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

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Description. EPSDT is a comprehensive child health program of prevention, treatment, correction, and improvement (amelioration) of physical and mental health problems for AHCCCS members under the age of 21. The purpose of EPSDT is to ensure the availability and accessibility of health care resources as well as to assist Medicaid recipients 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 problems for AHCCCS members less than 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 mental illnesses and conditions identified in an EPSDT screening whether or not the services are covered under the AHCCCS State Plan. 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 and includes all screenings and services described in the AHCCCS EPSDT visit and includes all screenings and services described in the AHCCCS EPSDT and Dental Periodicity Schedules throughout this Chapter.

Refer to 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.

<u>Amount, Duration and Scope</u>. 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 28 optional and mandatory categories of "Medical Assistance" as defined in the Medicaid Act. Services covered under EPSDT include all 28 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.

EPSDT screening services are provided in compliance with the periodicity requirements of Title 42 of the Code of Federal Regulations (42 CFR 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 Schedules for EPSDT 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 and 430-1A). The service intervals represent minimum requirements, and any services determined by a primary care provider 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

1. 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.

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

3. Screening means regularly scheduled examinations and evaluations of the general physical and behavioral health, growth, development, and nutritional status of infants, children and youth, 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.

4. 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.

5. Treatment means any of the 28 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. SCREENING REQUIREMENTS

Comprehensive periodic screenings must be performed by a clinician according to the time frames identified in the AHCCCS EPSDT (Early and Periodic Screening, Diagnostic and Treatment) Periodicity Schedule, the AHCCCS Dental Periodicity Schedule and 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 will encourage providers to utilize AHCCCS approved standard developmental screening tools and complete training in the use of the tools. The Contractor must monitor providers and implement interventions for non-compliance. Contractors must ensure that the newborn screening tests are conducted, including initial and second screening, 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 guidelines of the American Academy of Pediatrics. EPSDT screenings must include the following:

1. A comprehensive health and developmental history, including growth and development screening (42 CFR 441.56(B)(1) which includes physical, nutritional and behavioral health assessments (See Appendix I, Body Mass Index Charts).

   As of January 1, 2006, the Parents' Evaluation of Developmental Status (PEDS) developmental screening tool should be utilized for developmental screening by all participating primary care providers (PCPs) who care for EPSDT-age members admitted to the Neonatal Intensive Care Unit (NICU) following birth. The PEDS screening should be completed for NICU-discharged EPSDT members from birth through eight (8) years of age.

   The PEDS tool may be obtained from www.pedstest.com or www.forepath.org.

   Refer to Subsection 430-D of this Policy for PCP training and reimbursement.

2. A comprehensive unclothed physical examination

3. Appropriate immunizations according to age and health history

4. 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)

5. Health education

6. Appropriate oral health screening, intended to identify oral pathology, including tooth decay and/or oral lesions, conducted by a physician, physician's assistant or nurse practitioner

7. Appropriate vision, hearing, and speech testing and diagnosis, as well as treatments for defects in vision and hearing, including provision of eyeglasses and hearing aids. Appropriate medically necessary therapies, including speech therapy, are also covered under EPSDT.

Contractors must ensure that:

a. Each hospital or birthing center screens all newborns using a physiological hearing screening method as early as clinically possible prior to initial discharge

b. Each hospital or birthing center provides outpatient re-screening for babies who were missed or are referred from the initial screen. Outpatient 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 is referred to a medical home for appropriate assessment, and

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

8. 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 compliance with AHCCCS standards (see Appendix B). The tracking forms must be signed by the clinician who performs the screening.

EPSDT providers must adhere to the following specific standards and requirements:

1. **Immunizations** - EPSDT covers all child and adolescent immunizations as specified in the AHCCCS EPSDT Periodicity Schedule. All appropriate immunizations must be provided to establish, and maintain, up-to-date immunization status for each EPSDT member (see Exhibit 430-2 for schedule).

   Effective 12/01/2006, AHCCCS will cover the human papilloma virus (HPV) vaccine for female EPSDT members per the Advisory Committee on Immunization Practices recommended schedule.

   Providers must coordinate with the Arizona Department of Health Services 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 included in Exhibit 430-2. 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 VFC vaccines for members younger than 19 years of age.

   Contractors must ensure providers document each EPSDT member's immunization in the Arizona State Immunization Information System (ASIIS) and maintain the ASIIS immunization records of each EPSDT member in ASIIS in accordance with A.R.S. Title 36, Section 135.

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. Prescriptive lenses are provided to correct or ameliorate defects, physical illness and conditions discovered by EPSDT screenings, subject to medical necessity.

3. **Blood Lead Screening** - EPSDT covers blood lead screening. All children are considered at risk and must be screened for lead poisoning. All children must receive a screening blood lead test at 12 months 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. 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 6 through 72 months of age (up to 6 years of age) to assist in determining risk.

Contractors must ensure that providers report blood lead levels equal to or greater than 10 micrograms of lead per deciliter of whole blood to the Arizona Department of Health Services (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, and

b. Transitioning a child who has an elevated blood lead level to or from another AHCCCS Contractor.

Refer to Chapter 500 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 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 nutrition intervention. AHCCCS covers the assessment of nutritional status provided by the member's primary care provider (PCP) as a part of the EPSDT screenings 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 under or overweight.

To initiate the referral for a nutritional assessment, the PCP must use the Contractor referral form in accordance with Contractor protocols. Prior authorization (PA) is not required when the assessment is ordered by the PCP.

If an AHCCCS covered member qualifies for nutritional therapy due to a medical condition as described in this section, then AHCCCS Contractors are the primary payor for:

- WIC-eligible infant formulas
- Medical foods
- Parenteral feedings
- Enteral feedings

If an AHCCCS covered member has a congenital metabolic disorder (such as Phenylketonuria, Homocystinuria, Maple Syrup Urine Disease or Galactosemia), refer to Chapter 300, Policy 320 (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.

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 PA Unit 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 Prior Authorization 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.

(1) PA is required for commercial oral nutritional supplements unless the member is also currently receiving nutrition through enteral or parenteral feedings. PA is not required for the first 30 days if the member requires commercial oral nutritional supplements on a temporary basis due to an emergent condition.

(2) Medical necessity for commercial oral nutritional supplements must be determined on an individual basis by the member's PCP or attending physician, using at least 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 attending physician must use the AHCCCS approved form, "Certificate of Medical Necessity for Commercial Oral Nutritional Supplements" (Exhibit 430-3) to obtain PA from the Contractor.

(3) The Certificate of Medical Necessity for Commercial Oral Nutritional Supplements must document that the PCP or attending physician has provided nutritional counseling as a part of the EPSDT services provided to the member. The documentation must specify alternatives that were tried in an effort to boost caloric intake and/or change food consistencies before considering commercially available nutritional supplements for oral feedings, or to supplement feedings.

d. 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. At least two of the following criteria must be met:

(1) The member is at or below the 10th percentile on the appropriate growth chart for their age and gender for three months or more

(2) The member has reached a plateau in growth and/or nutritional status for more than six months (prepubescent)

(3) The member has already demonstrated a medically significant decline in weight within the past three months (prior to the assessment)

(4) The member is able to consume/eat no more than 25% of his/her nutritional requirements from age-appropriate food sources

(5) Absorption problems as evidenced by emesis, diarrhea, dehydration, and/or weight loss and intolerance to milk or formula products has been ruled out

(6) The member requires nutritional supplements on a temporary basis due to an emergent condition; i.e. post-hospitalization (PA is not required for the first 30 days), or

(7) The member is at high risk for regression due to chronic disease or condition and there are no alternatives for adequate nutrition.

Contractors must develop guidelines for use by the PCP in providing the following:

a. Information necessary to obtain PA for commercial oral nutritional supplements

b. Encouragement and assistance to the caregiver in weaning the member from the necessity for supplemental nutritional feedings, and

c. 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 blenderized or specially prepared for the member.

Contractors must implement protocols for transitioning a child (who is receiving nutritional therapy) to or from another Contractor, or another service program (i.e., Women, Infants and Children).

Refer to Chapter 500, Policy 520, 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. Depending on the results of the oral health screening, referral to a dentist must be made as outlined in the Acute Care contract:

Category	Recommendation for Next Dental Visit
Emergent	Within 24 hours of request
Urgent	Within three days of request
Routine	Within 45 days of request

An oral health screening must be part of an EPSDT screening conducted by a PCP, however, it does not substitute for examination through direct referral to a dentist. PCPs are expected to refer EPSDT members for appropriate services based on needs identified through the screening process and for routine dental care based on the AHCCCS EPSDT Periodicity Schedule. Evidence of this referral must be documented on the EPSDT form.

Note: Although the AHCCCS Dental Periodicity Schedule identifies when routine referrals begin, PCPs may refer EPSDT members for a dental assessment at an earlier age if their oral health screening reveals potential carious lesions or other conditions requiring assessment and/or treatment by a dental professional. In addition to PCP referrals, EPSDT members are allowed self-referral to a dentist who is included in the Contractor's provider network.

EPSDT covers the following dental services:

a. Emergency dental services including:

(1) Treatment for pain, infection, swelling and/or injury

(2) Extraction of symptomatic (including pain), infected and non-restorable primary and permanent teeth, as well as retained primary teeth (extractions are limited to teeth which are symptomatic), and

(3) General anesthesia, conscious sedation or anxiolysis (minimal sedation, patients respond normally to verbal commands) when local anesthesia is contraindicated or when management of the patient requires it.

(See #9 of this section regarding conscious sedation policy)

b. Preventive dental services provided as specified in the AHCCCS Dental Periodicity Schedule (Exhibit 430-1A), including, but not limited to:

(1) Diagnostic services including comprehensive and periodic examinations

All Contractors must allow two oral examinations and two oral prophylaxis and fluoride treatments per member per year (i.e., one every six months) for members 12 months through 20 years of age

(2) Radiology services which are screening in nature for diagnosis of dental abnormalities and/or pathology, including panoramic or full-mouth x-rays, supplemental bitewing x-rays, and occlusal or periapical films as needed, and

(3) Preventive services which include:

(a) Oral prophylaxis performed by a dentist or dental hygienist which includes self-care oral hygiene instructions to member, if able, or to the parent/legal guardian

(b) Application of topical fluorides. Use of a prophylaxis paste containing fluoride and fluoride mouth rinses do not meet the AHCCCS standard for fluoride treatment (fluoride treatment in the PCP office is not a covered service)

(c) For members under age sixteen, dental sealants on all non-carious permanent first and second molars, and

(d) Space maintainers when posterior primary teeth are lost permanently.

c. All therapeutic dental services will be covered when they are considered medically necessary and cost effective but may be subject to PA by the Contractor, or AHCCCS Division of Fee-for-Service Management for FFS members. These services include but are not limited to:

   (1) Periodontal procedures, scaling/root planing, curettage, gingivectomy, and osseous surgery

   (2) Crowns:

      (a) When appropriate, stainless steel crowns may be used for both primary and permanent posterior teeth; composite, prefabricated stainless steel crowns with a resin window or crowns with esthetic coatings should be used for anterior primary teeth, or

      (b) Precious or cast semi-precious crowns may be used on functional permanent endodontically treated teeth, except third molars, for members who are 18 through 20 years old.

   (3) Endodontic services including pulp therapy for permanent and primary teeth, except third molars (unless a third molar is functioning in place of a missing molar)

   (4) Restoration of carious permanent and primary teeth with accepted dental materials other than cast or porcelain restorations unless the member is 18 through 20 years of age and has had endodontic treatment, and

   (5) Removable dental prosthetics, including complete dentures and removable partial dentures

   (6) Orthodontic services and orthognathic surgery are covered only when these services are necessary to treat a handicapping malocclusion. Services must be medically necessary and determined to be the primary treatment of choice or an essential part of an overall treatment plan developed by both the PCP and the dentist in consultation with each other. Orthodontic services are not covered when the primary purpose is cosmetic.

Examples of conditions that may require orthodonic treatment include the following:

(a) Congenital craniofacial or dentofacial malformations requiring reconstructive surgical correction in addition to orthodontic services, or

(b) Trauma requiring surgical treatment in addition to orthodontic services, or

(c) Skeletal discrepancy involving maxillary and/or mandibular structures.

Services or items furnished solely for cosmetic purposes are excluded from AHCCCS coverage (9 A.A.C. 22, Article 2).

Refer to Chapter 800 for information related to FFS dental services and prior authorization requirements.

Refer to Chapter 300, Policy 320, Affiliated Practice Dental Hygienist Policy, regarding services for members 18 years of age or younger provided by dental hygienists with an affiliated practice agreement.

8. **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, as described in Chapter 300, Policy 320, for EPSDT members.

   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.

   Cochlear implantation requires PA from the Contractor Medical Director, or from the AHCCCS Chief Medical Officer or designee for FFS members.

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 will be 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 Chapter 300, 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, Appendix E for children and adolescents and Appendix F for adults. For the diagnosis of attention deficit disorder/attention deficit hyperactivity disorder, 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.

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. **Case Management Services** – AHCCCS covers case management services as appropriate for members eligible for EPSDT services. In EPSDT, case 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, 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 twenty-one years old

    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 providers in 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:

       (1) The member is over age three and under age twenty-one;

       (2) The member has a disability that causes incontinence of bladder and/or bowel;

       (3) 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

       (4) 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 and physical and mental illnesses and conditions discovered by the screening services. Therapies are covered under both an inpatient and outpatient basis when medically necessary.

D. 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 aged members, inform members of the availability of EPSDT services, coordinate their care, conduct adequate follow up, and ensure that members receive timely and appropriate treatment.

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

Contractors must:

1. Employ sufficient numbers of appropriately qualified personnel in order to meet the health care needs of members and fulfill Federal and State EPSDT requirements as well as to achieve contractual compliance.

2. Inform all participating primary care providers (PCPs) about EPSDT requirements.

   This must include informing PCPs of Federal, State and AHCCCS policy requirements for EPSDT and updates of new information as it becomes available, including the 01/01/2006 implementation of the Parents' Evaluation of Developmental Screening (PEDS) tool for developmental screening by trained PCPs at each visit for NICU discharged members from birth to eight years of age.

3. Develop processes to:

   a. Ensure PCPs providing care to children are trained to use the PEDS tool. The PCP will obtain additional reimbursement for use of the PEDS tool during EPSDT visits for NICU-discharged EPSDT members only when there is proof of PEDS tool training.

b. Assist families with NICU-discharged children in the selection of PEDS trained providers. AHCCCS Contractors may verify PEDS training with online resources.

c. Notify PCPs when a NICU-discharged member is assigned to their panel.

d. Ensure appropriate reimbursement of claims is submitted for use of the PEDS tool.

e. Monitor providers for compliance with training and use of the PEDS tool.

f. Implement specific interventions to improve provider compliance of PEDS training and use.

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. A statement that there is no co-payment or other charge for EPSDT screening and resultant services, and

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

   g. Outreach requirements for Contractors are included in ACOM Policy 404.

5. Provide EPSDT information, defined in #4 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 (available online at www.azahcccs.gov).

6. Develop and implement processes to assist members and their families regarding community health resources, including but not limited to WIC, AZEIP, and behavioral health.

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

8. Attend EPSDT related meetings when requested by AHCCCS Administration.

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

10. Develop, implement, and maintain a procedure for ensuring timeliness of re-screening and treatment for all conditions identified as a result of examination, screening, and diagnosis. Treatment, if required, must occur on a timely basis and generally no longer than 6 months beyond the request for screening services (refer to contractor requirements in this chapter).

11. 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 screening and services are conducted during each EPSDT visit.

12. Develop, implement and maintain a procedure to notify all members/caretakers prior to visits required by the AHCCCS EPSDT and Dental Periodicity Schedules. This procedure must include:

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

    b. Notification of members or responsible parties regarding due date of an annual dental visit. If a dental visit has not taken place, a second notice must be sent.

13. Develop and implement processes to reduce no-show appointment rates for EPSDT services, and

14. Provide targeted outreach to those members who did not show for appointments.

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

15. 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 EPSDT Coordinator).

16. Distribute EPSDT Tracking Forms to contracted providers.

17. Require the use of the AHCCCS EPSDT and Dental Periodicity Schedules and AHCCCS approved, standardized EPSDT Tracking Forms (see 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 visits must be rendered by providers.

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

    a. Use the EPSDT Tracking Forms at every EPSDT visit

    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 PEDS Tool as described in this Chapter.

    c. Sign EPSDT Tracking Forms and place them in the member's medical record.

    d. Send copies of the EPSDT Tracking Forms to the Contractor. Providers are not required to submit EPSDT Tracking Forms to AHCCCS Administration.

    e. Providers of fee-for-service members must maintain a copy of the EPSDT Tracking Forms (per AHCCCS policy) in the medical record but do not need to send copies elsewhere.

18. Submit to AHCCCS DHCM, within 15 days of the end of each reporting quarter, a detailed progress report that describes the activities of the quarter and the progress made in reaching the established goals of the plan (see Exhibit 400-1). 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 Improvement and Adult Quarterly Monitoring Report, for report template and requirements/instructions). As noted on Appendix A, effective 10/01/09, shaded areas are not in effect.

19. Have a written EPSDT plan including oral health, which addresses the objectives, monitoring and evaluation activities of their program.

20. Participate in an annual review of EPSDT requirements conducted by AHCCCS Administration; including, but not limited to, Contractor results of on-site visits to providers and medical record audits.

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

    a. Provide EPSDT services for all assigned members from birth through 20 years of age. Services must be provided in accordance with the AHCCCS EPSDT and Dental Periodicity Schedules, and

    b. Agree to utilize the standardized AHCCCS EPSDT Tracking Forms.

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

23. 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).

24. 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.

    a. Refer eligible members to 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 (refer to Exhibit 430-3)

    b. Coordinate with Head Start programs to ensure eligible members receive appropriate EPSDT services to optimize child health and development

    c. Coordinate with the Arizona Early Intervention Program (AzEIP) to identify children 0-3 years of age with developmental disabilities for 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 educate their providers on the Contractor's requirements for

accessing AzEIP services. Contractors must encourage their providers to communicate results of assessments and services provided to AzEIP enrollees within 45 days of the member's AzEIP enrollment.

d. AHCCCS Contractors must reimburse all AHCCCS registered Arizona Early Intervention Program (AzEIP) providers whether or not they are contracted with the AHCCCS Contractor. The individual family service plan services must be reviewed for medical necessity prior to reimbursement, and

e. 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.

E. CONTRACTOR REQUIREMENTS FOR THE WRITTEN EPSDT PLAN

The written EPSDT plan must contain the following:

1. A narrative description of all planned activities, 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 mental health problems for AHCCCS members under the age of 21. The narrative description must also include Contractor activities to identify member needs, coordinate care and follow-up activities to ensure appropriate treatment is received in a timely manner. Contractors must attach relevant policies and procedures to this section.

2. An evaluation and assessment that documents the effectiveness of EPSDT/dental program strategies, interventions, and activities directed at achieving healthy outcomes, at least annually (report on the last year).

3. A work plan that formally documents the EPSDT/Dental program objectives, strategies and activities and demonstrates how these activities will improve the quality of services, the continuum of care, and health care outcomes (including Childhood Obesity Program according to AHCCCS policy) containing:

   a. Specific measurable objectives. These objectives may be based on AHCCCS established minimum performance standards or other generally accepted benchmarks. In cases where AHCCCS minimum performance standards have been met, other generally accepted benchmarks may be used (e.g., National Committee

on Quality Assurance, Healthy People 2010 standards). The Contractors may also develop their own specific measurable goals and objectives aimed at enhancing the EPSDT program.

b. Strategies and activities 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. Monitoring of work plan activities and evaluation of outcomes

e. Evaluation of outcome of activities

f. Identification and implementation of new interventions, or modifications to improve existing interventions, to reach goals, and

g. Contractor assigned resources for EPSDT activities, including staff designated to specific EPSDT responsibilities.

3. The plan must be submitted annually to AHCCCS/Division of Health Care Management as per the contract and is subject to approval (see Exhibit 400-1).

F. 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), 1396 a (a) (43), 42 CFR 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.

EXHIBIT 430-1

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
EPSDT PERIODICITY SCHEDULE

EXHIBIT 430-1
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
EPSDT PERIODICITY SCHEDULE

PROCEDURES	INFANCY								EARLY CHILDHOOD					MIDDLE CHILDHOOD			ADOLESCENCE
AGE	new born	2-4 days	by 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	3 yr	4 yr	5 yr	6 yr	8 yr	**Annually 10 -- 20 years of age**
History Initial/Interval	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Height & Weight, including Body Mass Index (BMI) for those 24 months and older	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Head Circumference	x	x	x	x	x	x	x	x	x	x	x						
Blood Pressure – PCP should assess the need for B/P measurement for children birth to 24 months	+	+	+	+	+	+	+	+	+	+	+	x	x	x	x	x	x
Nutritional Assessment	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Vision	SEE SEPARATE SCHEDULE																
Hearing/Speech	SEE SEPARATE SCHEDULE																
Dev./Behavioral Assess.	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Physical Examination	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Immunization	**SEE SEPARATE SCHEDULE**																
Tuberculin Test								+	+	+	+	+	+	+	+	+	+
Hematocrit/Hemoglobin							x ⟶	⟶	+ ⟶	⟶	⟶	⟶	⟶	⟶			⟵ +13 ⟶
Urinalysis														x			⟵ +16 ⟶
Lead Screen /Verbal						x	x		x	x		x	x	x	x		
Lead Screen/Blood Test								x			x	x*	x*	x*	x*		
Anticipatory Guidance	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Dyslipidemia Screening											x		x		x	x	x
Dislipidemia Testing																	x (one time testing between 18 and 20 years of age)
STI Screening																	x (risk assessment for those 11-20)
Cervical Dysplasia Screening																	x (risk assessment for those 11-20)
Dental Referral						+	+	+	+	+	+	x	x	x	x	x	x

These are minimum requirements. If at any time other procedures, tests, etc. are medically indicated, the physician is obligated to perform them. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.

Key:
- x = to be completed
- \+ = to be performed for members at risk when indicated
- ⟵ x ⟶ = the range during which a service may be provided, with the x indicating the preferred age
- * = Members not previously screened who fall within this range (36 to 72 months of age) must have a blood lead screen performed

NOTE: If American Academy of Pediatrics guidelines are used for the screening schedule and/or more screenings are medically necessary, those additional interperiodic screenings will be covered.

NOTE: The American Association of Pediatric Dentistry recommends that dental visits being by age one (1). PCP referrals for dental care are mandatory beginning at three (3) years of age. Referrals should be encouraged by one (1) year of age. Parents of young children may self refer to a dentist within the Contractor's network at any time.

Revised: 10/1/2008, 4/1/2007, 10/23/2006

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
VISION PERIODICITY SCHEDULE

	MONTHS OF AGE										
Procedure	New born	2 - 4 Days	by 1 mo	2	4	6	9	12	15	18	24
Vision +	S	S	S	S	S	S	S	S	S	S	S

	YEARS OF AGE														
Procedure	3*	4	5	6	8	10	11	12	13	14	15	16	17	18	19 through 20 years of age
Vision +	O	O	O	O	O	O	S	O	S	S	O	S	S	O	S

<u>These are minimum requirements</u>: If at any time other procedures, tests, etc. are medically indicated, the physician is obligated to perform them.

Key:
- **S = Subjective, by history**
- **O = Objective, by a standard testing method**
- *** = If the patient is uncooperative, rescreen in 6 months.**
- **+ = May be done more frequently if indicated or at increased risk.**

Revised: 4/1/2007, 8/1/2005

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
HEARING AND SPEECH PERIODICITY SCHEDULE

	MONTHS OF AGE												
Procedure	New born	2 - 4 days	2 weeks	By 1 mo	6 weeks	2	4	6	9	12	15	18	24
Hearing/ Speech+	O**	S	O** ←	—	→	S	S	S	S	S	S	S	S

	YEARS OF AGE														
Procedure	3	4	5	6	8	10	11	12	13	14	15	16	17	18	Through 20 years of age
Hearing/ Speech+	S	O	O	O	O	O	S	O	S	S	O	S	S	O	S

<u>These are minimum requirements</u>: If at any time other procedures, tests, etc. are medically indicated, the physician is obligated to perform them.

Key:
- **S = Subjective, by history**
- **O = Objective, by a standard testing method**
- *** = All children, including newborns, meeting risk criteria for hearing loss should be objectively screened.**
- **+ = May be done more frequently if indicated or at increased risk**
- **** = All newborns should be screened for hearing loss at birth and again 2 to 6 weeks afterward if indicated by the first screening or if a screening was not completed at birth.**

Revised: 4/1/2007, 8/1/2005

EXHIBIT 430-1A

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
DENTAL PERIODICITY SCHEDULE

Exhibit 430-1A

AHCCCS Dental Periodicity Schedule

RECOMMENDATIONS FOR PREVENTIVE PEDIATRIC ORAL HEALTH CARE*				
These recommendations are designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations may require modification for children with special health care needs.				
AGE	12-24 months	2-6 years	6-12 years	12 years and older
Clinical oral examination including but not limited to the following:[1]	X	X	X	X
➢ Assess oral growth and development	X	X	X	X
➢ Caries-risk Assessment	X	X	X	X
➢ Assessment for need for fluoride supplementation	X	X	X	X
➢ Anticipatory Guidance/Counseling	X	X	X	X
➢ Oral hygiene counseling	X	X	X	X
➢ Dietary counseling	X	X	X	X
➢ Injury prevention counseling	X	X	X	X
➢ Counseling for nonnutritive habits	X	X	X	X
➢ Substance abuse counseling			X	X
➢ Counseling for intraoral/perioral piercing			X	X
➢ Assessment for pit and fissure sealants		X	X	X
Radiographic Assessment	X	X	X	X
Prophylaxis and topical fluoride	X	X	X	X

[1] First examination is encouraged to begin by age 1. Repeat every 6 months or as indicated by child's risk status / susceptibility to disease.

Note: Parents or caregivers should be included in all consultations and counseling of members regarding preventive oral health care and the clinical findings.

Note: As in all medical care, dental care must be based on the individual needs of the patient and the professional judgment of the oral health provider.

* Adaptation from the American Academy of Pediatric Dentistry Schedule

EXHIBIT 430-2

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM RECOMMENDED CHILDHOOD AND ADOLESCENT IMMUNIZATION SCHEDULES

Recommended Immunization Schedule for Persons Aged 0 Through 6 Years—United States • 2009

For those who fall behind or start late, see the catch-up schedule

Vaccine ▼ Age ▶	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19–23 months	2–3 years	4–6 years
Hepatitis B[1]	HepB	HepB		*see footnote 1*	HepB						
Rotavirus[2]			RV	RV	*RV*[2]						
Diphtheria, Tetanus, Pertussis[3]			DTaP	DTaP	DTaP	*see footnote 3*	DTaP				DTaP
Haemophilus influenzae type b[4]			Hib	Hib	*Hib*[4]	Hib					
Pneumococcal[5]			PCV	PCV	PCV	PCV				PPSV	
Inactivated Poliovirus			IPV	IPV	IPV						IPV
Influenza[6]					Influenza (Yearly)						
Measles, Mumps, Rubella[7]						MMR		*see footnote 7*			MMR
Varicella[8]						Varicella		*see footnote 8*			Varicella
Hepatitis A[9]						HepA (2 doses)				HepA Series	
Meningococcal[10]										MCV	

Range of recommended ages

Certain high-risk groups

This schedule indicates the recommended ages for routine administration of currently licensed vaccines, as of December 1, 2008, for children aged 0 through 6 years. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. Licensed combination vaccines may be used whenever any component of the combination is indicated and other components are not contraindicated and if approved by the Food and Drug Administration for that dose of the series. Providers should consult the relevant Advisory Committee on Immunization Practices statement for detailed recommendations, including high-risk conditions: http://www.cdc.gov/vaccines/pubs/acip-list.htm. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at http://www.vaers.hhs.gov or by telephone, 800-822-7967.

1. Hepatitis B vaccine (HepB). ***(Minimum age: birth)***

At birth:
- Administer monovalent HepB to all newborns before hospital discharge.
- If mother is hepatitis B surface antigen (HBsAg)-positive, administer HepB and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth.
- If mother's HBsAg status is unknown, administer HepB within 12 hours of birth. Determine mother's HBsAg status as soon as possible and, if HBsAg-positive, administer HBIG (no later than age 1 week).

After the birth dose:
- The HepB series should be completed with either monovalent HepB or a combination vaccine containing HepB. The second dose should be administered at age 1 or 2 months. The final dose should be administered no earlier than age 24 weeks.
- Infants born to HBsAg-positive mothers should be tested for HBsAg and antibody to HBsAg (anti-HBs) after completion of at least 3 doses of the HepB series, at age 9 through 18 months (generally at the next well-child visit).

4-month dose:
- Administration of 4 doses of HepB to infants is permissible when combination vaccines containing HepB are administered after the birth dose.

2. Rotavirus vaccine (RV). ***(Minimum age: 6 weeks)***
- Administer the first dose at age 6 through 14 weeks (maximum age: 14 weeks 6 days). Vaccination should not be initiated for infants aged 15 weeks or older (i.e., 15 weeks 0 days or older).
- Administer the final dose in the series by age 8 months 0 days.
- If Rotarix® is administered at ages 2 and 4 months, a dose at 6 months is not indicated.

3. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP). ***(Minimum age: 6 weeks)***
- The fourth dose may be administered as early as age 12 months, provided at least 6 months have elapsed since the third dose.
- Administer the final dose in the series at age 4 through 6 years.

4. *Haemophilus influenzae* type b conjugate vaccine (Hib). ***(Minimum age: 6 weeks)***
- If PRP-OMP (PedvaxHIB® or Comvax® [HepB-Hib]) is administered at ages 2 and 4 months, a dose at age 6 months is not indicated.
- TriHiBit® (DTaP/Hib) should not be used for doses at ages 2, 4, or 6 months but can be used as the final dose in children aged 12 months or older.

5. Pneumococcal vaccine. ***(Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPSV])***
- PCV is recommended for all children aged younger than 5 years. Administer 1 dose of PCV to all healthy children aged 24 through 59 months who are not completely vaccinated for their age.
- Administer PPSV to children aged 2 years or older with certain underlying medical conditions (see *MMWR* 2000;49[No. RR-9]), including a cochlear implant.

6. Influenza vaccine. ***(Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 2 years for live, attenuated influenza vaccine [LAIV])***
- Administer annually to children aged 6 months through 18 years.
- For healthy nonpregnant persons (i.e., those who do not have underlying medical conditions that predispose them to influenza complications) aged 2 through 49 years, either LAIV or TIV may be used.
- Children receiving TIV should receive 0.25 mL if aged 6 through 35 months or 0.5 mL if aged 3 years or older.
- Administer 2 doses (separated by at least 4 weeks) to children aged younger than 9 years who are receiving influenza vaccine for the first time or who were vaccinated for the first time during the previous influenza season but only received 1 dose.

7. Measles, mumps, and rubella vaccine (MMR). ***(Minimum age: 12 months)***
- Administer the second dose at age 4 through 6 years. However, the second dose may be administered before age 4, provided at least 28 days have elapsed since the first dose.

8. Varicella vaccine. ***(Minimum age: 12 months)***
- Administer the second dose at age 4 through 6 years. However, the second dose may be administered before age 4, provided at least 3 months have elapsed since the first dose.
- For children aged 12 months through 12 years the minimum interval between doses is 3 months. However, if the second dose was administered at least 28 days after the first dose, it can be accepted as valid.

9. Hepatitis A vaccine (HepA). ***(Minimum age: 12 months)***
- Administer to all children aged 1 year (i.e., aged 12 through 23 months). Administer 2 doses at least 6 months apart.
- Children not fully vaccinated by age 2 years can be vaccinated at subsequent visits.
- HepA also is recommended for children older than 1 year who live in areas where vaccination programs target older children or who are at increased risk of infection. See *MMWR* 2006;55(No. RR-7).

10. Meningococcal vaccine. ***(Minimum age: 2 years for meningococcal conjugate vaccine [MCV] and for meningococcal polysaccharide vaccine [MPSV])***
- Administer MCV to children aged 2 through 10 years with terminal complement component deficiency, anatomic or functional asplenia, and certain other high-risk groups. See *MMWR* 2005;54(No. RR-7).
- Persons who received MPSV 3 or more years previously and who remain at increased risk for meningococcal disease should be revaccinated with MCV.

The Recommended Immunization Schedules for Persons Aged 0 Through 18 Years are approved by the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/recs/acip), the American Academy of Pediatrics (http://www.aap.org), and the American Academy of Family Physicians (http://www.aafp.org).

DEPARTMENT OF HEALTH AND HUMAN SERVICES • CENTERS FOR DISEASE CONTROL AND PREVENTION

CS103164

Recommended Immunization Schedule for Persons Aged 7 Through 18 Years—United States • 2009

For those who fall behind or start late, see the schedule below and the catch-up schedule

Vaccine ▼ Age ▶	7–10 years	11–12 years	13–18 years
Tetanus, Diphtheria, Pertussis[1]	*see footnote 1*	Tdap (Range of recommended ages)	Tdap (Catch-up immunization)
Human Papillomavirus[2]	*see footnote 2*	HPV (3 doses) (Range of recommended ages)	HPV Series (Catch-up immunization)
Meningococcal[3]	MCV (Certain high-risk groups)	MCV (Range of recommended ages)	MCV (Catch-up immunization)
Influenza[4]	Influenza (Yearly) (Range of recommended ages)	Influenza (Yearly) (Range of recommended ages)	Influenza (Yearly) (Range of recommended ages)
Pneumococcal[5]	PPSV (Certain high-risk groups)	PPSV (Certain high-risk groups)	PPSV (Certain high-risk groups)
Hepatitis A[6]	HepA Series (Certain high-risk groups)	HepA Series (Certain high-risk groups)	HepA Series (Certain high-risk groups)
Hepatitis B[7]	HepB Series (Catch-up immunization)	HepB Series (Catch-up immunization)	HepB Series (Catch-up immunization)
Inactivated Poliovirus[8]	IPV Series (Catch-up immunization)	IPV Series (Catch-up immunization)	IPV Series (Catch-up immunization)
Measles, Mumps, Rubella[9]	MMR Series (Catch-up immunization)	MMR Series (Catch-up immunization)	MMR Series (Catch-up immunization)
Varicella[10]	Varicella Series (Catch-up immunization)	Varicella Series (Catch-up immunization)	Varicella Series (Catch-up immunization)

Legend:
- Range of recommended ages
- Catch-up immunization
- Certain high-risk groups

This schedule indicates the recommended ages for routine administration of currently licensed vaccines, as of December 1, 2008, for children aged 7 through 18 years. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. Licensed combination vaccines may be used whenever any component of the combination is indicated and other components are not contraindicated and if approved by the Food and Drug Administration for that dose of the series. Providers should consult the relevant Advisory Committee on Immunization Practices statement for detailed recommendations, including high-risk conditions: http://www.cdc.gov/vaccines/pubs/acip-list.htm. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at http://www.vaers.hhs.gov or by telephone, 800-822-7967.

1. Tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap). ***(Minimum age: 10 years for BOOSTRIX® and 11 years for ADACEL®)***
- Administer at age 11 or 12 years for those who have completed the recommended childhood DTP/DTaP vaccination series and have not received a tetanus and diphtheria toxoid (Td) booster dose.
- Persons aged 13 through 18 years who have not received Tdap should receive a dose.
- A 5-year interval from the last Td dose is encouraged when Tdap is used as a booster dose; however, a shorter interval may be used if pertussis immunity is needed.

2. Human papillomavirus vaccine (HPV). ***(Minimum age: 9 years)***
- Administer the first dose to females at age 11 or 12 years.
- Administer the second dose 2 months after the first dose and the third dose 6 months after the first dose (at least 24 weeks after the first dose).
- Administer the series to females at age 13 through 18 years if not previously vaccinated.

3. Meningococcal conjugate vaccine (MCV).
- Administer at age 11 or 12 years, or at age 13 through 18 years if not previously vaccinated.
- Administer to previously unvaccinated college freshmen living in a dormitory.
- MCV is recommended for children aged 2 through 10 years with terminal complement component deficiency, anatomic or functional asplenia, and certain other groups at high risk. See *MMWR* 2005;54(No. RR-7).
- Persons who received MPSV 5 or more years previously and remain at increased risk for meningococcal disease should be revaccinated with MCV.

4. Influenza vaccine.
- Administer annually to children aged 6 months through 18 years.
- For healthy nonpregnant persons (i.e., those who do not have underlying medical conditions that predispose them to influenza complications) aged 2 through 49 years, either LAIV or TIV may be used.
- Administer 2 doses (separated by at least 4 weeks) to children aged younger than 9 years who are receiving influenza vaccine for the first time or who were vaccinated for the first time during the previous influenza season but only received 1 dose.

5. Pneumococcal polysaccharide vaccine (PPSV).
- Administer to children with certain underlying medical conditions (see *MMWR* 1997;46[No. RR-8]), including a cochlear implant. A single revaccination should be administered to children with functional or anatomic asplenia or other immunocompromising condition after 5 years.

6. Hepatitis A vaccine (HepA).
- Administer 2 doses at least 6 months apart.
- HepA is recommended for children older than 1 year who live in areas where vaccination programs target older children or who are at increased risk of infection. See *MMWR* 2006;55(No. RR-7).

7. Hepatitis B vaccine (HepB).
- Administer the 3-dose series to those not previously vaccinated.
- A 2-dose series (separated by at least 4 months) of adult formulation Recombivax HB® is licensed for children aged 11 through 15 years.

8. Inactivated poliovirus vaccine (IPV).
- For children who received an all-IPV or all-oral poliovirus (OPV) series, a fourth dose is not necessary if the third dose was administered at age 4 years or older.
- If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.

9. Measles, mumps, and rubella vaccine (MMR).
- If not previously vaccinated, administer 2 doses or the second dose for those who have received only 1 dose, with at least 28 days between doses.

10. Varicella vaccine.
- For persons aged 7 through 18 years without evidence of immunity (see *MMWR* 2007;56[No. RR-4]), administer 2 doses if not previously vaccinated or the second dose if they have received only 1 dose.
- For persons aged 7 through 12 years, the minimum interval between doses is 3 months. However, if the second dose was administered at least 28 days after the first dose, it can be accepted as valid.
- For persons aged 13 years and older, the minimum interval between doses is 28 days.

The Recommended Immunization Schedules for Persons Aged 0 Through 18 Years are approved by the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/recs/acip), the American Academy of Pediatrics (http://www.aap.org), and the American Academy of Family Physicians (http://www.aafp.org).

DEPARTMENT OF HEALTH AND HUMAN SERVICES • CENTERS FOR DISEASE CONTROL AND PREVENTION

CS103164

Catch-up Immunization Schedule for Persons Aged 4 Months Through 18 Years Who Start Late or Who Are More Than 1 Month Behind—United States • 2009

The table below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age.

CATCH-UP SCHEDULE FOR PERSONS AGED 4 MONTHS THROUGH 6 YEARS

Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
Hepatitis B[1]	Birth	**4 weeks**	**8 weeks** (and at least 16 weeks after first dose)		
Rotavirus[2]	6 wks	**4 weeks**	**4 weeks**[2]		
Diphtheria, Tetanus, Pertussis[3]	6 wks	**4 weeks**	**4 weeks**	**6 months**	**6 months**[3]
Haemophilus influenzae type b[4]	6 wks	**4 weeks** if first dose administered at younger than age 12 months **8 weeks (as final dose)** if first dose administered at age 12-14 months **No further doses needed** if first dose administered at age 15 months or older	**4 weeks**[4] if current age is younger than 12 months **8 weeks (as final dose)**[4] if current age is 12 months or older and second dose administered at younger than age 15 months **No further doses needed** if previous dose administered at age 15 months or older	**8 weeks (as final dose)** This dose only necessary for children aged 12 months through 59 months who received 3 doses before age 12 months	
Pneumococcal[5]	6 wks	**4 weeks** if first dose administered at younger than age 12 months **8 weeks (as final dose for healthy children)** if first dose administered at age 12 months or older or current age 24 through 59 months **No further doses needed** for healthy children if first dose administered at age 24 months or older	**4 weeks** if current age is younger than 12 months **8 weeks (as final dose for healthy children)** if current age is 12 months or older **No further doses needed** for healthy children if previous dose administered at age 24 months or older	**8 weeks (as final dose)** This dose only necessary for children aged 12 months through 59 months who received 3 doses before age 12 months or for high-risk children who received 3 doses at any age	
Inactivated Poliovirus[6]	6 wks	**4 weeks**	**4 weeks**	**4 weeks**[6]	
Measles, Mumps, Rubella[7]	12 mos	**4 weeks**			
Varicella[8]	12 mos	**3 months**			
Hepatitis A[9]	12 mos	**6 months**			

CATCH-UP SCHEDULE FOR PERSONS AGED 7 THROUGH 18 YEARS

Vaccine	Minimum Age for Dose 1	Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
Tetanus, Diphtheria/ Tetanus, Diphtheria, Pertussis[10]	7 yrs[10]	**4 weeks**	**4 weeks** if first dose administered at younger than age 12 months **6 months** if first dose administered at age 12 months or older	**6 months** if first dose administered at younger than age 12 months	
Human Papillomavirus[11]	9 yrs	**Routine dosing intervals are recommended**[11]			
Hepatitis A[9]	12 mos	**6 months**			
Hepatitis B[1]	Birth	**4 weeks**	**8 weeks** (and at least 16 weeks after first dose)		
Inactivated Poliovirus[6]	6 wks	**4 weeks**	**4 weeks**	**4 weeks**[6]	
Measles, Mumps, Rubella[7]	12 mos	**4 weeks**			
Varicella[8]	12 mos	**3 months** if the person is younger than age 13 years **4 weeks** if the person is aged 13 years or older			

1. Hepatitis B vaccine (HepB).
- Administer the 3-dose series to those not previously vaccinated.
- A 2-dose series (separated by at least 4 months) of adult formulation Recombivax HB® is licensed for children aged 11 through 15 years.

2. Rotavirus vaccine (RV).
- The maximum age for the first dose is 14 weeks 6 days. Vaccination should not be initiated for infants aged 15 weeks or older (i.e., 15 weeks 0 days or older).
- Administer the final dose in the series by age 8 months 0 days.
- If Rotarix® was administered for the first and second doses, a third dose is not indicated.

3. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP).
- The fifth dose is not necessary if the fourth dose was administered at age 4 years or older.

4. *Haemophilus influenzae* type b conjugate vaccine (Hib).
- Hib vaccine is not generally recommended for persons aged 5 years or older. No efficacy data are available on which to base a recommendation concerning use of Hib vaccine for older children and adults. However, studies suggest good immunogenicity in persons who have sickle cell disease, leukemia, or HIV infection, or who have had a splenectomy; administering 1 dose of Hib vaccine to these persons is not contraindicated.
- If the first 2 doses were PRP-OMP (PedvaxHIB® or Comvax®), and administered at age 11 months or younger, the third (and final) dose should be administered at age 12 through 15 months and at least 8 weeks after the second dose.
- If the first dose was administered at age 7 through 11 months, administer 2 doses separated by 4 weeks and a final dose at age 12 through 15 months.

5. Pneumococcal vaccine.
- Administer 1 dose of pneumococcal conjugate vaccine (PCV) to all healthy children aged 24 through 59 months who have not received at least 1 dose of PCV on or after age 12 months.
- For children aged 24 through 59 months with underlying medical conditions, administer 1 dose of PCV if 3 doses were received previously or administer 2 doses of PCV at least 8 weeks apart if fewer than 3 doses were received previously.
- Administer pneumococcal polysaccharide vaccine (PPSV) to children aged 2 years or older with certain underlying medical conditions (see *MMWR* 2000;49[No. RR-9]), including a cochlear implant, at least 8 weeks after the last dose of PCV.

6. Inactivated poliovirus vaccine (IPV).
- For children who received an all-IPV or all-oral poliovirus (OPV) series, a fourth dose is not necessary if the third dose was administered at age 4 years or older.
- If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.

7. Measles, mumps, and rubella vaccine (MMR).
- Administer the second dose at age 4 through 6 years. However, the second dose may be administered before age 4, provided at least 28 days have elapsed since the first dose.
- If not previously vaccinated, administer 2 doses with at least 28 days between doses.

8. Varicella vaccine.
- Administer the second dose at age 4 through 6 years. However, the second dose may be administered before age 4, provided at least 3 months have elapsed since the first dose.
- For persons aged 12 months through 12 years, the minimum interval between doses is 3 months. However, if the second dose was administered at least 28 days after the first dose, it can be accepted as valid.
- For persons aged 13 years and older, the minimum interval between doses is 28 days.

9. Hepatitis A vaccine (HepA).
- HepA is recommended for children older than 1 year who live in areas where vaccination programs target older children or who are at increased risk of infection. See *MMWR* 2006;55(No. RR-7).

10. Tetanus and diphtheria toxoids vaccine (Td) and tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap).
- Doses of DTaP are counted as part of the Td/Tdap series
- Tdap should be substituted for a single dose of Td in the catch-up series or as a booster for children aged 10 through 18 years; use Td for other doses.

11. Human papillomavirus vaccine (HPV).
- Administer the series to females at age 13 through 18 years if not previously vaccinated.
- Use recommended routine dosing intervals for series catch-up (i.e., the second and third doses should be administered at 2 and 6 months after the first dose). However, the minimum interval between the first and second doses is 4 weeks. The minimum interval between the second and third doses is 12 weeks, and the third dose should be given at least 24 weeks after the first dose.

Information about reporting reactions after immunization is available online at http://www.vaers.hhs.gov or by telephone, 800-822-7967. Suspected cases of vaccine-preventable diseases should be reported to the state or local health department. Additional information, including precautions and contraindications for immunization, is available from the National Center for Immunization and Respiratory Diseases at http://www.cdc.gov/vaccines or telephone, 800-CDC-INFO (800-232-4636).

DEPARTMENT OF HEALTH AND HUMAN SERVICES • CENTERS FOR DISEASE CONTROL AND PREVENTION

CS113897

EXHIBIT 430-3

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
CERTIFICATE OF MEDICAL NECESSITY
FOR COMMERCIAL ORAL NUTRITIONAL SUPPLEMENTS
(EPSDT MEMBERS)

EXHIBIT 430-3

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
CERTIFICATE OF MEDICAL NECESSITY
FOR COMMERCIAL ORAL NUTRITIONAL SUPPLEMENTS
(EPSDT MEMBERS)

SUBMITTED BY:

Provider Name: ____

Provider AHCCCS ID Number: ________________ Telephone: ________________

MEMBER INFORMATION

Member's Name: ____________________________________ Date of Birth: ______________
Last First Initial

Member's AHCCCS ID Number: _______________ Enrollment: ____________________________
(Contractor)

Member's Address: ____

____

ASSESSMENT FOR COMMERCIAL ORAL NUTRITIONAL SUPPLEMENTS

Assessment performed by: ____

AHCCCS Provider ID: ____________________ Telephone Number: ________________

Date of Assessment: ____________________

Assessment Findings: (If necessary, add attachments to provide the most complete information)

1. Indicate which of the following criteria have been met to determine that oral supplemental nutritional feedings are medically necessary. (At least two of the following must be met.) Check all that apply.

a. The member is at or below the 10th percentile on the appropriate growth chart for their age and gender for 3 months or more.	
b. The member has reached a plateau in growth and/or nutritional status for more than 6 months (prepubescent).	
c. The member has already demonstrated a medically significant decline in weight within the past 3 months (prior to the assessment).	
d. The member is able to consume/eat no more than _25_% of his/her nutritional requirements from normal food sources.	
e. Absorption problems are evidenced by emesis, diarrhea, dehydration, weight loss, and intolerance to milk or formula products has been ruled out.	
f. The member requires oral supplemental nutritional feedings on a temporary basis due to an emergent condition; i.e. post-hospitalization (No PA for first 30 days).	
g. The member is at risk for regression due to chronic disease or condition.	

2. List past nutritional counseling efforts and alternative nutritional feedings which were tried (include by whom and the length of time that counseling was conducted and/or the alternative feedings that were used).

ORAL SUPPLEMENTAL NUTRITIONAL FEEDING RECOMMENDATIONS

Type of Nutritional Feeding	Source of Nutrition
Weaning from Tube Feeding	
Oral Feeding - Sole Source (PA required)	
Oral Feeding - Supplemental (PA Required)	
Emergency Supplemental Nutrition (No PA required for first 30 days)	

Additional Comments:

Nutritional Assessment Provider Date

Member's PCP/Attending Physician Date

Revised: 4/01/2007
Effective: 1/01/2000