Member Handbook
2017 - 2018
“Serving Arizona’s Children in Out-of-Home Care”

Arizona Department of Child Safety
What Is CMDP?

The Comprehensive Medical and Dental Program (CMDP) was formed in 1970 and is the health plan for Arizona’s children in out-of-home care. Membership is based on state rule and law. CMDP pays for health care services for children placed in and outside of Arizona.

Most CMDP members are eligible for health services covered by and funded under contract with the Arizona Health Care Cost Containment System (AHCCCS). AHCCCS is Arizona’s Medicaid and KidsCare programs. CMDP is the AHCCCS and KidsCare health plan for its members. CMDP provides the same services for all members regardless of AHCCCS eligibility status.

Member Handbook

The CMDP Member Handbook tells you how to get healthcare services. It also tells you what to do when you have an emergency or other problem. This handbook is for caregivers. It is printed in English and in Spanish. If you need it in another language or in another format, please call. CMDP Member Services can be reached by emailing (CMDPMemberServices@azdcs.gov) or calling 602-351-2245 or 1-800-201-1795, Option 3-1.
Table of Contents

CMDP COMMUNICATIONS DIRECTORY AND INSTRUCTIONS .................................................. 1
  CMDP Telephone / Fax / Email Directory ................................................................. 1
  Fax and Email Information: .................................................................................. 1
  Telephone Information: ....................................................................................... 2
ELIGIBILITY AND ENROLLMENT ........................................................................... 3
MEMBER CONFIDENTIALITY AND HIPAA NOTICE .............................................. 3
CORPORATE COMPLIANCE .................................................................................... 4
  Corporate Compliance Hotline ........................................................................... 4
PROVIDER SERVICES ............................................................................................. 4
CHILDREN’S REHABILITATIVE SERVICES (CRS) .................................................... 4
BEHAVIORAL HEALTH SERVICES ........................................................................ 6
AFTER HOURS CARE (URGENT CARE) ............................................................... 7
BEHAVIORAL HEALTH CRISIS SERVICES .......................................................... 7
  RBHA Crisis Telephone Numbers ........................................................................ 7
CULTURAL AND LANGUAGE SERVICES .............................................................. 8
MEDICAL HOME .................................................................................................... 8
DENTAL HOME ....................................................................................................... 9
MEMBER INFORMATION ......................................................................................... 9
THE MEMBER ID CARD ......................................................................................... 10
MEMBER SERVICES .............................................................................................. 10
MEMBER AND CAREGIVER RESPONSIBILITIES .................................................. 11
OUT-OF-AREA MOVES ......................................................................................... 11
LEAVING OUT-OF-HOME CARE ............................................................................ 12
MEDICAL AND DENTAL APPOINTMENTS ............................................................ 12
EMERGENCY TRANSPORTATION ........................................................................ 14
MEDICALLY NEEDED NON-EMERGENCY TRANSPORTATION ............................ 14
COVERED SERVICES ............................................................................................ 14
CMDP BEHAVIORAL HEALTH COVERAGE ......................................................... 14
CHILDREN’S REHABILITATIVE SERVICES (CRS) BEHAVIORAL HEALTH COVERAGE .... 15
  CRS County Crisis Lines ..................................................................................... 15
BEHAVIORAL HEALTH INFORMATION AND PRIVACY .................................... 16
URGENT CARE ....................................................................................................... 16
EMERGENCY CARE ............................................................................................... 16
INCONTINENCE BRIEFS ......................................................................................... 17
SERVICES NOT COVERED OR PAID FOR BY CMDP ........................................... 17
SERVICES OUT-OF-HOME CAREGIVERS CANNOT AUTHORIZE .......................... 18
END OF LIFE CARE SERVICES .............................................................................. 18
SEEING A SPECIALIST AND OTHER PROVIDERS ............................................. 18
AMERICAN INDIAN MEMBERS ............................................................................ 19
CHOOSING A PRIMARY CARE PROVIDER (PCP) AND PRIMARY DENTAL PROVIDER (PDP) ........................................................... 19
  Changing Your PCP/PDP.................................................................................... 19
  Making an Appointment ..................................................................................... 20
  Cancelling or Changing an Appointment .......................................................... 20
  Maintaining Good Health .................................................................................. 20
WELL-CHILD SERVICES, OR EARLY PERIODIC SCREENING, DIAGNOSTIC AND
  TREATMENT (EPSDT) .......................................................................................... 20
EPSDT PERIODICITY SCHEDULE ....................................................................... 23
CMDP COMMUNICATIONS DIRECTORY AND INSTRUCTIONS

<table>
<thead>
<tr>
<th>CMDP Mailing Address</th>
<th>DCS/CMDP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Site Code C010-18</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 29202</td>
</tr>
<tr>
<td></td>
<td>Phoenix, AZ 85038-9202</td>
</tr>
<tr>
<td>CMDP Website</td>
<td>dcs.az.gov/cmdp</td>
</tr>
</tbody>
</table>

CMDP service representatives are available to assist you Monday through Friday from 8:00AM to 5:00PM. For more information, please visit CMDP on the internet at the web address above.

Fax and Email Information:
Questions regarding CMDP Claims, Provider Services, Behavioral Health, Medical Services and Member Services can be sent by fax, email or phone. Fax numbers and email address are listed below:

<table>
<thead>
<tr>
<th>CMDP Telephone / Fax / Email Directory</th>
</tr>
</thead>
</table>

**CMDP Telephone Numbers**

<table>
<thead>
<tr>
<th>Service</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local</td>
<td>(602) 351-2245</td>
</tr>
<tr>
<td>Toll Free</td>
<td>1 (800) 201-1795</td>
</tr>
<tr>
<td>Grievances</td>
<td>(602) 351-2245</td>
</tr>
<tr>
<td>Administration</td>
<td>(602) 255-3551</td>
</tr>
</tbody>
</table>

**CMDP FAX Numbers**

<table>
<thead>
<tr>
<th>Service</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider/Member Services</td>
<td>(602) 264-3801</td>
</tr>
<tr>
<td>Medical Services</td>
<td>(602) 351-8529</td>
</tr>
<tr>
<td>Claims</td>
<td>(602) 265-2297</td>
</tr>
<tr>
<td>Administration</td>
<td>(602) 235-9146</td>
</tr>
</tbody>
</table>

**CMDP Email Contacts**

<table>
<thead>
<tr>
<th>Service</th>
<th>Email Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims</td>
<td><a href="mailto:CMDPClaimsStatus@azdcs.gov">CMDPClaimsStatus@azdcs.gov</a></td>
</tr>
<tr>
<td>Provider Services</td>
<td>CMDPP提供商<a href="mailto:Services@azdcs.gov">Services@azdcs.gov</a></td>
</tr>
<tr>
<td>Behavioral Health</td>
<td><a href="mailto:CMDPBHC@azdcs.gov">CMDPBHC@azdcs.gov</a></td>
</tr>
<tr>
<td>Medical Services</td>
<td><a href="mailto:CMDPNurse@azdcs.gov">CMDPNurse@azdcs.gov</a></td>
</tr>
<tr>
<td>Member Services</td>
<td><a href="mailto:CMDPMemberServices@azdcs.gov">CMDPMemberServices@azdcs.gov</a></td>
</tr>
</tbody>
</table>
Telephone Information:

Telephone calls are answered in the order in which they are received. Please listen carefully to the instructions and choose the prompt that best addresses your question(s). Calls may be monitored for training purposes. The following charts will help you to get to the service representative that best fits your needs; however, options may change as CMDP strives to serve you with the best possible service.

<table>
<thead>
<tr>
<th>LANGUAGE PROMPT SELECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Language</strong></td>
</tr>
<tr>
<td>English</td>
</tr>
<tr>
<td>Spanish</td>
</tr>
<tr>
<td>Translations Other than Spanish</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PROMPT SELECTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy Services</td>
</tr>
<tr>
<td>Provider</td>
</tr>
<tr>
<td>Member, Caregiver or Case Manager</td>
</tr>
<tr>
<td>To Speak to an Agent</td>
</tr>
<tr>
<td>Operator</td>
</tr>
</tbody>
</table>

If you have selected option 3 from the selections above you will be directed to select one of the following:

<table>
<thead>
<tr>
<th>MEMBER, CAREGIVER OR CASE MANAGER OPTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility (Includes ID Cards, Member Questions)</td>
</tr>
<tr>
<td>Behavioral Health Questions</td>
</tr>
<tr>
<td>Provider Questions</td>
</tr>
<tr>
<td>Medical Questions</td>
</tr>
<tr>
<td>Claim Questions</td>
</tr>
</tbody>
</table>
ELIGIBILITY AND ENROLLMENT

Children are eligible for CMDP when placed into out-of-home care. They do not have to be eligible for AHCCCS or the KidsCare program. Agencies that place children in out-of-home care are:

- Arizona Department of Child Safety (DCS),
- Arizona Department of Juvenile Corrections (ADJC)
- Administrative Office of the Court/Juvenile Probation Office (AOC/JPO)

Children are enrolled with CMDP by the agencies that place them into out-of-home care.

When DCS places a child into out-of-home care, the out-of-home caregiver should get the **Notice to Providers, (Out-of-Home, Educational and Medical) form**. This form is part of the child’s placement packet. It has the member’s CMDP Identification (ID) number and is used as a temporary ID card.

The member ID number should have 9 numbers total. If the member’s ID on the Notice to Provider form does not have 9 numbers, add zeros to the front of the ID number listed until there is a total of 9. For example, the ID number is 123456 (not 9 numbers). Add 000 to the 123456 to get 000123456 (9 numbers). This is the member’s CMDP ID number.

Show the Notice to Provider form to health care providers and pharmacies, or give them the CMDP ID number. Use this form until a permanent ID card is given to you by the member’s Child Safety Specialist.

If you do not get an ID number, email CMDPMemberServices@azdcs.gov or call CMDP Member Services (602) 351-2245 or toll-free 1-800-201-1795 for help.

MEMBER CONFIDENTIALITY AND HIPAA NOTICE

The privacy of our members’ medical information is very important to CMDP; we want to keep member information private and confidential. For example, CMDP verifies the identity of all incoming callers before releasing any information. Our Member Services staff will only give information to the member’s legal guardian (custodial agency representative), the member’s caregiver and/or the member. Any other callers requesting information are referred to the member’s legal guardian for further assistance. The Health Insurance Portability and Accounta- bility Act (HIPAA) affects health care in several ways. CMDP is required to have safeguards for protecting members’ health information. This applies to all health care providers and other stakeholders.

A member’s Protected Health Information (PHI) may be used for treatment, payment and health plan operations and as permitted by law. The member or the legal guardian must give written approval for any non-health care uses of PHI.

CMDP provides a notice of members’ rights and responsibilities on the use, disclosure and access to PHI. It is called the “Notice of Privacy Practices” (NPP). The NPP is sent to the legal guardians of CMDP members. It is also included in the New Member Packets. Anyone can request the NPP by calling the CMDP Privacy Officer or downloading it from dcs.az.gov/sites/default/files/media/DCS-1039A.doc.

The CMDP Privacy Officer explains the NPP and answers questions about HIPAA. Call 602-351-2245 or 1-800-201-1795 and ask to speak to the Privacy Officer.
CORPORATE COMPLIANCE

The Corporate Compliance Program outlines the legal and ethical behavior of CMDP employees. The CMDP Code of Conduct cannot cover every situation, nor is it a substitute for common sense, individual judgment and personal integrity. It is the duty of each CMDP employee to follow these principles:

- Respect the rights, dignity and diversity of each individual
- Maintain the appropriate levels of confidentiality for information and documents
- Comply with all applicable laws
- Conduct CMDP affairs in accordance with the highest ethical standards
- Ensure proper payment for services
- Avoid conflicts of interest
- Provide a safe working environment
- Provide equal opportunity to each employee
- Promote open communication
- Conduct all business with honesty and integrity

Corporate Compliance Hotline

The CMDP Corporate Compliance Hotline is the confidential voice mailbox of the CMDP Compliance Officer. It is available 24 hours a day, 7 days a week. Anyone can use this resource to report, in good faith, concerns involving CMDP employees and potential fraud, unethical, illegal or unacceptable practices or compliance violations. The Compliance Hotline can be reached by calling 602-771-3555.

All calls are kept confidential to the extent permitted by law. Although the caller is encouraged to identify him or herself, the call can be an anonymous report. The CMDP Compliance Officer will investigate all reports of improper conduct, and take action equitably and consistently. Reports may also be made by calling CMDP and asking for the Corporate Compliance Officer at 602-351-2245 or 1-800-201-1795.

PROVIDER SERVICES

The staff in the Provider Services Unit works with health care providers. They register providers with AHCCCS and CMDP and work to resolve issues concerning providers. Provider Services works with Member Services to share the names and locations of registered providers. Members and caregivers can also contact Provider Services directly to get help in finding health care providers.

CHILDREN’S REHABILITATIVE SERVICES (CRS)

When a member with a possible CRS condition is known, CMDP will complete the CRS application with the Child Safety Specialist. Evaluation and treatment for the member’s CRS condition will be provided by CRS. The member will continue to receive all other health care services through CMDP.

The CRS member may be assigned to a Multi-Specialty Interdisciplinary Clinic (MSIC). MSICs are facilities or provider groups where doctors and other providers meet with CRS members and caregivers. This helps doctors, providers and caregivers/members work together to coordinate the members’ care all at one location and sometimes at the same appointment.

The services offered by MSIC include primary care, specialty care and behavioral health services. CMDP may assign the member to one of these clinics to better meet their health care needs.
To make, change or cancel the member’s appointment at the MSIC, contact the CRS clinic or provider in your region.

The MSICs and the services they offer are listed below:

<table>
<thead>
<tr>
<th>Metro Phoenix Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>DMG Children’s Rehabilitative Services</td>
</tr>
<tr>
<td>• CRS specialty care</td>
</tr>
<tr>
<td>• New primary care services</td>
</tr>
<tr>
<td>• Expanded behavioral health services</td>
</tr>
<tr>
<td>DMG Children’s Rehabilitative Services</td>
</tr>
<tr>
<td>3141 N 3rd Avenue</td>
</tr>
<tr>
<td>Phoenix, AZ 85013</td>
</tr>
<tr>
<td>602-914-1520 1-855-598-1871</td>
</tr>
<tr>
<td><a href="http://www.dmgcrs.org">www.dmgcrs.org</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Southern Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s Clinics for Rehabilitative Services</td>
</tr>
<tr>
<td>• CRS specialty care</td>
</tr>
<tr>
<td>• Primary care services</td>
</tr>
<tr>
<td>• Expanded behavioral health services</td>
</tr>
<tr>
<td>Children’s Clinics Square &amp; Compass Building</td>
</tr>
<tr>
<td>2600 North Wyatt Drive</td>
</tr>
<tr>
<td>Tucson, AZ 85712</td>
</tr>
<tr>
<td>520-324-5437 1-800-231-8261</td>
</tr>
<tr>
<td><a href="http://www.childrensclinics.org">www.childrensclinics.org</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Northern Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s Rehabilitative Services at Flagstaff Regional Medical Center</td>
</tr>
<tr>
<td>• CRS specialty care</td>
</tr>
<tr>
<td>Children’s Rehabilitative Services</td>
</tr>
<tr>
<td>1200 North Beaver</td>
</tr>
<tr>
<td>Flagstaff, AZ 86001</td>
</tr>
<tr>
<td>928-773-2054 1-800-232-1018</td>
</tr>
<tr>
<td><a href="http://www.flagstaffmedicalcenter.com">www.flagstaffmedicalcenter.com</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Southwestern Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s Rehabilitative Services Tuscany Medical Plaza</td>
</tr>
<tr>
<td>Yuma CRS Clinic</td>
</tr>
<tr>
<td>• CRS specialty care</td>
</tr>
<tr>
<td>Children’s Rehabilitative Services</td>
</tr>
<tr>
<td>Tuscany Medical Plaza</td>
</tr>
<tr>
<td>2851 S Avenue B, Suite 25</td>
</tr>
<tr>
<td>Yuma, AZ 85364</td>
</tr>
<tr>
<td>928-336-7095 1-800-837-7309</td>
</tr>
<tr>
<td><a href="http://www.yumaregional.org">www.yumaregional.org</a></td>
</tr>
</tbody>
</table>

Members who have a private primary insurance are not required to use CRS for their health care services. Members who do not have a private primary insurance and decide not to enroll and receive CRS covered services may be billed by the provider who renders an unauthorized CRS covered service. CMDP will only be responsible for any deductibles and copayments.

For assistance, contact the CMDP Medical Care Coordinator at (602) 351-2245 or 1-800-201-1795, Option 3-4.
BEHAVIORAL HEALTH SERVICES

Behavioral health issues are the most common health problems reported in children in out-of-home care. If these issues are not addressed, problems may arise in placements. They may also result in long-term behavior problems. Members receive their behavioral health coverage through an AHCCCS contracted Regional Behavioral Health Authority (RBHA), CMDP, and/or Children’s Rehabilitative Services (CRS).

Behavioral health services include, but are not limited to:

- Behavior management (behavioral health personal assistance, family support, home care training, self-help, peer support)
- Behavioral health case management services (limited)
- Behavioral health nursing services
- Behavioral health residential facilities/BHRFs (previously called Therapeutic Group Homes or TGHs)
- Behavior health therapeutic home care services (HCTCs sometimes called therapeutic foster care)
- Emergency behavioral health care
- Emergency and non-emergency transportation
- Evaluation and assessment
- Individual, group, and family therapy and counseling
- Inpatient hospital services
- Non-hospital inpatient psychiatric facilities (Behavioral Health Inpatient Facilities/BHIFs (previously called residential treatment centers or RTCs)
- Laboratory and radiology services for psychotropic medication regulation and diagnosis
- Opioid agonist treatment
- Partial care (supervised day program, therapeutic day program, and medical day program)
- Psychosocial rehabilitation (living skills training, health promotion, supportive employment services)
- Psychotropic medication
- Psychotropic medication adjustment and monitoring
- Respite care
- Rural substance abuse transitional agency services
- Behavioral health screening

A PCP may treat members that have depression, anxiety, and attention deficit-hyperactivity disorders. The PCP can prescribe medications and perform medication-monitoring visits. A behavioral health referral is always recommended for children in out-of-home care and is especially important for youth under six years of age. It is best practice to have a Behavioral Health Medical Professional, such as a psychiatrist, assess, evaluate, and monitor the unique behavioral health needs of children in out-of-home care.
AFTER HOURS CARE (URGENT CARE)

Urgent appointments are appointments that are needed quickly but where you are not in immediate danger. For example: a medication refill, a sore throat or cold, a rash or headache.

Ask your PCP or CMDP which urgent care centers or emergency rooms to use after regular business hours. Always call the PCP before going to the urgent care or emergency room, unless it is a life-threatening emergency.

You can check the Provider Directory or call Member Services for the approved facilities to use. Tell the PCP and DCS when a member has to go to the emergency room. It is important for them to know.

BEHAVIORAL HEALTH CRISIS SERVICES

In the event of a crisis, call the Crisis Line for the RBHA in your area. If it is a life-threatening emergency, dial 9-1-1.

RBHA Crisis Telephone Numbers

- Mercy Maricopa 1-800-631-1314
- Cenpatico Integrated Care 1-866-495-6735
- Health Choice Integrated Care 1-877-756-4090

IF YOUR CHILD IS FACING A CRISIS, DON’T WAIT. CALL THE BEHAVIORAL HEALTH CRISIS LINE

| Maricopa county and Pinal zip codes 85120, 85140, 85143, 85220, 85240, 85243 | 1-800-631-1314 |
| Cochise, Graham, Greenlee, La Paz, Pima, Pinal, Santa Cruz and Yuma counties | 1-866-495-6735 |
| Apache, Coconino, Gila, Mohave, Navajo and Yavapai counties | 1-877-756-4090 |

A crisis is any situation in which a person’s behaviors puts them at risk of hurting themselves or others and/or when they are not able to resolve the situation with the skills and resources available.

For behavioral health emergencies, contact your provider (if you have one) or the 24-hour Behavioral Health Crisis Line. The Crisis Line is available at no cost, 24 hours a day, 7 days a week.

Crisis Line Services include: dispatch of a mobile team, providing stabilization services over the phone, initiating rapid response assessment (for DCS-involved children), as well as warm transfers to representatives of the behavioral health plans.

If the crisis mobile team does not respond within two hours, call the crisis line and your behavioral health plan.

IF A SITUATION IS LIFE THREATENING, ALWAYS CALL 911.

BEHAVIORAL HEALTH PLANS

- Mercy Maricopa Integrated Care
  - Children’s Liaison: 480-751-5471
  - Member Services: 1-800-564-5465
  - DCS@mercymaricopa.org

- Cenpatico Integrated Care
  - Children’s Liaison: 520-809-6432
  - Member Services: 1-844-365-3144
  - DCS@cenpatico.com

- Health Choice Integrated Care
  - Children’s Liaison: 928-214-2370
  - Member Services: 1-800-640-2123
  - DCS@healthchoice.com

PUNCHHEALTH Community Plan CRS

- Children’s Liaison: 602-205-1692
- Member Services: 1-800-348-4058
- CRSCS_specialneeds@uhco.com

AHCCCS Customer Service: 602-364-4558 or 1-800-867-5808 or DCS@azahcccs.gov

Revised 4/18/2017
All members should go to the RBHA for an initial evaluation. For CMDP members there is a special RBHA Urgent Response. Most CMDP members will be evaluated by the RBHA at the time of entry to out-of-home care. CMDP covers transportation to the first Intake Assessment at the Behavioral Health Evaluation, if the caregiver, DCS or juvenile justice representative cannot provide it.

CULTURAL AND LANGUAGE SERVICES
CMDP wants to help members of all cultures and languages get health care services that are best for them.

If you do not speak English, we can help. We want you to know how to use your health insurance. If you need any information in another language, please call member services. We will use our translation service to speak to you in your language.

We can also give you CMDP information in another language or format. Auxiliary aids and services are available upon request.

Auxiliary aids means services or devices that enable persons with impaired sensory, manual, or speaking skills to have an equal opportunity to participate in, and enjoy the benefits of, programs or activities conducted by CMDP. For example, auxiliary aids useful for persons with impaired vision include readers, Brailled materials, audio recordings, and other similar services and devices. Auxiliary aids useful for persons with impaired hearing include telephone handset amplifiers, telephones compatible with hearing aids, telecommunication devices for deaf persons (TDD’s), interpreters, notetakers, written materials, and other similar services and devices.

American Sign Language is also available to help members and caregivers communicate with health care providers.

We can help find health care providers who have certain language or cultural strengths. Call CMDP Member Services if you need

• A specific language or gender, ethnic, geographical or specialized health care provider
• Health care services responsive to a member’s cultural or religious beliefs
• Translation services for health care appointments when a language-specific provider is unavailable
• Interpretation services orally or for hearing impaired members
• Written health care information in another language
• Health care information in an alternative format for the visually impaired
• Information identifying network provider offices that accommodate members with physical disabilities

If you would like to access any of these services or obtain a directory of providers contact CMDP Member Services by emailing (CMDPMemberServices@azdc.gov) or calling 602-351-2245 or 1-800-201-1795, Option 3-1.

Cultural/language services and member materials are available at no cost to the member or caregiver.

MEDICAL HOME
Despite the challenges faced by the temporary nature of out-of-home placement and the individual needs between placement types, CMDP strives to establish a true medical home for every child during the
period that they are in care. This medical home is one in which care is delivered in accordance with the requirements of EPSDT and in a manner that is accessible, continuous, comprehensive, coordinated, compassionate, and culturally effective.

CMDP’s primary care providers (PCPs) play a critical role in establishing the member’s medical home and ensuring members receive needed EPSDT screenings and other medically necessary services.

Provider Services, Member Services and Medical Services work together to monitor a provider’s ability to provide care to members with limited proficiency in English and with special medical, behavioral health, social, and cultural needs.

DENTAL HOME
The American Academy of Pediatric Dentistry (AAPD) and the American Dental Association (ADA) support the concept of a “dental home,” which is the ongoing relationship between the dentist who is the Primary Dental Provider (PDP) and the patient, and includes comprehensive oral health care, beginning no later than age one.

By selecting a PDP, a dental home is established. This means that a licensed dentist manages a child’s oral health care in a comprehensive, continuously accessible, coordinated, and family-centered way. The concept of the Dental Home reflects AAPD and ADA policies and best principles for the proper delivery of oral health care to all, with an emphasis on initiating preventive strategies during infancy. An infant oral health exam is simple, easy and effective.

The dental home enhances the PDP’s ability to provide optimal oral health care, beginning with the age one dental visit for successful preventive care and treatment as part of an overall oral health care foundation for life. Additionally, the establishment of the dental home assures appropriate referral to dental specialists when care cannot be provided within the dental home.

The dental home concept allows providers to outreach to members who have not completed visits, as specified in the AHCCCS Dental Periodicity Schedule and allows outreach to those members who have had no-show appointments. The dental home can also assist members in being referred for additional oral health care concerns requiring additional evaluation and/or treatment.

MEMBER INFORMATION
CMDP sends new member packets to the agencies that have custody of members. The materials in the packet are to be given to the new members’ caregivers. The materials include the member ID card and health care information, including the choice of a Primary Care Provider (PCP) and a Primary Dental Provider (PDP) or Dental Home.

The CMDP Member Handbook is revised every year. The member handbook can be found on the CMDP website, dcs.az.gov/cmdp.

The CMDP Provider Directory is a list of registered health care providers. The list includes PCPs and health care specialists. The directory assists in the selection of a PCP and a PDP. The directory can be found on the CMDP website. Members and caregivers can also contact Member Services to have a copy of the member handbook and the directory mailed to them at no cost. When new placements are identified, member information packets, including member handbooks, are mailed to them.
THE MEMBER ID CARD

The Member ID card has a lot of valuable information. Take your member ID card to your healthcare appointments. Show your member ID card to pharmacies and health care providers so they can bill CMDP for payment. Do not let someone else use your member ID card. It is against the law.

A temporary member ID card is made when a child first is enrolled with CMDP. It does not include the Regional Behavioral Health Authority (RBHA) information.

Your ID card has a phone number to access behavioral health and substance abuse services. Services are assigned to a provider based on where you live. If you have questions or need help getting behavioral health services, please call the number on your card.

A permanent member ID card is sent shortly afterward. The permanent card will have the name of the behavioral health agency (RBHA, CMDP or CRS) that is responsible for providing behavioral health services.

The member is assigned a RBHA based on the member’s court of jurisdiction. The RBHA will pay for most behavioral health services, including most prescriptions for behavioral health conditions. If you have questions or need help in getting behavioral health services, please call the RBHA phone number on the card.

The Pharmacy information is on the Member ID card. If you have problems getting a prescription at the pharmacy call the Member Helpline telephone number shown on the front of the CMDP ID card 1-800-788-2949.

If the member has an Arizona driver’s license or state issued ID, AHCCCS will obtain the member’s picture from the Arizona Department of Transportation Motor Vehicle Division (MVD). The AHCCCS eligibility verification screen viewed by providers contains the member’s picture (if available) and coverage details.

Do not throw the member ID card away. The card should be kept safe and in the possession of the member and child’s caregivers. The member/caregiver is responsible for protecting his or her ID card. Misuse of the card, including loaning, selling or giving it to others could result in loss of the member’s eligibility and/or legal action.

If you do not get a member ID number, or need a replacement Member ID card please email (CMDPMemberServices@azdcs.gov) or call CMDP Member Services (602) 351-2245 or toll-free 1-800-201-1795 for help.

MEMBER SERVICES

Member Services is here to help you. If you have any questions, concerns or issues about health care services please call us.

Member Services can answer questions about:

- Enrollment
- Eligibility
- Member identification cards
- Finding a doctor, dentist, hospital or pharmacy
- Finding a health care provider who speaks your language and understands your culture
Member Services can be reached by emailing (CMDPMemberServices@azdcs.gov) or calling 602-351-2245 or 1-800-201-1795, Option 3-1.

Call Member Services to:

- Report any changes for members
- Change your primary care provider (PCP)
- Report a change of address

MEMBER AND CAREGIVER RESPONSIBILITIES

Members and caregivers are responsible for:

- Always listing DCS/CMDP as the responsible party, and the CMDP address for submitting claims (CMDP – C010-18, P.O. Box 29202, Phoenix, AZ 85038-9202).
- Providing as much information as possible to the healthcare providers working with the member.
- Telling CMDP about any other insurance coverage the member may have.
- Protecting the member’s ID card at all times. Do not lose it or share it with anyone. Show the ID card when checking in for services.
- Following prescribed treatment plan prescribed by the member’s health care providers.
- Knowing the name of the member’s PCP or doctor and PDP or dentist.
- Scheduling appointments with the doctor during office hours whenever possible, before using urgent care or a hospital emergency room.
- Scheduling appointments outside of school hours whenever possible.
- Taking the member to medical appointments, or contacting the assigned DCSS or CMDP if you need help with transportation.
- Arriving to appointments on time.
- Arriving at the office early if the member is seeing the doctor for the first time
- Notifying the health care provider at least one day in advance when unable to keep an appointment.
- Carrying the CMDP ID card (or Notice to Provider form, if the card has not arrived) at all times, and presenting it to the health care provider.
- Bringing all available shot records and medical history information to the doctor or PCP.
- Taking the member for well-child checkups.
- Taking the member for a dental exam at least twice a year.
- Using Children’s Rehabilitative Services (CRS) when asked to do so by CMDP or the PCP.
- Working with CMDP, the DCSS, the PCP and PDP to make certain the member is receiving the best care possible.
- Ensuring that each member has all childhood and teenage immunizations (shots). (See the Center for Disease Control and Prevention website for immunization schedules and more information at http://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html).
- Ensuring each member has all the Well child visits for their age.
• Notifying CMDP if there is any change in address or phone number.
• Notifying the member’s PCP and PDP if there is any change in address or phone number.
• Notifying DCS/CMDP when family size or any other demographic information changes.

OUT-OF-AREA MOVES
Contact Member Services when you move with a CMDP member from one area, county or to another state. CMDP needs to know the new address for the member. The Child Safety Specialist, PCP and the PDP should also be contacted.

Advance notice to the PCP and PDP allows time for the transfer of medical files to a new provider. This ensures continuity of care for the member.

If you move with a member to another state, contact the Child Safety Specialist for assistance in getting health care services in the new state. The caregiver should give CMDP and the DCSS the new address of the member.

The Child Safety Specialist must tell the new state about the plans to provide health care services for the member. The Child Safety Specialist will find out if the member can get Medicaid services in the new state. If so, the caregiver is informed of how to apply for Medicaid services.

If the member is not eligible, CMDP covers all medically necessary health care services. Provider Services and Member Services Units work with the Child Safety Specialist to locate and register providers.

Contact Member Services if you need help finding a pharmacy for the member. If you have problems filling your medications contact Medical Services for help.

LEAVING OUT-OF-HOME CARE
CMDP members who are AHCCCS eligible while in out-of-home care receive the benefits of an ex parte process when leaving out-of-home care. This process allows continued AHCCCS coverage through a transition period (up to 60 days) when they exit out-of-home care. Members continue health care coverage with another AHCCCS Health Plan until a re-determination is made. CMDP members cannot lose all AHCCCS benefits simply because they have left out-of-home care.

CMDP members that reach the age of 18 years of age and who are AHCCCS eligible while in out-of-home care receive the benefits of the Young Adult Transitional Insurance (YATI) Program for continued medical coverage with AHCCCS when they exit out-of-home care. The member’s DCSS must complete the AHCCCS enrollment paperwork in order for the member to transition to another AHCCCS Health Plan.

Caregivers and members: Check with the DCSS before members leave out-of-home care to ensure the ex parte process or the YATI Program transition is in place.

MEDICAL AND DENTAL APPOINTMENTS
Call the PCP and the PDP to make an appointment. The phone number is in the Provider Directory and on the letter from CMDP. When you call, tell them the member is covered by CMDP.
Children must have a full physical exam and a dental visit within the first 30 days of being placed into care. Please schedule a physical exam and a dental visit for members who have not had this exam.

When you call your Doctor – you should be able to get in to see the doctor for the care you need.

<table>
<thead>
<tr>
<th>Routine Visits- Appointments for Well checks, follow up visits, yearly exams, immunizations. Call your Doctor or Dentist for an appointment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>You Should be able to see your Doctor for the appointment for -</strong></td>
</tr>
<tr>
<td><strong>Primary Care</strong></td>
</tr>
<tr>
<td><strong>Specialty Care</strong></td>
</tr>
<tr>
<td><strong>Dental Care</strong></td>
</tr>
<tr>
<td><strong>Maternity Care</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Urgent Visits- Appointments that are needed quickly but where you are not in danger. For example- a medication refill, a sore throat or cold, a rash or headache. Call your Doctor for an appointment. If it is after hours the doctor will have an answering service that can answer your questions, or have the doctor call you back. You should not go to the emergency room for urgent visits or sick care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>You should be able to see your Doctor for an urgent visit-</strong></td>
</tr>
<tr>
<td><strong>Primary Care</strong></td>
</tr>
<tr>
<td><strong>Specialty Care</strong></td>
</tr>
<tr>
<td><strong>Dental Care</strong></td>
</tr>
<tr>
<td><strong>Maternity Care</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency Visits- This is where you may need to be seen because you have a serious medical condition and are in danger of losing your life or serious harm. For example- Poisoning or Overdose, broken bones, trouble breathing, or seizures. In these cases- call 911 or go to the nearest emergency Room- You do NOT have to call your Doctor first. Emergency services do not need a Prior Authorization.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>You should be able to be seen for an emergency-</strong></td>
</tr>
<tr>
<td><strong>Primary Care</strong></td>
</tr>
<tr>
<td><strong>Specialty Care</strong></td>
</tr>
<tr>
<td><strong>Dental Care</strong></td>
</tr>
<tr>
<td><strong>Maternity Care</strong></td>
</tr>
</tbody>
</table>

Call Member Services if you have a problem getting an appointment.

Let DCS or the juvenile justice representative know if the child has any special health care needs. This includes, but is not limited to, pregnancy, chronic asthma and diabetes.

CMDP will help locate a doctor, dentist or specialist for the member.
EMERGENCY TRANSPORTATION
Dial 9-1-1 or contact the local ambulance service for transportation in a life-threatening emergency situation. This service is covered by CMDP.

MEDICALLY NEEDED NON-EMERGENCY TRANSPORTATION
Caregivers should arrange their own transportation to and from medical appointments. This includes your own car, taking the bus, having a family member or friends give you a ride. If unsuccessful in arranging transportation, contact your DCSS. They will help you arrange transportation. (It is recommended this process start no later than 4 days prior to the appointment.) If unable to reach your DCSS, contact Member Services at (602) 351-2245 or 1-800-201-1795 for assistance arranging transportation. Arrangements for non-emergent transportation must be made at least 24 hours in advance of the appointment.

COVERED SERVICES
Call Member Services if there are any questions or concerns about covered health care services.

CMDP pays for health care services that are medically needed. The services include, but are not limited to:

- Doctor office visits
- Well-child check-ups/EPSDT/adolescent screenings and treatment
- Screening tests- Such as Lead, Anemia, hearing, vision, sexually transmitted infection, cervical cancer screening etc.
- Immunizations (See the Center for Disease Control and Prevention website for immunization schedules and more information at http://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html).
- Behavioral health services
- Hospital care
- Specialist care, as needed
- Family planning services
- Home and community-based services
- Lab and X-ray services
- Pregnancy care
- 24-hour emergency medical care
- Dental Care – Preventative, diagnostic and restorative
- Emergency transportation
- Vision care and eyeglasses
- Medically-needed transportation
- Pharmacy services, medical supplies and equipment
- Transplants (CMDP will only pay for transplants listed as covered by AHCCCS)

CMDP BEHAVIORAL HEALTH COVERAGE
Children that are not AHCCCS (Non-Title XIX) or KidsCare (Non-Title XXI) eligible receive their behavioral health services through CMDP and DCS regional contracts. CMDP covers inpatient psychiatric hospitalization, psychiatric evaluation, psychiatric medication management, therapies and
other direct services provided to the CMDP member and caregivers. Prior Authorization is required for services at non-emergent Behavioral Health out-of-home services. DCS Regional staff may provide some behavioral health services in addition. Members should contact the DCS Behavioral Health Clinical Coordinator in their region to request these services.

A PCP may treat members that have depression, anxiety, and attention deficit-hyperactivity disorders. The PCP can prescribe medications and do medication-monitoring visits. However, a behavioral health referral is always recommended for children in out-of-home care and is especially important for youth under six years of age. It is best practice to have a Behavioral Health Medical Professional, such as a psychiatrist, assess, evaluate, and monitor the unique behavioral health needs of children in out-of-home care.

For assistance, contact the CMDP Behavioral Health Clinical Coordinator at (602) 351-2245 or 1-800-201-1795, Option 3-2.

CHILDREN’S REHABILITATIVE SERVICES (CRS) BEHAVIORAL HEALTH COVERAGE

CRS provides behavioral health services for members enrolled with CRS due to a qualifying condition. Please refer to Children’s Rehabilitative Services section in this handbook to learn more about eligibility. Members enrolled with CRS will receive their behavioral health coverage with CRS no matter where they live.

The CMDP ID card has CRS’ phone number. CRS will pay for most behavioral health services including prescriptions for behavioral health conditions. If you have questions or need help in getting behavioral health services, please call the phone number on your card.

Please do not use the CMDP ID card to pay for CRS covered medications. CMDP does not cover this service. CRS is responsible for payment. Ask the CRS doctor which pharmacy to use, and give the member’s CRS ID number to the pharmacist. You can call CRS Member Services at 1(800) 348-4058.

In the event of a crisis, please call the CRS Crisis Line. If it is a life-threatening emergency, dial 9-1-1.

**CRS County Crisis Lines**

<table>
<thead>
<tr>
<th>Counties Served</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cochise, Gila, Graham, Greenlee, La Paz, Pinal, Santa Cruz and Yuma Counties</td>
<td>1-866-495-6735</td>
</tr>
<tr>
<td>Pima County</td>
<td>1-800-796-6762</td>
</tr>
<tr>
<td>Maricopa County</td>
<td>1-800-631-1314</td>
</tr>
</tbody>
</table>
BEHAVIORAL HEALTH INFORMATION AND PRIVACY

There are laws about who can see your behavioral health information with or without your permission. Substance abuse treatment and communicable disease information (for example, HIV/AIDS information) cannot be shared with others without your written permission.

At times your permission is not needed to share your behavioral health information to help arrange and pay for your care. These times could include the sharing of information with:

- Physicians and other agencies providing health, social, or welfare services;
- Your medical primary care provider;
- Certain state agencies involved in your care and treatment, as needed; and
- Members of the clinical team involved in your care.

At other times, it may be helpful to share your behavioral health information with other agencies, such as schools. Your written permission may be required before your information is shared.”

URGENT CARE

Call your PCP to get advice after normal business hours, at night or on weekends. You may be told to come to the office in the morning or to go to a hospital right away. If you cannot reach the PCP, go to an urgent care center if the member’s life is not in danger. (See emergency care definitions.) To access afterhours/urgent care contact information, you can check the Provider Directory or call Member Services (602-264-3801 or toll free 1(800)201-1795).

Urgent care centers can be used for a cough, sprain, high fever or earache. Urgent care centers have many of the same services as a doctor's office. They can also call 9-1-1 to take a child to the hospital if needed.

Tell the PCP and the DCSS when a member has had to go to urgent care. This is important for them to know.

EMERGENCY CARE

Emergencies are medical problems that may be life threatening if not treated quickly. Examples of emergencies are major bleeding, broken bones, breathing difficulties, seizures, and unconsciousness.

In a true medical emergency, the well-being of the member is most important. Please dial 9-1-1 or go to the nearest hospital emergency room (members have the right to obtain emergency services at any hospital or other emergency room facility). Show the CMDP ID card to pay for any services. Emergency services do NOT need a prior authorization from CMDP.

*A hospital emergency room is not to take the place of a doctor’s office. Do not use it for minor medical problems.*

Tell the PCP and the DCSS when members receive emergency care. This is important for them to know.
INCONTINENCE BRIEFS

Incontinence briefs (diapers), including Pull-Ups and/or Incontinence Pads, may be provided by CMDP if the child needs diapers to:

- Prevent skin breakdown
- Participate in social, community, therapeutic and educational activities

**These are the CMDP guidelines for incontinence briefs (diapers):**

- The child must be older than 3 years of age.
- The child has a documented medical condition that is causing them to have problems with bladder and/or bowel control.
- The child needs the incontinence briefs to prevent skin breakdown and to enable participation in social, community, therapeutic, and educational activities under limited circumstances.
- The PCP has written a prescription for up to 240 diapers per month, unless more are needed depending on the medical condition.
- If DCS is currently providing a stipend toward the purchase of the diapers and CMDP is going to supply them, the Child Safety Specialist must discontinue the stipend and cannot give the family a future stipend.
- CMDP will have the diapers delivered to the home by a designated supply company.

For questions about diaper requests, please contact Medical Services at (602) 351-2245 or 1-800-201-1795, Option 3-4.

SERVICES NOT COVERED OR PAID FOR BY CMDP

Listed below are general guidelines of services CMDP **does not cover:**

- Any care that is not medically needed
- Any hospital admission, service or item that needed prior authorization (PA) but was not approved in advance or was denied
- Services or items for cosmetic purposes; services needed for the psychological well-being of the member need a PA
- Services or items that are free of charge or for which charges are not usually made
- Pregnancy termination, unless prior approved and pregnancy termination counseling
- Personal care items such as shampoo, mouthwash, or diapers for members, newborn to three years old
- Dietary formulas or diet supplements (unless they are the only source of nutrition and/or medically necessary)
- Medical services to an inmate of a public institution, such as a jail or correction facility
- Care provided by individuals who are not properly licensed or certified and who are not CMDP registered
SERVICES OUT-OF-HOME CAREGIVERS CANNOT AUTHORIZE

• General anesthesia
• Blood transfusions
• Pregnancy termination
• Any surgery or medical treatment that is not routine

If the Department of Child Safety has temporary custody of a child or has legal custody pursuant to a court order the Department may consent to the following:

• Evaluation and treatment for emergency conditions that are not life threatening;
• Routine medical and dental treatment and procedures including early periodic screening diagnosis and treatment services, and services by health care providers to relieve pain and treat symptoms of common childhood illness or conditions;
• Surgery;
• General anesthesia;
• Blood transfusion; or
• Testing for the presence of the human immunodeficiency virus.

When parental rights have not been severed, the Department shall to the greatest extent possible, consult with biological parents of the child when making health care decisions for a child in the Department’s custody.

END OF LIFE CARE SERVICES

End of Life (EOL) care is a member centered approach with the goal of keeping the member’s rights and dignity while getting any other medically necessary Medicaid covered services.

EOL care includes information about how to keep healthy; giving more flexibility in picking what treatment will be no matter your age or the stage of the illness. Advance Care Planning, Palliative care, Supportive care, Hospice services.

When necessary, advance directives are made by the attorney general’s office for member’s under the age 18, if they are in out-of-home care or DCS custody.

SEEING A SPECIALIST AND OTHER PROVIDERS

A referral from your PCP or PDP is not needed to see a specialist (except for an orthodontist). Initial evaluations and consultations do not need prior approval (PA), with the exception of chiropractic, podiatry and pediatric developmental/behavioral health assessments. Specialists must get a PA from CMDP before health care services are given. If the services are not approved, a letter is sent stating why and how to appeal that decision. The letter is sent to the agency with custody of the member.

Female members have direct access to preventative care and well care services from a gynecologist within the CMDP network without a referral from a primary care provider.

Pregnant members may choose their OB-GYN provider as their PCP.

Member Services can give you and the PCP or PDP a list of specialists that are registered with CMDP. They can also be found in the *CMDP Provider Directory*. If you do not have a copy of the directory, call Member Services. The directory is also on the CMDP web site, [dcs.az.gov/cmdp](http://dcs.az.gov/cmdp).
AMERICAN INDIAN MEMBERS
American Indian members are able to receive health care services from any Indian Health Service provider or tribally owned and/or operated facility at any time.

CHOOSING A PRIMARY CARE PROVIDER (PCP) AND PRIMARY DENTAL PROVIDER (PDP)
CMDP members should have a PCP and a PDP, who act as a personal care doctor and dentist. The PCP and PDP will provide or arrange for the needed health services. Caregivers may want to select a PCP and a PDP that has a focus on children and teens with special health care issues. The PCP and PDP work with specialists, pharmacies, hospitals and other providers to track all care a member receives.

To qualify as a PCP or PDP, a provider must practice in one of the following areas:
- Pediatrics (Medical or Dental)
- Family practice (Medical or Dental)
- General internist
- Certified nurse practitioner
- Physician’s assistant and supervised by an physician
- Obstetrics and gynecology (OB-GYN) (for pregnant members)

REASONS TO HAVE A PCP AND PDP
- Manages the member’s medical and dental needs
- Knows the member’s medical and dental history
- Will help get the care the member needs and provide coordination of care
- Can help find a specialist when needed by the member
- Will get the member’s medical and dental information to those who need it to provide the best care for the member
- Will provide better care for chronic health problems

CMDP has a Preferred Provider Network (PPN) to meet the needs of members. The PPN is made up of PCPs, specialists, PDPs, pharmacies, hospitals and other health care providers. These providers are listed in the CMDP Provider Directory. The directory is available by request, at no cost, by calling Member Services. The directory is also on the CMDP web site, des.az.gov/cmdp. The list of providers can be searched by ZIP code and type of provider.

Contact Member Services if you need assistance in selecting a PCP and a PDP. CMDP must know who the PCP and PDP is for each member. To provide the name of the PCP and PDP, contact Member Services by phone, mail, or e-mail (CMDPMemberServices@azdcs.gov).

Changing Your PCP/PDP
When members move, they may need to change providers. If you change PCP or PDP, please ask your old PCP or PDP to transfer your medical records to the new PCP or PDP. CMDP will work with you to select a new PCP or PDP. To request a change, or to notify CMDP of a change, call Member Services.
Making an Appointment
In most cases, you will need to make an appointment to see a PCP or PDP. To make an appointment you will need to call the assigned PCP or PDP and tell them the following:

- Member Name
- Member ID
- Reason for Appointment
- That the Member is insured by CMDP

Cancelling or Changing an Appointment
To cancel or change an appointment with your PCP, PDP, specialist or CRS, call providers at least one day before the appointment. Some providers may attempt to charge a fee for a missed appointment. By State of Arizona law, CMDP cannot pay for missed or no-show appointments.

Maintaining Good Health
How to help keep members healthy:

- Make sure members get all their well child visits
- Make sure members get their Dental visits twice a year
- Follow up on all referrals made during visits with the Primary Care Provider (PCP).
- Make sure all members receive their vaccines (shots). Be sure shots are up-to-date (See the Center for Disease Control and Prevention website for immunization schedules and more information at http://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html).
- Sometimes you need to go to a new doctor. When this happens, make sure to get copies of all medical records sent to the new doctor.
- Make sure teens go to their well visits. These include well woman visits for girls. The teen’s doctor should talk about reproductive health and birth control with them. They should also talk about safe sex. Safe sex includes how to prevent sexually transmitted diseases. There is often discussion of drugs and alcohol use at these visits as well. The member’s out-of-home caregiver should also talk to them about these subjects.
- Members should go to all prenatal care appointments. Make sure all postpartum doctor visits are kept after the baby is born.

Well visits (well exams) such as, but not limited to, well woman exams, breast exams, and prostate exams are covered for members 21 years of age and older. Most well visits (also called checkup or physical) include a medical history, physical exam, health screenings, health counseling and medically necessary immunizations. (See EPSDT for well exams for members under 21 years of age)

WELL-CHILD SERVICES, OR EARLY PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT)
Early Periodic Screening, Diagnostic and Treatment (EPSDT) is a comprehensive child health program of prevention and 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 U.S.C. 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 and dental periodicity schedules.

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 U.S.C. 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the (AHCCCS) state plan.”

This means that EPSDT covered services include services that correct or ameliorate physical and mental defects, conditions, and illnesses discovered by the screening process when those services fall within one of the 29 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 solely for cosmetic purposes, or that are not cost effective when compared to other interventions.

An EPSDT or well check is required at:

<table>
<thead>
<tr>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-5 days of age</td>
</tr>
<tr>
<td>1 month of age</td>
</tr>
<tr>
<td>2 months of age</td>
</tr>
<tr>
<td>4 months of age</td>
</tr>
<tr>
<td>6 months of age</td>
</tr>
<tr>
<td>9 months of age</td>
</tr>
<tr>
<td>12 months of age</td>
</tr>
</tbody>
</table>
15 months of age
18 months of age
24 months of age
After 2 years of age, a yearly well check until 21 years

CMDP also supports the use of the enhanced visit schedule for children in out-of-home care recommended by the American Academy of Pediatrics. These visits allow the PCP to follow the child in out-of-home care and address the complex issues that many children in out-of-home care may have. Such as developmental delays, adjustment to new placements, school issues etc.

<table>
<thead>
<tr>
<th>Age</th>
<th>EPSDT or well checks</th>
<th>Additional recommended visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth- 6 months</td>
<td>2 wk, 1, 2, 4, and 6 month of age</td>
<td>Ideal to be seen monthly – especially if preterm or has chronic medical problems</td>
</tr>
<tr>
<td>8-24 months</td>
<td>9, 12, 15, 18, and 24 months of age</td>
<td>At 21 months to assess behavior and development</td>
</tr>
<tr>
<td>24 months – 21 years</td>
<td>Every 12 months</td>
<td>Ideal to see at least every 6 months to assess behavioral health, development and educational needs and monitor adjustment to out-of-home care and visitation. Children with significant issues should be seen more frequently.</td>
</tr>
</tbody>
</table>

Reasons for additional visits for children in out-of-home care

- Out-of-home caregiver support and education
- Need for frequent monitoring for the impact of transitions, visitation, and uncertainty and ongoing adaptation to placement
- Address any emerging problems, especially behavioral, emotional, developmental and educational
## EPSDT Periodicity Schedule

### Arizona Health Care Cost Containment System

#### EPSDT Periodicity Schedule

<table>
<thead>
<tr>
<th>Procedure/Age</th>
<th>Newborn</th>
<th>0-3 mo</th>
<th>4-6 mo</th>
<th>7-9 mo</th>
<th>10-12 mo</th>
<th>13-15 mo</th>
<th>16-18 mo</th>
<th>19-24 mo</th>
<th>25-36 mo</th>
<th>37-48 mo</th>
</tr>
</thead>
<tbody>
<tr>
<td>History Initial Interval</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Length &amp; Height &amp; Weight</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Weight &amp; Length</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Head Circumference</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Body Mass Index (BMI)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Blood Pressure – 2-D (should assess the need for B-P instrument for children before 24 months)</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Nutritional Assessment</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Vision Hearing Speech</td>
<td>SEE SEPARATE SCHEDULE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Developmental Surveillance</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Developmental Screening</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Psychosocial Behavioral Assessment</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Alcohol and Drug Use Assessment</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Physical Examination</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Newborn Metabolic Screening</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Immunizations</td>
<td>SEE CENTERS FOR DISEASE CONTROL AND PREVENTION WEBSITE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuberculin Test</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Hemoglobin Hematocrit</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Lead Screening Test</td>
<td>OUTSIDE HIGH RISK ZIP CODE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verbal Lead Screen</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Blood Lead Testing</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Lead Screening Testing</td>
<td>WITHIN HIGH RISK ZIP CODE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verbal Lead Screen</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Blood Lead Testing</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Dysplasia Screening</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Dysplasia Testing</td>
<td>ONE TIME TESTING BETWEEN 18 AND 20 YEARS OF AGE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SHH Screening</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Cervical Dysplasia Screening</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Oral Health Screening by PCP</td>
<td>X</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Topical Fluoride Varnish</td>
<td>X</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Dental Referent</td>
<td>X</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Anticipatory Guidance</td>
<td>X</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>
1. Utilization of the ARHCCS 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.

2. Newborn metabolic screening should be done according to state law. Results should be reviewed at visits and appropriate retesting or referral done as needed.

3. Oral health screenings to be conducted by the PCP at each visit starting at 6 months of age.

4. 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.

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

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
- **=** = 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 test performed

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

**NOTE:** The American Association of Pediatric Dentistry recommends that dental visits begin by age one (1). 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:** 04/01/15, 04/01/2014, 04/01/2013, 10/01/2008, 04/01/07, 10/23/2006

---

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM**

**HEARING/SPEECH SCHEDULE**

<table>
<thead>
<tr>
<th>PROCEDURE</th>
<th>AGE</th>
<th>0**</th>
<th>S</th>
<th>O***</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing/Speech</td>
<td>New born</td>
<td>3-5 days</td>
<td>2 Wks</td>
<td>By 1mo</td>
</tr>
<tr>
<td></td>
<td>2 mo</td>
<td>4 mo</td>
<td>6 mo</td>
<td>9 mo</td>
</tr>
</tbody>
</table>

These are minimum requirements: 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:** 04/01/15, 04/01/2014, 04/01/07, 04/01/06
RECOMMENDED IMMUNIZATION SCHEDULES

Caregivers in the State of Arizona are obligated to abide by the statutes governing the health of children in out-of-home care. Article 58, of the Arizona Administrative Code, R6-5-5830, Medical and Dental Care, states: “A caregiver shall arrange for a foster child to have routine medical and dental care, which shall include an annual medical exam, semi-annual dental exams, immunizations and standard medical tests.” (See the Centers for Disease Control and Prevention (CDC) website for immunization schedules and more information at http://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html).

Arizona law requires schoolchildren and childcare enrollees to be age-appropriately immunized. The exceptions and additions to the rules are as follows:

- Biological parents whose religious beliefs do not allow immunizations must sign a religious exemption.
- The child’s doctor must sign a medical exemption form if there is evidence of immunity or a medical reason why the child cannot receive shots. A copy of the lab results must be kept on file to prove the child’s immunity.

Vaccine reactions rarely happen and usually are no worse than minor flu symptoms. Serious reactions are very rare. The dangers of not being immunized are far worse than the possibility of serious reaction. See the Center for Disease Control and Prevention website for immunization schedules and more information at http://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html.

Note: The recommended immunization schedules are periodically changed by the Centers for Disease Control and Prevention. Discuss your child’s immunizations with the PCP or doctor.

Vaccines are not just for babies. Children get most of their vaccines between birth and 4-6 years. However, teenagers also need vaccines. Talk to your PCP about the vaccines needed and help protect them as they grow older.

Don’t forget to remember the yearly flu vaccine that can help protect the member and the family from the flu.

You can call the EPSDT Coordinator at 602-351-2245 or toll-free at 1-800-201-1795. Select option 3-4, if you would like a Lifetime Immunization Card. You can use this card to keep track of all the vaccines your CMDP member gets.

WHEN DO CHILDREN AND TEENS NEED VACCINATIONS?

Immunization schedules can be found online through the Centers for Disease Control website at the following link: https://www.cdc.gov/vaccines/schedules/easy-to-read/index.html

Printable immunization schedules are also available in the appendix section of this handbook.

MATERNITY CARE SERVICES

If a member thinks she is pregnant, make an appointment with the PCP at right away. The PCP can prove that the member is pregnant. The PCP will provide the names of Primary Care Obstetricians (PCOs) for the member to choose. A member can also call Member Services for help in choosing a PCO. If the member is new to care and has already been receiving care from an OB, the member can...
continue to see the same OB for care. If the OB is not registered with CMDP, efforts will be made to register this provider.

CMDP pays for obstetric (OB) services. The PCO specializes in OB care. The PCO monitors and treats pregnant women during pregnancy. The services include care during pregnancy, the delivery and post-partum or after-delivery care. Members should remain with the same PCO for the entire pregnancy. However, if a member moves or has to change her PCO, which is her right, every effort is made to ensure there is communication between the PCOs so there is no interruption in care.

The PCO will see the member for regular checkups. The check-ups are to make sure the pregnancy is going well. Early health care and regular checkups during pregnancy are important to the health of the mother and baby.

MATERNAL HEALTH COORDINATORS

CMDP Maternal Health Coordinators (MHC) will ensure all needed services are provided to pregnant members. For assistance, call Medical Services at (602) 351-2245 or 1-800-201-1795, Option 3-4, and ask to speak to the Maternal Health Coordinator. The MHC contacts the Child Safety Specialist and/or caregiver to ensure the member is getting prenatal care.

The MHC also ensures the Primary Care OB offers the member the appropriate testing and screening during and after her pregnancy. This includes testing for HIV and screening for depression during and after the pregnancy.

The MHC will follow up with the Child Safety Specialist to arrange for counseling, as needed.

The standards regarding appointment times for all pregnant members to see their PCO:

- First Trimester (the first 3 months of pregnancy), within 14 days of request
- Second Trimester (the second 3 months of pregnancy), within 7 days of request
- Third Trimester (the last 3 months of pregnancy), within 3 days of request
- High Risk (having special needs that put the mother or the baby at risk of harm), within 3 days of request
- Emergency (when a member has to be seen immediately because of a crisis, like bleeding, etc.), immediately.

If you have any problems getting an appointment within these timeframes, please contact Member Services at (602) 351-2245 or 1-800-201-1795, select option 3-1.

It is important for the member to keep all appointments scheduled by the OB, including the post-partum visit. The Primary Care OB can also ask for a listing of CMDP registered specialists if the pregnant member needs specialist care.

WOMEN'S CARE

Female members have direct access to preventative and well care services. They can get this from a gynecologist in the CMDP network without a referral from a primary care provider. The provider must be in the CMDP network. It is very important for sexually active or age-appropriate female members to get a well-woman exam. They should get the exam at least once a year. This will allow the doctor to monitor their health. It will also assist them to stay healthy. Preventive services include, but are not limited to:
• PAP smear – as indicated
• Breast exam
• Mammogram – when medically required
• Vaccinations- including HPV vaccine
• Screening for sexually transmitted infections

Human papillomavirus (HPV) is a common virus. It can cause cancer of the cervix. The virus is spread through sexual contact. Often HPV has no symptoms. This makes it hard for someone to know they have it. It is important that both females and males get the HPV vaccine. They should get the vaccine before they are sexually active. This is when the vaccine can give the most protection.

Both family planning and well woman care are available from the PCP and often incorporated into the EPSDT or well check. If more comfortable for the member, they can see the PCP or a gynecologist for these services.

FAMILY PLANNING

Family Planning services are for all male and female members of age 12 and older. CMDP sends a Family Planning letter to the home of these members. CMDP asks members to talk with their doctors about Family Planning. This is so that good choices can be made. Family Planning services are free to CMDP members. Family Planning includes, but is not limited to:
• Education on how to prevent a pregnancy
• Medications
• Supplies (including, but not limited to, diaphragms, condoms, foams, patches, and implanted birth control methods)
• Annual physical exams
• Lab tests
• Radiological exams related to family planning
• Treatment of problems caused by the use of contraceptives
• Emergency oral contraception within 72 hours after unprotected sex

CMDP members should see their doctor if they are sexually active. Their doctor will give them yearly exams. They will also do lab tests. Female members can see a gynecology provider. A referral is not needed and cannot be required by CMDP.

CMDP providers teach members about sexually transmitted diseases (STDs). They teach the members how STDs are passed on to others. The providers teach members how to prevent STDs. CMDP covers tests for STDs. CMDP also covers the test for HIV (the virus that causes AIDS). If testing is needed, the CMDP member must receive HIV testing counseling from the health care provider or the local health department. They can also get this counseling from another health related provider in or out-of-network.

**Members 12 years of age and older can consent when a doctor states HIV testing is necessary. No other approval is needed.** Members less than 12 years old must have approval. This approval can come from the out-of-home caregiver or the Child Safety Specialist. It can also come from a juvenile justice representative. Talk with them if HIV testing is needed.
Female members wanting birth control should talk to their doctor. They should have a physical exam. They may also need lab tests before starting birth control. Any member on birth control should follow up regularly with their doctor to make sure they are doing well.

The following are **not covered** for the purpose of family planning:
- Infertility services
- Pregnancy termination counseling
- Pregnancy termination
- Sterilization
- Hysterectomies

**MEDICALLY NECESSARY PREGNANCY TERMINATIONS**

Pregnancy terminations are an AHCCCS covered service only in special situations. AHCCCS covers pregnancy termination if one of the following criteria is present:

1. The pregnant member suffers from a physical disorder, physical injury, or physical illness including a life-endangering physical condition caused by, or arising from, the pregnancy itself that would, as certified by a physician, place the member in danger of death, unless the pregnancy is terminated.

2. The pregnancy is a result of incest.

3. The pregnancy is a result of rape.

4. The pregnancy termination is medically necessary according to the medical judgment of a licensed physician, who attests that continuation of the pregnancy could reasonably be expected to pose a serious physical or behavioral health problem for the pregnant member by:
   a. Creating a serious physical or behavioral health problem for the pregnant member,
   b. Seriously impairing a bodily function of the pregnant member,
   c. Causing dysfunction of a bodily organ or part of the pregnant member,
   d. Exacerbating a health problem of the pregnant member, or
   e. Preventing the pregnant member from obtaining treatment for a health problem.

Authorization from the member, legal representative, a court order and CMDP approval are needed, unless it is an emergency.

**SUBSTANCE-EXPOSED NEWBORNS (SEN)**

Many children who come to the attention of DCS are identified as having substance-exposure at birth and are considered “substance-exposed newborns” or SEN’s. Substances identified by hospitals and other medical professionals can include exposure to alcohol, amphetamines, cocaine, inhalants, marijuana, heroin, prescription pain medications, opioids and other drugs of abuse. Being aware of the signs of a substance-exposed newborn is very important for those caring for these vulnerable infants and children.
What to expect when caring for a SEN:
Not all infants/children exposed to drugs will have problems. There are several myths associated with SENs. The labels of “ice babies” or “meth babies” are inaccurate due to lack of scientific evidence to support these labels.

The effects of drugs on infants/children will depend upon the amount of drug used and how long the drug was used during the pregnancy. The drug-exposed infant may be at risk for problems later in life, such as speech delay, attention deficit hyperactivity disorder and behavioral problems that may not be clinically present until the child is over age two or even school age.

The signs of drug exposure are not exclusive to a SEN baby and may be present in other instances. A detailed history of drug/alcohol used during pregnancy, in addition to stressors and environmental effects is the key to the diagnosis of substance-exposure.

Common Symptoms and Suggested Care Plans:
The care plan for the infant/child should be made with the child’s pediatrician to ensure appropriate medical needs are met. Care and/or treatment is based on the symptoms the infant/child may be showing, not on the fact that the child is drug exposed.

It is important that the PCP follow the child closely to monitor growth and development.

Consistent routine is extremely important, especially if child is going on visitations with parents. Caregivers need to be aware that best way to interact with the infant/child is to decrease the infant/child’s reaction. The infant/child’s reaction may not be due to rejection or poor attachment, but rather a coping response to loss and grief.

CMDP publishes a brochure titled "Handle with Care: Special Care for the Substance Exposed Newborn" that contains information and tips on caring for SENs. It is available online at http://dcs.az.gov/sites/default/files/CSO-1072A.pdf

You may also call CMDP and request a copy of the brochure.

SAFE SLEEP FOR BABIES
What Does a Safe Sleep Environment Look Like For Babies?
The following are safe sleep guidelines to reduce the risk of Sudden Infant Death Syndrome (SIDS) and other sleep related causes of infant death:

- Always place the baby on their back for safe sleeping
- Use safety-approved crib, covered by a fitted sheet
- No pillows, blankets, sheepskins, or crib bumpers
- No soft objects, toys, and loose bedding near the baby’s sleep area
- No smoking around the baby
- Baby should not sleep in an adult bed, on a couch, or on a chair alone or with you, and
- Nothing should cover or be near the baby’s head

Remember that the substance-exposed newborn is at much greater risk of Sudden Unexplained Death and Sudden Infant Death Syndrome (SIDS). Safe sleep is very important for this group of infants. For more information on the care of the substance-exposed newborn, please see: http://dcs.az.gov/sites/default/files/CSO-1072A.pdf

Let’s keep babies safe while they sleep!

DENTAL CARE

The first set of teeth, (often called “baby teeth”), are important and should be cared for. The teeth begin to appear in a child’s mouth at about 6 months of age. The baby teeth not only help your baby chew and later speak, but they help save room for the permanent teeth.

Tooth decay can occur in the baby teeth so it is important to start dental care at an early age. This includes having your Primary Dental Provider (PDP) apply fluoride varnish. Fluoride varnish can help protect baby teeth from tooth decay before seeing a dentist.

PCPs can also apply fluoride varnish to members who are at least 6 months of age, with at least one tooth eruption. Fluoride varnish can be applied every 6 months during an EPSDT visit or visit with the Primary Dental Provider until the members 2nd birthday.

The American Dental Association recommends that you take your baby to the dentist at 1 year of age. This early visit to the dental office is known as a “well-baby checkup” and establishes a Dental Home for future care (see the Dental Home Section of this handbook).

CMDP members should start dental services at 1 year of age! Regular dental checkups should occur every 6 months following the first visit. These allow the dentist to look for decay and begin any necessary treatment as soon as possible. Checkups include dental cleaning and fluoride treatment to help ensure the long-term health of the child’s teeth and gums.

An oral health screening should also be part of an EPSDT screening done by a PCP. This oral health screening does NOT take the place of an exam by a dentist. The baby should still be seen by the dentist at 1 year of age

Members do not need a referral from their PCP and can see any dentist listed in the Provider Directory. Call CMDP if you need help finding a dentist.

To cancel or change an appointment with your PDP, call the provider at least one day before the appointment. Some providers may attempt to charge a fee for a missed appointment. Arizona law states CMDP cannot pay for missed or no-show appointments.

Routine dental services are covered by CMDP without a PA or Predetermination.

A dentist needs approval in advance (PA or Predetermination) for major dental services, such as braces.

The following is a list of covered dental services:

- Dental exams and X-rays
- Treatment for pain, infection, swelling and dental injuries
- Cleanings and fluoride treatments
- Dental sealants
- Fillings, extractions and medically-necessary crowns
- Pulp therapy and root canals
- Fluoride varnish applied by a PCP or PDP
- Dental education

**DENTAL PERIODICITY SCHEDULE**

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM**

<table>
<thead>
<tr>
<th>RECOMMENDATIONS FOR PREVENTIVE PEDIATRIC ORAL HEALTH CARE*</th>
<th>12-24 months</th>
<th>2-6 years</th>
<th>6-12 years</th>
<th>12 years and older</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical oral examination including but not limited to the following:</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>- Assess oral growth and development</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>- Caries-risk Assessment</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>- Assessment for need for fluoride supplementation</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>- Anticipatory Guidance/Counseling</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>- Oral hygiene counseling</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>- Dietary counseling</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>- Injury prevention counseling</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>- Counseling for nonrestorative habits</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>- Substance abuse counseling</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>- Counseling for intranasal/personal piercing</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>- Assessment for pit and fissure sealants</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>- Radiographic Assessment</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>- Prophylaxis and topical fluoride</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

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 member and the professional judgment of the oral health provider.

* Adaptation from the American Academy of Pediatric Dentistry Schedule

**VISION CARE**

Vision care services include:
- Eye exams
- Eyeglasses and bifocals
- Scratch coating
- Repairs and replacement of eyeglasses
- Tinted lenses (when medically needed)
- Contact lenses (with a statement of why they are medically needed)
VISION PERIODICITY SCHEDULE

PRESCRIPTIONS

When a CMDP provider writes a prescription, it should be filled at a pharmacy that is both registered with AHCCCS and in the CMDP Pharmacy Network. Over-the-counter medications are covered by CMDP when “medically necessary” (it will help the member get better). A prescription from the PCP is needed. Use the CMDP ID card or the Notice to Provider form for payment.

The major food and retail stores in our program are listed in the CMDP Provider Directory. Most of the pharmacies in Arizona are in the directory. For help finding a pharmacy, call Member Services. You can also go to the CMDP website to view the directory. If you have questions or problems getting pharmacy services during business hours or non-business hours, or you have been turned away while attempting to pick up a prescription, call the Member Helpline telephone number shown on the front of the CMDP ID card.

CMDP has a Preferred Drug List (PDL). The PDL, or formulary, is a list of drugs approved by CMDP. Health care providers should refer to the PDL when prescribing drugs. For drugs not on the PDL, your provider will need a PA from CMDP before you go to the pharmacy.

Not all of the drugs on the PDL are shown. If you are not able to find your drugs on the list, please remember:

• Most generic drugs are approved by CMDP.
• CMDP covers all drugs when your health care provider tells us that it is medically necessary (it will make a member better) and a PA is obtained.
• Infant formulas and diapers are not covered through the PDL/pharmacy.

VISION PERIODICITY SCHEDULE

| PROCEDURE/AGE | New | 1-3 days | 4 weeks | 6 weeks | 12 weeks | 18 months | 3 years | 4 years | 5 years | 6 years | 7 years | 8 years | 9 years | 10 years | 11 years | 12 years | 13 years | 14 years | 15 years | 16 years | 17 years | 18 years | 19 years | 20 years |
|---------------|-----|----------|---------|---------|----------|-----------|---------|---------|---------|---------|---------|---------|---------|---------|----------|---------|---------|---------|---------|---------|---------|---------|---------|
| Vision +      | S   | S        | S       | S       | S        | S         | O       | O       | O       | O       | O       | S       | S       | S        | O       | O       | O       | O       | O       | O       | O       | S       | S       | S       |

These are minimum requirements: 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 member is uncooperative, rescreen in 6 months.
† = May be done more frequently if indicated or at increased risk.

Ocular photoscreening with interpretation and report, bilateral, 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.

Revised: 04/01/15, 04/01/14, 01/2007, 01/2005

PRESCRIPTIONS

When a CMDP provider writes a prescription, it should be filled at a pharmacy that is both registered with AHCCCS and in the CMDP Pharmacy Network. Over-the-counter medications are covered by CMDP when “medically necessary” (it will help the member get better). A prescription from the PCP is needed. Use the CMDP ID card or the Notice to Provider form for payment.

The major food and retail stores in our program are listed in the CMDP Provider Directory. Most of the pharmacies in Arizona are in the directory. For help finding a pharmacy, call Member Services. You can also go to the CMDP website to view the directory. If you have questions or problems getting pharmacy services during business hours or non-business hours, or you have been turned away while attempting to pick up a prescription, call the Member Helpline telephone number shown on the front of the CMDP ID card.

CMDP has a Preferred Drug List (PDL). The PDL, or formulary, is a list of drugs approved by CMDP. Health care providers should refer to the PDL when prescribing drugs. For drugs not on the PDL, your provider will need a PA from CMDP before you go to the pharmacy.

Not all of the drugs on the PDL are shown. If you are not able to find your drugs on the list, please remember:

• Most generic drugs are approved by CMDP.
• CMDP covers all drugs when your health care provider tells us that it is medically necessary (it will make a member better) and a PA is obtained.
• Infant formulas and diapers are not covered through the PDL/pharmacy.
The PDL is updated as often as needed to make important changes. The PDL can be viewed on the CMDP website at dcs.az.gov/cmdp.

Prescriptions written by RBHA providers should be filled using the RBHA ID number, not the CMDP ID card.

If the member is CRS eligible and needing to fill a CRS medication, questions regarding fills can be answered through the CRS pharmacy help line at 1-800-310-6826. Please have the member’s CRS ID# number available. The pharmacy may ask you for the following information:

- RX BIN#61094
- GRP#ACUAZ
- RX PCN #9999

MEDICARE DRUG COVERAGE FOR BARBITURATES AND BENZODIAZEPINES

CMDP covers drugs which are medically necessary, cost effective, and allowed by federal and state law.

For CMDP recipients with Medicare, CMDP does NOT pay for any drugs paid by Medicare, or for the cost sharing (co-insurance, deductibles, and co-payments) for these drugs. AHCCCS and its Contractors are prohibited from paying for these drugs or the cost sharing (coinsurance, deductibles, and co-payments) for drugs available through Medicare Part D, even if the member chooses not to enroll in the Part D plan.

**Beginning January 1, 2013, CMDP will no longer pay** for barbiturates used to treat epilepsy, cancer or mental health problems, or any benzodiazepines for members with Medicare. This is because federal law requires Medicare to begin paying for these drugs starting January 1, 2013.

CMDP will still pay for barbiturates that are NOT used to treat epilepsy, cancer, or mental health problems for Medicare members after January 1, 2013.

Some of the common names for benzodiazepines and barbiturates are:

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alprazolam</td>
<td>Xanax</td>
</tr>
<tr>
<td>Diazepam</td>
<td>Valium</td>
</tr>
<tr>
<td>Lorazepam</td>
<td>Ativan</td>
</tr>
<tr>
<td>Clorazepate Dipotassium</td>
<td>Tranxene</td>
</tr>
<tr>
<td>Chlordiazepoxide Hydrochloride</td>
<td>Librium</td>
</tr>
<tr>
<td>Clonazepam</td>
<td>Klonopin</td>
</tr>
<tr>
<td>Oxazepam</td>
<td>Serax</td>
</tr>
<tr>
<td>Temazepam</td>
<td>Restoril</td>
</tr>
<tr>
<td>Flurazepam</td>
<td>Dalmane</td>
</tr>
</tbody>
</table>
CMDP monitors controlled and non-controlled medications on an ongoing basis. This monitoring includes an evaluation of prescription use by member, physician prescribing patterns and drugs dispensed by pharmacies.

This information is used to identify high-risk members and providers who may need drug diversion. Drugs that fall into the therapeutic classes below are included in monitoring activities:

a. Atypical Antipsychotics,
b. Benzodiazepines,
c. Hypnotics,
d. Muscle Relaxants,
e. Opioids, and
f. Stimulants.

Evaluation Criteria is as follows:

- Over-utilization = A Member using the following in a 3 month time period:
  - ≥ 4 prescribers; and
  - ≥ 4 different abuse potential drugs; and
  - ≥ 4 pharmacies or
  - Member has received 12 or more prescriptions of medications listed in the previously listed therapeutic classes in the past three months
- Fraud = Member has presented a forged or altered prescription to the pharmacy

If CMDP finds that overutilization or fraud has happened, the member will be assigned to a single pharmacy and/or prescriber for a designated period.

REGIONAL BEHAVIORAL HEALTH AUTHORITY (RBHA) BEHAVIORAL HEALTH COVERAGE

Most AHCCCS and KidsCare eligible CMDP members get behavioral health services, which include drug and alcohol abuse services, from the AHCCCS Regional Behavioral Health Authority (RBHA). New members are assigned to a RBHA when enrolled with CMDP or another AHCCCS health plan. The assignment of a RBHA for all CMDP members is based on the member’s court of jurisdiction.

The following is a list of the RBHAs:

**Mercy Maricopa Integrated Care** .......................... 1-800-564-5465  
*Counties served:* Maricopa and certain zip codes in Pinal County

**Cenpatico Integrated Care** ............... 1-866-495-6738  
*Counties served:* Pinal, La Paz, Yuma, Cochise, Greenlee, Graham, Santa Cruz, and Pima

**Health Choice Integrated Care** ...... 1-800-640-2123  
*Counties served:* Mohave, Gila, Coconino, Apache, Navajo, and Yavapai
Children’s Rehabilitation Services CRS……..1-800-640-2123

Counties served: Statewide

The RBHA will pay for most behavioral health services including prescriptions for behavioral health conditions. If you have questions or need help in getting behavioral health services, please call the phone number on your card.

Please do not use the CMDP ID card to pay for RBHA medications. CMDP does not cover this service. The RBHA is responsible for payment. Ask the RBHA doctor which pharmacy to use, and give the member’s RBHA ID number to the pharmacist.
MULTI-SPECIALTY INTERDISCIPLINARY CLINIC (MSIC)

Some members may be assigned to a Multi-Specialty Interdisciplinary Clinic (MSIC). MSICs are facilities or provider groups where doctors and other providers meet with CRS members and caregivers. This helps doctors, providers and caregivers/members work together to coordinate the members’ care all at one location and sometimes at the same appointment.

The services offered by MSIC include primary care, specialty care and behavioral health services. CMDP may assign the member to one of these clinics to better meet their health care needs.

The MSICs and the services they offer are listed below:

<table>
<thead>
<tr>
<th>Metro Phoenix Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>DMG Children’s Rehabilitative Services</td>
</tr>
<tr>
<td>• CRS specialty care</td>
</tr>
<tr>
<td>• New primary care services</td>
</tr>
<tr>
<td>• Expanded behavioral health services</td>
</tr>
<tr>
<td>DMG Children’s Rehabilitative Services</td>
</tr>
<tr>
<td>3141 N 3rd Avenue</td>
</tr>
<tr>
<td>Phoenix, AZ 85013</td>
</tr>
<tr>
<td>602-914-1520 1-855-598-1871</td>
</tr>
<tr>
<td><a href="http://www.dmgcrs.org">www.dmgcrs.org</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Southern Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s Clinics for Rehabilitative Services</td>
</tr>
<tr>
<td>• CRS specialty care</td>
</tr>
<tr>
<td>• Primary care services</td>
</tr>
<tr>
<td>• Expanded behavioral health services</td>
</tr>
<tr>
<td>Children’s Clinics Square &amp; Compass Building</td>
</tr>
<tr>
<td>2600 North Wyatt Drive</td>
</tr>
<tr>
<td>Tucson, AZ 85712</td>
</tr>
<tr>
<td>520-324-5437 1-800-231-8261</td>
</tr>
<tr>
<td><a href="http://www.childrensclinics.org">www.childrensclinics.org</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Northern Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s Rehabilitative Services at Flagstaff Regional Medical Center</td>
</tr>
<tr>
<td>• CRS specialty care</td>
</tr>
<tr>
<td>Children’s Rehabilitative Services</td>
</tr>
<tr>
<td>1200 North Beaver</td>
</tr>
<tr>
<td>Flagstaff, AZ 86001</td>
</tr>
<tr>
<td>928-773-2054 1-800-232-1018</td>
</tr>
<tr>
<td><a href="http://www.flagstaffmedicalcenter.com">www.flagstaffmedicalcenter.com</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Southwestern Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s Rehabilitative Services Tuscany Medical Plaza Yuma CRS Clinic</td>
</tr>
<tr>
<td>• CRS specialty care</td>
</tr>
<tr>
<td>Children’s Rehabilitative Services</td>
</tr>
<tr>
<td>Tuscany Medical Plaza</td>
</tr>
<tr>
<td>2851 S Avenue B, Suite 25</td>
</tr>
<tr>
<td>Yuma, AZ 85364</td>
</tr>
<tr>
<td>928-336-7095 1-800-837-7309</td>
</tr>
<tr>
<td><a href="http://www.yumaregional.org">www.yumaregional.org</a></td>
</tr>
</tbody>
</table>
To make, change or cancel the member’s appointment at the MSIC, contact the CRS clinic or provider in your region.

CRS provides screening, evaluation, medical treatment and rehabilitation for members under the age of 21 with qualifying chronic and disabling conditions. Members must also be AHCCCS (Title XIX) eligible to receive services from CRS.

Some of these conditions include, but not limited to:

- Spina bifida
- Congenital heart defects
- Cerebral palsy
- Certain birth defects, cleft lip and/or palate

PRIOR AUTHORIZATION (PA)

Some services may need approval from CMDP before being provided. It is up to your health care provider to get a Prior Authorization (PA) from CMDP. The services or procedures that require prior authorization are posted on our website at dcs.az.gov/cmdp.

CMDP reviews the request for prior authorization and makes a decision based on the information sent in by the provider. The request has to be medically necessary. Sometimes a second opinion may be needed. More tests may also be needed before services are approved, if in the best interest of the member. It is up to the health care provider to know what services will need a PA or not. A CMDP nurse reviews each request.

CMDP may send out a Notice of Extension letter to get more information from a provider. This can help us make a decision in the best interest of the member. This can lead to the decision not being made for another 14 days. If CMDP does not get the new information, the PA request can be denied or delayed. If the request is denied, a Notice of Adverse Benefit Determination letter is sent to the member’s Child Safety Specialists or legal guardian.

If there are questions on how CMDP made a decision, please contact Medical Services at 602-351-2245 or 1-800-201-1975, Option 3-4. CMDP can also give the member’s DCSS or legal guardian information about the criteria that a prior authorization decision was based on.

Emergency services do not need a PA from CMDP.

Members along with their caregivers may select a provider of their choice, but are encouraged to select from CMDP’s Preferred Provider Network (PPN) of health care professionals, which includes specialists in all fields, who are currently registered with CMDP and AHCCCS.

COPAYMENTS

Some people who get AHCCCS Medicaid benefits are asked to pay copayments for some of the AHCCCS medical services that they receive.

*NOTE: Copayments referenced in this section means copayments charged under Medicaid (AHCCCS). It does not mean a person is exempt from Medicare copayments.

THE FOLLOWING PERSONS ARE NOT ASKED TO PAY COPAYMENTS:
• People under age 19,
• People determined to be Seriously Mentally Ill (SMI),
• An individual eligible for the Children’s Rehabilitative Services program under A.R.S. §36-2906(E),
• Acute care members who are residing in nursing facilities or residential facilities such as an Assisted Living Home and only when the members medical condition would otherwise require hospitalization. The exemption from copayments for these members is limited to 90 days in a contract year,
• People who are enrolled in the Arizona Long Term Care System (ALTCS),
• People who are Qualified Medicare Beneficiaries,
• People who receive hospice care,
• American Indian members who are active or previous users of the Indian Health Service, tribal health programs operated under Public Law 93-638, or urban Indian health programs,
• People in the Breast and Cervical Cancer Treatment Program (BCCTP),
• People receiving child welfare services under Title IV-B on the basis of being a child in foster care or receiving adoption or foster care assistance under Title IV-E regardless of age,
• People who are pregnant and throughout postpartum period following the pregnancy, and
• Individuals in the adult Group (for a limited time**).

**NOTE:** For a limited time persons who are eligible in the Adult Group will not have any copays. Members in the Adult Group include persons who were transitioned from the AHCCCS Care program as well as individuals who are between the ages of 19-64, and who are not entitled to Medicare, and who are not pregnant, and who have income at or below 133% of the Federal Poverty Level (FPL) and who are not AHCCCS eligible under any other category. Copays for persons in the Adult Group with income over 106% FPL are planned for the future. Members will be told about any changes in copays before they happen.

**IN ADDITION, COPAYMENTS ARE NOT CHARGED FOR THE FOLLOWING SERVICES FOR ANYONE:**
• Hospitalizations,
• Emergency services,
• Family Planning services and supplies,
• Pregnancy related health care and health care for any other medical condition that may complicate the pregnancy, including tobacco cessation treatment for pregnant women,
• Preventive services, such as well visits, pap smears, colonoscopies, mammograms and immunizations,
• Provider preventable services, and
• Services received in the emergency department.

**People with Optional (Non-Mandatory) Copayments**
Individuals eligible for AHCCCS through any of the programs below may be charged non-mandatory copays, unless:
1. They are receiving one of the services above that cannot be charged a copay, or
2. They are in one of the groups above that cannot be charged a copay.

Non-mandatory copays are also called optional copays. If a member has a non-mandatory copay, then a provider cannot deny the service if the member states that s/he is unable to pay the copay. Members in the following programs may be charged non-mandatory copay by their provider:
• AHCCCS for Families with Children (1931),
• Young Adult Transitional Insurance (YATI) for young people in foster care,
• State Adoption Assistance for Special Needs Children who are being adopted,
• Receiving Supplemental Security Income (SSI) through the Social Security Administration for people who are age 65 or older, blind or disabled,
• SSI Medical Assistance Only (SSI MAO) for individual who are age 65 or older, blind or disabled,
• Freedom to Work (FTW).

Ask your provider to look up your eligibility to find out what copays you may have. You can also find out by calling CMDP member services. You can also check the CMDP website for more information.

AHCCCS members with non-mandatory copays may be asked to pay the following non-mandatory copayments for medical services:

**OPTIONAL (NON-MANDATORY) COPAYMENT AMOUNTS FOR SOME MEDICAL SERVICES**

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>COPAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>$2.30</td>
</tr>
<tr>
<td>Out-patient services for physical, occupational and speech therapy</td>
<td>$2.30</td>
</tr>
<tr>
<td>Doctor or other provider outpatient office visits for evaluation and management of your care</td>
<td>$3.40</td>
</tr>
</tbody>
</table>

Medical providers will ask you to pay these amounts but will **NOT** refuse you services if you are unable to pay. If you cannot afford your copay, tell your medical provider you are unable to pay these amounts so you will not be refused services.

**People with Required (Mandatory) Copayments**

Some AHCCCS members have required (or mandatory) copays unless they are receiving one of the services above that cannot be charged a copay or unless they are in one of the groups above that cannot be charged a copay. Members with required copays will need to pay the copays in order to get the services. Providers can refuse services to these members if they do not pay the mandatory copays. Mandatory copays are charged to persons in Families with Children that are no Longer Eligible Due to Earnings - also known as Transitional Medical Assistance (TMA)

Adults on TMA have to pay required (or mandatory) copays for some medical services. If you are on the TMA Program now or if you become eligible to receive TMA benefits later, the notice from DES or AHCCCS will tell you so. Copays for TMA members are listed below.

**REQUIRED (MANDATORY) COPAYMENT AMOUNTS FOR PERSONS RECEIVING TMA BENEFITS**

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>COPAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>$2.30</td>
</tr>
<tr>
<td>Doctor or other provider outpatient office visits for evaluation and management of your care</td>
<td>$4.00</td>
</tr>
<tr>
<td>Physical, Occupational and Speech Therapies</td>
<td>$3.00</td>
</tr>
</tbody>
</table>
Pharmacists and Medical Providers can refuse services if the copayments are not made.

**5% Limit on All Copayments**
The amount of total copays cannot be more than 5% of the family’s total income (before taxes and deductions) during a calendar quarter (January through March, April through June, July through September, and October through December.) The 5% limit applies to both nominal and required copays.

AHCCCS Administration will track each member’s specific copayment levels to identify members who have reached the 5% copayment limit. If you think that the total copays you have paid are more than 5% of your family’s total quarterly income and AHCCCS has not already told you this has happened, you should send copies of receipts or other proof of how much you have paid to AHCCCS, 801 E. Jefferson, Mail Drop 4600, Phoenix, Arizona 85034.

If you are on this program but your circumstances have changed, contact your local DES office to ask them to review your eligibility. Members can always request a reassessment of their 5% limit if their circumstances have changed.

**DO CAREGIVERS PAY FOR ANYTHING?**

There are no payments, fees, or copayments for members or their caregivers. Members and caregivers should NOT be billed for any services that CMDP covers.

CMDP payments are considered payment in full.

Do not agree to pay for any services unless you have spoken to CMDP first or it is an emergency.

If a member and/or caregiver are billed for a covered service, please contact Member Services. Call Member Services or mail the bill to the attention of Member Services. CMDP will contact the health care provider to address the billing problem.

You may be billed if you ask for a non-covered service and agree in writing to pay for it before you get the service.

If you have to sign any forms, please write all of this information shown below:

(Caregiver’s name) for DCS/CMDP

Send all bills or claims to DCS/CMDP—C010-18, P.O. Box 29202, Phoenix, AZ 85038-9202

CMDP should be listed as the responsible party. Do not list your home address, phone number or Social Security number on any bills or claims.

**NOTE:** When the PCP writes a prescription for a brand name medication and a generic medication is available, CMDP covers the cost of the generic. **When the caregiver insists on the brand name medication when a generic is available, the caregiver may be held responsible for the difference in cost between the generic and the brand name medication.**
OTHER INSURANCE
CMDP is the payer of last resort for members with other health insurance. CMDP coordinates benefits with the other health insurance plan. Deductibles and co-pays are paid by CMDP. The agencies with custody of CMDP members (DCS, ADJC, AOC/JPO) should give CMDP Member Services written notice of current insurance for the new member. This should be done at the time of enrollment or as soon as it is known.

DUAL ELIGIBILITY
CMDP members who are eligible for Medicare and Medicaid (AHCCCS) services have dual eligibility. They may be classified as a Qualified Medicare Beneficiary (QMB) or as non-QMB eligible.

QMB-eligible members receive coverage for all Medicaid services including inpatient psychiatric, psychological, respite and chiropractic services.

For dual eligible members, Medicare is the primary payor and CMDP is the secondary payor. CMDP is responsible for payment of co-insurance or deductibles. (In this instance, please call CMDP Member Services for instructions on submitting these charges for reimbursement.) CMDP covers the cost of pharmacy co-payments, any co-insurance or deductibles. CMDP members must use health care providers registered with AHCCCS and CMDP.

AHCCCS does NOT pay for any drugs paid by Medicare, or for the cost sharing (coinsurance, deductibles, and copayments) for these drugs. AHCCCS does not pay for barbiturates to treat epilepsy, cancer, or mental health problems or any benzodiazepines for members with Medicare. AHCCCS pays for barbiturates for Medicare members that are NOT used to treat epilepsy, cancer, or chronic mental health conditions.

GRIEVANCES AND APPEALS
A grievance is a complaint, which means an expression of dissatisfaction about any matter other than an action/notice of adverse benefit determination. Grievances include, but are not limited to, the quality of care or services provided, rudeness of a provider or employee, or failure to have a member’s rights respected.

A member or an authorized representative (the Child Safety Specialist or juvenile justice representative) can file a grievance. A provider can file a grievance on the member’s behalf, but only with the written consent of the member’s authorized representative.

A grievance can be filed at any time either orally or in writing to CMDP. To file a grievance by phone, call Member Services. To file a grievance in writing, you can send an e-mail to CMDPMemberServices@azdcs.gov, or you can send a letter to:

CMDP
Attn: Member Grievances
Site Code C010-18
P.O. Box 29202
Phoenix, AZ 85038-9202

A disposition will be completed and provided no later than 90 days after the day CMDP received the grievance. A grievance resolution/response cannot be appealed or be the subject of a hearing.
Call the Member Services Manager at 602-351-2245 or 1-800-201-1795 if you have any questions or need more information about member grievances.

A Notice of Adverse Benefit Determination (denial letter) is a response from CMDP regarding a requested service. If a member disagrees with the Notice of Adverse Benefit Determination response, the member or an authorized representative can file an appeal. The Notice of Adverse Benefit Determination by CMDP includes, but is not limited to the following:

- The denial or limited authorization of a requested service, including the type or level of service
- The reduction, suspension, or termination of a previously authorized service
- Denial, in whole or in part, of payment for a service

CMDP members also have the right to file a complaint with AHCCCS, Division of Health Care Management, Medical Management Unit if CMDP does not resolve the complaints about the Notice of Adverse Benefit Determination Letter to the member’s satisfaction.

An appeal is a request for review of a denial listed in the Notice of Adverse Benefit Determination. Appeals can be filed either orally or in writing within 60 days after the date of the Notice of Adverse Benefit Determination. Information on how to file an appeal is given with the denial, reduction, suspension or termination of service notice, or the Notice of Adverse Benefit Determination form.

CMDP and our providers are not allowed to discriminate against anyone exercising their appeal rights or filing a grievance.

If you would like to file an appeal in writing, send a letter to:

CMDP
Attn: Dispute and Appeal Manager
Site Code C010-18
P.O. Box 29202
Phoenix, AZ  85038-9202

Call the Dispute and Appeal Manager at 602-351-2245 or 1-800-201-1795 if you have any questions or need more information.

CMDP makes a final decision on appeals within 30 days of receiving a written or oral appeal. A letter will be mailed to the appellant (whomever filed the appeal), stating CMDP’s decision and the reason for the decision.

For members who believe that their life or health could be in danger by waiting 30 days, the member or authorized representative can request an expedited appeal.

An expedited appeal is a faster review. The member’s health care provider must provide documentation to support the request for an expedited appeal. A decision on an expedited appeal is provided within 3 working days.

Sometimes more information is needed to make an appeal decision. If a decision cannot be made in time, a 14-day extension may be requested. This can be done by the member, authorized custodial agency representative or CMDP.

If the member or authorized representative disagrees with a decision that CMDP has made on an appeal, a State Fair Hearing can be requested.
The member or authorized representative can request a State Fair Hearing by writing CMDP no later than 30 days after receiving the appeal decision. CMDP will forward the case file and information to the AHCCCS Office of Administrative Legal Services (OALS). If the member or authorized representative has questions or needs more information regarding a State Fair Hearing, contact the Dispute and Appeal Manager at 602-351-2245 or 1-800-201-1795.

The member or authorized representative may request continuation of services while the appeal is pending. The services will continue if:

- The appeal is filed timely
- The appeal involves the termination, suspension or reduction of previously authorized services
- Services were authorized by CMDP
- Original period covered by original authorization has not expired
- The member requests and CMDP approves that services continue

Requests for continuation must be filed within 10 days after the date CMDP mailed the “Notice of Adverse Benefit Determination” or the effective date of the action as indicated in the “Notice of Adverse Benefit Determination.” The member may be responsible to pay for the cost of services if a continuation has been granted and the appeal or hearing decision is not in the favor of the member.

**BEHAVIORAL HEALTH GRIEVANCES**

If there is a concern about the behavioral health services the member is receiving, contact the Child Safety Specialist, juvenile justice representative, DCS Behavioral Health Clinical Coordinator or a CMDP Behavioral Health Coordinator to determine if the services are being paid by CMDP or the AHCCCS - Regional Behavioral Health Authority.

If the member is getting services paid by CMDP, the CMDP Behavioral Health Care Coordinator will help contact the CMDP Dispute and Appeal Manager to resolve a grievance. Call the Behavioral Health Care Coordinators at 602-351-2245 or 1-800-201-1795, Option 3-2.

If the member is getting services paid by the RBHA, contact the patient representative at the RBHA.

If the member and caregiver are not happy with the decision, there is the right to file an appeal with the RBHA. Ask your Child Safety Specialist or the juvenile justice representative for help.

**MEMBER RIGHTS**

For members to receive the health care services they need and deserve, members and their caregivers should be aware that each member has the right to:

- File a complaint with AHCCCS about CMDP, if CMDP does not resolve the issue for the member.
- Request information on the structure and operation of CMDP or CMDP’s contractors (42 CFR 438.10(g)(3)(i)).
- Request information regarding if CMDP has physician incentive plans that affect referral from doctors.
- To know about the type of compensation arrangements with providers, whether stop-loss insurance is required of providers and the right to review member survey results.
- Not be discriminated against in the delivery of health care services based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.
- Know the right to privacy includes protection of any identifying information except when otherwise required or permitted by law.
- To know that coordination of care with schools and state agencies may occur, within the limits of applicable regulations.
- To have a second opinion from a qualified health care professional within the PPN or have a second opinion arranged outside the PPN, only if there is not adequate in-network coverage, at no cost to the member.
- To receive information on available treatment options and alternatives, in a manner appropriate to the member’s condition and ability to understand.
- To request annually and receive at no cost a copy of his/her medical records as specified in 45 CFR 164.524.
- Have access to review his/her medical records in accordance with applicable federal and state laws.
- Know that CMDP must respond within 30 days to the member’s request for a copy of the records, the response may be the copy of the record or, if necessary to deny the request, the written denial must include the basis for the denial and written information about how to seek review of the denial in accordance with 45 CFR Part 164.
- To amend or correct his/her medical records as specified in 45 CFR 164.526 (CMDP may require the request be made in writing).
- The member’s right of access to inspect and obtain a copy of his/her medical records may be denied if the information is:
  - Psychotherapy Notes;
  - Information compiled for, or in reasonable anticipation of, a civil, criminal or administrative action; or
  - Protected health information that is subject to the Federal Clinical Laboratory Improvements Amendments of 1988, or exempt pursuant to 42 CFR 493.3(a)(2).
- An individual may be denied access to read or receive a copy of medical record information without an opportunity for review in accordance with 45 CFR Part 164 (above) if:
  - The information meets the criteria stated above;
  - The provider is a correctional institution or acting under the direction of a correctional institution as defined in 45 CFR 164.501;
  - The information is obtained during the course of current research that includes treatment and the member agreed to suspend access to the information during the course of research when consenting to participate in the research;
  - The information was compiled during a review of quality of care for the purpose of improving the overall provision of care and services;
  - The denial of access meets the requirements of the Privacy Act, 5 U.S.C. 552a; or
  - The information was obtained from someone other than a health care provider under the protection of confidentiality, and access would be reasonably likely to reveal the source of the information.
- Except as above, the member has the right to seek review if access to inspect or request to obtain a copy of medical record information is denied when:
A licensed health care professional has determined the access requested would reasonably be likely to endanger the life or physical safety of the member or another person; or
- The protected health information refers to another person and access would reasonably be likely to cause substantial harm to the member or another person.

- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- Receive information about CMDP, the services CMDP provides, the CMDP provider network and your rights and responsibilities. We will send you a member handbook when you first enroll. We will send you newsletters when you first enroll and twice a year. You can also find information about CMDP on our website at dcs.az.gov/cmdp. You can call Member Services and request material about CMDP by emailing CMDPMemberServices@AZDCS.gov or calling 602-351-2245 or 1-800-201-1795, Option 3-1
- Be treated with respect and with recognition of the member’s dignity and need for privacy.
- Participate in decision-making regarding his or her health care, including:
  - The right to refuse treatment (42 CFR 438.100), and/or
  - Have a representative facilitate care or treatment decisions when the member is unable to do so.
- Have the opportunity to choose a primary care provider (PCP), and primary dental provider (PDP) within the limits of the provider network, and choose other providers as needed from among those affiliated with the network:
  - This also includes the right to refuse care from specified providers.
- To know about providers who speak languages other than English.
- Have the right to obtain, at no charge, a directory of health care providers in the PPN.
- To use any hospital or other setting for emergency care (438.10(g)(2)(v)(C))
- Have services provided in a culturally competent manner, with consideration for members with limited English proficiency or reading skills, and those with diverse cultural and ethnic backgrounds as well as members with visual or auditory limitation:
  - Options include access to a language interpreter, a person proficient in sign language for the hearing impaired and written materials available in Braille for the blind or in different formats, as appropriate.
- Be provided with information about formulating advance directives to provide for involvement by the member or his/her representative in decisions to withhold resuscitative services, or to forgo or withdraw life-sustaining treatment within the requirements of federal and state law with respect to advance directives 42 CFR 438.6. When necessary, advance directives are made by the attorney general’s office for member’s under the age 18, if they are in out-of-home care or DCS custody.
- Receive information, in a language and format that the member understands, about member rights and responsibilities, the amount, duration and scope of all services and benefits, service providers, services included and excluded as a condition of enrollment, and other information including:
  - Provisions for after-hours and emergency health care services, which includes the right to access emergency health care services from a provider without prior authorization, consistent with the member’s determination of the need for such services as prudent;
  - Information about available treatment options (including the option of no treatment) or alternative courses of care;
Procedures for obtaining services, including authorization requirements and any special procedures for obtaining mental health and substance abuse services, or referrals for specialty services not furnished by the member’s PCP;

Procedures for obtaining services outside the CMDP Preferred Provider Network (PPN);

Provisions for obtaining AHCCCS covered services that are not offered or available through CMDP, and notice of the right to obtain family planning services from an appropriate AHCCCS registered provider, and

A description of how CMDP evaluates new technology for inclusion as a covered benefit.

The criteria used as a basis for decisions. This is available upon request, or it can be viewed on the CMDP web site under the PA Guidelines tab.

- Be provided with information regarding grievances, appeals and requests for a hearing about CMDP or the care provided.
- Have the right to file a complaint to CMDP about inadequate Notice of Adverse Benefit Determination letters or any aspect of CMDP’s service.
- Have the right to file a complaint with AHCCCS, Division of Health Care Management, Medical Management Unit if CMDP does not resolve the complaints about the Notice of Adverse Benefit Determination Letter to the member’s satisfaction.
- The right to contact Member Services if there are any questions regarding member rights.

FRAUD, WASTE AND ABUSE

Fraud is defined by CMDP as an intentional deception made with the knowledge that it could result in some unauthorized benefit.

Waste is defined as over-utilization or inappropriate utilization of services, misuse of resources, or practices that result in unnecessary costs.

Abuse is defined as the action of a provider that does not meet sound business or medical practices. The result is payment by CMDP for services that do not help a member feel better (medically necessary).

An example of provider fraud and abuse is a doctor billing for services that were not given to the member or services that the member did not need.

An example of member fraud and abuse is loaning, giving or selling CMDP ID cards to others. You may contact Member Services if you feel fraud or abuse has occurred, by calling 602-351-2245, or 1-800-201-1795, Option 3-1.

You can also make an anonymous report to the CMDP Corporate Compliance Hotline at 602-771-3555.

The CMDP Corporate Compliance Officer reviews and refers incidents of potential fraud, waste and abuse to the AHCCCS Office of the Inspector General (OIG). Members and out-of-home caregivers have the option of referring potential incidents of fraud, waste, or abuse to the OIG directly at 602-417-4193. Penalties for persons involved in fraud, waste and/or abuse may be both civil and criminal.
COMMUNITY SERVICES

Tobacco Cessation
CMDP will help members who want to stop using tobacco. There are products that can help this. CMDP will pay for these products if the doctor writes a prescription. Members can see their doctor to get this. This includes over-the-counter products and products like Nicotine replacement treatment. Young adults may also contact the Arizona Smokers Helpline (ASH). This is a no cost phone service that helps people to quit smoking. They can be called at 1-800-556-6222. Other information about tobacco cessation, treatment care and services can be found at http://www.azdhs.gov/tobaccofreeaz/

WIC
The special Supplemental Nutrition Program for Women, Infants and Children (WIC) serves to safeguard the health of women, infants and children up to the age of 5 who are at risk nutritionally. CMDP members qualify for WIC services. WIC can give a family many services. WIC provides nutritious foods to supplement diets. They also give information on healthy eating and referrals for health care. WIC provides services to pregnant, breastfeeding or post-partum women, as well as children under 5 years. Coverage for the mother lasts for 6 months after pregnancy if not breastfeeding. They cover for 1 year if breastfeeding. The website address for more WIC information is www.azdhs.gov/azwic. The toll-free Arizona number is 1-800-252-5942.

Head Start
Head Start and Early Head Start are child development programs that serve children from birth to age 5, pregnant women and their families. They have the overall goal of increasing school readiness of young children who are in low-income families. Children in out-of-home care qualify to go to the head of the list for Head Start programs. The website address for more Head Start information is www.azheadstart.org. The phone number is 1-866-763-6481.

AzEIP
The Arizona Early Intervention Program (AzEIP) is a statewide system of programs and services. AzEIP is designed to provide support for families of infants and toddlers, newborn to 3 years old, with disabilities or delays. The goal is to help these children reach their full potential. A newborn to 3-year-old child who is the victim of abuse or neglect can get an AzEIP evaluation. The website address for AzEIP is www.azdes.gov/azeip/.

The phone number for the Phoenix area is 602-532-9960, and toll free 1-888-439-5609 for all other areas of the state.

Additional resources for treating obesity and nutritional information include
- Nutrition, Physical Activity and Obesity (NUPAO) www.azdhs.gov/phs/bnp/nupao/
- Arizona Nutrition Network www.eatwellbewell.org/

Other helpful web links
- www.healthearizonaplus.gov
- www.azlinks.gov
You can also contact CMDP Member Services to learn more and for help getting services from any of these programs.

**CMDP Member Advocates**

An advocate is anyone who supports and promotes the rights of the member. Listed below are advocates for members in out-of-home care. Advocates can provide support for both physical and behavioral health.

- The member’s Child Safety Specialist (Custodial Agent), the Supervisor or the Program Manager of the Child Safety Specialist and Supervisor
- The member’s Juvenile Justice Probation or Parole Officer
- The Assistant Attorney General (AAG) assigned to the members’ case
- The Arizona Center for Disability Law (a non-profit public interest law firm dedicated to protection and advocacy of individuals with disabilities. The website address for more information is [www.acdl.com](http://www.acdl.com). The phone number is 602-274-6287, and toll free 1-800-927-2260.
- Arizona Ombudsman-Citizens Aide (If you feel you have been treated unfairly by a state administrator, if you find yourself in a disagreement or dispute with a state agency or department you can turn to the ombudsman-citizen aide. The website address for more information is [www.azleg.gov/ombudsman](http://www.azleg.gov/ombudsman). The phone number is 602-277-7292; toll free 1-800-872-2879.
- The child’s PCP or doctor

**MANAGED CARE DEFINITIONS**

**Appeal** means a request for review of a decision that denies a benefit or payment.

**Co-Payment** is a monetary amount that the member pays directly to a provider at the time covered services are rendered.

**Durable Medical Equipment** is equipment and supplies ordered by a health care provider for everyday or extended use. DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

**Emergency Medical Condition** is an illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

**Emergency Medical Transportation** refers to ambulance services for an emergency medical condition.

**Emergency Room Care** is emergency services you get in an emergency room.

**Emergency Services** refer to an evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

**Excluded Services** are health care services that your health insurance or plan doesn’t pay for or cover.

**Grievance** is a complaint that you communicate to your health insurer or plan.

**Habilitation Services and Devices** are health care services that help you keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.
Health Insurance is a contract that requires your health insurer to pay some or all of your health care costs.

Home Health Care is health care services a person receives at home.

Hospice Services are services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization means care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care is care in a hospital that usually doesn’t require an overnight stay.

Medically Necessary refers to health care services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Network means the facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Participating Provider means a provider who doesn’t have a contract with your health insurer or plan to provide services to you.

Physician Services are health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan is an organization or entity that has a contract with AHCCCS to provide goods and services to members either directly or through subcontracts with providers.

Preauthorization is a decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn’t a promise your health insurance or plan will cover the cost.

Participating Provider means a provider who has a contract with your health insurer or plan to provide services to you.

Premium means the amount you pay for your health insurance every month. CMDP Members do not pay a premium.

Prescription Drug Coverage is health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs are drugs and medications that, by law, require a prescription.

Primary Care Physician (PCP) is a physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider is a physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider is any person or entity that contracts with AHCCCS or a CMDP to provide services to you.
Rehabilitation Services and Devices are health care services that help you keep, get back, or improve skills and functioning for daily living that have been lost or impaired because you were sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care is services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist is a physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

Urgent Care means care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe it requires emergency room care.

MATERNITY CARE SERVICE DEFINITIONS

Maternity care includes medically needed services related to all aspects of pregnancy. This may include but is not limited to pregnancy identification, prenatal care, labor and delivery services, and postpartum care. Other services include medically needed preconception (before pregnancy) counseling.

Maternity care coordination includes maternity care related activities that help consider all aspects of pregnancy. This may include identification of care needs through risk assessment and evaluation; development of a care plan to address care needs, and monitoring the care plan to make sure all services appropriately addressed.

Practitioner refers to certified nurse practitioners in midwifery, physician’s assistants and other nurse practitioners.

Postpartum care refers to the health care provided up to 60 days after delivery. Family planning services are included during this time, if provided by the physician or practitioner.

Preconception counseling is provided as part of the annual well woman visit when medically necessary. This counseling focuses on the early detection and management of risk factors before pregnancy, and includes efforts to influence behaviors that can affect a fetus (even before conception is confirmed), as well as regular health care. The purpose of preconception counseling is to ensure that a woman is healthy prior to pregnancy. Preconception counseling does not include genetic counseling.

Prenatal care refers to the health care provided during pregnancy and includes: early and ongoing risk assessment; health education; and medical monitoring, intervention and follow-up.

High-risk pregnancy is when you have health problems like asthma, high blood pressure, diabetes, depression or HIV.

You may have had problems with a previous pregnancy. If you have a high-risk pregnancy, you may need to see your Obstetrical (OB) doctor more often during pregnancy.

Low birth weight infant is a baby weighing 5 lbs., 8 oz. or less at birth. Women who have a history of low birth weight babies should contact their OB doctor as soon as they find out that they are pregnant.

Early prenatal care is very important. Early care may decrease your risk of having another low birth weight baby.
**OB case manager** is a nurse or social worker who assists pregnant members with their health needs before, during and after pregnancy. The OB case manager may also help with referrals to community agencies such as WIC, behavioral health and Healthy Families.

**Obstetrician** is a doctor who takes care of women while they are pregnant, during delivery and after the baby is born.

**Maternal fetal medicine doctor** is a specialist in treating pregnant women who have high-risk medical conditions during their pregnancy.

**Certified nurse midwife** is a specially trained nurse that can provide OB care, support and education to women during their pregnancy, labor, delivery and after delivery.

**Licensed midwife** is a state licensed person that can provide OB care, support and education to healthy women who have no health risks. The licensed midwife provides this service during pregnancy, labor, during childbirth and after baby is born.

**CMDP does not recommend the use of midwife providers, as we consider our members “at risk” and recommend a certified nurse practitioner, or OB/GYN see them.**
### APPENDIX 1 – 2017 RECOMMENDED IMMUNIZATIONS FOR CHILDREN FROM BIRTH THROUGH 6 YEARS OLD

#### 2017 Recommended Immunizations for Children from Birth Through 6 Years Old

<table>
<thead>
<tr>
<th>Age</th>
<th>HepB</th>
<th>RV</th>
<th>DTaP</th>
<th>Hib</th>
<th>PCV</th>
<th>IPV</th>
<th>Influenza (Yearly)*</th>
<th>MMR</th>
<th>Varicella</th>
<th>HepA*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth</td>
<td>HepB</td>
<td>RV</td>
<td>DTaP</td>
<td>Hib</td>
<td>PCV</td>
<td>IPV</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 month</td>
<td>HepB</td>
<td>RV</td>
<td>DTaP</td>
<td>Hib</td>
<td>PCV</td>
<td>IPV</td>
<td></td>
<td>MMR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 months</td>
<td>HepB</td>
<td>RV</td>
<td>DTaP</td>
<td>Hib</td>
<td>PCV</td>
<td>IPV</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 months</td>
<td>HepB</td>
<td>RV</td>
<td>DTaP</td>
<td>Hib</td>
<td>PCV</td>
<td>IPV</td>
<td></td>
<td>MMR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 months</td>
<td>HepB</td>
<td>RV</td>
<td>DTaP</td>
<td>Hib</td>
<td>PCV</td>
<td>IPV</td>
<td></td>
<td>MMR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 months</td>
<td>HepB</td>
<td>RV</td>
<td>DTaP</td>
<td>Hib</td>
<td>PCV</td>
<td>IPV</td>
<td></td>
<td>MMR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 months</td>
<td>HepB</td>
<td>RV</td>
<td>DTaP</td>
<td>Hib</td>
<td>PCV</td>
<td>IPV</td>
<td></td>
<td>MMR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 months</td>
<td>HepB</td>
<td>RV</td>
<td>DTaP</td>
<td>Hib</td>
<td>PCV</td>
<td>IPV</td>
<td></td>
<td>MMR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19–23 months</td>
<td>HepB</td>
<td>RV</td>
<td>DTaP</td>
<td>Hib</td>
<td>PCV</td>
<td>IPV</td>
<td></td>
<td>MMR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2–3 years</td>
<td>HepB</td>
<td>RV</td>
<td>DTaP</td>
<td>Hib</td>
<td>PCV</td>
<td>IPV</td>
<td></td>
<td>MMR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4–6 years</td>
<td>HepB</td>
<td>RV</td>
<td>DTaP</td>
<td>Hib</td>
<td>PCV</td>
<td>IPV</td>
<td></td>
<td>MMR</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NOTE:**
- If your child misses a shot, you don’t need to start over; just go back to your child’s doctor for the next shot. Talk with your child’s doctor if you have questions about vaccines.

**Footnotes:**
- *Two doses given at least four weeks apart are recommended for children aged 6 months through 6 years of age who are getting an influenza (flu) vaccine for the first time and for some other children in this age group.*
- *Two doses of HepA vaccine are needed for lasting protection. The first dose of HepA vaccine should be given between 12 months and 23 months of age. The second dose should be given 6 to 18 months later. HepA vaccination may be given to any child 12 months and older to protect against HepA. Children and adolescents who did not receive the HepA vaccine and are at high risk, should be vaccinated against HepA.*

If your child has any medical conditions that put him at risk for infection or is traveling outside the United States, talk to your child’s doctor about additional vaccines that he may need.

For more information, call toll free 1-800-CDC-INFO (1-800-232-4636) or visit [www.cdc.gov/vaccines/parents](http://www.cdc.gov/vaccines/parents)
# Vaccine-Preventable Diseases and the Vaccines that Prevent Them

<table>
<thead>
<tr>
<th>Disease</th>
<th>Vaccine</th>
<th>Disease spread by</th>
<th>Disease symptoms</th>
<th>Disease complications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chickenpox</td>
<td>Varicella vaccine protects against chickenpox.</td>
<td>Air, direct contact</td>
<td>Rash, tiredness, headache, fever</td>
<td>Infected blisters, bleeding disorders, encephalitis (brain swelling), pneumonia (infection in the lungs)</td>
</tr>
<tr>
<td>Diphtheria</td>
<td>DTaP* vaccine protects against diphtheria.</td>
<td>Air, direct contact</td>
<td>Sore throat, mild fever, weakness, swollen glands in neck</td>
<td>Swelling of the heart muscle, heart failure, coma, paralysis, death</td>
</tr>
<tr>
<td>Hib</td>
<td>Hib vaccine protects against Haemophilus influenzae type b.</td>
<td>Air, direct contact</td>
<td>May be no symptoms unless bacteria enter the blood</td>
<td>Meningitis (infection of the covering around the brain and spinal cord), intellectual disability, epiglottitis (life-threatening infection that can block the windpipe and lead to serious breathing problems), pneumonia (infection in the lungs), death</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>HepA vaccine protects against hepatitis A.</td>
<td>Direct contact, contaminated food or water</td>
<td>May be no symptoms, fever, stomach pain, loss of appetite, fatigue, vomiting, jaundice (yellowing of skin and eyes), dark urine</td>
<td>Liver failure, arthralgia (joint pain), kidneys, pancreatic, and blood disorders</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>HepB vaccine protects against hepatitis B.</td>
<td>Contact with blood or body fluids</td>
<td>May be no symptoms, fever, headache, weakness, vomiting, jaundice (yellowing of skin and eyes), joint pain</td>
<td>Chronic liver infection, liver failure, liver cancer</td>
</tr>
<tr>
<td>Influenza (Flu)</td>
<td>Flu vaccine protects against influenza.</td>
<td>Air, direct contact</td>
<td>Fever, muscle pain, sore throat, cough, extreme fatigue</td>
<td>Pneumonia (infection in the lungs)</td>
</tr>
<tr>
<td>Measles</td>
<td>MMR** vaccine protects against measles.</td>
<td>Air, direct contact</td>
<td>Rash, fever, cough, runny nose, pinkeye</td>
<td>Exanthematos (brain swelling), pneumonia (infection in the lungs), death</td>
</tr>
<tr>
<td>Mumps</td>
<td>MMR** vaccine protects against mumps.</td>
<td>Air, direct contact</td>
<td>Swollen salivary glands (under the jaw), fever, headache, tiredness, muscle pain</td>
<td>Meningitis (infection of the covering around the brain and spinal cord), encephalitis (brain swelling), inflammation of testicles or ovaries, deafness</td>
</tr>
<tr>
<td>Pertussis</td>
<td>DTaP* vaccine protects against pertussis (whooping cough).</td>
<td>Air, direct contact</td>
<td>Severe cough, runny nose, apnea (a pause in breathing in infants)</td>
<td>Pneumonia (infection in the lungs), death</td>
</tr>
<tr>
<td>Polio</td>
<td>IPV vaccine protects against polio.</td>
<td>Air, direct contact, through the mouth</td>
<td>May be no symptoms, sore throat, fever, nausea, headache</td>
<td>Paralysis, death</td>
</tr>
<tr>
<td>Pneumococcal</td>
<td>PCV vaccine protects against pneumococcal.</td>
<td>Air, direct contact</td>
<td>May be no symptoms, pneumonia (infection in the lungs)</td>
<td>Bacteremia (blood infection), meningitis (infection of the covering around the brain and spinal cord), death</td>
</tr>
<tr>
<td>Rotavirus</td>
<td>RV vaccine protects against rotavirus.</td>
<td>Through the mouth</td>
<td>Diarrhea, fever, vomiting</td>
<td>Severe diarrhea, dehydration</td>
</tr>
<tr>
<td>Rubella</td>
<td>MMR** vaccine protects against rubella.</td>
<td>Air, direct contact</td>
<td>Children infected with rubella virus sometimes have a rash, fever, swollen lymph nodes</td>
<td>Very serious in pregnant women—can lead to miscarriage, stillbirth, premature delivery, birth defects</td>
</tr>
<tr>
<td>Tetanus</td>
<td>DTaP* vaccine protects against tetanus.</td>
<td>Exposure through cuts in skin</td>
<td>Stiffness in neck and abdominal muscles, difficulty swallowing, muscle spasms, fever</td>
<td>Broken bones, breathing difficulty, death</td>
</tr>
</tbody>
</table>

* DTaP combines protection against diphtheria, tetanus, and pertussis.
** MMR combines protection against measles, mumps, and rubella.
APPENDIX 2 – 2017 RECOMMENDED IMMUNIZATIONS FOR CHILDREN 7-18 YEARS OLD

### INFORMATION FOR PARENTS

#### 2017 Recommended Immunizations for Children 7-18 Years Old

Talk to your child's doctor or nurse about the vaccines recommended for their age.

<table>
<thead>
<tr>
<th>Age</th>
<th>Flu</th>
<th>Tetanus, diphtheria, pertussis</th>
<th>HPV Human papillomavirus</th>
<th>Men ACWY</th>
<th>MenB</th>
<th>Pneumococcal</th>
<th>Hepatitis B</th>
<th>Hepatitis A</th>
<th>Inactivated Polio</th>
<th>MMR Measles, mumps, rubella</th>
<th>Chickenpox Varicella</th>
</tr>
</thead>
<tbody>
<tr>
<td>7-8 Years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9-10 Years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11-12 Years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13-15 Years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16-18 Years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**More Information**

- Pertussis and tetanus should get a flu vaccine every year.
- Infants and tetanus should get one shot of DTap at age 5 or 6 months.
- All 1-12 year olds should get a 2-dose series of DTP vaccine at least 6 months apart.
- 3-dose series is needed for those with weakened immune systems and those age 4 or older.
- All 11-12 year olds should get a single shot of a quadrivalent meningococcal conjugate vaccine (MenACWY).
- A booster shot is recommended at age 16.
- Infants 10-18 months old may be vaccinated with a MenB vaccine.
- Infants 10-18 months old may be vaccinated with a MenB vaccine.

---

**Shaded Boxes**

- **Green**: These shaded boxes indicate when the vaccine is recommended for all children unless your doctor tells you that your child cannot safely receive the vaccine.
- **Orange**: These shaded boxes indicate the vaccine should be given if a child is catching up on missed vaccines.
- **Purple**: These shaded boxes indicate the vaccine is recommended for children with certain health or lifestyle conditions that put them at an increased risk for serious diseases. See vaccine-specific recommendations at [www.cdc.gov/vaccines/pubs/ACP-List.htm](http://www.cdc.gov/vaccines/pubs/ACP-List.htm).
- **Teal**: This shaded box indicates the vaccine is recommended for children not at increased risk but who wish to get the vaccine after speaking to a provider.
Figure 1. Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger—United States, 2017.

(FOR THOSE WHO FALL BEHIND OR START LATE, SEE THE CATCH-UP SCHEDULE [FIGURE 2]).

These recommendations must be read with the footnotes that follow. For those who fall behind or start late, provide catch up vaccination at the earliest opportunity as indicated by the green bars in Figure 1. To determine minimum intervals between doses, see the catch-up schedule (Figure 2). School entry and adolescent vaccine age groups are shaded in gray.

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Birth</th>
<th>1 mo</th>
<th>2 mos</th>
<th>4 mos</th>
<th>6 mos</th>
<th>9 mos</th>
<th>12 mos</th>
<th>15 mos</th>
<th>18 mos</th>
<th>19-23 mos</th>
<th>2-3 yrs</th>
<th>4-6 yrs</th>
<th>7-10 yrs</th>
<th>11-12 yrs</th>
<th>12-15 yrs</th>
<th>16 yrs</th>
<th>17-18 yrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B (HepB)</td>
<td>1st dose</td>
<td>2nd dose</td>
<td>3rd dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rotavirus (RV)</td>
<td></td>
<td></td>
<td></td>
<td>1st dose</td>
<td>2nd dose</td>
<td>See footnote 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diphtheria, tetanus, &amp; acellular pertussis (DTaP)</td>
<td></td>
<td></td>
<td></td>
<td>1st dose</td>
<td>2nd dose</td>
<td>3rd dose</td>
<td>4th dose</td>
<td></td>
<td>5th dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hemophilus influenza type b (HiB)</td>
<td></td>
<td></td>
<td></td>
<td>1st dose</td>
<td>2nd dose</td>
<td>See footnote 4</td>
<td></td>
<td></td>
<td></td>
<td>3rd or 4th dose</td>
<td>5th dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal conjugate (PCV13)</td>
<td></td>
<td></td>
<td></td>
<td>1st dose</td>
<td>2nd dose</td>
<td>3rd dose</td>
<td>4th dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inactivated poliovirus (IPV) -&lt;18 yrs</td>
<td></td>
<td></td>
<td></td>
<td>1st dose</td>
<td>2nd dose</td>
<td>3rd dose</td>
<td>4th dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influenza (IV)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Annual vaccination (IV) 1 or 2 doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles, mumps, rubella (MMR)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1st dose</td>
<td>2nd dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella (VVR)</td>
<td>1st dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2nd dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A (HepA)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2 dose series, See footnote 10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningococcus C (MenCY) &gt;4 weeks; MenACWY-D ≥2 doses; MenACWY-CRM ≥3 doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>See footnote 11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tetanus, diphtheria, &amp; acellular pertussis (Tdap)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1st dose</td>
<td>2nd dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human papilloma virus (HPV)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1st</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningococcal B (MenB)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>See footnote 13</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal polysaccharide (PPV23)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>See footnote 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Range of recommended ages for all children
Range of recommended ages for catch-up immunization
Range of recommended ages for certain high-risk groups
Range of recommended ages for non-high-risk groups that may receive vaccine, subject to individual clinical decision making
No recommendation

NOTE: The above recommendations must be read along with the footnotes of this schedule.
Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger, UNITED STATES, 2017

This schedule includes recommendations in effect as of January 1, 2017. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Vaccination providers should consult the relevant Advisory Committee on Immunization Practices (ACIP) statement for detailed recommendations, available online at www.cdc.gov/vaccines/hcp/acip-recs/index.html. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (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 vaccination, is available from CDC online (www.cdc.gov/vaccines/hcp/admin/contraindications.html) or by telephone (800-CDC-INFO [800-232-4636]).

The Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger are approved by the

Advisory Committee on Immunization Practices
(www.cdc.gov/vaccines/acip)

American Academy of Pediatrics
(www.aap.org)

American Academy of Family Physicians
(www.aafp.org)

American College of Obstetricians and Gynecologists
(www.acog.org)

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention
Figure 1. Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger—United States, 2017. (FOR THOSE WHO FALL BEHIND OR START LATE, SEE THE CATCH-UP SCHEDULE [FIGURE 2]).

These recommendations must be read with the footnotes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars in Figure 1. To determine minimum intervals between doses, see the catch-up schedule (Figure 2). School entry and adolescent vaccine age groups are shaded in gray.

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Birth</th>
<th>1 mo</th>
<th>2 mos</th>
<th>4 mos</th>
<th>6 mos</th>
<th>9 mos</th>
<th>12 mos</th>
<th>15 mos</th>
<th>18 mos</th>
<th>19-23 mos</th>
<th>2-3 yrs</th>
<th>4-6 yrs</th>
<th>7-10 yrs</th>
<th>11-12 yrs</th>
<th>13-15 yrs</th>
<th>16 yrs</th>
<th>17-18 yrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B (HepB)</td>
<td>1st dose ← 2nd dose → 3rd dose ← 4th dose →</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rotavirus (RV) [RV1 (5-dose series); RV5 (3-dose series)]</td>
<td>1st dose ← 2nd dose → See footnote 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diphtheria, tetanus, &amp; acellular pertussis (DTaP &lt;7 yrs)</td>
<td>1st dose ← 2nd dose → 3rd dose ← 4th dose →</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haemophilus influenza type b (Hib)</td>
<td>1st dose ← 2nd dose → See footnote 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal conjugate (PCV13)</td>
<td>1st dose ← 2nd dose → 3rd dose ← 4th dose →</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inactivated poliovirus (IPV&lt;18 yrs)</td>
<td>1st dose ← 2nd dose → See footnote 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influenza (IV)</td>
<td>Annual vaccination (IV) 1 or 2 doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles, mumps, rubella (MMR)</td>
<td>See footnote 8 ← 1st dose → 2nd dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella (VAR)</td>
<td>1st dose ← 2nd dose →</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A (HepA)</td>
<td>3-dose series, See footnote 10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningococcal [CrBC; CrbD; MenB; MenC; MenD]</td>
<td>See footnote 11</td>
<td>1st dose ← 2nd dose →</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tetanus, diphtheria, &amp; acellular pertussis (Tdap ≥7 yrs)</td>
<td>1st dose ← 2nd dose →</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human papillomavirus (HPV)</td>
<td>See footnote 13</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningococcal B [CrBC; CrbD; MenB; MenC; MenD]</td>
<td>See footnote 11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal polysaccharide (PPSV23)</td>
<td>See footnote 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Range of recommended ages for all children**

**Range of recommended ages for catch-up immunization**

**Range of recommended ages for certain high-risk groups**

**Range of recommended ages for non-high-risk groups that may receive vaccine, subject to individual clinical decision making**

**No recommendation**

**NOTE:** The above recommendations must be read along with the footnotes of this schedule.
## FIGURE 2. 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, 2017.

The figure 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. Always use this table in conjunction with Figure 1 and the footnotes that follow.

### Children age 4 months through 6 years

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Minimum Age for Dose 1</th>
<th>Minimum Interval Between Doses</th>
<th>Dose 1 to Dose 2</th>
<th>Dose 2 to Dose 3</th>
<th>Dose 3 to Dose 4</th>
<th>Dose 4 to Dose 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B†</td>
<td>Birth</td>
<td>8 weeks and at least 16 weeks after first dose. Minimum age for the final dose is 24 weeks.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rotavirus†</td>
<td>6 weeks</td>
<td>4 weeks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diphtheria, tetanus, and acellular pertussis†</td>
<td>6 weeks</td>
<td>4 weeks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haemophilus influenzae type b†</td>
<td>6 weeks</td>
<td>4 weeks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal†</td>
<td>6 weeks</td>
<td>4 weeks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inactivated poliovirus†</td>
<td>6 weeks</td>
<td>4 weeks</td>
<td></td>
<td></td>
<td></td>
<td>6 months† (minimum age ≥ 1 year for final dose).</td>
</tr>
<tr>
<td>Measles, mumps, rubella†</td>
<td>12 months</td>
<td>4 weeks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella†</td>
<td>12 months</td>
<td>3 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A†</td>
<td>12 months</td>
<td>6 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningococcal (MenB, MenC, MenY, MenACWY)</td>
<td>6 weeks</td>
<td>8 weeks†</td>
<td></td>
<td></td>
<td></td>
<td>See footnote 11.</td>
</tr>
</tbody>
</table>

### Children and adolescents age 7 through 18 years

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Minimum Age for Dose 1</th>
<th>Minimum Interval Between Doses</th>
<th>Dose 1 to Dose 2</th>
<th>Dose 2 to Dose 3</th>
<th>Dose 3 to Dose 4</th>
<th>Dose 4 to Dose 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meningococcal (MenB, MenC, MenY, MenACWY)</td>
<td>Not Applicable (N/A)</td>
<td>8 weeks†</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tetanus, diphtheria, tetanus, and acellular pertussis†</td>
<td>7 years†</td>
<td>4 weeks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human papillomavirus†</td>
<td>9 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A†</td>
<td>N/A</td>
<td>6 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B†</td>
<td>N/A</td>
<td>4 weeks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inactivated poliovirus†</td>
<td>N/A</td>
<td>4 weeks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles, mumps, rubella†</td>
<td>N/A</td>
<td>4 weeks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella†</td>
<td>N/A</td>
<td>3 months if younger than 13 years or 4 weeks if age 13 years or older.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NOTE:** The above recommendations must be read along with the footnotes of this schedule.
Figure 3. Vaccines that might be indicated for children and adolescents aged 18 years or younger based on medical indications

<table>
<thead>
<tr>
<th>VACCINE</th>
<th>INDICATION</th>
<th>Immunocompromised status (excluding HIV infection)</th>
<th>HIV infection CD4+ count (cells/μL)</th>
<th>Kidney failure, end-stage renal disease, or hemodialysis</th>
<th>Heart disease, chronic lung disease</th>
<th>CSF leaks, cochlear implants</th>
<th>Asplenia and persistent complement component deficiencies</th>
<th>Chronic liver disease</th>
<th>Diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rotavirus</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diphtheria, tetanus, &amp; acellular pertussis (DTaP)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haemophilus influenza type b</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal conjugate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inactivated poliovirus</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influenza</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles, mumps, rubella</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningococcal A/C/W/Y</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tetanus, diphtheria, &amp; acellular pertussis (Tdap)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human papillomavirus</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningococcal B</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal polysaccharide</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Vaccination according to the routine schedule recommended
- Recommended for persons with an additional risk factor for which the vaccine would be indicated
- Vaccination is recommended, and additional doses may be necessary based on medical condition. See footnotes.
- No recommendation
- Contraindicated
- Precaution for vaccination

*Severe Combined Immunodeficiency

NOTE: The above recommendations must be read along with the footnotes of this schedule.
Footnotes — Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger, UNITED STATES, 2017
For further guidance on the use of the vaccines mentioned below, see: www.cdc.gov/vaccines/hcp/acip-recs/index.html.
For vaccine recommendations for persons 19 years of age and older, see the Adult Immunization Schedule.

Additional information
• For information on contraindications and precautions for the use of a vaccine and for additional information regarding that vaccine, vaccination providers should consult the ACP General Recommendations on Immunization and the relevant ACP statement, available online at www.cdc.gov/vaccines/hcp/acip-recs/index.html.
• For purposes of calculating intervals between doses, 4 weeks = 28 days. Intervals of 4 months or greater are determined by calendar months.
• Vaccine doses administered 4 days before the minimum interval are considered valid. Doses of any vaccine administered ≥5 days earlier than the minimum interval or minimum age should not be counted as valid doses and should be repeated as age-appropriate. The repeat dose should be spaced after the invalid dose by the recommended minimum interval. For further details, see Table 1, Recommended minimum ages and intervals between vaccine doses, in MMWR, General Recommendations on Immunization and Reports / Vol. 60 / No. 2, available online at www.cdc.gov/mmwr/pdf/hl/nr6002.pdf.
• Information on travel vaccine requirements and recommendations is available at wwwnc.cdc.gov/travel.
• The National Vaccine Injury Compensation Program (VICP) is a no-fault alternative to the traditional legal system for resolving vaccine injury petitions. Created by the National Childhood Vaccine Injury Act of 1986, it provides compensation to people found to be injured by certain vaccines. All vaccines within the recommended childhood immunization schedule are covered by VICP except for pneumococcal polysaccharide vaccine (PPSV23). For more information, see www.hrsa.gov/vaccinecompensation/index.html.

1. Hepatitis B (HepB) vaccine. (Minimum age: birth)
Routine vaccination:
At birth:
• Administer monovalent HepB vaccine to all newborns within 24 hours of birth.
• For infants born to hepatitis B surface antigen (HBSAg)-positive mothers, administer HepB vaccine and 0.5 mL of hepatitis B immune globulin (HBlG) within 12 hours of birth. These infants should be tested for HBSAg and antibody to HBSAg (anti-HBs) at age 9 through 12 months (preferably at the next well-child visit) or 1 to 2 months after completion of the HepB series if the series was delayed.
• If mother’s HBSAg status is unknown, within 12 hours of birth, administer HepB vaccine regardless of HBSAg status. For infants weighing less than 2,000 grams, administer HBIG in addition to HepB vaccine within 12 hours of birth. Determine mother’s HBSAg status as soon as possible and, if mother is HBSAg-positive, also administer HBIG to infants weighing 2,000 grams or more as soon as possible, but no later than age 7 days.
Doses following the birth dose:
• The second dose should be administered at age 1 or 2 months. Monovalent HepB vaccine should be used for doses administered before age 6 weeks.
• Infants who did not receive a birth dose should receive 3 doses of a HepB-containing vaccine on a schedule of 0, 1 to 2 months, and 6 months, starting as soon as feasible (see figure 2).
• Administer the second dose 1 to 2 months after the first dose (minimum interval of 4 weeks); administer the third dose at least 8 weeks after the second dose AND at least 16 weeks after the first dose. The final (third or fourth) dose in the HepB vaccine series should be administered no earlier than age 24 weeks.
• Administration of a total of 4 doses of HepB vaccine is permitted when a combination vaccine containing HepB is administered after the birth dose.
Catch-up vaccination:
• Unvaccinated persons should complete a 3-dose series.
• A 2-dose series (doses separated by at least 4 months) of adult formulation Recombivax HB is licensed for use in children aged 11 through 15 years.
• For other catch-up guidance, see Figure 2.

2. Rotavirus (RV) vaccines. (Minimum age: 6 weeks for both RV1 [Rotarix®] and RV5 [Rotaveg®])
Routine vaccination:
Administer a series of RV vaccine to all infants as follows:
• If Rotarix is used, administer a 2-dose series at ages 2 and 4 months.
• If Rotaveg is used, administer a 3-dose series at ages 2, 4, and 6 months.
• If any dose in the series was Rotarix or vaccine product is unknown for any dose in the series, a total of 3 doses of RV vaccine should be administered.
Catch-up vaccination:
• The maximum age for the first dose in the series is 14 weeks, 6 days; vaccination should not be initiated for infants aged 15 weeks, 0 days, or older.
• The maximum age for the final dose in the series is 8 months, 0 days.
• For other catch-up guidance, see Figure 2.

3. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks. Exceptions: DTaP-IPV [Kinrix, Quadracel®]; 4 years)
Routine vaccination:
• Administer a 5-dose series of DTaP vaccine at ages 2, 4, 6, 15 through 18 months, and 4 through 6 years. The fourth dose may be administered as early as age 12 months, provided at least 6 months have elapsed since the third dose.
• Inadvertent administration of fourth DTaP dose early: If the fourth dose of DTaP was administered at least 4 months after the third dose of DTaP and the child was 12 months of age or older, it does not need to be repeated.
Catch-up vaccination:
• The fifth dose of DTaP vaccine is not necessary if the fourth dose was administered at age 4-6 years or older.
• For other catch-up guidance, see Figure 2.

4. Haemophilus influenzae type b (Hib) conjugate vaccine.
(Minimum age: 6 weeks for PRP-T [ActHIB, DTaP-IPV/Hib (Pentacel), Hibermune, and Hib-MenCY [MenHibrix]]). PRP-OMP (PedvaxHIB)
Routine vaccination:
• Administer a 2- or 3-dose Hib vaccine primary series and a booster dose (dose 3 or 4, depending on vaccine used in primary series) at age 12 through 15 months to complete a full Hib vaccine series.
• The primary series with ActHIB, MenHibrix, Hibermune, or Pentacel consists of 3 doses and should be administered at ages 2, 4, and 6 months. The primary series with PedvaxHIB consists of 2 doses and should be administered at ages 2 and 4 months; a dose at age 6 months is not indicated.
• One booster dose (dose 3 or 4, depending on vaccine used in primary series) of any Hib vaccine should be administered at age 12 through 15 months.
• For recommendations on the use of MenHibrix in patients at increased risk for meningococcal disease, refer to the meningococcal vaccine footnotes and also to MMWR February 22, 2014 / 63(03)RR011-13, available at www.cdc.gov/mmwr/pdf/hl/nr6301.pdf.
For further guidance on the use of the vaccines mentioned below, see: [www.cdc.gov/vaccines/hcp/acip-recs/index.html](http://www.cdc.gov/vaccines/hcp/acip-recs/index.html).

Catch-up vaccination:
- If dose 1 was administered at ages 12 through 14 months, administer a second (final) dose at least 8 weeks after dose 1, regardless of Hib vaccine used in the primary series.
- If both doses were PRP-OMP (Pediavim-Hib or COVIVAX) and were administered before the first birthday, 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 the second dose at least 4 weeks later and a third (and final) dose at age 12 through 15 months or 8 weeks after second dose, whichever is later.
- If first dose is administered before the first birthday and second dose administered at younger than 15 months, a third (and final) dose should be administered 8 weeks later.
- For unvaccinated children aged 15–59 months, administer only 1 dose.
- For other catch-up guidance, see Figure 2. For catch-up guidance related to MenHibola, see the meningococcal vaccine footnotes and also MMWR February 28, 2014 / 63(RR01)-1-3, available available at [www.cdc.gov/mmwr/PDF/rr/rr6301.pdf](http://www.cdc.gov/mmwr/PDF/rr/rr6301.pdf).

Vaccination of persons with high-risk conditions:
- Children aged 12 through 59 months who are at increased risk for Hib disease, including chemotherapy recipients and those with anatomic or functional asplenia (including sickle cell disease), human immunodeficiency virus (HIV) infection, immunoglobulin deficiency, or early component complement deficiency, who have received either no doses or only 1 dose of Hib vaccine before age 12 months, should receive 2 additional doses of Hib vaccine, 8 weeks apart; children who received 2 or more doses of Hib vaccine before age 12 months should receive 1 additional dose.
- For patients younger than age 5 years undergoing chemotherapy or radiation treatment who received a Hib vaccine dose(s) within 14 days of starting therapy or during therapy, repeat the dose(s) at least 3 months following therapy completion.
- Recipients of hematopoietic stem cell transplant (HSCT) should be revaccinated with a 3-dose regimen of Hib vaccine starting 6 to 12 months after successful transplant, regardless of vaccination history; doses should be administered at least 4 weeks apart.
- A single dose of any Hib-containing vaccine should be administered to unimmunized* children and adolescents 15 months of age and older undergoing an elective splenectomy; if possible, vaccine should be administered at least 14 days before procedure.
- Hib vaccine is not routinely recommended for patients 5 years or older. However, 1 dose of Hib vaccine should be administered to unimmunized* persons aged 5 years or older who have anatomic or functional asplenia (including sickle cell disease) and unimmunized persons 5 through 18 years of age with HIV infection.
- Patients who have not received a primary series and booster dose or at least 1 dose of Hib vaccine after 14 months of age are considered unimmunized.

5. Pneumococcal vaccines. (Minimum age: 6 weeks for PCV13, 2 years for PPSV23)

Routine vaccination with PCV13:
- Administer a 4-dose series of PCV13 at ages 2, 4, and 6 months and at age 12 through 15 months.

Catch-up vaccination with PCV13:
- Administer 1 dose of PCV13 to all healthy children aged 2 through 59 months who are not completely vaccinated for their age.
- For other catch-up guidance, see Figure 2.

Vaccination of persons with high-risk conditions with PCV13 and PPSV23:
- All recommended PCV13 doses should be administered prior to PPSV23 vaccination if possible.
- For children aged 2 through 5 years with any of the following conditions: chronic heart disease (particularly cyanotic congenital heart disease and cardiac failure); chronic lung disease (including asthma if treated with high-dose oral corticosteroid therapy); diabetes mellitus; cerebrospinal fluid leak; cochlear implant; sickle cell disease and other hemoglobinopathies; anatomic or functional asplenia; HIV infection; chronic renal failure; nephrotic syndrome; diseases associated with treatment with immunosuppressive drugs or radiation therapy, including malignant neoplasms, leukemia, lymphomas, and Hodgkin disease; solid organ transplantation; or congenital immunodeficiency.
- Administer 1 dose of PCV13 if any incomplete schedule of 3 doses of PCV13 was received previously.
- Administer 2 doses of PCV13 at least 8 weeks apart if unvaccinated or any incomplete schedule of fewer than 3 doses of PCV13 was received previously.
- The minimum interval between doses of PCV13 is 8 weeks.
- For children with no history of PPSV23 vaccination, administer PPSV23 at least 8 weeks after the most recent dose of PCV13.
- For children aged 6 through 18 years who have cerebrospinal fluid leak; cochlear implant; sickle cell disease and other hemoglobinopathies; anatomic or functional asplenia; congenital or acquired immunodeficiencies; HIV infection; chronic renal failure; nephrotic syndrome; diseases associated with treatment with immunosuppressive drugs or radiation therapy, including malignant neoplasms, leukemia, lymphomas, and Hodgkin disease; generalized malignancy; solid organ transplantation; or multiple myeloma.
- For children aged 6 through 18 years with chronic heart disease (particularly cyanotic congenital heart disease and cardiac failure), chronic lung disease (including asthma if treated with high-dose oral corticosteroid therapy), diabetes mellitus, alcoholism, or chronic liver disease, who have not received PPSV23, administer 1 dose of PPSV23.

6. Inactivated poliovirus vaccine (IPV). (Minimum age: 6 weeks)

Routine vaccination:
- Administer a 4-dose series of IPV at ages 2, 4, 6 through 18 months, and 4 through 6 years. The final dose in the series should be administered on or after the fourth birthday and at least 6 months after the previous dose.

Catch-up vaccination:
- In the first 6 months of life, minimum age and minimum intervals are only recommended if the person is at risk of imminent exposure to circulating poliovirus (i.e., travel to a polio-endemic region or during an outbreak).
- If 4 or more doses are administered before age 4 years, an additional dose should be administered at age 4 through 6 years and at least 6 months after the previous dose.
- A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose.
- If both oral polio vaccine (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.
- If only OPV was administered, and all doses were given prior to age 4 years, 1 dose of IPV should be given at 4 years or older, at least 4 weeks after the last OPV dose.
- IPV is not routinely recommended for U.S. residents aged 18 years or older.

- For other catch-up guidance, see Figure 2.
For further guidance on the use of the vaccines mentioned below, see: www.cdc.gov/vaccines/hcp/acip-recs/index.html.

7. Influenza vaccines. (Minimum age: 6 months for inactivated influenza vaccine [IIV], 18 years for recombinant influenza vaccine [RIV])
   Routine vaccination:
   • Administer influenza vaccine annually to all children beginning at age 6 months. For the 2016-17 season, use of live attenuated influenza vaccine (LAIV) is not recommended.
   For children aged 6 months through 8 years:
   • For the 2016-17 season, administer 2 doses (separated by at least 4 weeks) to children who are receiving influenza vaccine for the first time or who have not previously received ≥2 doses of trivalent or quadrivalent influenza vaccine before July 1, 2016. For additional guidance, follow dosing guidelines in the 2016-17 AOP influenza vaccine recommendations (see MMWR August 26, 2016;65(5):1-54, available at www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6505.pdf).
   • For the 2017-18 season, follow dosing guidelines in the 2017-18 AOP influenza vaccine recommendations.
   For persons aged 9 years and older:
   • Administer 1 dose.

8. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months for routine vaccination)
   Routine vaccination:
   • Administer a 2-dose series of MMR vaccine at ages 12 through 15 months and 4 through 6 years. The second dose may be administered before age 4 years, provided that at least 4 weeks have elapsed since the first dose.
   • Administer 1 dose of MMR vaccine to infants aged 6 through 11 months before departure from the United States for international travel. These children should be revaccinated with 2 doses of MMR vaccine, the first at age 12 through 15 months (12 months if the child remains in an area where disease risk is high), and the second dose at least 4 weeks later.
   • Administer 2 doses of MMR vaccine to children aged 12 months and older before departure from the United States for international travel. The first dose should be administered on or after age 12 months and the second dose at least 4 weeks later.
   Catch-up vaccination:
   • Ensure that all school-aged children and adolescents have had 2 doses of MMR vaccine; the minimum interval between the 2 doses is 4-6 weeks.

9. Varicella (VAR) vaccine. (Minimum age: 12 months)
   Routine vaccination:
   • Administer a 2-dose series of VAR vaccine at ages 12 through 15 months and 4 through 6 years. The second dose may be administered before age 4 years, provided that at least 3 months have elapsed since the first dose. If the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.
   Catch-up vaccination:
   • Ensure that all persons aged 7 through 18 years without evidence of immunity (see MMWR 2017;56(No. RR-4), available at www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6504.pdf) have 2 doses of varicella vaccine. For children aged 7 through 12 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid) for persons aged 13 years and older, the minimum interval between doses is 4 weeks.

10. Hepatitis A (HepA) vaccine. (Minimum age: 12 months)
    Routine vaccination:
    • Initiate the 2-dose HepA vaccine series at ages 12 through 23 months; separate the 2 doses by 6 to 18 months.
    • Children who have received 1 dose of HepA vaccine before age 24 months should receive a second dose 6 to 18 months after the first dose.
    • For any person aged 2 years and older who has not already received the HepA vaccine series, 2 doses of HepA vaccine separated by 6 to 18 months may be administered if immunity against hepatitis A virus infection is desired.
    Catch-up vaccination:
    • The minimum interval between the 2 doses is 6 months.
    Special populations:
    • Administer 2 doses of HepA vaccine at least 6 months apart to previously unvaccinated persons who live in areas where vaccination programs target older children, or who are at increased risk for infection. This includes persons traveling to or working in countries that have high or intermediate endemicity of infection; men having sex with men; users of injection and non-injection illicit drugs; persons who work with HIV-infected primates or with HIV in a research laboratory; persons with clotting factor disorders; persons with chronic liver disease; and persons who anticipate close personal contact (e.g., household or regular babysitting) with an international adoptee during the first 60 days after arrival in the United States from a country with high or intermediate endemicity. The first dose should be administered as soon as the adoption is planned, ideally, 2 or more weeks before the arrival of the adoptee.

11. Meningococcal vaccines. (Minimum age: 6 weeks for Hib-MeningCY [Meningrix®], 2 months for MenACWY-CRM [Menveo®], 9 months for MenACWY-D [Menactra®], 10 years for serogroup B meningococcal [MenB] vaccines: MenB-4C [Bexsero®] and MenB-4F-HB [Trumenba®])
    Routine vaccination:
    • Administer a single dose of Meningrix® or Menveo vaccine at age 11 through 12 years, with a booster dose at age 16 years.
    • For children aged 2 months through 18 years with high-risk conditions, see “Meningococcal conjugate ACWY vaccination of persons with high-risk conditions and other persons at increased risk of disease” below.
    Catch-up vaccination:
    • Administer Menactra or Menveo vaccine at age 13 through 18 years if not previously vaccinated.
    • If the first dose is administered at age 13 through 15 years, a booster dose should be administered at age 16 through 18 years, with a minimum interval of at least 8 weeks between doses.
    • If the first dose is administered at age 16 years or older, a booster dose is not needed.
    • For other catch-up guidance, see Figure 2.
    Clinical discretion:
    • Young adults aged 16 through 23 years (preferred age range is 16 through 18 years) who are not at increased risk for meningococcal disease may be vaccinated with a 2-dose series of either Bexsero (0, 2-3 months) or Trumenba (0.6 months) vaccine to provide short-term protection against most strains of serogroup B meningococcal disease. The two MenB vaccines are not interchangeable; the same vaccine product must be used for all doses.
    • If the second dose of Trumenba is given at an interval of <8 months, a third dose should be given at least 6 months after the first dose; the minimum interval between the second and third doses is 4 weeks.
    Meningococcal conjugate ACWY vaccination of persons with high-risk conditions and other persons at increased risk:
    Children with anatomic or functional asplenia (including sickle cell disease), children with HIV infection, or children with persistent complement component deficiency includes persons with inherited or chronic deficiencies in C1, C5-9, properdin, factor D, factor H, or taking eculizumab (Soliris). (Soliris®):
    • Menveo
    o Children who initiate vaccination at 8 weeks. Administer doses at ages 2, 4, 6, and 12 months.
    o Unvaccinated children who initiate vaccination at 7 through 23 months. Administer 2 primary doses, with the second dose at least 12 weeks after the first dose AND after the first birthday.
    o Children 24 months and older who have not received a complete series. Administer 2 primary doses at least 8 weeks apart.
    • Meningrix
    o Children who initiate vaccination at 6 weeks. Administer doses at ages 2, 4, 6, and 12 through 15 months.
    o If the first dose of Meningrix is given at or after age 12 months, a total of 2 doses should be given at least 8 weeks apart to ensure protection against serogroups C and Y meningococcal disease.
For further guidance on the use of the vaccines mentioned below, see: www.cdc.gov/vaccines/hcp/acip-recs/index.html.

- Menactra
  - Children with anatomic or functional asplenia or HIV infection
    - Children 24 months and older who have not received a complete series. Administer 2 primary doses at least 8 weeks apart. If Menactra is administered to a child with asplenia (including sickle cell disease) or HIV infection, do not administer Menactra until age 2 years and at least 4 weeks after the complete of all PCV13 doses.
  - Children with persistent complement component deficiency
    - Children 9 through 23 months. Administer 2 primary doses at least 12 weeks apart.
    - Children 24 months and older who have not received a complete series. Administer 2 primary doses at least 8 weeks apart.
  - All high-risk children
    - If Menactra is to be administered to a child at high risk for meningococcal disease, it is recommended that Menactra be given neither before or at the same time as DTaP.

Meningococcal B vaccination of persons with high-risk conditions and other persons at increased risk of disease:
- Children with anatomic or functional asplenia (including sickle cell disease) or children with persistent complement component deficiency (includes persons with inherited or chronic deficiencies in C3, C5-9, properdin, factor D, factor H, or taking eculizumab (Soliris))
- Bexsero or Trumenba
  - Persons 10 years or older who have not received a complete series. Administer a 2-dose series of Bexsero, with doses at least 1 month apart, or a 3-dose series of Trumenba, with the second dose at least 1–2 months after the first and the third dose at least 6 months after the first. The two MenB vaccines are not interchangeable; the same vaccine product must be used for all doses.

For children who travel to or reside in countries in which meningococcal disease is hyperendemic or epidemic:
- Children in the African meningitis belt or the Hajj
  - Administer an age-appropriate formulation and series of Menactra or Menveo for protection against serogroups A and W meningococcal disease. Prior receipt of MenHibrix is not sufficient for children traveling to the meningitis belt or the Hajj because it does not contain serogroups A or W.

For children at risk during an outbreak attributable to a vaccine serogroup:
- For serogroup A, C, W, or Y: Administer or complete an age- and formulation-appropriate series of MenHibrix, Menactra, or Menveo.

For serogroup B: Administer a 2-dose series of Bexsero, with doses at least 1 month apart, or a 3-dose series of Trumenba, with the second dose at least 1–2 months after the first and the third dose at least 6 months after the first. The two MenB vaccines are not interchangeable; the same vaccine product must be used for all doses.


12. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine. (Minimum age: 10 years for both Boostrix and Adacel)

Routine vaccination:
- Administer 1 dose of Tdap vaccine to all adolescents aged 11 through 12 years.
- Tdap may be administered regardless of the interval since the last tetanus and diphtheria toxoid-containing vaccine.
- Administer 1 dose of Tdap vaccine to pregnant adolescents during each pregnancy (preferably during the early part of gestational weeks 27 through 36), regardless of time since prior Td or Tdap vaccination.

Catch-up vaccination:
- Persons aged 7 years and older who are not fully immunized with DTaP vaccine should receive Tdap vaccine as a dose (preferably the first) in the catch-up series if additional doses are needed, used Td vaccine. For children 7 years and older who receive a dose of Tdap vaccine in the catch-up series. An adolescent Tdap vaccine dose at age 11 through 12 years may be administered.
- Persons aged 11 through 18 years who have not received Tdap vaccine should receive a dose, followed by tetanus and diphtheria toxoids (Td) booster doses every 10 years thereafter.
- Inadvertent doses of DTaP vaccine:
  - If administered inadvertently to a child aged 7 through 10 years, the dose may count as part of the catch-up series. This dose may count as the adolescent Tdap dose, or the child may receive a Tdap booster dose at age 11 through 12 years.
  - If administered inadvertently to an adolescent aged 11 through 18 years, the dose should be counted as the adolescent Tdap booster.

For other catch-up guidance, see Figure 2.

13. Human papillomavirus (HPV) vaccines. (Minimum age: 9 years for 4vHPV [Gardasil] and 9vHPV [Gardasil 9])

Routine and catch-up vaccination:
- Administer a 2-dose series of HPV vaccine on a schedule of 0, 6-12 months to all adolescents aged 11 or 12 years. The vaccination series can start at age 9 years.
- Administer HPV vaccine to all adolescents through age 18 years who were not previously adequately vaccinated. The number of recommended doses is based on age at administration of the first dose.
- For persons initiating vaccination before age 15, the recommended immunization schedule is 2 doses of HPV vaccine at 0, 6-12 months.
- For persons initiating vaccination at age 15 years or older, the recommended immunization schedule is 3 doses of HPV vaccine at 0, 1-2, 6 months.
- A vaccine dose administered at a shorter interval should be readministered at the recommended interval.
- In a 2-dose schedule of HPV vaccine, the minimum interval is 5 months between the first and second dose. If the second dose is administered at a shorter interval, a third dose should be administered a minimum of 12 weeks after the second dose and a minimum of 5 months after the first dose.
- In a 3-dose schedule of HPV vaccine, the minimum intervals are 4 weeks between the first and second dose, 12 weeks between the second and third dose, and 5 months between the first and third dose. If a vaccine dose is administered at a shorter interval, it should be readministered after another minimum interval has been met since the most recent dose.

Special populations:
- For children with history of sexual abuse or assault, administer HPV vaccine beginning at age 9 years.
- Immunocompromised persons*, including those with human immunodeficiency virus (HIV) infection, should receive a 3-dose series at 0, 1–2, and 6 months, regardless of age at vaccine initiation.
- Note: HPV vaccination is not recommended during pregnancy; however, there is no evidence that the vaccine poses harm. If a woman is found to be pregnant after initiating the vaccination series, no intervention is needed; the remaining vaccine doses should be delayed until after the pregnancy. Pregnancy testing is not needed before HPV vaccination.

*See MMWR December 16, 2016/65(49):1405-1408, available at www.cdc.gov/mmwr/volumes/65/wr/pdfs/mm6549a5.pdf.