PA) requirements.

ii. Parenteral nutritional therapy: Provides nourishment through the venous system to members with severe pathology of the alimentary tract, which does not allow absorption of sufficient nutrients to maintain weight and strength. Refer to the Division for managed care members and the Division's AIHP (Fee-For-Service) regarding PA requirements.

iii. Commercial Oral Supplemental Nutritional Feedings: Provides nourishment and increases caloric intake as a supplement to the member's intake of other age-appropriate foods, or as the sole source of nutrition for the member. Nourishment is taken orally and is generally provided through commercial nutritional supplements available without prescription.

PA is required from the member's AdSS the Division for Fee-For-Service members for commercial oral nutritional supplements, unless the member is also currently receiving nutrition through enteral or parenteral feedings.

Medical necessity for commercial oral nutritional supplements must be determined by the member's PCP or specialty provider, using the criteria specified in this policy. An example of a nutritional supplement is an amino acid-based formula used by a member for eosinophilic gastrointestinal disorder. The PCP or specialty provider must use the AHCCCS-approved form, AHCCCS Certificate of Medical Necessity for Commercial Oral Nutritional Supplements (AMPM Exhibit 430-2) to obtain authorization from the member's AdSS or the Division for FFS members.

The Certificate of Medical Necessity for Commercial Oral Nutritional Supplements must indicate which of the following criteria were met when assessing the medical necessity of providing commercial oral nutritional supplements.

(a) The member has been diagnosed with a chronic disease or condition, 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 American Academy of Pediatrics, and there are no alternatives for adequate nutrition.

OR:

(b) The member had met at least two of the following criteria to establish medical necessity:

- 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.

- 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.
- Demonstrated a medically significant decline in weight within the three month period prior to the assessment.
- Can consume/eat no more than 25% of his/her nutritional requirements from age-appropriate food sources.

Additionally, each of the following requirements must be met:

(a) The member has been evaluated and treated for medical conditions that may cause problems with growth (such as feeding problems, behavioral conditions or psychosocial problems, endocrine or gastrointestinal problems).

(b) 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 the Certificate of Medical Necessity for Commercial Oral Nutritional Supplements located in the AHCCCS Medical Policy Manual, Exhibit 430-2), along with supporting documentation demonstrating the risk posed to the member, for the AdSS Medical Director or Designee's consideration in approving the provider's prior authorization request.

iv. Supporting documentation must accompany the Certificate of Medical Necessity for Commercial Oral Nutritional Supplements (Members 21 Years of Age or Greater - Initial or Ingoing Requests). This documentation must demonstrate that the member meets all of the required criteria, and it includes:

(a) Initial Requests

Documentation demonstrating that nutritional

counseling has been provided as a part of the health risk assessment and screening services provided to the member by the PCP or specialty provider, or through consultation with a registered dietitian

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 the Certificate of Medical Necessity (The physical assessment must include the member's current/past weight-for-length and BMI percentiles (if member is two years of age or older.)

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, and as member adherence to the prescribed dietary plan/alternatives attempted.

(b) Ongoing Requests

Subsequent submissions must 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 must include the member's tolerance to formula, recent hospitalizations, current weight-for-length or BMI percentile (if member is two year of age or older).

Note: Members receiving nutritional therapy must 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 caregiver in weaning the member from supplemental nutritional feedings should be included, when appropriate.

c. AdSS Requirements

The AdSS must:

i. Develop guidelines for use by the PCP in providing:

- Information necessary to obtain PA for commercial oral

nutritional supplements

- Encouragement and assistance to the caregiver in weaning the member from the necessity for supplemental nutritional feedings
- Education and training, if the member's parent or guardian 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.

ii. Implement protocols for transitioning a child who is receiving nutritional therapy, to or from another AdSS or another service program (e.g., Women, Infants and Children).

iii. 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 must 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 member meeting all of the required criteria, as indicated on the Certificate of Medical Necessity.

d. Provider Requirements

When requesting initial or ongoing Prior Authorization (PA) for commercial oral nutritional supplements, providers must ensure:

i. Documents are submitted with the completed Certificate of Medical Necessity to support all of the necessary requirements for Commercial Oral Nutritional Supplements as detailed above.

ii. If the member's parent or guardian 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.

iii. 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.

iv. Documentation demonstrating encouragement and assistance provided to the caregiver in weaning the member from the necessity for supplemental nutritional feedings, when appropriate.

e. Oral Health Services – As part of the physical examination, the physician, physician's assistant, or nurse practitioner must 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 must be made as outlined in policy. Refer to AHCCCS Dental Periodicity Schedule (AMPM Exhibit 431-1) for more details pertaining to covered services, and provider and AdSS requirements.

7. Cochlear and Osseointegrated Implantation

a. Cochlear Implantation

Cochlear implantation provides an awareness and identification of sounds and facilitates communication for persons who have profound, sensorineural hearing loss (nerve deafness). Deafness may be prelingual/perilingual or postlingual. The Division covers medically necessary services for cochlear implantation solely for member of EPSDT age. Cochlear implantation is limited to one functioning implant per member. The Division will not cover cochlear implantation in instances where individuals have one functioning cochlear implant.

i. Candidates for cochlear implants must meet criteria for medical necessity, including but not limited to, the following indications:

- A diagnosis of 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
- 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
- No known contraindications to surgery
- Demonstrated age-appropriate cognitive ability to use auditory clues

- The device must be used in accordance with the FDA approved labeling.

ii. Coverage of cochlear implantation includes:

- Complete auditory testing and evaluation by an otolaryngologist, speech-language pathologist or audiologist
- Presurgery inpatient/outpatient evaluation by a board certified otolaryngologist
- Diagnostic procedures and studies, including CT scan or other appropriate radiologic evaluation, for determining candidacy suitability
- Preoperative psychosocial assessment/evaluation by psychologist or counselor
- Prosthetic device for implantation (must be non-experimental/non-investigational and be Food and Drug Administration approved and used according to labeling instructions)
- Surgical implantation and related services
- Postsurgical rehabilitation, education, counseling and training
- Equipment maintenance, repair and replacement of the internal/external components or both if not operating effectively and is cost effective. Examples include but are not limited to: the device is no longer functional or the used component compromises the member's safety. Documentation that establishes the need to replace components not operating effectively must be provided at the time prior authorization is sought.

  Cochlear implantation requires PA from the AdSS Medical Director, or from the Division Medical Director or designee for Division AIHP (Fee-For-Service) members.

b. Osseointegrated Implants (Bone Anchored Hearing Aid [BAHA])

Coverage of medically necessary services for osseointegrated implantation is limited to EPSDT 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 used due to congenital malformation, chronic disease, severe sensorineural hearing loss or surgery. Osseointegrated implantation requires PA from the Division Medical Director, or from the Division Medical Director or designee, for Division AIHP (Fee-For-Service) members. Maintenance is the same as in Item 7.a.ii above.

8. Conscious Sedation – The Division covers conscious sedation for members receiving EPSDT services. Conscious sedation provides a state of consciousness that allows the member to:

   a. Tolerate an unpleasant procedure while continuously maintaining adequate cardiovascular and respiratory function.

   b. Respond purposely to verbal command and/or tactile stimulation.

   Except as specified below, coverage is limited to:

   a. Bone marrow biopsy with needle or trocar

   b. Bone marrow aspiration

   c. Intravenous chemotherapy administration, push technique

   d. Chemotherapy administration into central nervous system by spinal puncture

   e. Diagnostic lumbar spinal puncture

   f. Therapeutic spinal puncture for drainage of cerebrospinal fluid.

   Additional applications of conscious sedation for members receiving EPSDT services are considered on a case by case basis and require medical review and prior authorization by the AdSS Medical Director for enrolled members or by the Division Chief Medical Officer or designee for Division AIHP (Fee-For-Service) members.

9. Behavioral Health Services –

   The Division covers behavioral health services for members eligible for EPSDT services, as described in Policy 310 of this Policy Manual. EPSDT behavioral health services include the services listed in 42 U.S.C. 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.

   The Division has adopted the following AHCCCC Medical Policy Manual appendices: Appendix E for children and adolescents and Appendix F for adults. For the diagnosis of Attention Deficit Disorder/Attention Deficit

Hyperactivity Disorder (ADHD), depression (including postnatal depression), and/or anxiety disorders, there are clinical guidelines that include assessment tools and algorithms. PCPs are to use the clinical guidelines as an aid in treatment decisions. PCPs that prescribe medications to treat ADHD, depression, or anxiety disorders must complete an annual assessment of the member's behavioral health condition and treatment plan. The AdSS must establish a medication management process that results in the annual assessment being completed by the PCP in order for ADHD, depression, and anxiety medication prescriptions to continue beyond a 12-month period. To ensure there is not a gap in medications for these conditions, the AdSS must identify and conduct outreach to members approaching the 12-month reassessment timeframe and provide assistance in scheduling the appointment with the member's PCP.

The Division has implemented the following 12 Principles to maintain the integrity of the best practices and approaches to providing behavioral health services for children. The AdSS must integrate these principles in the provision of behavioral health services for members of EPSDT age:

a. Collaboration with the Child and Family: Respect for and active collaboration with the child and parents is the cornerstone to achieving positive behavioral health outcomes. Parent and children are treated as partners in the assessment process, and the planning, delivery, and evaluation of behavioral health services, and their preferences are taken seriously.

b. Functional Outcomes: Behavioral health services are designed and implemented to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Implementation of the behavioral health services plan stabilizes the child's condition and minimizes safety risks.

c. Collaboration with Others: When children have multi-agency, multi-system involvement, a joint assessment is developed and a jointly established behavioral health services plan is collaboratively implemented. Client centered teams plan and deliver services. Each child's team includes the child, parents, any foster parent, and any individual important in the child's life who is invited to participate by the child or parents. The team also includes all other persons needed to develop an effective plan, including as appropriate, the child's teacher, the child's Department of Child Safety case worker and/or Division of Developmental Disabilities Support Coordinator, and the child's probation officer. The team develops a common assessment of the child's and family's strengths and needs, develops an Individualized Service Plan/Person Centered Plan and monitors the implementation of the plan and makes adjustments in the plan if it is not succeeding.

d. Accessible Services: Children have access to a comprehensive array

of behavioral health services, sufficient to ensure that they receive the treatment they need. Case management is provided as needed. Behavioral health services plans identify transportation the parents and the child need to access behavioral health services, and how transportation assistance will be provided. Behavioral health services are adapted or created when they are needed but not available.

e. Best Practices: Behavioral health services are provided by competent individuals who are adequately trained and supervised. Behavioral health service plans identify and appropriately address behavioral symptoms that are reactions to death of a family member, abuse or neglect, learning disorders, and other similar traumatic or frightening circumstances, substance abuse problems, the specialized behavioral health needs of children are developmentally disabled, maladaptive sexual behavior, including abusive conduct and risky behavior, the need for stability and the need to promote permanency in the members' lives, especially members in foster care. Behavioral health services are continuously evaluated and modified if ineffective in achieving desired outcomes.

f. Most appropriate setting: Children are provided behavioral health services in their home and community to the extent possible. Behavioral health services are provided in the most integrated setting appropriate to meet the child's needs. When provided in a residential setting, the setting is the most integrated and most home-like setting that is appropriate to the child's needs.

g. Timeliness: Children identified as needing behavioral health services are assessed and served promptly.

h. Services tailored to the child and family: The unique strengths and needs of children and their families dictate the type, mix, and intensity of behavioral health services provided. Parents and children are encouraged and assisted to articulate their own strengths and needs, the goals they are seeking, and what services they think are required to meet these goals.

i. Stability: Behavioral health service places strive to minimize multiple placements. Service plans identify whether a member is at risk of experiencing a placement disruption and, if so, identify the steps to be taken to minimize or eliminate the risk. Behavioral health service plans anticipate crisis that might develop and include specific strategies and services that will be employed if a crisis develops. In responding to crises, the behavioral health system uses all appropriate behavioral health services to help the child remain at home, minimize placement disruptions, and avoid the inappropriate use of the police and the criminal justice system. Behavioral health service plans anticipate and appropriately plan for transition in children's lives, including transitions to new schools and new placements, and

transitions to adult services.

j. Respect for the child and family's unique cultural heritage: Behavioral health services are provided in a manner that respects the cultural tradition and heritage of the child and family. Services are provided in Spanish to children and parents whose primary language is Spanish.

k. Independence: Behavioral health services include support and training for parents in meeting their child's behavioral health needs, and support and training for children in self-management. Behavioral health service plans identify parents' and children's needs for training and support to participate as partners in the assessment process, and in the planning and delivery, and evaluation of services, and provide that such training and support, including transportation assistance, advance discussions, and help with the understanding of written materials, will be made available.

l. Connection to natural supports: The behavioral health system identifies and appropriately uses natural supports available from the child and parents' own network of associates, including friends and neighbors, and from community organizations, including service and religious organizations.

Note: PCPs are encouraged to implement postpartum depression screenings to identify and refer mothers who would benefit from additional treatment due to concerns related to postpartum depression during EPSDT visits for infants up to one year of age.

11. Religious Non-medical Health Care Institution Services – The Division covers religious non-medical health care institution services for members eligible for EPSDT services as described in Division Medical Policy Manual Chapter 300, Policy 310.

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

13. Chiropractic Services – The Division covers chiropractic services to members eligible for EPSDT services, when ordered by the member's PCP and approved by the AdSS in order to ameliorate the member's medical condition.

14. Personal Care Services – The Division covers personal care services, as appropriate, for members eligible for EPSDT services.

15. Incontinence Briefs

a. The AdSS must provide incontinence briefs, including pull-ups and incontinence pads, for members between 3 and 21 years of age and who are eligible for ALTCS. Briefs may be provided in order to prevent skin breakdown and to enable participation in social, community, therapeutic, and education activities. These supplies will be provided under the following circumstances when:

i. The member is incontinent due to a documented disability that caused incontinence of bowel and/or bladder.

ii. The PCP or attending physician has issued a prescription ordering the incontinence briefs.

iii. 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.

iv. The member obtains incontinence briefs from providers in the AdSS network.

v. Appropriate prior authorization requirements are applied. Prior authorization 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.

Prior authorization is permitted to ascertain that:

- The member is over age 3 and under age 21.
- The member has a disability that causes incontinence of bladder and/or bowel.
- 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 brief supplied by the AdSS.
- The prescription is for 240 briefs or fewer per month, unless evidence of medical necessity for over 240 briefs is provided.

b. The Division provides incontinence briefs for members who are between 3 and 21 years of age who are:

i. Group home residents that do not qualify for Medicaid (ALTCS or targeted).

ii. Group home residents that qualify for Medicaid (ALTCS) and have been denied incontinence briefs by the AdSS and other medical insurance coverage (e.g., Medicare), if applicable.

c. Authorized services must be for at least a 12-month period of time.

d. The AdSS may require a new prior authorization to be issued no more frequently than every 12 months.

e. Payments for the use of incontinence briefs for the convenience of caregivers will not be authorized.

f. If a member is eligible for Fee-For-Service coverage, the Health Care Services Unit will prior authorize using the same criteria outlined above. Health Care Services Prior Authorization can be contacted by calling 602-771-8080.

g. Any exceptions to this policy section must have the approval of the Assistant Director.

h. For information regarding incontinence briefs for members over the age of 21, see the Division Medical Policy Manual, 310-P, Medical Supplies, Durable Medical Equipment, and Prosthetic Devices (Acute Care Services.)

16. Medically Necessary Therapies – The Division 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.

When medically necessary, inpatient and outpatient therapies are covered. For children identified by the PCP as needing early intervention services, the AdSS must provide services in the natural environment whenever possible.

The Division has adopted Exhibit 430-3 in the AHCCCS Medical Policy Manual, to Procedures for the Coordination of Services under Early Periodic Screening, Diagnostic and Treatment, and Early Intervention (AMPM Exhibit 430-3). This Exhibit provides more information related to the coordination and referral process for early intervention services.

D. Sick Visit Performed in Addition to an EPSDT Visit

Billing of a "sick visit" (CPT Codes 99201-99215) at the same time as an EPSDT is a separately billable service if:

1. An abnormality is found or a preexisting problem is addressed while performing an EPSDT service and the problem or abnormality requires more work to perform the key components of a problem-oriented E/M service.

2. The "sick visit" is documented on a separate note.

3. History, Exam, and Medical Decision Making components of the separate "sick visit" already performed during the course of an EPSDT visit are not to be considered when determining the level of the additional service (CPT Code 99201-99215).

4. The current status (not history) of the abnormality or preexisting condition is the basis of determining medical necessity.

Modifier 25 must be added to the Office/Outpatient code to indicate that a significant, separately identifiable evaluation and management service was provided by the same physician on the same day as the preventive medicine service.

Acute diagnosis codes not applicable to the current visit should not be billed.

An insignificant or trivial problem/abnormality that is encountered during the preventive medicine evaluation and management service, but does not require additional work and the performance of the key components of a problem-oriented E/M service, is included in the EPSDT visit and should not be reported.

E. Requirements for Providing EPSDT Services

The AdSS must:

1. Develop policies and procedures to:

   a. Identify the needs of EPSDT-age members, inform members of the availability of EPSDT services, coordinate their care, provide care management, conduct appropriate follow up, and ensure members receive timely and appropriate treatment.

   b. Monitor, evaluate, and improve EPSDT participation.

2. Employ sufficient numbers of appropriately qualified local personnel to meet the health care needs of members and fulfill federal, state, and contractual EPSDT requirements.

3. Inform all participating PCPs about EPSDT requirements and monitor compliance with the requirements.

   This must include informing PCPs of Federal, State and AHCCCS and Division policy requirements for EPSDT and updates of new information as it becomes available.

4. Ensure PCPs providing care to children are trained to use implemented developmental screening tools. This will also include a process to monitor the use of an approved developmental screening tools (ASQ and PEDS Tool) for members at 9, 18, and 24 months of age. The MCHAT may be used for members 16-30 months of age to assess the risk of autism spectrum disorders in place of the ASQ or PEDS Tool when medically indicated. Providers are expected to be trained as specified by the American Academy of

Pediatrics, in order for the PCP to obtain additional reimbursement for use of an approved developmental screening tool during an EPSDT visit.

Note: Approved developmental screening tool training resources may be found on the Arizona Department of Health Services website.

5. Develop, implement, and maintain a program to inform members about EPSDT services within 30 days of enrollment with the AdSS. This information must include:

   a. The benefits of preventive health care

   b. Information that an EPSDT visit is a well-child visit

   c. A complete description of the services available as described in this section

   d. Information on how to obtain these services and assistance with scheduling appointments

   e. Availability of care management assistance in coordinating EPSDT covered services

   f. A statement that there is no copayment or other charge for EPSDT screening and resultant services, and

   g. A statement that assistance with medically necessary transportation and scheduling appointments is available to obtain EPSDT services.

6. The AdSS must conduct written and other member educational outreach related to immunizations, available community resources (WIC, AzEIP, and Head Start), dangers of lead exposure and recommended/mandatory testing, childhood obesity and prevention measures, age-appropriate risk prevention efforts (addressing injury and suicide prevention, bullying, violence, and risky sexual behavior), education on importance of using PCP in place of ER visits for non-emergent concerns, recommended periodicity schedule, and other AdSS-selected topics at least once every 12 months. These topics may be addressed separately or combined into one written outreach material; each topic must be covered during the twelve month period. EPSDT related outreach material, must include a statement informing members that an EPSDT visit is synonymous to a well-child visit. The Division has adopted Exhibit 400-3 in the AHCCCS Medical Policy Manual, AHCCCS Maternal Child Health/EPSDT Member Outreach which serves as an easy reference guide regarding member outreach.

   Outreach requirements for AdSS are included in the Division's Operations Policy Manual, Chapter 404.

7. Provide EPSDT information (as defined in paragraphs #5 and #6 above), in a second language, in addition to English, in accordance with the

requirements of the in Chapter 405-Cultural Competency in the Division's Operations Manual, Chapter 405.

8. Develop and implement processes to assist members and their families regarding community health resources, including but not limited to WIC, AzEIP, and Head Start.

9. Develop and implement processes to ensure the identification of member's needing care management services and the availability of care management assistance in coordinating EPSDT covered services.

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

11. Attend EPSDT-related meetings when requested by the Division.

12. Coordinate with other entities when the AdSS determines a member has other payor coverage.

13. 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, must occur on a timely basis, generally initiating services no longer than six months beyond the request for screening services, unless stated otherwise in this policy (refer to the AdSS Requirements section of this Policy).

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

15. Develop and implement a process for monitoring that providers use the most current EPSDT Tracking Forms at every EPSDT visit and that all age-appropriate screenings and services are conducted during each visit. If an electronic medical record is used, the electronic medical record must include all of the elements of the most current age-appropriate EPSDT Tracking Form.

16. Develop, implement, and maintain a procedure to notify all members/responsible parties of visits required by the AHCCCS EPSDT and Dental Periodicity Schedules. Processes other than mailings must be pre-approved by the Division. This procedure must include:

    a. Notification to members or responsible parties regarding due dates of each EPSDT visit. If an EPSDT visit has not taken place, a second written notice must be sent.

    b. Notification to members or responsible parties regarding due dates of biannual (one visit every six months) dental visits. If a dental visit has not taken place, a second notice must be sent.

18. Develop and implement processes to reduce no-show appointment rates for EPSDT services, and Provide targeted outreach to those members who did not show for appointments.

    Note: The AdSS must encourage all providers to schedule the next EPSDT screening at the current office visit, particularly for children 24 months of age and younger.

19. Implement processes to print two part carbonless EPSDT Tracking Forms (a copy for the medical record and a copy for providers to send to the AdSS Maternal Child Health/EPSDT Coordinator).

20. Distribute EPSDT Tracking Forms to contracted providers who do not use and submit electronic EPSDT forms to the AdSS.

21. Require the use of the AHCCCS EPSDT and Dental Periodicity Schedules and approved, standardized EPSDT Tracking Forms by all contracted providers. The AHCCCS EPSDT and Dental Periodicity Schedules give providers necessary information regarding timeframes in which age-related required screenings and services must be rendered by providers.

    The AdSS must require providers to complete all of the following requirements:

    a. Use the EPSDT Tracking Forms (or electronic equivalent) at every EPSDT visit. The AdSS must monitor the anticipated volume of EPSDT Tracking Forms received based on the number and age of the PCPs EPSDT age member panel.

    b. Perform all age-appropriate screening and services during each EPSDT visit in accordance with the AHCCCS EPSDT and Dental Periodicity Schedules, including, but not limited to, using the approved developmental screening tools, as described in this Chapter.

    c. Sign EPSDT Tracking Forms and place them in the member's medical record. If an electronic medical record is used, an electronic signature by the provider must be included.

    d. Send copies of the EPSDT Tracking Forms (or electronic equivalent) to the AdSS. Providers are not required to submit EPSDT Tracking Forms to the Division.

    e. Providers of Fee-For-Service members must maintain a copy of the EPSDT Tracking Forms (or electronic equivalent), per Division policy, in the medical record. Providers do not need to send copies to the Division. If an electronic medical record is used, an electronic signature by the provider must be included.

22. Submit the EPSDT/Adult Monitoring and Performance Measure Quarterly Report to the Division, a detailed progress report that describes the activities

of the quarter and the progress made in reaching the established goals of the plan, within 15 days of the end of each reporting quarter. The Division has adopted Exhibit 400-1-Maternal and Child Health Reporting Requirements in the AHCCCS Medical Policy Manual that outlines the requirements. Quarterly reports must include documentation of monitoring and evaluation of EPSDT requirements, and implementation of improvement processes. The quarterly report must include results of ongoing AdSS monitoring of performance rates, in a format that will facilitate comparison of rates in order to identify possible need for interventions to improve or sustain rates. The report must also identify the goals established by the AdSS; see EPSDT/Adult Monitoring and Performance Measure Quarterly Report (AMPM Appendix A), which has been adopted for use by the Division.

23. Participate in an annual review of EPSDT requirements conducted by the Division; including, but not limited to, AdSS results of on-site visits to providers and medical record audits.

24. Include language in PCP contracts that requires PCPs to:

    a. Provide EPSDT services for all assigned members from birth to 21 years of age in accordance with the AHCCCS EPSDT and Dental Periodicity Schedules.

    b. Agree to use the standardized AHCCCS EPSDT Tracking Forms or, if electronic medical records are use, they must contain all the elements of the current AHCCCS EPSDT Tracking Forms.

    c. Implement procedures to ensure compliance by PCPs with all EPSDT standards and contract requirements.

    d. 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).

    e. Have a process for to assisting members in navigating the healthcare system, as well as inform members of any other community-based resources that support optimal health outcomes, to ensure members receive appropriate support services.

    f. Implement protocols for coordinating care and services with the appropriate state agencies for members eligible for EPSDT, and ensure members are referred to support services, as well as other community-based resources to support good health outcomes.

    g. Refer eligible members to Head Start and the special supplemental nutrition program for Women, Infants and Children (WIC), for WIC approved formula and support services. Ensure medically necessary nutritional supplements are covered by the AdSS (For more

information, refer to the Nutritional Assessment and Nutritional Therapy section of this policy).

h. Use the criteria specified in this policy when requesting medically necessary nutritional supplements (refer Nutritional Assessment and Nutritional Therapy section of this policy and Exhibit 430-2, AHCCCS Certificate of Medical Necessity for Commercial Oral Nutritional Supplements in the AHCCCS Medical Policy Manual.

i. Coordinate with Arizona Early Intervention Program (AzEIP) to identify children 0-3 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 A.A.C. R9-22-201 et seq, must be provided by the AdSS). AdSS must require their providers to communicate results of assessments and services provided to AzEIP enrollees within 45 days of the member's AzEIP enrollment. Refer to Procedures for the Coordination of Services Under EPSDT and Early Intervention in the AHCCCS Medical Policy Manual (AMPM Exhibit 430-3) for more information related to the coordination and referral process for early interventions services.

25. Educate providers to comply with AHCCCS/AzEIP in the AMPM Exhibit 430-3, when the need for medically necessary services are identified for members birth to three years of age. This includes:

a. Ensuring medically necessary services are initiated within 45 days of a completed Individual Family Service Plan (IFSP), when services are requested by the AzEIP service coordinator.

b. Reimbursing all AHCCCS registered AzEIP providers, whether or not they are contracted with the AdSS. Non-contracted AHCCCS registered AzEIP providers will be reimbursed for authorized services at the Fee-For-Service (FFS) rates. IFSP services must be reviewed for medical necessity prior to reimbursement

26. Provide education and assists with referrals of eligible members to the special supplemental nutrition program for Women, Infants and Children (WIC), for WIC approved formula and support services and ensures medically necessary nutritional supplements are covered. Refer to C, EPSDT Service Standards and Nutritional Assessment and Nutritional Therapy sections of this policy and Exhibit 430-2, AHCCCS Certificate of Medical Necessity for Commercial Oral Nutritional Supplements in the AHCCCS Medical Policy Manual

27. Provide education and assists with referrals of eligible members to Head Start to ensure eligible members receive appropriate EPSDT services to optimize child health and development.

F. Each AdSS must have a written EPSDT Annual Plan that addresses minimum AdSS

requirements as specified in the prior section (Requirements for Providing EPSDT Services and Requirements for Oral Health Care), as well as the objectives of the AdSS' program that are focused on achieving Division and AHCCCS requirements. It must also incorporate monitoring and evaluation activities for these minimum requirements (see Exhibit 400-2B, EPDST Annual Plan Checklist).

The EPSDT Annual Plan must be submitted to the Division Health Care Services unit through the Division's Compliance Unit no later than December 15th for review and approval; see Maternal and Child Health Reporting Requirements (AMPM Exhibit 400-1). The written EPSDT Annual Plan must contain, at a minimum, the following:

1. EPSDT Narrative Plan – A written description of all planned activities to address the Division's minimum requirements for EPSDT services, as specified in the prior section (AdSS Requirements for Providing EPSDT Services), including, but not limited to, informing providers and members that EPSDT is a comprehensive child health program of prevention, treatment, correction, and improvement (amelioration) of physical and behavioral/mental health problems for members under the age of 21. The narrative description must also include AdSS activities to identify member needs, coordination of care, and follow-up activities to ensure appropriate treatment is received in a timely manner.

2. EPSDT Work Plan Evaluation – An evaluation of the previous year's Work Plan to determine the effectiveness of strategies, interventions, and activities used toward meeting stated objectives.

3. EPSDT Work Plan that includes:

    a. Specific measurable objectives based on Division established Minimum Performance Standards. When Division Minimum Performance Standards have been met, other generally accepted benchmarks that continue the improvement efforts by the AdSS will be used (e.g., National Committee on Quality Assurance, Healthy People 2020 standards). The AdSS may also develop its own specific measurable goals and objectives aimed at enhancing the EPSDT program when Minimum Performance Standards have been met. Objectives must include a focus toward blood lead testing and follow-up for abnormal blood lead test levels identified, childhood obesity, care coordination efforts, and member utilization.

    b. Strategies and specific measurable interventions to accomplish objectives (e.g., member outreach, provider education and provider compliance with mandatory components of the EPSDT program).

    c. Targeted implementation and completion dates of work plan activities.

    d. Assigned local staff position(s) responsible and accountable for meeting each established goal and objective.

e. Identification and implementation of new interventions, continuation of or modification to existing interventions, based on analysis of the previous year's Work Plan Evaluation.

4. Relevant policies and procedures, referenced in the EPSDT Annual Plan, submitted as separate attachments.

G. Fee-for-Service/EPSDT Provider Requirements

This section discusses the procedural requirements for FFS EPSDT service providers. FFS providers must:

1. Provide EPSDT services in accordance with 42 U.S.C. 1396d(a) and (r), 1396a (a) (43), 42 CFR 441.50 *et seq*., AHCCCS rules, and AHCCCS and Division policies.

2. Provide and document EPSDT screening services in accordance with the AHCCCS EPSDT and Dental Periodicity Schedules.

3. Refer members for follow up, diagnosis and treatment, ensuring that treatment is initiated within 60 days of screening services.

4. If appropriate, document in the medical record the member's or responsible person's decision not to use EPSDT services or receive immunizations.

5. Document a health database assessment on each EPSDT participant. The database must be interpreted by a physician or licensed health professional who is under the supervision of a physician, and Provide health counseling/education at initial and follow up visits.

H. Claim Forms

Claims for EPSDT services must be submitted on a CMS (formerly HCFA) 1500 form. Providers must bill for preventative EPSDT services using the preventative service, office or other outpatient services and preventive medicine CPT codes (99381 – 99385, 99391 – 99395) with an EP modifier. EPSDT visits are paid at a global rate for the services specified in this Chapter. With the exception of those items listed above as separately reimbursable services, no additional reimbursement is allowed. Providers must use an EP modifier to designate all services related to the EPSDT well child check-ups, including routine vision and hearing screenings.