Clinical Policy: Early and Periodic Screening, Diagnostic, and Treatment Benefits for Pediatric Members

Reference Number: AZ.CP.PMN.234
Effective Date: 05.01.22
Last Review Date: 04.23
Line of Business: Arizona Medicaid (AzCH-CCP and Care1st) Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
The purpose of EPSDT is to ensure the availability and accessibility of health care resources as well as to assist 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 members under the age of 21 years. EPSDT covered services include services that correct or ameliorate physical and behavioral conditions and illnesses discovered by the screening process, when those services fall within one of the optional and mandatory categories of "Medical Assistance", as defined in the Medicaid Act. Refer to Attachment E for the AHCCCS EPSDT Clinical Sample Templates (or Contractor/Provider's electronic equivalent) for required information related to EPSDT screenings and visits. The EPSDT Program provides comprehensive treatment and preventive health care services for Title XIX members under the age of 21. EPSDT, which is comprised of Screening, Diagnostic, and Treatment services, is critical for ensuring that children and adolescents receive appropriate preventive, dental, physical health, behavioral health, developmental, and specialty services. Under EPSDT, federal law requires that Title XIX cover all Medicaid-covered services listed in 42 USC 1396d(a) for members under the age of 21 when medically necessary and cost effective and even when the services are not listed as covered services in the AHCCCS State Plan, AHCCCS statutes, rules, or policies. This means that Contractors shall cover all physical and behavioral health services described within all 30 categories of Medicaid covered services listed in 42 USC 1396d(a) if the treatment or service is necessary to "correct or ameliorate" defects or physical and behavioral illnesses or conditions. Medical necessity is determined on a case-by-case basis.

FDA approved indications
Refer to the prescribing information for the requested agent.

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of Arizona Complete Health-Complete Care Plan and Care1st that the requested agent is **medically necessary** when the following criteria are met:

CLINICAL POLICY
EPSDT Benefit for Pediatric Members

I. Initial Approval Criteria

A. Medication Request Through EPSDT Benefit (must meet all)**:**

1. Age < 21 years old.
2. Member meets one of the following (a or b):
    a. Drug requested meets initial approval criteria as outlined by the drug specific policy;
    b. If no drug specific policy exists, drug requested meets general medical necessity policies*

    **When available, drug-specific policies supersede general medical necessity policies. If no drug specific policies exist for the requested agent, refer to AHCCCS Non-Preferred Drugs.*

3. Failure of formulary alternatives if required in the drug-specific or general medical necessity policy, unless clinically significant adverse effects are experienced, all are contraindicated, or there are no other alternatives to therapy;
4. Request meets medical necessity (must meet all):
    a. Authority: The health intervention is recommended by the treating physician and is determined to be necessary;
    b. Purpose: The health intervention has the purpose of treating a medical condition and is a necessary treatment to correct or ameliorate the member's physical or mental condition (provider must submit supporting documentation);
    c. Scope: The health intervention provides the most appropriate level of service, considering potential benefits and harms to the patient;
    d. Evidence: The health intervention is known to be effective in improving health outcomes. For new interventions, effectiveness shall be determined by scientific evidence (Controlled clinical trials, observational studies, guidelines/Professional standard of care, etc.);
    e. Value: The health intervention is cost-effective for the condition compared to alternative interventions, including no intervention.
5. If requested medication is not on the plan's PDL or is excluded from coverage (NDC not on the labeler, bulk powders, compound, etc.), member has tried and failed all other appropriate alternatives to therapy or there are no other alternatives to therapy;
6. The requested agent and prescribed dose are not considered experimental or investigational for the member's diagnosis and age;

Approval duration: 6 months

II. Continued Therapy

A. Medication Request Through EPSDT Benefit (must meet all):

1. Member meets one of the following (a, b or c):
    a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;

b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
c. The continued therapy criteria in the drug-specific or general medical necessity policy are met;

2. Member is responding positively to therapy;
3. If request is for a dose increase, the prescribed dose is not considered experimental or investigational for the member's diagnosis and age;

Approval duration: 12 months

III. Diagnoses/Indications for which coverage is NOT authorized: Not applicable

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
EPSDT: early and periodic screening, diagnostic and treatment
FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives
Refer to the drug-specific or general medical necessity policy.*

Appendix C: Contraindications/Boxed Warnings
Refer to the prescribing information for the requested agent.

Appendix D: General Information

- AHCCCS EPSDT Policy: AMPM 430- Early and Periodic Screening, Diagnostic, and Treatment Services: AHCCCS Medical Policy Manual (AMPM) (azahcccs.gov)
- Age for EPSDT benefit eligibility: under the age of 21;
- EPSDT benefit coverage under Section 1905(r)(5) of the Social Security Act includes "Such other necessary health care, diagnostic services, treatment, and other measures described in Section 1905(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 State plan."
    - A service need not cure a condition in order to be covered under EPSDT.
    - Services that maintain or improve the child's current health condition are also covered in EPSDT because they "ameliorate" a condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. Services are covered when they prevent a condition from worsening or prevent development of additional health problems.
- EPSDT includes, but is not limited to, coverage of: inpatient and outpatient hospital services, laboratory and x-ray services, physician services, naturopathic services, nurse practitioner services, medications, dental services, therapy services, behavioral health services, medical equipment, medical appliances and medical supplies,

orthotics, prosthetic devices, eyeglasses, transportation, family planning services and supplies, women's preventive care services, and maternity services when applicable, as specified in AMPM Chapter 400. EPSDT also includes diagnostic, screening, preventive, and rehabilitative services.

- 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.

V. Dosage and Administration

Refer to the prescribing information for the requested agent

VI. Product Availability

Refer to the prescribing information for the requested agent

VII. References

1. AHCCCS AMPM Policy 430: Early and Periodic Screening, Diagnostic, and Treatment Services. Available at: AHCCCS Medical Policy Manual (AMPM) (azahcccs.gov) Accessed on April, 17, 2023.
2. Social Security Act, Section 1905. Available at: https://www.ssa.gov/OP_Home/ssact/title19/1905.htm. Accessed January 23, 2023.
3. EPSDT Coverage Guide. Published June 2014. Available at: https://www.medicaid.gov/sites/default/files/2019-12/epsdt_coverage_guide.pdf. Accessed January23, 2023.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created to align with AHCCCS required verbiage around compounded medications.	03.23.2022	05.22
2Q2023 annual review: removed reference to CP.PMN.53 for formulary medications and CP.PMN.16 for non-formulary medications and added redirection to AHCCCS non-preferred policy if no drug specific policy exists; updated language from FDA max recommended dose to dose is not considered experimental or investigational for the member's diagnosis and age; references reviewed and updated;	04.17.2023	05.23

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional

organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

Note:

For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.