



**430 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT
(EPSDT) SERVICES**

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DESCRIPTION

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is a comprehensive child health program of prevention, treatment, correction, and improvement (amelioration) of physical and behavioral/mental health conditions for AHCCCS members under 21 years of age. The purpose of EPSDT is to ensure the availability and accessibility of health care resources, as well as to assist Medicaid members in effectively utilizing 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 AHCCCS 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 USC 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. Members receiving EPSDT and Oral Health services through the RBHA are only covered for members 18 to 21 years of age. 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 the AHCCCS EPSDT section of this Chapter, as well as referenced EPSDT Periodicity Schedule (AMPM Exhibit 430-1) and AHCCCS Dental Periodicity Schedule (AMPM Exhibit 431-1).

Refer to AMPM Appendix B for the AHCCCS EPSDT Tracking Forms, 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 provided by AHCCCS Contractors (or electronic equivalent that includes all components found in the hard copy form) at every EPSDT visit.



AMOUNT, DURATION AND SCOPE

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 Federal Law Subsection 42 USC 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, AHCCCS statutes, rules, or policies, as long as the services are medically necessary and cost effective.

EPSDT includes, but is not limited to, coverage of: inpatient and outpatient hospital services, laboratory and x-ray services, physician services, nurse practitioner services, medications, dental services, therapy services, behavioral health services, medical supplies, prosthetic devices, eyeglasses, transportation, and family planning services. EPSDT also includes diagnostic, screening, preventive and rehabilitative services. However, 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 Title 42 of the Code of Federal Regulations (42 C.F.R. 441.58). Contractors must ensure members receive required health screenings in compliance with the AHCCCS EPSDT Periodicity Schedule and the AHCCCS Dental Periodicity Schedule. The AHCCCS Periodicity Schedule for EPSDT and dental services are intended to meet reasonable and prevailing standards of medical and dental practice and specifies screening services at each stage of the child's life (see Exhibits 430-1, AHCCCS EPSDT Periodicity Schedule and 431-1, AHCCCS Dental Periodicity Schedule). The service intervals represent 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 means, in the case of a child already enrolled with an AHCCCS Contractor, as early as possible in the child's life, or in other cases, as soon after the member's eligibility for AHCCCS services has been established.



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

Screening means 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 EPSDT program, screening and diagnosis are not synonymous.

Diagnostic means the 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 means any of the 29 mandatory or optional services described in Federal Law 42 USC 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, as well as inter-periodic screenings, as appropriate, for each member. Contractors must implement processes to ensure age appropriate screening and care coordination when member needs are identified. The Contractor must ensure providers utilize AHCCCS approved standard developmental screening tools and complete training in the use of these tools, as indicated by the American Academy of Pediatrics. The Contractor must monitor providers and implement interventions for non-compliance. Contractors must ensure that the Bloodspot Newborn Screening Panel and hearing tests are conducted, including initial and secondary screenings, in accordance with 9 A.A.C. 13, Article 2.

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 represent minimum requirements, and 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 (AMPM Exhibit 430-1). Exceptions to payments are noted in each of the paragraphs listed below. Only those services specifically identified below as a separately billable service may be billed separately or in addition to the EPSDT visit.



EPSDT/Well Child visits must include the following:

1. A comprehensive health and developmental history, including growth and development screening [42 C.F.R. 441.56(B)(1)] which includes physical, nutritional and behavioral health assessments. (Refer to the Centers for Disease Control and Prevention website at <http://www.cdc.gov/growthcharts/> 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 (AMPM Exhibit 430-1), 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 - AHCCCS covers behavioral health services for members eligible for EPSDT. EPSDT behavioral health services include the services listed in Federal Law 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. 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 Tribally operated 638 facility, regardless of health plan enrollment or behavioral health assignment. PCPs that elect to 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 included as part of an EPSDT visit and are 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 utilized 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.

AHCCCS 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 primary care provider, 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 Section C,



EPSDT Service Standards, Item 3 – Blood Lead Screening of this policy for more information.

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

8. Health education, counseling, and chronic disease self-management are not separately billable services and are considered 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 primary care provider'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 are covered during an EPSDT visit. EPSDT covers eye examinations as appropriate to age according to the AHCCCS EPSDT Periodicity Schedule (AMPM Exhibit 430-1) 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 considered part of the EPSDT visit and are not a separately billable services.

Ocular photoscreening with interpretation and report, bilateral (CPT code 99177) is covered for children ages 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 photoscreening 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 AHCCCS 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.

Contractors must 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 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), and
 - 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:
- 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, and
 - 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 AHCCCS standards (see [Appendix B](#)). The tracking forms must be signed by the clinician who performs the screening. Contractors are responsible for monitoring PCPs' use of and submission of EPSDT Tracking Forms, whether hard copy or electronic, to the Contractor's Maternal and Child Health Unit.

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 at <http://www.cdc.gov/vaccines/schedules/index.html> for current immunization schedules.)

AHCCCS will cover the human papilloma virus (HPV) vaccine for female and male EPSDT members age 11 to 21 years of age. AHCCCS will cover members nine and ten years of age, if the member is deemed to be in a high-risk situation. For adult immunizations, refer to AMPM Policy 310-M, *Immunizations*. 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 at <http://www.cdc.gov/vaccines/schedules/index.html> where this information is included). Contractors must ensure providers enroll and re-enroll annually with the VFC program, in accordance with AHCCCS Contract requirements. The Contractor shall not utilize AHCCCS funding to purchase vaccines covered through the VFC program for members younger than 19 years of age.

Contractors must ensure providers document each EPSDT age member's immunizations in the Arizona State Immunization Information System (ASIIS) registry. In addition, Contractors must ensure providers maintain the ASIIS immunization records of each EPSDT member in ASIIS, in accordance with A.R.S. Title 36, Section 135. Contractors are required to 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 fingerstick, 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.

Contractors 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).

Contractors 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 AHCCCS Contractor, and
- c. Referral of members who lose AHCCCS 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 AMPM Chapter 500, *Care Coordination Requirements* for more information related to transitioning members.

4. **Organ and Tissue Transplantation Services** - Refer to Chapter 300 (Policy 310-DD with Attachment A) in this Manual for a discussion of AHCCCS-covered transplantations.
5. **Tuberculosis (TB) Screening** - EPSDT covers TB screening. Contractors 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

Nutritional Assessments Nutritional assessments are conducted to assist EPSDT members whose health status may improve with nutritional intervention. AHCCCS 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. 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.

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

If an AHCCCS covered member qualifies for nutritional therapy due to a medical condition (as described in the Nutritional Therapy section, paragraph D found below), then AHCCCS Contractors are the primary payor for:

- a. Infant formulas above the amount provided through the WIC program or formula types deemed medically necessary that are not provided through the 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.
 - i. For AHCCCS members, infants and children under the age of five, requiring formula types deemed medically necessary that are not provided through the WIC program, an AHCCCS Certificate of Medical Necessity for Commercial Oral Nutritional Supplements (Exhibit 430-3) is to be submitted directly to the member's Contracted Health Plan, as WIC is considered a secondary payor of specialty exempt formulas.
 - ii. For AHCCCS members, infants (0-1 year), requiring infant formulas above the amount provided through the WIC program, an AHCCCS Certificate of Medical Necessity for Commercial Oral Nutritional Supplements (AMPM Exhibit 430-3) is to be submitted directly to the member's Contracted Health Plan for the amount of formula that exceeds that provided through the WIC program.
NOTE: WIC is considered a secondary payor of infant formulas above the amount provided through the WIC program.
- b. Medical foods
- c. Parenteral feedings
- d. Enteral feedings

If an AHCCCS covered 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 AMPM Policy 320-H, *Metabolic Medical Foods*.



Nutritional Therapy AHCCCS 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. AHCCCS Contractors are the primary payor for parenteral and enteral feedings, unless nutritional therapy is covered by a member's primary insurance.

- a. 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 AHCCCS Contractor for managed care members, and the AHCCCS Care Management Systems Unit (CMSU) for Fee-For-Service members regarding PA requirements.
- b. 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 specific AHCCCS Contractor for managed care members, and the AHCCCS CMSU Unit for Fee-For-Service members regarding PA requirements.
- c. 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.
 - i. Prior Authorization (PA) is required from the member's Managed Care Contractor or Tribal Case Manager or the AHCCCS Care Management Systems Unit (CMSU) Unit for Fee-For-Service members for commercial oral nutritional supplements, unless the member is also currently receiving nutrition through enteral or parenteral feedings.
 - ii. Medical necessity for commercial oral nutritional supplements must be determined on an individual basis 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, Exhibit 430-2, *AHCCCS Certificate of Medical Necessity for Commercial Oral Nutritional Supplements* to obtain authorization from the member's Managed Care Contractor or the AHCCCS Administration for FFS members.
 - iii. The Certificate of Medical Necessity for Commercial Oral Nutritional Supplements must indicate which 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:

At least two of the following criteria have been met for the basis of establishing medical necessity:

- (a) 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.
- (b) 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.
- (c) The member has already demonstrated a medically significant decline in weight within the the three month period prior to the assessment.
- (d) The member is able to 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, etc.), and
 - (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 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 Exhibit 430-2, *Certificate of Medical Necessity for Commercial Oral Nutritional Supplements* 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 prior authorization request.
- d. 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 includes:
- i. Initial Requests
 - (a) 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.



- (b) 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).
 - (c) 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.
- ii. Ongoing Requests
- (a) 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.
 - (b) Additionally, documentation demonstrating encouragement and assistance provided to the caregiver in weaning the member from supplemental nutritional feedings should be included, when appropriate.

Refer to the specific AHCCCS Contractor for managed care members, and the Utilization Management/Care Management Unit for Fee-For-Service members regarding PA requirements.

CONTRACTOR REQUIREMENTS

- a. Contractors must develop guidelines for use by the PCP in providing the following:
 - i. Information necessary to obtain PA for commercial oral nutritional supplements,
 - ii. Encouragement and assistance to the caregiver in weaning the member from the necessity for supplemental nutritional feedings, and
 - iii. 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.
- b. Contractors must implement protocols for transitioning a child who is receiving nutritional therapy, to or from another Contractor or another service program (e.g., Women, Infants and Children).



- c. Contractors must 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.

PROVIDER REQUIREMENTS

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

- a. 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.
- b. 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.
- c. 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.
- d. Documentation demonstrating encouragement and assistance provided to the caregiver in weaning the member from the necessity for supplemental nutritional feedings, when appropriate.

Refer to AMPM Policy 520, *Member Transitions* for more information related to transitioning members.

7. **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 Exhibit 431-1, *AHCCCS Dental Periodicity Schedule*, of this Chapter for more details pertaining to covered services, provider and Contractor requirements.
8. **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. AHCCCS covers medically necessary services for cochlear implantation solely for EPSDT age members. Cochlear implantation is limited to one functioning implant per member. AHCCCS 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) 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,
 - (b) 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,
 - (c) No known contraindications to surgery,
 - (d) Demonstrated age appropriate cognitive ability to use auditory clues, and
 - (e) The device must be used in accordance with the FDA approved labeling.
- ii. Coverage of cochlear implantation includes the following treatment and service components:
 - (a) Complete auditory testing and evaluation by an otolaryngologist, speech-language pathologist or audiologist
 - (b) Pre-surgery inpatient/outpatient evaluation by a board certified otolaryngologist
 - (c) Diagnostic procedures and studies, including CT scan or other appropriate radiologic evaluation, for determining candidacy suitability
 - (d) Pre-operative psychosocial assessment/evaluation by psychologist or counselor
 - (e) Prosthetic device for implantation (must be non-experimental/non-investigational and be Food and Drug Administration approved and used according to labeling instructions)
 - (f) Surgical implantation and related services
 - (g) Post-surgical rehabilitation, education, counseling and training
 - (h) 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 which 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 Contractor Medical Director, or from the AHCCCS Medical Director or designee for FFS



members. Refer to AMPM Chapter 800 PA requirements for FFS providers.

- b. Osseointegrated implants (Bone Anchored Hearing Aid [BAHA])
AHCCCS 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 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 is the same as in Item 8.a.(1)(i) above.

9. **Conscious Sedation** – AHCCCS covers conscious sedation for members receiving EPSDT services. Conscious sedation provides a state of consciousness that allows the member to tolerate an unpleasant procedure while continuously maintaining adequate cardiovascular and respiratory function, as well as the ability to respond purposely to verbal command and/or tactile stimulation.

Coverage is limited to the following procedures except as specified below:

- 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, and
- 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 Contractor Medical Director for enrolled members or by the AHCCCS Chief Medical Officer or designee for FFS members.

10. **Behavioral Health Services** – AHCCCS covers behavioral health services for members eligible for EPSDT services as described in AMPM Policy 310 and the Behavioral Health Services Guide. EPSDT behavioral health services include the services listed in Federal Law 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.

There are two appendices, AMPM Appendix E for children and adolescents and AMPM 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. The clinical guidelines are to be used by the PCPs as an aid in treatment decisions. PCPs that elect to prescribe medications



to treat ADHD, depression, or anxiety disorders must complete an annual assessment of the member's behavioral health condition and treatment plan. Contractors 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, Contractors are required to identify and conduct outreach to members approaching the 12 month re-assessment timeframe and provide assistance in scheduling the appointment with the member's PCP.

AHCCCS has implemented 12 Principles to maintain the integrity of the best practices and approaches to providing behavioral health services for children. Contractors are required to integrate these principles in the provision of behavioral health services for EPSDT age members.

Principles:

1. 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.
2. 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.
3. 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 Child Protective Service and/or Division of Developmental Disabilities case worker, 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 and monitors the implementation of the plan and makes adjustments in the plan if it is not succeeding.
4. 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.

5. **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 class members' lives, especially class members in foster care. Behavioral health services are continuously evaluated and modified if ineffective in achieving desired outcomes.
6. **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.
7. **Timeliness:** Children identified as needing behavioral health services are assessed and served promptly.
8. **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.
9. **Stability:** Behavioral health service places strive to minimize multiple placements. Service plans identify whether a class 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.
10. **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.

11. 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.
12. Connection to natural supports: The behavioral health system identifies and appropriately utilizes 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** – AHCCCS covers religious non-medical health care institution services for members eligible for EPSDT services as described in Chapter 300, Policy 310.
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 a child, 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 in order 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
- f. Prior authorization has been obtained as required by the Administration, Contractor, or Contractor's designee. Contractors may require a new prior authorization to be issued no more frequently than every twelve months. 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 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 children identified by the PCP as needing early intervention services, Contractors are required to provide services in the natural environment whenever possible. Refer to Procedures for the Coordination of Services under Early Periodic Screening, Diagnostic and Treatment, and Early Intervention (Exhibit 430-3), for more information related to the coordination and referral process for early interventions 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 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 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 in the process of performing the preventive medicine evaluation and management 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 EPSDT visit and should not be reported.

E. CONTRACTOR REQUIREMENTS FOR PROVIDING EPSDT SERVICES

This section provides the procedural requirements for Contractors.

The Contractor must develop policies and procedures to 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.

Contractors must develop policies and procedures to monitor, evaluate, and improve EPSDT participation.

Contractors must:

1. Employ sufficient numbers 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.



2. Inform all participating Primary Care Providers (PCPs) about EPSDT requirements and monitor compliance with the requirements.

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

3. Ensure PCPs providing care to children are trained to use implemented developmental screening tools. This will also include a process to monitor the utilization of AHCCCS 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 one AHCCCS 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.

4. Develop, implement, and maintain a program to inform members about EPSDT services within 30 days of enrollment with the Contractor. 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.
5. Contractors must conduct written and other member educational outreach related to immunizations, available community resources (WIC, AzeIP, CRS, Behavioral Health, 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 utilizing primary care provider 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 must be covered during the twelve month period. EPSDT related outreach material, must include a statement informing members that an



EPSDT visits is synonymous to a well child visit. (Refer to Exhibit 400-3, *AHCCCS Maternal Child Health/EPSDT Member Outreach*.)

Outreach requirements for Contractors are included in ACOM Policy 404.

6. Provide EPSDT information (as defined in paragraphs #4 and #5 above), in a second language, in addition to English, in accordance with the requirements of the AHCCCS Division of Health Care Management (DHCM) “Cultural Competency” policy available in the AHCCCS Contractor Operations Manual.
7. Develop and implement processes to assist members and their families regarding community health resources, including but not limited to WIC, AzEIP, and Head Start.
8. 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.
9. Participate in community and/or quality initiatives, to promote and support best local practices and quality care, within the communities served by the Contractor.
10. Attend EPSDT related meetings when requested by AHCCCS.
11. Coordinate with other entities when the Contractor determines a member has third party coverage.
12. 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 Contractor Requirements section within this Policy).
13. Develop, implement, and maintain a process to provide appropriate follow-up care for members who have abnormal blood lead test results.
14. 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 utilized, the electronic medical record must include all of the elements of the most current age appropriate EPSDT Tracking Form.
15. 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 AHCCCS Clinical Quality Management. 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.

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

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

18. 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 Contractor Maternal Child Health/EPSDT Coordinator).
19. Distribute EPSDT Tracking Forms to contracted providers who do not use and submit electronic EPSDT forms to the Contractor.
20. Require the use of the AHCCCS EPSDT and Dental Periodicity Schedules and AHCCCS approved, standardized EPSDT Tracking Forms (see AMPM Appendix B) 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.

Contractors must require providers to complete all of the following requirements:

- a. Use the EPSDT Tracking Forms (or electronic equivalent) at every EPSDT visit. Contractors 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, utilizing the AHCCCS 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 Contractor. Providers are not required to submit EPSDT Tracking Forms to AHCCCS.
 - e. Providers of Fee-For-Service members must maintain a copy of the EPSDT Tracking Forms (or electronic equivalent), per AHCCCS policy, in the medical record. Providers do not need to send copies to AHCCCS. If an electronic medical record is used, an electronic signature by the provider must be included.
21. Submit the EPSDT/Adult Monitoring and Performance Measure Quarterly Report to AHCCCS DHCM CQM, 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 (see Exhibit 400-1, *Maternal and Child Health Reporting 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 Contractor's ongoing 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 Contractor's established goals (see Appendix A, *EPSDT/Adult Monitoring and Performance Measure Quarterly Report*, for report template and requirements/instructions).
22. Participate in an annual review of EPSDT requirements conducted by AHCCCS; including, but not limited to, Contractor results of on-site visits to providers and medical record audits.
23. Include language in PCP contracts that requires PCPs to:
- a. Provide EPSDT services for all assigned members from birth to 21 years of age. Services must be provided in accordance with the AHCCCS EPSDT and Dental Periodicity Schedules.
 - b. Agree to utilize the standardized AHCCCS EPSDT Tracking Forms or, if electronic medical records are utilized, 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 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 that members receive appropriate support services.



- f. Implement protocols for coordinating care and services with the appropriate state agencies for EPSDT eligible members, and ensure that 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 that medically necessary nutritional supplements are covered by the Contractor (For more information, refer to Refer to Section C, EPSDT Service Standards, Item 6 - Nutritional Assessment and Nutritional Therapy of this policy).
 - h. Utilize the criteria specified in this policy when requesting medically necessary nutritional supplements (Refer to Section C, EPSDT Service Standards, Item 6 - Nutritional Assessment and Nutritional Therapy of this policy and AMPM Exhibit 430-2, *AHCCCS Certificate of Medical Necessity for Commercial Oral Nutritional Supplements*).
 - 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 9 A.A.C. 22, Article 2, must be provided by the Contractors). Contractors 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 (Exhibit 430-3) for more information related to the coordination and referral process for early interventions services.
24. Educate providers to comply with AHCCCS/AzEIP Procedures for the Coordination of Services under Early Periodic Screening, Diagnostic and Treatment, and Early Intervention (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 AHCCCS Contractor. 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
25. 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 Section C, EPSDT Service Standards, and Item



6 - Nutritional Assessment and Nutritional Therapy of this policy and AMPM Exhibit 430-2, *AHCCCS Certificate of Medical Necessity for Commercial Oral Nutritional Supplements*).

26. 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.
27. 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.

F. CONTRACTOR REQUIREMENTS FOR THE EPSDT ANNUAL PLAN

Each Contractor must have a written EPSDT Annual Plan that addresses minimum Contractor requirements as specified in the prior section (Contract Requirements for Providing EPSDT Services – numbers one through 27 and Contractor Requirements for Oral Health Care – numbers one through four), as well as the objectives of the Contractor’s program that are focused on achieving 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 no later than December 15th to the AHCCCS Division of Health Care Management/Clinical Quality Management Unit and is subject to approval (see Exhibit 400-1, Maternal and Child Health Reporting Requirements). 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 Contractor’s minimum requirements for EPSDT services, as specified in the prior section (Contractor Requirements for Providing EPSDT Services - Numbers 1 through 27), 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 AHCCCS members under the age of 21. The narrative description must also include Contractor 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. These objectives must be based on AHCCCS established Minimum Performance Standards. In cases where AHCCCS



Minimum Performance Standards have been met, other generally accepted benchmarks that continue the Contractor's improvement efforts will be used (e.g., National Committee on Quality Assurance, Healthy People 2020 standards). The Contractor may also develop their 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 Section 42 USC 1396d(a) and (r), 1396a (a) (43), 42 C.F.R. 441.50 et seq. and AHCCCS rules and 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 legal guardian's decision not to utilize 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
6. 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.