CHAPTER 300
MEDICAL POLICY FOR AHCCCS COVERED SERVICES

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- EXHIBIT 300-3 DENTAL HCPC CODE INFORMATION (LIMITED TO ADULT MEMBERS 21 YEARS OF AGE AND OLDER)
- EXHIBIT 300-3A APPLICATION OF PHYSICAL THERAPY 15 VISIT OUTPATIENT LIMIT FOR ACUTE & ALTCS MEMBERS 21 YEARS OF AGE AND OLDER
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- **Attachment C:** Arizona Health Care Cost Containment System Certificate of Medical Necessity for Commercial Oral Nutritional Supplements for Members 21 Years or Age or Greater – Initial or Ongoing Requests
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CHAPTER 300
MEDICAL POLICY FOR AHCCCS COVERED SERVICES

330 COVERED CONDITIONS AND SERVICES FOR THE CHILDREN’S REHABILITATIVE SERVICES (CRS) PROGRAM

- Exhibit 330-1 Covered Conditions in the CRS Program
This chapter provides information about the acute care services that are covered by AHCCCS and the conditions and services provided under the Children’s Rehabilitative Services Program (CRS).

- The AHCCCS acute care program offers comprehensive preventive, acute and behavioral health care services with limited coverage of rehabilitative services, home health care and long term care, as specified in Arizona Administrative Code Title 9, Chapter 22, Article 2. The latter services are covered more extensively through the Arizona Long Term Care System (ALTCS) described in Chapter 1200 of this Manual. All covered services must be medically necessary and provided by a primary care provider, or other qualified providers as defined in Chapter 600 of this Manual.

- AHCCCS enrolls EPSDT members who require treatment for medically disabling or potentially disabling conditions, as defined in A.A.C. R9-7-202 (refer to Exhibit 330-1), into the Children’s Rehabilitative Services (CRS) program. The CRS program is based upon a member’s need for active treatment of CRS conditions through medical, surgical, or therapy modalities where the following three criteria are present:
  - Specialized treatment is necessary
  - Functional improvement is potentially achievable, and
  - Long-term follow-up may be required for maximum achievable results.

Out-of-state services are covered as provided for under Title 42 of the Code of Federal Regulations, Part 431, Subpart B. This includes services that, as determined on the basis of medical advice, are more readily available in other states, and services needed due to a medical emergency. Services furnished to AHCCCS members outside the United States are not covered. AHCCCS will not register nor reimburse providers who are located outside the United States.

**NOTE:** In relation to services provided outside of the United States, for purposes of Chapter 300, Chapter 1200, and Chapter 1600, United States (U.S.) includes
the 50 states of the U.S., the District of Columbia, and the U.S. Territories (Puerto Rico, U.S. Virgin Islands, Guam, American Samoa and the Northern Mariana Islands).

This chapter does not discuss maternal and child health services or services provided through the Federal Emergency Service Program (FESP). Maternal and child health services, including the KidsCare program (Title XXI), are described in Chapter 400. FESP services are described in Chapter 1100.

Exhibit 300-1 identifies covered AHCCCS acute care program services and Exhibit 300-2 identifies covered behavioral health services for Title XIX and Title XXI members.

The remaining pages of this chapter provide a description and a discussion of the amount, duration and scope limitations based on member eligibility and/or member age for AHCCCS acute care program services and the CRS program. Prior Authorization (PA) requirements for covered services are not provided in this chapter.

AHCCCS PA requirements for covered services provided by Contractors are focused on inpatient hospital services and AHCCCS requires Contractors to implement an appropriate PA procedure for inpatient hospital services. AHCCCS also encourages Contractors to implement PA and utilization management methods for other services as appropriate. Specific Contractor PA requirements are not identified in this Manual; for details regarding Contractor PA requirements for specific services, contact the Contractor.

If a service requiring PA is denied by a Contractor or by AHCCCS Administration, notice of action must be provided to the member in accordance with Arizona Administrative Code Title 9, Chapter 34 (9 A.A.C. 34). For Contractors, ACOM Policy 414 also applies.

The Administration requires PA from the Division of Fee-for-Service Management (DFSM) PA Unit for many covered acute services that are provided to a Fee-For-Service (FFS) member, (i.e., a member not enrolled with a Contractor). Exceptions include emergency services.

AHCCCS PA requirements for services provided to FFS members are specified in Chapter 800. Refer to the PA section of Policy 810 for information regarding requirements for notification of FFS providers and FFS members if PA is denied. Refer to the concurrent review section of Policy 810 for information related to approval or denial of the continuation of inpatient hospital services for FFS members.

Refer to Chapter 1600 for information on ALTCS program covered services that require PA.
Refer to the AHCCCS FFS Provider Manual and the Encounter Reporting User Manual for complete information regarding claim and encounter reporting procedures for covered services. These manuals are both available on the AHCCCS Website (http://www.azahcccs.gov/).

**REFERENCES**


2. Arizona Revised Statutes (A.R.S.) Title 36, Chapter 29, Articles 1-5.

3. (A.R.S.) Title 36, Chapter 2, Article 3

4. Arizona Administrative Code (A.A.C.) Title 9, Chapter 7, 22, 28, 31 and 34.

5. Chapter 100 of this Manual includes 42 C.F.R., State Statute and Rule citations related to services and settings addressed in the Chapter.

6. Chapter 600 of this Manual, Exhibit 610-1, includes 42 C.F.R., State Statute and Rule citations related to provider requirements.

7. AHCCCS Contractor Operations Manual (ACOM)

8. AHCCCS Contracts
EXHIBIT 300-1

AHCCCS COVERED SERVICES
ACUTE CARE
# EXHIBIT 300-1
AHCCCS COVERED SERVICES
ACUTE CARE

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<td>Breast Reconstruction After Mastectomy</td>
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<td>Chiropractic Services</td>
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<td>Cochlear Implants</td>
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<td>Emergency Dental Services</td>
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<td>Preventive &amp; Therapeutic Dental Services</td>
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<td>Limited Medical and Surgical Services by a Dentist (for Members Age 21 and older)</td>
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<td>Dialysis</td>
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<td>Emergency Eye Exam</td>
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<td>Vision Exam/Prescriptive Lenses</td>
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<td>Lens Post Cataract Surgery</td>
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<td>Treatment for Medical Conditions of the Eye</td>
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<td>HIV/AIDS Antiretroviral Therapy</td>
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<td>Medical Foods</td>
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<td>Nursing Facilities (up to 90 days)</td>
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<td>Physician Services</td>
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See Chapter 300 for age and service delivery site restrictions, scope and time limitations, provider specialty requirement and eligibility limitations.
See Chapter 400 for Maternal and Child Health Service restrictions and limitations.
See Chapter 800 for FFS/PA requirements.
See Chapter 1100 for covered services for the Emergency Services Program (ESP)
See Arizona Administrative Code, Title 9, Chapter 22,28 and 31 regarding AHCCCS covered services

REV: 11/01/2011, 10/01/2010, 10/01/2009, 10/01/2007, 10/01/2001, 01/01/2001
### EXHIBIT 300-1
**AHCCCS COVERED SERVICES**  
**ACUTE CARE**

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<td>Triage</td>
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See Chapter 300 for age and service delivery site restrictions, scope and time limitations, provider specialty requirement and eligibility limitations.
See Chapter 400 for Maternal and Child Health Service restrictions and limitations.
See Chapter 800 for FFS/PA requirements.
See Chapter 1100 for covered services for the Emergency Services Program (ESP)
See Arizona Administrative Code, Title 9, Chapter 22,28 and 31 regarding AHCCCS covered services

REV: 11/01/2011, 10/01/2010, 10/01/2009, 10/01/2007, 10/01/2001, 01/01/2001
EXHIBIT 300-2

AHCCCS COVERED SERVICES
BEHAVIORAL HEALTH
## EXHIBIT 300-2
### AHCCCS COVERED SERVICES
#### BEHAVIORAL HEALTH

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### INPATIENT SERVICES

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### PROFESSIONAL SERVICES – THERAPY AND COUNSELING

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### TRANSPORTATION

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See the Behavioral Health Services Guide for restrictions, scope and time limitations, provider requirements and eligibility limitations for Title XIX and Title XXI behavioral health services.
EXHIBIT 300-3A

APPLICATION OF PHYSICAL THERAPY VISIT OUTPATIENT LIMIT
ACUTE & ALTCS MEMBERS 21 YEARS OF AGE AND OLDER
# Exhibit 300-3A

**Application of Physical Therapy 15 Visit Outpatient Limit**

*Acute & ALTCS Members 21 Years of Age and Older*

<table>
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<th>Condition</th>
<th>Contractor Implementation (Fiscal Implications)</th>
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</table>
| **Member is Medicaid Only and is Not Medicare Eligible. (Also Known as Non QMB Dual)** | Contractor is responsible for the visit up to:  
a. 15 visits per contract year (10/01—9/30) for persons age 21 years or older to restore a particular skill or function the individual previously had but lost due to injury or disease and maintain that function once restored; and,  
b. 15 visits per contract year (10/01—9/30) for persons age 21 years or older to attain or acquire a particular skill or function never learned or acquired and maintain that function once acquired. |
| **Member is Dual Eligible (Also Known as Medicare Primary, Non QMB Dual)** | Contractor is responsible for Medicare cost sharing (copay, coinsurance, and deductible) up to:  
a. 15 visits per contract year (10/01—9/30) for persons age 21 years or older to restore a particular skill or function the individual previously had but lost due to injury or disease and maintain that function once restored; and,  
b. 15 visits per contract year (10/01—9/30) for persons age 21 years or older to attain or acquire a particular skill or function never learned or acquired and maintain that function once acquired.  
• In the event that the PT visit limit is reached prior to the Medicare maximum dollar amount, the Contractor will pay the Medicare cost sharing up to the visit limit per contract year. As part of their Medicare benefit, members may opt to receive service up to Medicare maximum dollar amount; however, the Medicare cost sharing for any visits beyond the visit limit allowed by AHCCCS are the members’ responsibility.  
• In the event that the member exhausts the Medicare dollar maximum amount prior to utilizing the PT visit limit allowed by AHCCCS, the additional visits up to the maximum are the responsibility of the Contractor. |
| **Member is QMB Dual** | Contractor is responsible for Medicare cost sharing up to Medicare maximum dollar amount.  
• In the event that the PT visit limit is reached prior to the Medicare maximum dollar amount, the Contractor will continue to pay the Medicare cost sharing for PT visits until the Medicare maximum dollar amount for therapy is reached.  
• In the event that member exhausts the Medicare maximum dollar amount prior to utilizing the PT visit limit allowed by AHCCCS, the additional visits up to maximum of are the responsibility of the Contractor. |

**Definitions:**

- **Visit** -- A visit equals PT services received in one day. The visit limit applies regardless that the member has the same contractor or changes contractors during the contract year.
- **Setting** -- Any outpatient place of service (nursing homes, nursing facilities and custodial care setting are considered inpatient settings).
- **Dual Eligible (Non-QMB Dual)** -- An individual who is Medicare and Medicaid eligible with Income above 100% FPL. The individual does not qualify for QMB.
- **QMB Dual** -- An individual who is Medicare and Medicaid eligible with income not exceeding 100% FPL.
EXHIBIT 300-3B

INPATIENT LIMIT: MEMBER & CONTRACTOR RESPONSIBILITY
ACUTE & ALTCS MEMBERS 21 YEARS OF AGE AND OLDER
(MEDICAID ONLY, QMB DUAL AND NON-QMB DUAL STATUS)

Effective October 1, 2014 and forward there is no longer a 25 day limitation of in-state and out-of-state inpatient hospital services per benefit year.

CYE 2014 Limitations
The limitation of in-state and out-of-state inpatient hospital services to 25 days per benefit year ended effective September 30, 2014. The following policy is meant to act as guidance to Contractors when determining reimbursement for hospital services provided during CYE 2014.
# EXHIBIT 300-3B
### INPATIENT LIMIT: MEMBER & CONTRACTOR RESPONSIBILITY
#### ACUTE & ALTCS MEMBERS 21 YEARS OF AGE AND OLDER
**(Medicaid Only, QMB Dual and Non-QMB Dual Status)**

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>CONTRACTOR IMPLEMENTATION (FISCAL IMPLICATIONS)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MEMBER IS MEDICAID ONLY AND IS NOT MEDICARE ELIGIBLE. (ALSO KNOWN AS NON-DUAL)</strong></td>
<td>Contractor is responsible for payment limited to the first 25 inpatient days per contract year. Contractor is not responsible for payment of inpatient days beginning with the 26th inpatient day in a contract year. The first 25 inpatient days are the first 25 inpatient days (with dates of service during the contract year) that are <strong>paid</strong> by the Administration or the member's Contractor irrespective of whether the date of payment was during or after the contract year. For more information about counting the 25 day inpatient limit and exclusions, refer to the “Adult Inpatient limits and member billing rule: <a href="http://www.azahcccs.gov/reporting/state/unpublishedrules.aspx">http://www.azahcccs.gov/reporting/state/unpublishedrules.aspx</a>**</td>
</tr>
</tbody>
</table>
| **MEMBER IS DUAL ELIGIBLE (ALSO KNOWN AS MEDICARE PRIMARY, NON-QMB DUAL)** | Contractor is responsible for Medicare cost sharing (co-pay, coinsurance, and deductible) associated with all admissions through the admission in which the 25<sup>th</sup> inpatient day of the contract year occurs.  
(Example: a non-QMB dual with 23 prior inpatient days during the contract year is admitted and remains in the hospital for 10 days. Since the admission occurs before the 25-day limit is reached, Contractor is responsible for Medicare cost sharing associated with the 10 days even though the member exceeds the 25-day annual limit during that admission.)  
Contractor is not responsible for Medicare cost sharing (co-pay, coinsurance and deductible) related to admissions occurring after the first 25 inpatient days per contract year. |
| **MEMBER IS QMB DUAL** | Contractor is responsible for all Medicare cost sharing (co-pay, coinsurance, and deductible) regardless of the number of inpatient days in contract year. |
| **MEMBER IS QMB ONLY** | AHCCCS FFS program is responsible for all Medicare cost sharing (co-pay, coinsurance, and deductible) regardless of the number of inpatient days in contract year. |

**Definitions:**

- **Inpatient Setting** – Acute Care hospital including Specialty Care Hospital and Rehabilitation Hospital (in-state and out of state)

- **Dual Eligible (Non-QMB Dual)** – An individual who is Medicare and Medicaid eligible with income **above** 100% FPL. The individual does not qualify for QMB.

- **QMB Dual** – An individual who is Medicare and Medicaid eligible with income not exceeding 100% FPL.

- **QMB Only** – An individual who is Medicare only who qualifies to have Medicare premiums, co-payments, and deductibles paid by the AHCCCS program.
EXHIBIT 300-3B
INPATIENT LIMIT: MEMBER & CONTRACTOR RESPONSIBILITY
ACUTE & ALTCS MEMBERS 21 YEARS OF AGE AND OLDER
(Medicaid Only, QMB Dual and Non-QMB Dual Status)

EXCLUSION

The following inpatient days are not included in the inpatient hospital limitation:

a. Days reimbursed under specialty contracts between AHCCCS and a transplant facility that are included within the component pricing referred to in the contract;

b. Days related to Behavioral Health:
   i. Inpatient days that qualify for the psychiatric tier under R9-22-712.09 and reimbursed by the Administration or its contractors, or
   ii. Inpatient days with a primary psychiatric diagnosis code reimbursed by the Administration or its contractors, or
   iii. Inpatient days paid by the Arizona Department of Health Services Division of Behavioral Health Services or an Integrated RBHA, RBHA or TRBHA.

c. Days related to treatment for burns and burn late effects at an American College of Surgeons verified burn center.

d. Same Day Admit Discharge services are excluded from the 25 day limit; and

e. Subject to approval by CMS, days for which the state claims 100% FFP, such as payments for days provided by IHS or 638 facilities.

Examples include the following:

Evaluation (Limited to inpatient days directly associated with the evaluation)

- **Harvest** (Tissue harvesting for autologous bone marrow transplants; The related costs/in-pt days for live donors; Note: if the donor is a Medicaid member this will not be included as part of their 25 day limit)
- **Total Body Irradiation** (Limited to the inpatient days associated with the series of conditioning regimens prior to bone marrow or peripheral blood stem cell transplantation)
- **Preparation and transplant** (10 days post transplant care for kidney transplants)
- **Post transplant care** (Up to 60 days for other covered transplants)
- **Placement of Circulatory Assist Devices (CADs)** also known as Ventricular Assistive Devices (VADs) and Total Artificial Hearts (TAHs) (Limited to day of surgery; Inpatient days before and after the placement of the CADs are to be counted towards the 25 day limit)

**NOTE:** Inpatient days while “wait listed” are to be counted towards the 25 day limit. This is the period of time after a member has been determined to be a candidate for transplant, by the transplant facility, and is waiting for an available organ.
310 Coverage Services

310-A Audiology

Revision Dates: 06/01/13, 01/01/11, 05/01/06, 09/01/04, 10/01/01, 10/01/99

Initial Effective Date: 10/01/1994

Description

Audiology is an AHCCCS covered service, within certain limitations, to evaluate hearing loss and rehabilitate persons with hearing loss through other than medical/surgical means.

Amount, Duration and Scope

AHCCCS covers medically necessary audiology services to evaluate hearing loss for all members, on both an inpatient and outpatient basis. For purposes of the AHCCCS Program only an AHCCCS registered dispensing audiologist or an AHCCCS registered individual with a valid hearing aid dispensing license may dispense hearing aids. Hearing aids, provided as a part of audiology services, are covered only for members under the age of 21 receiving Early Periodic Screening, Diagnostic and Treatment (EPSDT) services or are enrolled in KidsCare.

Audiology services must be provided by an audiologist who is licensed by the Arizona Department of Health Services (ADHS) and who meets the Federal requirements specified under Title 42 of the Code of Federal Regulations (42 C.F.R.) 440.110. Out-of-state audiologists must meet the Federal requirements.

The Federal requirements mandate that the audiologist must have a Master’s or Doctoral degree in audiology and meet one of the following conditions:

1. Have a certificate of clinical competence in audiology granted by the American Speech-Language-Hearing Association (ASHA), or

2. Have successfully completed a minimum of 350 clock-hours of supervised clinical practicum (or be in the process of accumulating such supervised clinical experience under the supervision of a qualified Master’s or Doctoral-level audiologist), performed at least nine months of supervised full-time audiology services under the supervision of a qualified master or doctoral-level audiologist after obtaining a Master’s or Doctoral degree in audiology or a related field, and
successfully completed a national examination in audiology approved by the Secretary of the U.S. Department of Health and Human Services.

Refer to Chapter 1200 for additional information on services provided to Arizona Long Term Care System (ALTCS) members.
310-B BEHAVIORAL HEALTH SERVICES

REVISION DATES: 03/01/14, 02/01/14, 10/01/11, 05/01/11, 10/01/10, 07/01/10, 05/01/09, 06/01/07, 10/01/06, 05/01/06, 10/01/01, 10/01/99

INITIAL

EFFECTIVE DATE: 10/01/1994

Description

AHCCCS covers behavioral health services (mental health and/or substance abuse services) within certain limits for all members. The following outlines the service delivery system for behavioral health services.

Acute Care Program

1. Title XIX and Title XXI Members are eligible to receive medically necessary behavioral health services. Services are provided through the Arizona Department of Health Services and its contracts with Integrated Regional Behavioral Health Authorities (Integrated RBHAs), Regional Behavioral Health Authorities (RBHA) and Tribal Regional Behavioral Health Authorities (TRBHAs). American Indian members may receive behavioral health services from an IHS/638 facility, a TRBHA, or be referred to an Integrated RBHA or RBHA. Services are listed in the amount, duration and scope section of this policy and described with limitations in the ADHS/Behavioral Health Services Guide.

Managed care primary care providers, within the scope of their practice, who wish to provide psychotropic medications and medication adjustment and monitoring services may do so for members diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder, depressive (including postnatal depression) and/or anxiety disorders. There are two appendices, Appendix E for children and adolescents and Appendix F for adults. For each of the three named diagnoses there are clinical guidelines that include assessment tools and algorithms. The clinical guidelines are to be used by the PCPs as an aid in treatment decisions.

2. Arizona Long Term Care System (ALTCS) Program

ALTCS members are eligible to receive medically necessary behavioral health services through ALTCS Contractors, Tribal Contractors, Department of Economic Security/Division of Developmental Disabilities, and AHCCCS registered Fee-For-Service (FFS) providers. Refer to the ADHS Behavioral Health Services Guide and Chapters 1200 and 1600.
of this Manual for additional information regarding ALTCS behavioral health services.

Amount, Duration and Scope

Covered behavioral health services for Acute and ALTCS members include, but are not limited to:

1. Inpatient hospital services
2. Inpatient Behavioral Health facility services
3. Institution for mental disease with limitations (refer to Chapter 100)
4. Behavioral health counseling and therapy, including electroconvulsive therapy
5. Psychotropic medication
6. Psychotropic medication adjustment and monitoring
7. Respite care. The combined total of short-term and/or continuous respite care cannot exceed 600 hours per benefit year.
8. Partial care (supervised day program, therapeutic day program and medical day program)
9. Behavior management (behavioral health home care training, behavioral health self-help/peer support)
10. Psychosocial rehabilitation (skills training and development, behavioral health promotion/education, psycho-educational services, ongoing support to maintain employment, and cognitive rehabilitation)
11. Screening, evaluation and assessment
12. Case management services
13. Laboratory, radiology, and medical imaging services for diagnosis and psychotropic medication regulation
14. Emergency and non-emergency medically necessary transportation
15. Behavioral health supportive home care services, and/or
16. Emergency behavioral health services for managed care and FFS members who are not in the FESP (refer to Chapter 1100 for all requirements regarding FESP).

   a. Emergency behavioral health services are described under A.A.C. R9-22-210.1 Emergency Behavioral Health Services for Non-FES members. An emergency behavioral health condition is a condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

      i. Placing the health, including mental health, of the member in serious jeopardy (this includes serious harm to self)
      ii. Serious impairment to bodily functions
      iii. Serious dysfunction of any bodily organ or part, or
      iv. Serious physical harm to another person

   Acute symptoms include severe psychiatric symptoms.

      i. An emergency behavioral health evaluation is covered as an emergency behavioral health service if:
      ii. Required to evaluate or stabilize an acute episode of mental disorder or substance abuse, and
      iii. Provided by a qualified provider who is:

         (a) A behavioral health medical practitioner as defined in 9 A.A.C. 22, Article 1, including a licensed psychologist, a licensed clinical social worker, a licensed professional counselor, a licensed marriage and family therapist, or

         (b) An ADHS/DBHS-contracted provider

   A provider is not required to obtain prior authorization for emergency services. Regarding emergency services, refer to Exhibit 310-1 for a reprint of A.A.C. R9-22-210.01 that describes general provisions for responsible entities, payment and denial of payment, notification requirements and post-stabilization requirements.

   Refer to A.A.C. R9-22-217 and Chapter 1100 of this Manual for information regarding behavioral health services for members eligible for services through the Federal Emergency Services Program.
Refer to Chapter 1200 for more information regarding behavioral health services for members eligible for the ALTCS program. Also refer to the “Policy for Management of Acute Behavioral Health Situations” found in Appendix H for information regarding ALTCS members residing in Nursing Facilities requiring behavioral health intervention.

Refer to the Behavioral Health Services Guide for further information on AHCCCS covered behavioral health services and settings.
310-C  BREAST RECONSTRUCTION AFTER MASTECTOMY

Description

AHCCCS covers breast reconstruction surgery for eligible members following a medically necessary mastectomy regardless of AHCCCS eligibility at time of mastectomy.

Amount, Duration and Scope

Breast reconstruction surgery is a covered service if the individual is AHCCCS eligible, and as noted in this section. The member may elect to have breast reconstruction surgery immediately following the mastectomy or may choose to delay breast reconstruction, but the member must be AHCCCS eligible at the time of breast reconstruction surgery. The type of breast reconstruction performed is determined by the physician in consultation with the member.

Coverage policies for breast reconstructive surgery include:

1. Reconstruction of the affected and the contralateral unaffected breast following a medically necessary mastectomy is considered an effective non-cosmetic procedure. Breast reconstruction surgery following removal of a breast for any medical reason is a covered service.

2. Medically necessary implant removal is a covered service. Replacement of implants is a covered service when the original implant was the result of a medically necessary mastectomy. Replacement of implants is not a covered service when the purpose of the original implant was cosmetic (e.g., augmentation).

3. External prostheses, including a surgical brassiere, will be covered for members who choose not to have breast reconstruction, or who choose to delay breast reconstruction until a later time.

Limitations

1. AHCCCS does not cover services provided solely for cosmetic purposes (R9-22-205). If a member has had an implant procedure for cosmetic purposes (e.g., augmentation) not related to a mastectomy, medically
necessary removal is covered but replacement is not.

2. Reconstructive breast surgery of the unaffected contralateral breast following mastectomy will be considered medically necessary only if required to achieve relative symmetry with the reconstructed affected breast. Except in extraordinary circumstances, the medical necessity of reconstructive breast surgery must be determined by the surgeon, in consultation with the Contractor’s Medical Director, at the time of reconstruction or during the immediate post-operative period.

Prior Authorization (PA) from the AHCCCS Division of Fee-For-Service Management is required for breast reconstruction surgery provided to FFS members. Refer to Chapter 800 for further discussion of PA requirements for FFS providers.
310-D  DENTAL SERVICES FOR MEMBERS 21 YEARS OF AGE AND OLDER

Description

As described in this Policy, AHCCCS covers medical and surgical services furnished by a dentist only to the extent that such services:

1. May be performed under State law by either a physician or by a dentist and

2. The services would be considered physician services if furnished by a physician.

Subject to the terms of this Policy, AHCCCS also covers limited dental services as a prerequisite to AHCCCS covered transplantation and when they are in preparation for radiation treatment for certain cancers.

Dental services for members younger than age 21, including preventive and therapeutic dental services, are discussed in Chapter 400 of this Manual.

Amount, Duration and Scope

Services furnished by dentists which are covered for members 21 years of age and older must be related to the treatment of a medical condition such as acute pain (excluding Temporomandibular Joint Dysfunction (TMJ) pain), infection, or fracture of the jaw. Covered services include a limited problem focused examination of the oral cavity, required radiographs, complex oral surgical procedures such as treatment of maxillofacial fractures, administration of an appropriate anesthesia and the prescription of pain medication and antibiotics. Diagnosis and treatment of TMJ is not covered except for reduction of trauma.

Exception for Transplant Cases

For members who require medically necessary dental services as a pre-requisite to AHCCCS covered organ or tissue transplantation, covered dental services are limited to the elimination of oral infections and the treatment of oral disease, which include dental cleanings, treatment of periodontal disease, medically necessary extractions and the provision of simple restorations. For purposes of this Policy, a simple restoration
means silver amalgam and/or composite resin fillings, stainless steel crowns or preformed crowns. AHCCCS covers these services only after a transplant evaluation determines that the member is an appropriate candidate for organ or tissue transplantation.

**Exception for Cancer Cases**

Prophylactic extraction of teeth in preparation for radiation treatment of cancer of the jaw, neck or head is covered.

**Limitations**

Except for limited dental services covered for pre-transplant candidates and for members with cancer of the jaw, neck or head described above, covered services furnished by dentists to members 21 years of age and older do not include services that physicians are not generally competent to perform. These services include, but are not limited to, dental cleanings, routine dental examinations, dental restorations including crowns and fillings, extractions, pulpotomies, root canals, and the construction or delivery of complete or partial dentures. Diagnosis and treatment of TMJ is not covered except for reduction of trauma.


310-E  DIALYSIS

REVISION DATES: 05/15/07, 10/01/06, 10/01/01

REVIEW DATE: 08/01/2011

INITIAL

EFFECTIVE DATE: 10/01/1994

Description

AHCCCS covers hemodialysis and peritoneal dialysis services provided by participating hospitals and End Stage Renal Disease facilities. All services, supplies, diagnostic testing (including routine medically necessary laboratory tests) and drugs medically necessary for the dialysis treatment are covered.

Amount, Duration and Scope

Medically necessary outpatient dialysis treatments are covered. Inpatient dialysis treatments are covered when the hospitalization is for:

1. Acute medical condition requiring dialysis treatments (hospitalization related to dialysis)

2. AHCCCS covered medical condition requiring inpatient hospitalization experienced by a member routinely maintained on an outpatient chronic dialysis program, or

3. Placement, replacement or repair of the chronic dialysis route.

NOTE: Hospital admissions solely to provide chronic dialysis are not covered.

NOTE: Hemoperfusion is covered when medically necessary.

Refer to Chapter 1100, Policy 1120, for policy related to dialysis coverage within the Federal Emergency Services Program (FESP).
310-F  EMERGENCY MEDICAL SERVICES

REVISION DATES:  10/01/06, 10/01/03, 10/01/01, 10/01/97

REVIEW DATE:  05/01/2011

INITIAL

EFFECTIVE DATE:  10/01/1994

Description

As specified in A.A.C. R9-22-210, AHCCCS covers emergency medical services for managed care and FFS members who are not in the Federal Emergency Services Program (FESP). Refer to Chapter 1100 for all requirements regarding FESP.

Emergency medical services are provided for the treatment of an emergency medical condition. An emergency medical condition is a medical condition, including labor and delivery, which manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

1. Placing the member's health in serious jeopardy
2. Serious impairment of bodily functions, or
3. Serious dysfunction of any bodily organ or part.

Amount, Duration and Scope

Emergency medical services are covered for members when there is a demonstrated need, and/or after triage/emergency medical assessment services indicate an emergency condition.

A provider is not required to obtain prior authorization for emergency services. Regarding emergency services, refer to Exhibit 310-1 for a reprint of A.A.C. R9-22-210 that describes general provisions for responsible entities, payment and denial of payment, notification requirements and post-stabilization requirements.

Utilization of emergency services  Managed care Contractors must educate their members regarding the appropriate utilization of emergency room services. Members should be encouraged to obtain services from non-emergency facilities (e.g., urgent care centers) to address member non-emergency care after regular office hours or on weekends.
Refer to Chapter 500 for the policy regarding member transfers after an emergency hospitalization.

Refer to Chapter 800 for additional information regarding emergency medical services for FFS members who are not in FESP.

Refer to Chapter 1100 for a complete discussion of covered emergency medical services under the FESP.

Refer to A.A.C. R9-22-217 and Chapter 1100 of this Manual for a complete discussion of covered emergency medical services under the FESP.
310-G  EYE EXAMINATIONS/OPTOMETRY SERVICES

REVISION DATES:  10/01/06, 10/01/01

REVIEW DATE:  05/01/2011

INITIAL

EFFECTIVE DATE:  10/01/1994

Description

AHCCCS covers eye and optometric services provided by qualified eye/optometry professionals within certain limits based on member age and eligibility.

Amount, Duration and Scope

Emergency eye care which meets the definition of an emergency medical condition is covered for all members. For members who are 21 years of age or older, treatment of medical conditions of the eye, excluding eye examinations for prescriptive lenses and the provision of prescriptive lenses, are covered. Vision examinations and the provision of prescriptive lenses are covered for members under the Early and Periodic Screening, Diagnosis and Treatment Program, KidsCare Program and for adults when medically necessary following cataract removal. Refer to Chapter 400 for detailed information regarding coverage of eye exams and prescriptive lenses for children.

Cataract removal is covered for all eligible members. Cataract removal is a covered service when the cataract is visible by exam, ophthalmoscopic or slit lamp, and any of the following apply:

1. Visual acuity that cannot be corrected by lenses to better than 20/70 and is reasonably attributable to cataract

2. In the presence of complete inability to see posterior chamber, vision is confirmed by potential acuity meter reading, or

3. For FFS members, who have corrected visual acuity between 20/50 and 20/70, a second opinion by an ophthalmologist to demonstrate medical necessity may be required. Refer to the Contractors regarding requirements for their enrolled members.
Cataract surgery is covered only when there is a reasonable expectation by the operating ophthalmic surgeon that the member will achieve improved visual functional ability when visual rehabilitation is complete.

Cataract surgeries are generally done on an outpatient basis, but an inpatient stay may be required due to the need for complex medical and nursing care, multiple ocular conditions or procedures, or the member's medical status. Admission to the hospital may be deemed safer due to age, environmental conditions or other factors.

Other cases that may require medically necessary ophthalmic services include, but are not limited to:

1. Phacogenic Glaucoma, and
2. Phacogenic Uveitis.

Refer to Chapter 800 for prior authorization requirements for FFS providers.
310-H HEALTH RISK ASSESSMENT AND SCREENING TESTS

REVISION DATES: 10/01/13, 10/01/10, 10/01/06, 01/01/04, 10/01/01

INITIAL
EFFECTIVE DATE: 10/01/1994

Description

AHCCCS covers health risk assessment and screening tests provided by a physician, primary care provider or other licensed practitioner within the scope of his/her practice under State law for all members. These services include appropriate clinical health risk assessments and screening tests, immunizations, and health education, as appropriate for age, history and current health status.

Health risk assessment and screening tests are also covered for members under the Early and Periodic Screening, Diagnosis and Treatment Program and KidsCare Program. Refer to Chapter 400 for complete details.

Amount, Duration and Scope

Preventive health risk assessment and screening test services for non-hospitalized adults include, but are not limited to:

1. Hypertension screening (annually)
2. Cholesterol screening (once, additional tests based on history)
3. Routine mammography annually after age 40 and at any age if considered medically necessary
4. Cervical cytology, including pap smears (annually for sexually active women; after three successive normal exams the test may be less frequent)
5. Colon cancer screening (digital rectal exam and stool blood test, annually after age 50, as well as baseline colonoscopy after age 50)
6. Sexually transmitted disease screenings (at least once during pregnancy, other based on history)
7. Tuberculosis screening (once, with additional testing based on history, or, for AHCCCS members residing in a facility, as necessary per health care institution
licensing requirement)

8. HIV screening

9. Immunizations (refer to Policy 310-M, Immunizations for details)

10. Prostate screening (annually after age 50; and, screening is recommended annually for males 40 and older who are at high risk due to immediate family history), and

11. Physical examinations (as of 10/01/13, includes well visits and well exams), periodic health examinations or assessments, diagnostic work ups or health protection packages designed to: provide early detection of disease; detect the presence of injury or disease; establish a treatment plan; evaluate the results or progress of a treatment plan or the disease; or to establish the presence and characteristics of a physical disability which may be the result of disease or injury

Screening services provided more frequently than these professionally recommended guidelines will not be covered unless medically necessary.

Physical examinations not related to covered health care services or performed to satisfy the demands of outside public or private agencies such as the following are not covered services:

1. Qualification for insurance

2. Pre-employment physical examination

3. Qualifications for sports or physical exercise activities

4. Pilots examinations (Federal Aviation Administration)

5. Disability certification for the purpose of establishing any kind of periodic payments

6. Evaluation for establishing third party liability, or

The AHCCCS Division of Fee-For-Service Management does not require prior authorization for medically necessary health risk assessment and screening services performed by Fee-For-Service providers.


310-I   HOME HEALTH SERVICES

REVISION DATES:  05/01/2011, 10/01/06, 10/01/01

INITIAL
EFFECTIVE DATE:  10/01/1994

Description

AHCCCS covers medically necessary home health services provided in the member's place of residence as a cost effective alternative to hospitalization. Covered services, within certain limits, include: home health nursing visits, home health aide services, medically necessary supplies and therapy services in accordance with A.R.S. 36-2907 for AHCCCS members.

ALTCS covers home health services for members who are either Elderly and/or have Physical Disabilities (E/PD) and/or members with developmental disabilities receiving home and community based services. Refer to Chapter 1200 for additional information.

Amount, Duration and Scope

Home health nursing and home health aide services are provided on an intermittent basis as ordered by a primary care provider or treating physician in accordance with 9 A.A.C. 10, Article 11, Home Health Agencies. Physical therapy services provided by a licensed Home Health Agency (HHA) are covered for acute care, Early and Periodic Screening, Diagnosis and Treatment (EPSDT), KidsCare and ALTCS members (subject to the limits described in Chapter 300, Policy 310-X). Speech and occupational therapy services provided by a licensed HHA are covered for EPSDT and ALTCS members only.

Refer to Chapter 800 for prior authorization requirements for FFS providers.
310-J  HOSPICE SERVICES

**Description**

AHCCCS covers hospice services for acute care and ALTCS members. Hospice services are allowable under A.R.S. §§ 36-2907 and 2989 and 42 C.F.R. 418.20 for terminally ill members who meet the specified medical criteria/requirements. Hospice services provide palliative and support care for terminally ill members and their family members or caregivers in order to ease the physical, emotional, spiritual and social stresses, which are experienced during the final stages of illness and during dying and bereavement.

Hospice services are provided in the member’s own home; a Home and Community Based (HCB) approved alternative residential setting as specified in Policy 1230 of this Manual; or the following inpatient settings when the conditions of participation are met as specified in 42 C.F.R. 418:

1. Hospital,
2. Nursing care institution, and
3. Free standing hospice.

Providers of hospice must be Medicare certified and licensed by the Arizona Department of Health Services (ADHS), and have a signed AHCCCS provider agreement.

As directed by the Affordable Care Act, EPSDT members may continue to receive curative treatment for their terminal illness while receiving hospice services. Adult members age 21 and older who elect hospice services must forgo curative care.

**NOTE:** For dual eligible members, Medicare is the primary payer of hospice services.
Definitions

For purposes of this policy, the following definitions apply:

1. **Continuous home care** means hospice provided during periods of crisis for a minimum of eight hours per 24-hour day (the hours do not have to be continuous). To qualify as home care under this section, the care must be predominantly nursing care, provided by a registered nurse or a licensed practical nurse. Homemaker and home health aide services may also be provided to supplement the care. Continuous home care is only furnished during brief periods of crisis and only as necessary to allow terminally ill hospice-eligible members to maintain residence in their own home or an HCB approved alternative residential setting. Continuous home care is not available to members residing in an NF Medicaid certified bed.

2. **Inpatient respite care** means services provided in an inpatient setting, such as an NF, on a short-term basis to relieve family members or other caregivers who provide care to hospice eligible members who have elected to receive hospice care and who reside in their own home or, HCB alternative residential setting.

3. **General inpatient care** means services provided in an inpatient setting, such as a hospital, to hospice eligible members who have elected to receive hospice. These services are provided for such purposes as pain control or acute or chronic symptom management, which cannot be managed in another setting.

4. **Period of crisis** means a period in which the hospice eligible member requires continuous care to achieve palliation or management of acute medical symptoms.

5. **Routine home care** means short term, intermittent hospice including skilled nursing, home health aide and/or homemaker services provided to a hospice eligible member in his or her own home or, HCB approved alternative residential setting. Routine home care services may be provided on a regularly scheduled and/or on-call basis. The hospice eligible member must not be receiving continuous home care services as defined in this section at the time routine home care is provided. Routine home care is available to members residing in an NF Medicaid certified bed.

Amount, Duration and Scope

In order to receive hospice services the member requires a physician’s certification stating that the member’s prognosis is terminal, with the member’s life expectancy not exceeding six months. Due to the uncertainty of predicting courses of illness, the hospice benefit is available beyond six months provided additional physician
certifications are completed.

The physician certification is only permitted for two 90-day periods. However, an unlimited number of physician certifications for 60 day periods are permitted thereafter.

State licensure standards for hospice care require providers to include skilled nursing, respite and bereavement services. Hospice providers must also have social services, counseling, dietary services, homemaker, personal care and home health aide services and inpatient services available as necessary to meet the member's needs. The following components are included in hospice service reimbursement when provided in approved settings:

1. Bereavement services provided by the hospice provider, which include social and emotional support, offered to the member's family both before and up to twelve months following the death of that member. There is no additional cost to AHCCCS for bereavement services provided to the family after the death of the member.

2. Continuous home care (as specified in the definition of hospice in this policy) which may be provided only during a period of crisis.

3. Dietary services, which include a nutritional evaluation and dietary counseling when necessary.

4. Home health aide services.

5. Homemaker services.

6. Nursing services provided by or under the supervision of a registered nurse.

7. Pastoral/counseling services provided by an individual who is qualified through the completion of a degree in ministry, psychology or a related field and who is appropriately licensed or certified.

8. Hospice respite care services which are provided on an occasional basis, not to exceed more than five consecutive days at a time. Respite care may not be provided when the member is a nursing facility resident or is receiving services in an inpatient setting indicated above.

9. Routine home care, as specified in the definition of hospice services.

10. Social services provided by a qualified social worker.

11. Therapies that include physical, occupational, respiratory, speech, music and recreational therapy.
12. Twenty-four hour on-call availability to provide services such as reassurance, information and referral for members and their family members or caretakers.

13. Volunteer services provided by individuals who are specially trained in hospice and who are supervised by a designated hospice employee. Under 42 C.F.R. 418.70, if providing direct patient care, the volunteer must meet qualifications required to provide such service(s).

14. Medical supplies, appliances and equipment, including pharmaceuticals, which are used in relationship to the palliation or management of the member’s terminal illness. Appliances may include durable medical equipment such as wheelchairs, hospital beds or oxygen equipment.

Refer to Chapter 1200, Policy 1250, of this Manual for further explanation regarding hospice and ALTCS members.
310-K  HOSPITAL INPATIENT SERVICES

Revision Dates:  10/01/14, 10/01/13, 10/01/12, 03/01/12, 10/01/11, 10/01/06, 10/01/01, 10/01/99

Review Date:  05/01/2011

Initial Effective Date:  10/01/1994

Description

AHCCCS covers medically necessary inpatient hospital services provided by a licensed participating hospital for all eligible members, as specified in A.A.C. R9-22, Article 2.

Amount, Duration and Scope

Inpatient hospital services for members include, but are not limited to, the following:

Hospital accommodation, and appropriate staffing, supplies, equipment and services for:

1. Routine acute medical care,
2. Intensive care and coronary care,
3. Neonatal intensive care,
4. Maternity care including labor, delivery and recovery rooms, birthing centers, and nursery and related services,
5. Nursery for newborns and infants,
6. Surgery including surgical suites and recovery rooms, and anesthesiology services,
7. Acute behavioral health emergency services,
8. Nursing services necessary and appropriate for the member's medical condition, including assistance with activities of daily living as needed,
9. Dietary services, and/or
10. Medical supplies, appliances and equipment consistent with the level of accommodation.

11. Perfusion and perfusionist services.

Ancillary Services

1. Chemotherapy,

2. Dental surgery for members in the Early and Periodic Screening, Diagnosis and Treatment Program,

3. Dialysis,

4. Laboratory services,

5. Pharmaceutical services and prescribed drugs,

6. Radiological and medical imaging services,

7. Rehabilitation services including physical, occupational and speech therapies,

8. Respiratory therapy,

9. Services and supplies necessary to store, process and administer blood and blood derivatives, and/or

10. Total parenteral nutrition.

Definition

Benefit Year – A one-year period of October 1st through September 30th.

Observation Services – A provider-ordered evaluation period in a hospital setting for services that do not meet the intensity requirements of an inpatient stay or to determine whether a person needs treatment or needs to be admitted as an inpatient.

The 25 day inpatient limit per benefit year for in State and out of State hospitals expires in contract year beginning October 1, 2014. Therefore, the 25 day inpatient limitation does not apply to inpatient claims with discharge dates on or after October 1, 2014. Refer to AHCCCS Rule R9-22-204 for more detail.
Limitations and Exclusions

For members 21 years of age or older, coverage of in-state and out-of-state inpatient hospital services is limited to 25 days per benefit year for claims with discharge dates on or before September 30, 2014. This limit applies to inpatient hospital services with dates of discharge on or before September 30, 2014 regardless of whether the member is enrolled in Fee for Service, is enrolled with one or more contractors, or both, during the benefit year.

1. For purposes of counting the annual 25 inpatient day limit:
   a. Inpatient days are counted towards the limit if paid in whole or part by the Administration or a contractor;
   b. Inpatient days will be counted toward the limit in the order of the adjudication date of a paid claim;
   c. Paid inpatient days are allocated to the benefit year in which the date of service occurs;
   d. Each 24 hours of paid observation services will count as one inpatient day if the patient is not admitted to the same hospital directly following the observation services;
   e. Observation services, which are directly followed by an inpatient admission to the same hospital are not counted towards the inpatient limit; and
   f. After 25 days of inpatient hospital services have been paid as provided for in this policy:
      i. Outpatient services that are directly followed by an inpatient admission to the same hospital, including observation services, are not covered.
      ii. Continuous periods of observation service lasting less than 24 hours that are not directly followed by an inpatient admission to the same hospital are covered.
      iii. For continuous periods of observation services of more than 24 hours that are not directly followed by an inpatient admission to the same hospital, AHCCCS will only pay for the first 23 hours of observation services.
Same Day Admit Discharge services are excluded from the 25 day limit. For additional information regarding the 25 day inpatient limit, refer to AHCCCS Rule R9-22-204.

AHCCCS covers semiprivate inpatient hospital accommodations, except when the member's medical condition requires isolation.

AHCCCS does not separately cover home-based services, such as Attendant/Personal Care, while the member is in inpatient settings.

Refer to Chapter 800 for prior authorization requirements for Fee-For-Service (FFS) providers.
310-L  HYSTERECTOMY

REVISION DATES:  07/01/2011, 10/01/06, 10/01/01, 05/01/97

REVIEW DATE:  05/01/2011

INITIAL
EFFECTIVE DATE:  10/01/1994

Description

AHCCCS covers medically necessary hysterectomy services in accordance with federal regulations 42 CFR 441.250 et seq. Federal regulations 42 CFR 441.251 defines a hysterectomy as “a medical procedure or operation for the purpose of removing the uterus.” Sterilization is defined by this regulation as “any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing.”

Amount, Duration and Scope

AHCCCS does not cover a hysterectomy procedure if:

1. It is performed solely to render the individual permanently incapable of reproducing or
2. There was more than one purpose to the procedure, it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing.

Coverage of hysterectomy services is limited to those cases in which medical necessity has been established by careful diagnosis, and, except as specified in Section B, below, prior to hysterectomy, there has been a trial of medical or surgical therapy which has not been effective in treating the member’s condition.

A. EXAMPLES OF CONDITIONS WHEN HYSTERECTOMY MAY BE INDICATED:

1. Dysfunctional Uterine Bleeding or Benign Fibroids associated with Dysfunctional Bleeding: A hysterectomy may be considered for members for whom medical and surgical therapy has failed, and childbearing is no longer a consideration.
2. **Endometriosis**: A hysterectomy is indicated for members with severe disease when future child-bearing is not a consideration, and when disease is refractory to medical or surgical therapy.

3. **Uterine Prolapse**: A hysterectomy may be indicated for the symptomatic women for whom childbearing is no longer a consideration and for whom non-operative and/or surgical correction, i.e., suspension or repair, will not provide the member adequate relief.

**B. CONDITIONS WHERE THERAPY IS NOT REQUIRED PRIOR TO Hysterectomy**

Hysterectomy services may be considered medically necessary *without prior trial of therapy* in the following cases:

1. Invasive carcinoma of the cervix
2. Ovarian carcinoma
3. Endometrial carcinoma
4. Carcinoma of the fallopian tube
5. Malignant gestational trophoblastic disease
6. Life-threatening uterine hemorrhage, uncontrolled by conservative therapy; or
7. Potentially life-threatening hemorrhage as in cervical pregnancy, interstitial pregnancy, or placenta abruption.

**C. PRIOR ACKNOWLEDGMENT AND DOCUMENTATION**

Except as described in Section D, the provider must comply with the following requirements *prior* to performing the hysterectomy:

1. Inform the member and her representative, if any, both orally and in writing that the hysterectomy will render the member incapable of reproducing i.e. result in sterility, and

2. Obtain from the member or representative, if any, a signed dated written acknowledgment stating that the information in number 1 above has been received and that the individual has been informed and understands the consequences of having a hysterectomy, i.e., that it will result in sterility. This documentation must be kept in the member's medical record. A copy must also be kept in the member's medical record maintained by the primary
care provider if enrolled with a Contractor.

The provider is not required to complete a Consent to Sterilization form prior to performing hysterectomy procedures and the 30 day waiting period required for sterilization does not apply to hysterectomy procedures described in this Policy.

D. EXCEPTIONS FROM PRIOR ACKNOWLEDGEMENT

The physician performing the hysterectomy is not required to obtain prior acknowledgment in either of the following situations:

1. The member was already sterile before the hysterectomy. In this instance the physician must certify in writing that the member was already sterile at the time of the hysterectomy and specify the cause of sterility.

2. The member requires a hysterectomy because of a life-threatening emergency situation in which the physician determines that prior acknowledgement is not possible. In this circumstance the physician must certify in writing that the hysterectomy was performed under a life-threatening emergency situation in which the physician determined that prior acknowledgement was not possible.

Contractors may elect to use the sample hysterectomy consent from for Fee-For-Service (FFS) providers found in Chapter 800 (Exhibit 820-1) or they may elect to use other formats.

Refer to Chapter 800 for prior authorization requirements for FFS providers.
### 310-M IMMUNIZATIONS

**Revision Dates:** 01/01/14, 07/01/10, 10/01/07, 10/01/06, 10/01/01

**Initial Effective Date:** 10/01/1994

**Description**

AHCCCS covers immunizations as appropriate for age, history and health risk, for adults and children.

AHCCCS follows recommendations as established by the Centers for Disease Control and Prevention (CDC) and the Advisory Committee on Immunization Practices (ACIP). Covered immunizations for adults include, but are not limited to:

1. Diphtheria-tetanus
2. Influenza
3. Pneumococcus
4. Rubella
5. Measles
6. Hepatitis-B
7. Pertussis, as currently recommended by the CDC or ACIP
8. Zoster vaccine, for members 60 and older
9. HPV vaccine, for females and males up to age 26 years. Covered immunizations for children are identified in Chapter 400.

**Amount, Duration and Scope**

Immunizations for passport or visa clearance are not covered by AHCCCS.

The AHCCCS Division of Fee-for-Service Management does not require prior authorization for medically necessary immunization services performed by FFS providers.
310-N LABORATORY

Description

AHCCCS covers medically necessary laboratory services ordered by a primary care provider, other practitioner or dentist which are ordinarily provided in Clinical Laboratory Improvement Act (CLIA) approved hospital, independent clinic, physician's office and other health care facility laboratories for all eligible members as defined in 9 A.A.C. 22, Article 2.

AHCCCS does not restrict the performance of laboratory tests to any particular lab. Any lab that has the proper CLIA certifications and is AHCCCS registered may perform laboratory tests. AHCCCS Contractors may preferentially contract with particular labs for services, provided that the lab has the necessary CLIA certifications to perform those tests.

Amount, Duration and Scope

Medically necessary diagnostic testing and screening are covered services.

Refer to the AHCCCS FFS Provider Manual for information regarding CLIA requirements for AHCCCS covered laboratory services. This Manual is available on the AHCCCS Web site (www.azahcccs.gov).

The AHCCCS Division of FFS Management does not require prior authorization for medically necessary routine non-genetic testing laboratory services performed by FFS providers.

Limitations

Genetic Testing Provisions:

All genetic testing requires prior authorization. Prior authorization requests must include documentation regarding how the genetic testing is consistent with the genetic testing coverage limitations.

Genetic testing is only covered when the results of such testing are necessary to
differentiate between treatment options. Genetic testing is not covered to determine specific diagnoses or syndromes when such diagnoses would not definitively alter the medical treatments of the member. Genetic testing is not covered to determine the likelihood of associated medical conditions occurring in the future. Routine, non-genetic testing for other medical conditions (e.g., renal disease, hepatic disease, etc.) that may be associated with an underlying genetic condition is covered when medically necessary.

Genetic testing is not covered as a substitute for ongoing monitoring or testing of potential complications or sequelae of a suspected genetic anomaly. Genetic testing is not a covered service for purposes of determining current or future family planning.

Genetic testing is not covered to determine whether a member carries a hereditary predisposition to cancer or other diseases. Genetic testing is also not covered for members diagnosed with cancer to determine whether their particular cancer is due to a hereditary genetic mutation known to increase the risks of developing that cancer.
310-O  MATERNAL AND CHILD HEALTH SERVICES

Revision Dates:  10/01/06, 10/01/01

Review Date:  05/01/2011

Initial Effective Date:  10/01/1994

Description

AHCCCS covers a comprehensive set of services for pregnant women, newborns and children, including maternity care, family planning services and services provided through the Early and Periodic Screening, Diagnosis and Treatment Program.

Refer to Chapter 400 for a complete discussion of covered maternal and child health services.
310-P  MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT AND ORTHOTIC/PROSTHETIC DEVICES

REVISION DATES:  08/01/15, 12/15/14, 10/01/14, 01/01/14, 10/01/10, 01/01/07, 02/01/07,
  10/01/06, 03/03/06, 04/01/04, 10/01/01, 06/01/01, 10/01/95

INITIAL
EFFECTIVE DATE:  10/01/1994

Description

AHCCCS covers reasonable and medically necessary medical supplies, Durable Medical Equipment (DME) and orthotic/prosthetic devices when ordered by a primary care provider or practitioner within certain limits based on member age and eligibility, as specified in 9 A.A.C. 22, Article 2. For the purposes of this policy, medical supplies are consumable items that are designed specifically to meet a medical purpose. DME means sturdy, long lasting items and appliances that can withstand repeated use, are designed to serve a medical purpose and are not generally useful to a person in the absence of a medical condition, illness or injury. Prosthetics are devices prescribed by a physician or other licensed practitioner to artificially replace a missing, deformed or malfunctioning portion of the body. Orthotics is an AHCCCS covered service, within certain limitations, to support a weak, injured, or deformed portion of the body, pursuant to Laws 2015, Chapter 264, Section 3 (HB 2373) and as specified in §36-2907. Prosthetics are covered when medically necessary for rehabilitation.

DME is used to assist members in optimizing their independence and maintaining placement in the most integrated setting. This may include an institutional setting as appropriate. An example for the institutional setting is the authorization of customized medical devices such as wheelchairs. Criteria for the authorization of a customized wheelchair must be the same regardless of setting as each setting is considered the member’s home.

Personal care items include items of personal cleanliness, hygiene and grooming and are generally not covered unless needed to treat a medical condition.

Amount, Duration and Scope

Examples of medically necessary medical supplies, durable medical equipment and orthotic/prosthetic devices are:
1. Medical supplies – such as incontinence briefs, surgical dressings, splints, casts and other consumable items, which are not reusable, and are designed specifically to meet a medical purpose.

2. Durable equipment – such as wheelchairs, walkers, hospital beds, and other durable items that are rented or purchased.

3. The Contractor shall provide orthotic devices for members as described below:
   a. Orthotics are covered for AHCCCS members under the age of 21 as outlined in Policy 430, *EPSDT Services*.
   b. Orthotics are covered for AHCCCS members 21 years of age and older if all of the following apply:
      i. The use of the orthotic is medically necessary as the preferred treatment option consistent with Medicare Guidelines.
      ii. The orthotic is less expensive than all other treatment options or surgical procedures to treat the same diagnosed condition.
      iii. The orthotic is ordered by a Physician or Primary Care Practitioner.

4. Prosthetic devices – such as artificial upper and lower limbs.

**Coverage Determinations**

The Contractor must make timely determinations of coverage. The Contractor must not refuse to render a timely determination based on the member’s dual eligibility status or the providers’ contract status with the Contractor. If a dual eligible member resides in a nursing facility, the prior authorization request must not be denied on the basis that Medicare is responsible for coverage of DME.

A. General requirements

The following criteria must be used in determining coverage of medically necessary services:

1. Setting up and/or maintaining the member in the most appropriate setting while maximizing the member’s independence and functional level both physically and mentally, and

2. Authorizing the most reasonable and cost effective alternative in the most appropriate setting while maximizing the member’s independence.

Medical equipment may be purchased or rented only when there are no reasonable alternative resources from which the medically necessary medical
equipment can be obtained at no cost. Additionally, the total expense of rental cannot exceed the purchase price of the item.

Rental fees must terminate no later than the end of the month in which the member no longer needs the medical equipment, or when the member is no longer eligible or enrolled with a Contractor, except during transitions as specified by the AHCCCS Chief Medical Officer or designee.

Reasonable repairs or adjustment of purchased medical equipment are covered when necessary to make the equipment serviceable and when the cost of the repair is less than the cost of rental or purchase of another unit.

B. Requirements for specific services

1. Incontinence Briefs for Members 21 years of age and older

Incontinence briefs, including pull-ups and incontinence pads, are covered when necessary to treat a medical condition. Contractors may require prior authorization.

For ALTCS members 21 years of age and older, incontinence briefs, including pull-ups and incontinence pads, are also covered in order to prevent skin breakdown when all the following are met:

   a. The member is incontinent due to a documented medical condition that causes incontinence of bowel and/or bladder,

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

   c. Incontinence briefs – including pull-ups and incontinence pads – do not exceed 180 in any combination per month, unless the prescribing physician presents evidence of medical necessity for more than 180 per month,

   d. The member obtains incontinence briefs from vendors within the Contractor’s network, AND

   e. Prior authorization has been obtained if required by the Administration, Contractor, or Contractor’s designee, as appropriate. Contractors shall not require a new prior authorization to be issued more frequently than every twelve months.
2. Incontinence Briefs for Members under the Age of 21 Years

   a. AHCCCS covers incontinence briefs when necessary to treat a medical condition. In addition, AHCCCS also covers incontinence briefs for preventative purposes for members over the age of three and under 21 years of age as described in Policy 430.

3. Orthotics Limitations

   a. Reasonable repairs or adjustments of purchased orthotics are covered for all members to make the orthotic serviceable and/or when the repair cost is less than purchasing another unit. The component will be replaced if, at the time authorization is sought, documentation is provided to establish that the component is not operating effectively.

4. Lower Limb Prosthetics

   The following applies for members 21 years of age and older regarding coverage for lower limb prosthetics:

   a. Factors for coverage of a lower limb prosthetic include but are not limited to:

      i. Consideration of the member’s:

         • Past history (including prior prosthetic use, if applicable)
         • Current condition (including status of the residual limb and the nature of other medical problems)
         • Degree of motivation to ambulate with a prosthesis, and

      ii. Assessment of the member’s functional level as described below (please note that within the functional classification hierarchy, bilateral amputees often cannot be strictly bound by functional level classifications):

         • Level 0: Does not have the ability or potential to ambulate or transfer safely with or without assistance and prosthesis. Does not enhance their quality of life or mobility.
         • Level 1: Has the ability or potential to use prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulator.
         • Level 2: Has the ability or potential for ambulation with the ability to traverse low-level environmental barriers such as curbs, stairs or uneven surfaces. Typical of the limited community ambulator.
         • Level 3: Has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may
have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.

- Level 4: Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete.

a. Limitations (Lower Limb Prosthesis):
   
   i. Lower limb prosthesis is not considered medically necessary for members with a functional level of zero.
   
   ii. If more than one prosthetic device can meet the enrollee’s functional needs, benefits are only available for the prosthetic device that meets the minimum specifications for the member’s needs.
   
   iii. Microprocessor controlled lower limb or microprocessor-controlled joints for lower limbs are not covered for members 21 years of age and older.

C. AHCCCS does not cover the following items:

1. Personal care items when not medically necessary to treat a medical condition except as otherwise specified for incontinence briefs pursuant to Policy 310-P, Policy 430, Policy 1240, and AHCCCS Rules,

2. First aid supplies (except under a prescription),

3. Hearing aids for members who are 21 years of age and older,

4. Prescriptive lenses for members who are 21 years of age and older (except if medically necessary following cataract removal), and/or

5. Penile implants or vacuum devices for AHCCCS members who are 21 years of age or older.

D. As of 10/1/2010 per A.R.S. 36-2907, the following prosthetics are not covered for members 21 years of age and older:

1. Bone Anchored Hearing Aids (BAHA), also known as osseointegrated implants

2. Cochlear implants

3. Percussive vests
E. Equipment Maintenance and Repair

Equipment maintenance and repair of component parts will continue for orthotics and the prosthetic devices listed in Section A. Components will be replaced if at the time authorization is sought documentation is provided to establish that the component is not operating effectively.

F. Non-covered prosthetic/orthotic devices are not included when determining whether an inpatient stay qualifies as an outlier. If an inpatient stay does qualify as an outlier without considering charges for non-covered devices, the charges for those devices are not included in the outlier payment calculations.

Refer to Policy 430 for further information related to EPSDT.

Refer to Chapter 800 for prior authorization requirements for FFS providers.

Refer to Chapter 1200 for further information related to ALTCS and HCBS.
310-Q  NON-PHYSICIAN SURGICAL FIRST ASSISTANT SERVICES

REVISION DATES:  07/01/08, 10/01/06, 04/01/04, 10/01/01, 10/01/95

REVIEW DATE:       07/01/2011

INITIAL

EFFECTIVE DATE:  10/01/1994

Description

AHCCCS will cover services provided by non-physician surgical first assistants who are licensed in Arizona as a physician’s assistant or registered nurse, and who are registered as an AHCCCS provider to render non-physician surgical first assistant services. The provider must furnish documentation of compliance with the following requirements:

1. Each non-physician surgical first assistant provider must have the sponsorship of an Arizona-licensed physician, and receive supervision from the physician as required under their scope of practice.

2. Non-physician surgical first assistant services must be provided under the supervision of a physician surgeon licensed to practice in Arizona and registered with AHCCCS as a provider.

3. Providers of non-physician surgical first assistant services must hold liability insurance which meets or exceeds limits required for AHCCCS registration.

4. Providers must be currently certified in advanced cardiac life support and CPR, and

5. Non-physician surgical first assistants must be an Arizona licensed registered nurse, or an Arizona licensed physician’s assistant, or an Arizona licensed nurse practitioner and meet the appropriate requirements listed below.

   a. Currently licensed in Arizona as a registered nurse and meet one of the following two requirements:

      i. Hold a Registered Nurse First Assistant Certification (CRNFA) issued by the competency & credentialing institute, or

      ii. Meet the requirements for CRNFA certification excluding the 2,000 hours of practice as an RNFA. Applicants will demonstrate that they meet this requirement by the following:
a) Completion of an acceptable formal RNFA program which meets the specific criteria and is recognized by CCI as an acceptable program for CRNFA eligibility. It is the applicant's responsibility to provide a certificate of completion demonstrating that the applicant has completed the RNFA program.

b) Must be a CNOR (Certified Nurse Operating Room).

c) Must hold a BSN or MSN degree.

b. Currently licensed in Arizona to practice as a physician's assistant.

Physician's assistants must provide services under the supervision of their supervising physician or a supervising physician agent who has been approved by the Arizona Joint Board on the Regulation of Physician Assistants as stipulated within their scope of practice and required by law.

c. Currently licensed in Arizona as a nurse practitioner with appropriate surgical first assistant training.

Amount, Duration and Scope

The non-physician surgical first assistant is governed by professional guidelines as determined by their licensing and/or certifying agency and the medical staffing bylaws of the facility where services are provided. Any non-physician surgical first assistant who has had his/her professional license suspended or revoked is ineligible for registration for this provider type or AHCCCS coverage for services.
310-R  NURSING FACILITY (NF) SERVICES

Description

AHCCCS covers medically necessary services provided in nursing facilities for those acute care program members who need nursing care 24 hours a day, but who do not require hospital care under the daily direction of a physician. NF service providers must be State licensed and Medicare certified. Religious nonmedical health care institutions are exempt from licensure or certification requirements.

The Arizona Long Term Care System (ALTCS) offers more extensive coverage of NF services for members. Refer to Chapter 1200 for information regarding ALTCS covered services. In lieu of NF services, the member may be placed in an alternative Home and Community Based Setting (HCBS), or may receive home and community based services in their home, as defined in the Arizona Administrative Code R9-22, Article 2 and R9-28, Article 2.

Amount, Duration and Scope

AHCCCS covers up to 90 days of NF services per contract year (generally October 1 through September 30) for members who have not been determined eligible for ALTCS. The following criteria apply:

1. The medical condition of the member must be such that if NF services are not provided, hospitalization of the individual will result or the treatment is such that it cannot be administered safely in a less restrictive setting, i.e., home with home health services.

2. The 90 days of coverage is per member, per contract year, and does not begin again if the member transfers to a different NF. Acute care members residing in a NF at the beginning of a new contract year begin a new 90-day coverage period. Unused days do not carry over. See the table below for examples.

3. The 90 days of AHCCCS acute care coverage for NF services begins on the day of admission regardless of whether the member is insured by a third
party insurance carrier, including Medicare. (Refer to the AHCCCS Contractor Operations Manual, Policies 201 regarding member cost sharing.)

4. If the member has applied for ALTCS and a decision is pending, the acute care Contractor must notify the ALTCS Eligibility Administrator (Mail Drop 2600) when the member has been residing in a NF for 45 days. This will allow for time to follow-up on the status of the ALTCS application. If the member becomes ALTCS eligible and is enrolled with an ALTCS Contractor before the end of the maximum 90 days of NF coverage, the acute care Contractor is only responsible for NF coverage during the time the member is enrolled with the acute care Contractor. The NF must coordinate with the member or representative on alternative methods of payment for continuation of services beyond the 90 days covered by the acute care Contractor until the member is enrolled in the ALTCS program, or until the beginning of the new contract year.

<table>
<thead>
<tr>
<th>MEMBER A</th>
<th>Admitted January 15</th>
<th>Discharged April 3</th>
<th>79 days. 11 days of NF services remain available through September 30.</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEMBER B</td>
<td>Admitted January 15</td>
<td>Still in NF April 14</td>
<td>90 days. NF should have contacted member's Contractor at least 15 days before to discuss alternatives. Contractor should have contacted AHCCCS by Day 60 regarding ALTCS application.</td>
</tr>
<tr>
<td>MEMBER C</td>
<td>Admitted July 3</td>
<td>Still in NF September 30</td>
<td>89 days, but new contract year begins October 1. 90 days begin again.</td>
</tr>
</tbody>
</table>

**NOTE:** For most, but not all, AHCCCS Contractors, the contract year runs from October 1<sup>st</sup> through September 30<sup>th</sup>. Providers should contact the member's Contractor for verification of contract dates and any discussion needed regarding the member's stay.

**Limitations**

Services that are not covered separately by Acute Care or ALTCS Contractors when provided in a NF include:

1. Nursing services, including:
   a. Administration of medication
b. Tube feedings

c. Personal care services

d. Routine testing of vital signs and blood glucose monitoring

e. Assistance with eating, and/or

f. Maintenance of catheters.

2. Basic patient care equipment and sickroom supplies such as bedpans, urinals, diapers, bathing and grooming supplies, walkers and wound dressings or bandages

3. Dietary services including, but not limited to, preparation and administration of special diets, and adaptive tools for eating

4. Administrative physician visits made solely for meeting State certification requirements

5. Non-customized durable equipment and supplies such as manual wheelchairs, geriatric chairs, and bedside commodes

6. Rehabilitation therapies ordered as a maintenance regimen

7. Administration, Medical Director services, plant operations and capital

8. Over-the-counter medications and laxatives

9. Social activity, recreational and spiritual services, or

10. Any other services, supplies or equipment that are State or County regulatory requirements or are included in the NF’s room and board charge.

Refer to Chapter 800 for PA requirements for FFS providers.
CHAPTER 300
MEDICAL POLICY FOR AHCCCS COVERED SERVICES

POLICY 310
COVERED SERVICES

310-S  OBSERVATION SERVICES

Revision Dates: 03/01/12, 01/01/12, 11/01/11, 10/01/11, 09/01/09, 10/01/06, 10/01/01, 07/22/96

Initial Effective Date: 10/01/1994

Description

Observation services are those reasonable and necessary services provided on a hospital's premises for evaluation to determine whether the member should be admitted for inpatient care, discharged or transferred to another facility. Observation services include: the use of a bed, periodic monitoring by a hospital's nursing or, if appropriate, other staff necessary to evaluate, stabilize or treat medical conditions of a significant degree of instability and/or disability on an outpatient basis.

It is not Observation when a member with a known diagnosis enters a hospital for a scheduled procedure/treatment that is expected to keep the member in the hospital for less than 24 hours (this is an outpatient procedure, regardless of the hour in which the member presented to the hospital, whether a bed was utilized or whether services were rendered after midnight).

Extended stays after outpatient surgery must be billed as recovery room extensions.

Amount, Duration and Scope

Observation must be ordered in writing by a physician, or other individual authorized by hospital staff bylaws, to admit patients to the hospital or to order outpatient diagnostic tests or treatments. There is no maximum time limit for observation services as long as medical necessity exists. The medical record must document the basis for observation services.

A. FACTORS THAT MUST BE TAKEN INTO CONSIDERATION BY THE PHYSICIAN OR AUTHORIZED INDIVIDUAL WHEN ORDERING OBSERVATION:

1. Severity of the signs and symptoms of the member

2. Degree of medical uncertainty that the member may experience an adverse occurrence

3. Need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the member to remain at the hospital
for 24 hours or more) to assist in assessing whether the member should be admitted

4. The availability of diagnostic procedures at the time and location where the member presents

5. It is reasonable, cost effective and medically necessary to evaluate a medical condition or to determine the need for inpatient admission, and

6. Length of stay for Observation is medically necessary for the member's condition.

B. REQUIRED MEDICAL RECORD DOCUMENTATION

The following are required for documenting medical records:

1. Orders for Observation must be written on the physician's order sheet, not the emergency room record, and must specify, "Observation." Rubber stamped orders are not acceptable

2. Follow-up orders must be written within the first 24 hours, and at least every 24 hours if Observation is extended.

3. Changes from "Observation to inpatient" or "inpatient to Observation" must be made per physician order.

4. Inpatient/outpatient status change must be supported by medical documentation.

C. LIMITATIONS

The following services are not AHCCCS covered Observation services:

1. Substitution of Observation services for physician ordered inpatient services

2. Services that are not reasonable, cost effective and necessary for diagnosis or treatment of member

3. Services provided solely for the convenience of the member or physician

4. Excessive time and/or amount of services medically required by the condition of the member
5. Services customarily provided in a hospital-based outpatient surgery center and not supported by medical documentation of the need for Observation.

Refer to Chapter 800 for prior authorization and utilization management requirements for Fee-For-Service (FFS) providers.

Refer to Policy 310-K, Hospital Inpatient Services, for further guidance regarding observation services for members who have received greater than 25 inpatient days.
310-T  PHYSICIAN SERVICES

REVISION DATES:  09/01/15, 10/01/13, 08/01/11, 10/01/09, 06/01/06, 10/01/01, 10/01/97

INITIAL EFFECTIVE DATE:  10/01/1994

Description

AHCCCS covers physician services for all members within certain limits based on member age and eligibility. Physician services include medical assessment, treatment, and surgical services performed in the office, clinic, hospital, home, nursing facility or other location by a licensed doctor of medicine or osteopathy.

Amount, Duration and Scope

Physician services are covered as appropriate to the member's medical need and the physician's scope of practice. Refer to Chapter 400, Policy 430, for criteria related to covered services for members under the age of 21.

Physical examinations and well visits for members to determine risk of disease; provide early detection and to establish a prevention or treatment plan for the member as well as annual periodic examinations to monitor health status are covered.

Limitations

- Services Not Directly Related to Medical Care - AHCCCS does not cover physician services routinely performed and not directly related to the medical care of a member (e.g., physician visits to a nursing facility for the purpose of 30-60 day certification).

- Moderate Sedation – AHCCCS does not cover moderate sedation (i.e., conscious sedation) performed by the physician performing the underlying procedure for which sedation is desired, or by another provider except as described below, for the adult population. Refer to Chapter 400, Policy 430, for criteria related to coverage of conscious sedation for members under the age of 21.

AHCCCS does cover monitored anesthesia care, including all levels of sedation, provided by qualified anesthesia personnel (physician anesthesiologist or certified registered nurse anesthetist) for the adult population and members under the age of 21. Anesthesia services (except epidurals) require the continuous presence of the anesthesiologist or certified
registered nurse anesthetist.

- **Allergy Immunotherapy** – Allergy immunotherapy including desensitization treatments administered via subcutaneous injections (allergy shots), sublingual immunotherapy (SLIT) or via other routes of administration, is not covered for persons age 21 years and older. Therefore, it is an excluded service for these members. Allergy immunotherapy is covered for persons under the age of 21 under EPSDT when medically necessary. Refer to Chapter 400 for additional information.

**Exceptions**

- **Allergy Testing** – Allergy testing, including testing for common allergens is not covered for persons age 21 years and older unless the member has either sustained an anaphylactic reaction to an unknown allergen or has exhibited such a severe allergic reaction (e.g., severe facial swelling, breathing difficulties, epiglottal swelling, extensive [not localized] urticaria, etc.) where it is reasonable to assume further exposure to the unknown allergen may result in a life-threatening situation. In the above instances, allergy testing is covered to identify the unknown allergen where such identification may help the member avoid repeat exposures to that particular allergen. Allergy testing is covered for persons under the age of 21 under EPSDT when medically necessary. Refer to Chapter 400 for additional information.

- **Self-administered epinephrine** – Self-administered epinephrine is covered for all members with a history of previous severe allergic reactions, whether or not the specific cause of that reaction has been identified.

For prescription medication coverage exceptions, please refer to Policy 310-V, *Prescription Medication/Pharmacy Services*.

- **Medical Marijuana** – AHCCCS does not cover an office visit or any other services that are primarily for determining if a member would benefit from medical marijuana. Refer to Policy 320-M, *Medical Marijuana*.

**Genetic Subspecialists**

Genetic subspecialists are subject to the limitations described in Policy 310-N, *Laboratory, Genetic Testing Provisions* subsection.

Refer to [Chapter 800](#) for prior authorization requirements for FFS providers.
310-U  FOOT AND ANKLE SERVICES

Revision Dates: 10/01/10, 11/01/06, 10/01/01

Initial Effective Date: 10/01/1994

Description

AHCCCS covers medically necessary foot and ankle care, including reconstructive surgeries, when ordered by a member’s primary care provider, attending physician or practitioner, within certain limits, for eligible members.

Definition

Routine Foot Care – Those services performed in the absence of localized illness, injury or symptoms involving the foot are considered routine foot care. Routine foot care is considered medically necessary in very limited circumstances as described in this Policy. These services include:

1. The cutting or removal of corns or calluses
2. The trimming of nails (including mycotic nails), and
3. Other hygienic and preventive maintenance care in the realm of self-care (such as cleaning and soaking the feet, and the use of skin creams to maintain skin tone of both ambulatory and bedfast patients).

Amount, Duration and Scope

Coverage includes medically necessary foot and ankle care such as wound care and treatment of pressure ulcers. Foot and ankle care also includes fracture care, reconstructive surgeries, and limited bunionectomy services.

Routine foot care is considered medically necessary when the member has a systemic disease of sufficient severity that performance of foot care procedures by a nonprofessional person would be hazardous. Conditions that might necessitate medically necessary foot care include metabolic, neurological and peripheral vascular systemic diseases. Examples include, but are not limited to:

1. Arteriosclerosis obliterans (arteriosclerosis of the extremities, occlusive peripheral arteriosclerosis)
2. Buerger's disease (thromboangiitis obliterans)

3. Chronic thrombophlebitis

4. Diabetes mellitus

5. Peripheral neuropathies involving the feet

6. Member receiving chemotherapy

7. Pernicious Anemia

8. Hereditary disorder, i.e., hereditary sensory radicular neuropathy, Fabry's disease

9. Hansen's disease or neurosyphilis

10. Malabsorption syndrome

11. Multiple sclerosis

12. Traumatic injury

13. Uremia (chronic renal disease)

14. Anticoagulation therapy

Treatment of a fungal (mycotic) infection is considered medically necessary foot care and is covered in the following circumstances:

1. A systemic condition, and

2. Clinical evidence of mycosis of the toenail, and

3. Compelling medical evidence documenting the member either:
   a. has a marked limitation of ambulation due to the mycosis which requires active treatment of the foot, or
   b. in the case of a nonambulatory member, has a condition that is likely to result in significant medical complications in the absence of such treatment.
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Limitations

1. Coverage for medically necessary routine foot care must not exceed two visits per quarter or eight visits per contract year (this does not apply to Early and Periodic Screening, Diagnosis and Treatment [EPSDT] members).

2. Coverage of mycotic nail treatments will not exceed one bilateral mycotic nail treatment (up to ten nails) per 60 days (this does not apply to EPSDT members).

3. Neither general diagnoses such as arteriosclerotic heart disease, circulatory problems, vascular disease, venous insufficiency or incapacitating injuries or illnesses such as rheumatoid arthritis, CVA (stroke) or fractured hip are diagnoses under which routine foot care is covered.

4. Services are not covered for members 21 years of age or older, when provided by a podiatrist or podiatric surgeon.

Bunionectomy - Bunionectomies are covered only when the bunion is present with:

1. Overlying skin ulceration, or

2. Neuroma secondary to bunion (neuroma to be removed at same surgery and documented by pathology report).

Bunionectomies are not covered if the sole indications are pain and difficulty finding appropriate shoes.

Refer to Chapter 800 for prior authorization requirements for FFS providers.
310-V  PRESCRIPTION MEDICATIONS/PHARMACY SERVICES

Definitions

**Biosimilar** refers to a biological drug that is approved by the FDA based on a showing that it is highly similar to an FDA-Approved biological drug, known as the reference product, and has no clinically meaningful differences in terms of safety and effectiveness from the reference product.

**Generic Drug** is a drug that contains the same active ingredient(s) as a brand name drug and the FDA has approved it to be manufactured and marketed after the brand name drugs patent expires.

**Non-Preferred Drug** is a drug that has been determined to have an alternate drug available on the AHCCCS Drug List that is therapeutically similar and more cost-effective than the non-preferred drug.

**Pharmacy and Therapeutics (P&T) Committee** is the advisory committee to AHCCCS responsible for developing, managing, updating, and administering the AHCCCS Drug List. The P&T Committee is primarily comprised of physicians, pharmacists, nurses and other health care professionals.

**Preferred Drug** means a medication that has been clinically reviewed and approved by the AHCCCS P&T Committee for inclusion on the AHCCCS Drug List as a preferred drug due to its proven clinical efficacy and cost effectiveness.

**AHCCCS Drug List** is defined as the list of specific medications and related products supported by current evidence-based medicine, health care clinicians and other experts. The primary purpose of the AHCCCS Drug List is to encourage the use of safe, effective, clinically appropriate, and the most cost-effective medications.

**Step Therapy** refers to the practice of initiating drug therapy for a medical condition with the most cost-effective and safest drug, and stepping up through a sequence of alternative drug therapies as a preceding treatment option fails.

Description

Medically necessary, cost-effective, and federally reimbursable medications prescribed by a physician, physician’s assistant, nurse practitioner, dentist or other AHCCCS
registered practitioner and dispensed by an AHCCCS registered licensed pharmacy are covered for members, as defined in Arizona Administrative Code 9 A.A.C. 22, Article 2.

**Amount, Duration and Scope**

**A. The AHCCCS Drug List**

The AHCCCS Pharmacy and Therapeutics (P&T) Committee is responsible for developing, managing, and updating the AHCCCS Drug List to assist providers in selecting clinically appropriate and cost-effective drugs for AHCCCS members. The AHCCCS P&T Operational Policy can be located at:


Each Contractor is required to maintain their own drug list to meet the unique needs of the members they serve; at a minimum, the Contractor’s drug list must have all the drugs that are listed on the AHCCCS Drug List as further detailed below. The AHCCCS Drug List is not an all-inclusive list of medications for AHCCCS members. Contractors are required to cover all medically necessary, clinically appropriate, and cost-effective medications that are federally reimbursable.

1. **Preferred Drugs**

The AHCCCS Drug List specifies medications that are preferred drugs for specific therapeutic classes. Contractors are required to list preferred drugs on their drug lists exactly as they are listed on the AHCCCS Drug List. Contractors shall not add other drugs to therapeutic classes on their drug list when the AHCCCS Drug List has a preferred drug(s) in the therapeutic class.

Contractors shall communicate the AHCCCS Drug List’s preferred drugs to their pharmacy benefit managers and require point-of-sale edits that communicate the preferred drug of a therapeutic class to the pharmacy when a claim is submitted for a drug other than the preferred drug. Preferred drugs, recommended by the AHCCCS P&T Committee and approved by AHCCCS, will become effective on the first day of the first month of the quarter following the P&T Meeting unless otherwise communicated by AHCCCS.

Contractors shall approve preferred drugs for medication classes listed on the AHCCCS Drug List before considering approval of non-preferred drugs. However, Contractors shall approve non-preferred drugs when:

- The member has previously completed step therapy using the preferred drug(s), or
- The member’s prescribing clinician supports the medical necessity of the
non-preferred drug over the preferred drug for the particular member.

Contractors are not required to provide a Notice of Action when the prescribing clinician is in agreement with the change to the preferred drug. A prior authorization may be submitted for the non-preferred drug when the prescribing clinician is not in agreement with the transition to the preferred drug. Contractors shall issue a Notice of Action in accordance with AHCCCS Contractor Operations Manual (ACOM) Chapter 414 – Notices of Action for Service Authorizations when a prior authorization is denied.

2. **Grandfathering of Non-preferred Drugs**

Grandfathering of non-preferred drugs refers to the continued coverage of non-preferred drugs that members are currently utilizing without a trial of the preferred drug(s) on the AHCCCS Drug List.

The AHCCCS P&T Committee shall make recommendations to AHCCCS on the grandfathering status of each non-preferred drug for each therapeutic class reviewed by the committee.

3. **Prior-Authorization**

The AHCCCS Drug List specifies which medications require prior-authorization (PA). For therapeutic classes that indicate preferred drugs that require PA prior to dispensing, Contractors must list the preferred drug with PA exactly as it is listed on the AHCCCS Drug List. For therapeutic classes that do not contain preferred drugs, Contractors may be less restrictive but not more restrictive with PA requirements.

**Federally reimbursable drugs not listed on the AHCCCS Drug List or on Contractors’ drug lists must be available through the prior authorization process.**

Prior authorization requests submitted for review must be evaluated for clinical appropriateness based on the strength of the scientific evidence and standards of practice that include, but are not limited, to the following:

a. Food and Drug Administration (FDA) approved indications and limits,
b. Published practice guidelines and treatment protocols,
c. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes,
d. Drug Facts and Comparisons,
e. American Hospital Formulary Service Drug Information,
f. United States Pharmacopeia – Drug Information,
g. DRUGDEX Information System,

h. UpToDate, and/or

i. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies.

A non-FDA indication shall not be the sole basis of denial, as off-label prescribing may be clinically appropriate as outlined above in b. through i.

Prescribing clinicians must submit a prior authorization request to the Contractor, or as applicable to the Contractor’s Pharmacy Benefit Manager (PBM), for review and coverage determination.

With the exception of smoking cessation and hepatitis C medications, the Contractors are responsible for creating and maintaining their own prior authorization criteria.

4. Requests for Changes to the AHCCCS Drug List

Requests for medication additions, deletions or other AHCCCS Drug List changes for review at the AHCCCS P&T Committee must include the following information:

a. Name of medication requested (brand name and generic name),

b. Dosage forms, strengths and corresponding costs of the medication requested,

c. Average daily dosage,

d. FDA indication and accepted off–label use,

e. Advantages or disadvantages of the medication over currently available products on the AHCCCS Drug List,

f. Adverse effects reported with the medication,

gh. Specific monitoring requirements and costs associated with these requirements, and

h. A detailed clinical summary.

Requests may be submitted to the AHCCCS Pharmacy Department email at AHCCCSSPharmacyDept@azahcccs.gov.
5. Other

The Contractor must specify quantity limits and step therapy exactly as they are listed on the AHCCCS Drug List. Contractors may utilize step therapy for additional therapeutic classes not listed on the AHCCCS Drug List with the exception of therapeutic classes which contain preferred drugs.

Step Therapy programs apply coverage rules at the point of service when a claim is adjudicated. If a claim is submitted for a second-line drug and the step therapy rule requiring the use of a first-line drug was not met, the claim is rejected, and a message is transmitted to the pharmacy indicating that the first-line drug treatment that must be tried before coverage of the second-line drug can be authorized unless there is a clinical justification not to use the first line drug.

Contractors are not required to provide a Notice of Action when the prescribing clinician is in agreement with the change to the first-line drug. A prior authorization may be submitted for the second-line drug when the prescribing clinician is not in agreement with the transition request to the first-line drug. Contractors shall issue a Notice of Action in accordance with AHCCCS Contractor Operations Manual (ACOM) Chapter 414 – Notices of Action for Service Authorizations when a prior authorization request is denied.

B. GENERIC AND BIOSIMILAR DRUG SUBSTITUTIONS

1. Contractors must utilize a mandatory generic drug substitution policy that requires the use of a generic equivalent drug whenever one is available. The exceptions to this requirement are:

   a. A brand name drug can be covered when a generic equivalent is available when the Contractor’s negotiated rate for the brand name drug is equal to or less than the cost of the generic drug.

   b. AHCCCS may require Contractors to provide coverage of a brand name drug when the cost of the generic drug has an overall negative financial impact to the state. The overall financial impact to the state includes consideration of the federal and supplemental rebates.

2. Prescribing clinicians must clinically justify the use of a brand-name drug over the use of its generic equivalent through the prior authorization process.

3. Generic and biosimilar substitutions shall adhere to Arizona State Board of Pharmacy rules and regulations.
4. AHCCCS Contractors shall not transition to a biosimilar drug until AHCCCS has determined that the biosimilar drug is overall more cost-effective to the state than the continued use of the brand name drug.

C. Behavioral Health Medication Coverage

The Arizona Department of Health Services, Division of Behavioral Health Services, through the RBHA, manages the Behavioral Health Drug List.

1. Behavioral Health Medication Coverage for Fee-For-Service and Acute Care members transitioning to a T/RBHA

The AHCCCS Administration and its Contractors shall provide coverage for medically necessary, cost-effective, and federally reimbursable behavioral health medications until such time that the member transitions to a Tribal or Regional Behavioral Health Authority (T/RBHA). The AHCCCS Contractor and T/RBHA are responsible for coordinating care to ensure that the member’s behavioral health medications are continued during this transition.

2. Behavioral Health Medications Prescribed by the Primary Care Provider (PCP) for the Treatment of Anxiety, Depression and Attention Deficit Hyperactivity Disorder (ADHD)

The AHCCCS Contractors shall provide coverage for medically necessary, cost-effective, and federally reimbursable behavioral health medications prescribed by a PCP when used to treat depression (including postpartum depression), anxiety and ADHD; this includes the monitoring and adjustments of behavioral health medications. The Contractor’s drug list must include medications for the treatment of these disorders.

3. Behavioral Health Medication Coverage for AHCCCS members transitioning from a Behavioral Health Medical Professional (BHMP) to a PCP.

Members transitioning from an BHMP to a PCP for their behavioral health medication management shall be continued on the medication(s) prescribed by the BHMP until they can transition to their PCP. The AHCCCS Contractors and RBHA must coordinate the care and ensure that the member has a sufficient supply of behavioral health medications to last through the date of the member’s first appointment with their PCP. Members receiving behavioral health medications from their PCP may simultaneously receive counseling and other medically necessary services from the RBHA.
4. Behavioral Health Medication Coverage for Members Enrolled in the Comprehensive Medical and Dental Program (CMDP), Children's Rehabilitative Services (CRS) and Arizona Long Term Care System (ALTCS) Programs

CMDP and Division of Developmental Disabilities (DDD) members who are not receiving any CRS services shall receive behavioral health services and medications through the T/RBHAs. CMDP and DDD members receiving CRS services shall receive behavioral health services and medications through the AHCCCS CRS Contractor. ALTCS E/PD members shall receive behavioral health services and medications through their ALTCS E/PD Contractor.

D. OVER-THE-COUNTER MEDICATION

Contractors may cover an over-the-counter medication under the pharmacy benefit when it is prescribed in place of a covered prescription medication that is clinically appropriate, equally safe and effective, and less costly than the covered prescription medication.

E. PRESCRIPTION DRUG COVERAGE LIMITATIONS

1. A new prescription or refill prescription in excess of a 30-day supply or a 100-unit dose is not covered unless:

   a. The medication is prescribed for chronic illness and the prescription is limited to no more than a 100-day supply or 100-unit dose, whichever is greater;

   b. The member will be out of the provider’s service area for an extended period of time and the prescription is limited to the extended time period, not to exceed 100 days or 100-unit dose, whichever is greater; or

   c. The medication is prescribed for contraception and the prescription is limited to no more than a 100-day supply.

2. Prescription drugs for covered transplantation services will be provided in accordance with AHCCCS transplantation policies.

3. AHCCCS covers the following for AHCCCS members who are eligible to receive Medicare:

   a. Over-the-counter medications that are not covered as part of the Medicare Part D prescription drug program and meet the requirements in section D of this policy.
F. AHCCCS Pharmacy Benefit Exclusions

1. Medication prescribed for the treatment of a sexual or erectile dysfunction, unless prescribed to treat a condition other than a sexual or erectile dysfunction and the Food and Drug Administration has approved the medication for the specific condition.

2. Medications that are personally dispensed by a physician, dentist or other provider except in geographically remote areas where there is no participating pharmacy or when accessible pharmacies are closed.

3. Drugs classified as Drug Efficacy Study Implementation (DESI) drugs by the Food and Drug Administration.

4. Outpatient medications for members under the Federal Emergency Services Program.


6. Drugs eligible for coverage under Medicare Part D for AHCCCS members eligible for Medicare whether or not the member obtains Medicare Part D coverage.

G. Return of and Credit for Unused Medications

AHCCCS and its Contractors shall require the return of unused medications to the outpatient pharmacy from Nursing Facilities (NFs) upon the discontinuance of prescriptions due to the transfer, discharge or death of a Medicaid member. A payment/credit reversal shall be issued for unused prescription medications by the outpatient pharmacy to AHCCCS or the appropriate Contractor. The pharmacy may charge a reasonable restocking fee as agreed upon with the AHCCCS Contractors and/or American Indian Health Plan/Fee-For-Service (AIHP/FFS) Program. The return of unused prescription medication shall be in accordance with Federal and State laws. Arizona Administrative Code (A.A.C. R4-23-409) allows for this type of return and the redistribution of medications under certain circumstances. Documentation must be maintained and must include the quantity of medication dispensed and utilized by the member. A credit must be issued to AHCCCS (if the member is FFS) or the member’s Contractor when the unused medication is returned to the pharmacy for redistribution.

H. Prior Authorization Criteria for Smoking Cessation Aids

AHCCCS has established a prior authorization criteria for smoking cessation aids. Refer to Policy 320-K-1, Tobacco Cessation Product Policy.
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POLICY 310
COVERED SERVICES

I. PRIOR AUTHORIZATION CRITERIA FOR TREATMENT OF HEPATITIS C

AHCCCS established prior authorization criteria for the use of medications for the treatment of Hepatitis C. Refer to Policy 320-N, Hepatitis C Prior Authorization Criteria Policy.

J. VACCINES AND EMERGENCY MEDICATIONS ADMINISTERED BY PHARMACISTS TO PERSONS AGE 21 YEARS AND OLDER

AHCCCS covers vaccines and emergency medication without a prescription order when administered by a pharmacist who is currently licensed and certified by the Arizona State Board of Pharmacy consistent with the limitations of this Policy and state law ARS §32-1974.

1. For purposes of this section “Emergency Medication” means emergency epinephrine and diphenhydramine. “Vaccines” are limited to pneumococcal and influenza vaccines.

2. The pharmacy providing the vaccine must be an AHCCCS registered provider (see note below regarding Indian Health Services (IHS)/638 outpatient facilities).

3. Contractors retain the discretion to determine the coverage of vaccine administration by pharmacists and coverage is limited to the Contractor’s network pharmacies.

NOTE: IHS and 638 facilities may bill the outpatient all-inclusive rate for pharmacist vaccine administration as noted in section F of this policy.

K. 340B REIMBURSEMENT

A.A.C. R-9-22-710 (C), describes the reimbursement methodology to be used by AHCCCS and its Contractors for Federally Qualified Health Center (FQHC) and FQHC Look-Alike Pharmacies for 340B drugs as well as reimbursement for Contract Pharmacies that have entered into a 340B drug purchasing arrangement with any 340B entity. The Rule also specifies reimbursement for FQHC and FQHC Look-Alike Pharmacies for drugs which are not part of the 340B Drug Pricing program. This rule is located on the AHCCCS Website and the link is provided below:

L. **Pharmaceutical Rebates**

The Contractor, including the Contractor’s PBM, is prohibited from negotiating any rebates with drug manufacturers for preferred or other pharmaceutical products when AHCCCS has a supplemental rebate contract for the product(s). A listing of products covered under supplemental rebate agreements will be available on the AHCCCS website under the Pharmacy Information section. If the Contractor or its PBM has an existing rebate agreement with a manufacturer, all outpatient drug claims, including provider-administered drugs for which AHCCCS is obtaining supplemental rebates, must be exempt from such rebate agreements.

**REFERENCES**

1. [Chapter 800](#) for prior authorization requirements for FFS providers

2. Section 1903(i)(10) of the Social Security Act as amended by Section 6033 of the Deficit Reduction Act of 2005

3. Centers for Medicare and Medicaid Services (CMS) State Medicaid Director Letter dated March 22, 2006

4. Arizona Revised Statute § 32-1974

5. Arizona Administrative Code R-9-22-710

6. U.S. Food and Drug Administration (FDA) [www.fda.gov/Drugs/DevelopmentApprovalProcess/HowDrugsareDevelopedandApproved/ApprovalApplications/TherapeuticBiologicApplications/Biosimilars/](#)

7. CMS Outpatient Drug List
310-W **Radiology and Medical Imaging**

**Revision Dates:** 10/01/06, 10/01/01, 10/01/97

**Review Date:** 05/01/2011

**Initial Effective Date:** 10/01/1994

**Description**

AHCCCS covers radiology and medical imaging services for all eligible members when ordered by a primary care provider, other practitioner or dentist for diagnosis, prevention, treatment or assessment of a medical condition, as defined in 9 A.A.C. Chapter 22, Article 2. Settings for the provision of services include hospitals, clinics, physician offices and other health care facilities.

**Amount, Duration and Scope**

The AHCCCS Acute care program covers medically necessary radiology and imaging services.

The AHCCCS Division of FFS Management does not require prior authorization for medically necessary radiology and medical imaging services performed by FFS providers.
Description

AHCCCS covers occupational, physical and speech therapy services that are ordered by a Primary Care Provider (PCP), or attending physician for FFS members, approved by AHCCCS Division of Fee-for-Service Management (DFSM) or the Contractor, and provided by or under the direct supervision of a licensed therapist as noted in this section.

Amount, Duration and Scope

The scope, duration and frequency of each therapeutic modality must be ordered by the PCP/attending physician as part of the rehabilitation plan. In order for the occupational, physical, and speech therapy services to be covered, the member must have the potential for improvement due to rehabilitation.

Refer to Chapter 800 for prior authorization requirements for FFS providers.

Refer to Chapter 1200 for additional information regarding ALTCS covered rehabilitation services.

Refer to Chapter 1200 for habilitation services.

A. OCCUPATIONAL THERAPY

Description

Occupational Therapy (OT) services are medically ordered treatments to improve or restore functions which have been impaired by illness or injury, or which have been permanently lost, or reduced by illness or injury. OT is intended to improve the member's ability to perform those tasks required for independent functioning.
Amount, Duration and Scope

AHCCCS covers medically necessary OT services provided to all members who are receiving inpatient care at a hospital (or a nursing facility) when services are ordered by the member’s PCP/attending physician. Inpatient occupational therapy consists of evaluation and therapy.

Outpatient OT services are covered only for members receiving Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services, KidsCare members and ALTCS members.

OT services must be provided by a qualified occupational therapist licensed by the Arizona Board of Occupational Therapy Examiners or a certified OT assistant (under the supervision of the occupational therapist according to 4 A.A.C. 43, Article 4) licensed by the Arizona Board of Occupational Therapy Examiners. Occupational therapists who provide services to AHCCCS members outside the State of Arizona must meet the applicable State and/or Federal requirements.

Therapy services may include, but are not limited to:

a. Cognitive training
b. Exercise modalities
c. Hand dexterity
d. Hydrotherapy
e. Joint protection
f. Manual exercise
g. Measuring, fabrication or training in use of prosthesis, arthrosis, assistive device or splint
h. Perceptual motor testing and training
i. Reality orientation
j. Restoration of activities of daily living
k. Sensory reeducation, and
l. Work simplification and/or energy conservation.
B. PHYSICAL THERAPY

Description

Physical Therapy (PT) is an AHCCCS covered treatment service to restore, maintain or improve muscle tone, joint mobility or physical function.

Amount, Duration and Scope

AHCCCS covers medically necessary PT services for members in an inpatient or outpatient setting, when services are ordered by the member's PCP/Attending physician as follows:

1. Inpatient
   a. Inpatient PT services are covered for all members who are receiving inpatient care at a hospital (or a nursing facility)

2. Outpatient
   a. Outpatient PT services are covered for EPSDT and KidsCare members when medically necessary.

   b. Outpatient PT services are covered for adult members, 21 years of age and older (Acute and ALTCS) as follows:

      i. AHCCCS members who are not Medicare eligible are limited to 15 outpatient visits per contract year regardless of whether or not the member changes Contractors.

      ii. For AHCCCS members who are also Medicare recipients, refer to Chapter 300, Exhibit 300-3A and the ACOM Manual Policies 201 regarding Medicare cost sharing and the outpatient physical therapy limit.

For the purposes of Section 2. b., a visit is considered to be PT services received in one day. Outpatient settings include, but are not limited to: physical therapy clinics, outpatient hospitals units, FQHCs, physicians’ offices and home health settings. Nursing facilities, nursing homes, custodial care facilities and schools are excluded from the visit limitations.

PT services must be rendered by a qualified physical therapist licensed by the Arizona Physical Therapy Board of Examiners or a Physical Therapy Assistant (under the supervision of the PT, according to 4 A.A.C. 24, Article 3) certified by the Arizona Physical Therapy Board of Examiners. Physical therapists who provide services to AHCCCS members outside the State of Arizona must meet the
applicable State and/or Federal requirements.

Outpatient physical therapy is not covered as a maintenance regimen.

Authorized treatment services include, but are not limited to:

1. The administration and interpretation of tests and measurements performed within the scope of practice of PT as an aid to the member’s treatment

2. The administration, evaluation and modification of treatment methodologies and instruction, and

3. The provision of instruction or education, consultation and other advisory services.

C. SPEECH THERAPY (ST)

Description

Speech therapy is the medically ordered provision of diagnostic and treatment services that include evaluation, diagnostic and treatment services that include evaluation, program recommendations for treatment and/or training in receptive and expressive language, voice, articulation, fluency, rehabilitation and medical issues dealing with swallowing.

Amount, Duration and Scope

AHCCCS covers medically necessary speech therapy services provided to all members who are receiving inpatient care at a hospital (or a nursing facility) when services are ordered by the member's PCP or attending physician for FFS members. Speech therapy provided on an outpatient basis is covered only for members receiving EPSDT services, KidsCare and ALTCS members.

Speech-language pathologists providing services to AHCCCS members outside the State of Arizona must meet the applicable State and/or Federal requirements.

ST may be provided by the following professionals within their scope of practice:

1. A qualified Speech-Language Pathologist (SLP) licensed by the Arizona Department of Health Services (ADHS), or
2. A speech-language pathologist who has a temporary license from ADHS and is completing a clinical fellowship year. He/she must be under the direct supervision of an ASHA certified speech-language pathologist. AHCCCS registration will be terminated at the end of two years if the fellowship is not completed at that time, or

3. A qualified SPL assistant (under the supervision of the speech-language pathologist and according to A.R.S. §36-1940.04 and R9-16-501 et seq) licensed by the Arizona Department of Health Services. The SLPA must be identified as the treating provider and bill for services under his or her individual NPI number (a group ID number may be utilized to direct payment).

Speech therapy by qualified professionals may include the list below. It is incumbent upon each professional to assure they are acting within the scope of their license. SLPAs may only perform services under the supervision of a SLP and within their scope of service as defined by regulations.

1. Articulation training
2. Auditory training
3. Cognitive training
4. Esophageal speech training
5. Fluency training
6. Language treatment
7. Lip reading
8. Non-oral language training
9. Oral-motor development, and
10. Swallowing training.
310-Y  RESPIRATORY THERAPY

REVISION DATES:  06/01/13, 01/01/2011, 03/01/06, 10/01/01, 07/01/99

INITIAL EFFECTIVE DATE:  10/01/1994

Description

Respiratory therapy is an AHCCCS covered treatment service, ordered by a primary care provider for members or attending physician for Fee-For-Service (FFS) members, to restore, maintain or improve respiratory functioning.

Services include administration of pharmacological, diagnostic and therapeutic agents related to respiratory and inhalation care procedures, observing and monitoring signs and symptoms, general behavioral and physical response(s) to respiratory treatment and diagnostic testing, including a determination of whether these signs, symptoms, reactions, or response exhibits abnormal characteristics; and implementing appropriate reporting referral, and respiratory care protocols or changes in treatment based on observed abnormalities and pursuant to a prescription by a physician.

Amount, Duration and Scope

AHCCCS covers medically necessary respiratory therapy services for all members on both an inpatient and outpatient basis. Services must be provided by a qualified respiratory practitioner under A.R.S. §32-3501 (respiratory therapist or respiratory therapy technician), licensed by the Arizona Board of Respiratory Care Examiners. Respiratory practitioners providing services to AHCCCS members outside the State of Arizona must meet the applicable State and/or Federal requirements.

Refer to Chapter 1200 for ALTCS covered respiratory therapy services.
310-Z  SLEEP STUDIES (POLYSOMNOGRAPHY)

Revision Dates: 02/01/15, 01/01/14, 12/01/13, 03/01/12, 10/01/09, 10/01/06

Initial Effective Date: 11/01/2003

Description

AHCCCS covers standard polysomnography inpatient and outpatient sleep studies performed in the settings described below.

Amount, Duration, and Scope

Sleep studies are only covered services in the following settings:

1. A licensed and certified hospital facility, or

2. A non-hospital facility that meets one of the following sets of criteria:
   a. Is licensed by the Arizona Department of Health Services (ADHS) and the facility is accredited by the American Academy of Sleep Medicine (AASM), or
   b. Has a Medical Director who is:
      i. Certified by the American Board of Sleep Medicine (ABSM) (must submit certification), or
      ii. Certified in sleep medicine by a member board of the American Board of Medical Subspecialties (ABMS) (must submit certification), or
      iii. Certified in sleep medicine by a member board of the American Osteopathic Association (AOA) (must submit certification).

In addition, a non-hospital facility must have a managing Sleep Technician who is registered by the Board of Registered Polysomnographic Technologists (BRPT), per the Arizona Administrative Code (proof of registration is required), or

   c. For sleep Electroencephalogram (EEG) only, the facility must have a physician who is a Board-certified neurologist. No ADHS license is required for this facility.
d. In-home settings in conjunction with a comprehensive sleep evaluation by a practitioner board certified in sleep medicine. Home Sleep Tests (HST) are only indicated for members with a pretest probability of moderate to severe Obstructive Sleep Apnea. Coverage of HST is optional and may be determined at the discretion of the Contractor or AHCCCS, whichever is appropriate.

A. INDICATIONS FOR COVERAGE

AHCCCS covers standard polysomnography only for the following indications:

1. Suspected sleep-related breathing disorders, such as Obstructive Sleep Apnea (OSA), when one of the following two criteria are met:
   a. Witnessed apnea during sleep greater than ten seconds in duration; or
   b. Any combination of two or more of the following i. through iv.
      i. Excessive daytime sleepiness:
         The following must be ruled out as a cause for these symptoms: poor sleep hygiene, medication, drugs, alcohol, hypothyroidism, other medical diagnoses, psychiatric, or psychological disorders, social or work schedule changes.
      ii. Persistent or frequent snoring;
      iii. Obesity (Body Mass Index [BMI]) greater than 30 kg/m²) or hypertension;
      iv. Choking or gasping episodes associated with awakenings

2. Suspected narcolepsy, demonstrated by symptoms such as sleep paralysis, hypnagogic hallucinations, cataplexy.

3. Suspected periodic movement disorder including excessive daytime sleepiness together with witnessed periodic limb movements of sleep.

4. Suspected parasomnias that are unusual or atypical based on patient's age, frequency, or duration of behavior.

5. Suspected restless leg syndrome, when uncertainty exists in the diagnosis.

6. To assist with the diagnosis of paroxysmal arousals or other sleep disruptions that are thought to be seizure-related when the initial clinical evaluation and results of a standard Electroencephalogram (EEG) are inconclusive.
7. Under limited circumstances, titration of positive airway pressure in adults with a documented diagnosis of OSA for whom positive airway pressure has been approved by the Contracted Health Plan or AHCCCS Administration for Fee-for-Service Members.

8. Other conditions in which sleep studies have been shown to be medically necessary for their proper diagnosis or treatment.

The preferred method is a split night study in which the sleep study is performed during the first half of the night and positive air pressure system (e.g. Continuous Positive Airway Pressure [CPAP], Biphasic Intermittent Positive Airway Pressure [BiPAP]) titration is performed during the second half of the night.

In cases where testing and titration cannot be completed in one session, a second night may be authorized subject to medical management and payment criteria set by Contractor.

B. LIMITATIONS

1. AHCCCS does not cover polysomnography for the following symptoms or conditions existing alone in the absence of other features suggestive of obstructive sleep apnea:
   a. Snoring
   b. Obesity
   c. Hypertension
   d. Morning headaches
   e. Decrease in intellectual functions
   f. Memory loss
   g. Frequent nighttime awakenings
   h. Other sleep disturbances, such as insomnia (acute or chronic), night terrors, sleep walking, epilepsy where nocturnal seizures are not suspected
   i. Common uncomplicated non-injurious parasomnias
2. AHCCCS does not cover follow-up sleep studies unless the member’s condition has changed significantly and those changes are likely to modify the need for CPAP or other treatments.

3. AHCCCS does not cover pulse oximetry alone as a sleep study.

AHCCCS does not cover repeat polysomnography in follow-up of patients with obstructive sleep apnea treated with CPAP when symptoms attributable to sleep apnea have resolved.
310-AA  TOTAL PARENTERAL NUTRITION (TPN)

REVISION DATES:  06/01/13, 10/01/06

REVIEW DATE:  01/01/2011

INITIAL

EFFECTIVE DATE:  11/01/2003

Description

Total Parenteral Nutrition (TPN) is the provision of total caloric needs by intravenous route for individuals with severe pathology of the alimentary tract which does not allow absorption of sufficient nutrients to maintain weight and strength appropriate for the individual’s general condition. Nutrients are provided through an indwelling intravenous catheter.

Amount, Duration and Scope

AHCCCS follows Medicare guidelines for the provision of TPN services. TPN is covered for members over age 21 when it is medically necessary and the only method to maintain adequate weight and strength.

AHCCCS covers TPN for members receiving Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and KidsCare members when medically necessary. Refer to Chapter 400, Policy 430 for complete information related to parenteral nutrition services.

Refer to Chapter 800 for prior authorization requirements for FFS providers.
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COVERED SERVICES  

310-BB   TRANSPORTATION  

REVISION DATES:  03/01/12, 10/01/08, 11/01/04, 10/01/01, 10/01/99, 02/18/98  

INITIAL  
EFFECTIVE DATE:  10/01/1994  

Description  
AHCCCS covers transportation within certain limitations for all members based on member age and eligibility, as specified in the Arizona Administrative Code (A.A.C.) R9-22-211. Covered transportation services include:  

1. Emergency transportation  
2. Medically necessary non-emergency transportation, and  
3. Medically necessary maternal and newborn transportation.  

Definitions  
The definitions relating to covered transportation services are as follows:  

1. Air ambulance - helicopter or fixed wing aircraft licensed under Arizona Department of Health Services (ADHS) as mandated by Arizona Revised Statutes to be used in the event of an emergency to transport members or to obtain services.  

2. Ambulance - motor vehicle licensed by ADHS pursuant to Arizona Revised Statutes especially designed or constructed, equipped and intended to be used, maintained and operated for the transportation of persons requiring ambulance services.  

3. Ambulatory vehicle – ambulatory transportation means a vehicle other than a taxi but includes vans, cars, minibus or mountain area transport. The AHCCCS member must be able to transfer with or without assistance into the vehicle and not require specialized transportation modes.  

4. Stretcher van – the vehicle must be specifically designed for the purpose of transportation of a member on a medically approved stretcher device. The stretcher must be secured to avoid injury to the member or other passengers. Safety features of stretcher vans must be maintained as
necessary. Any additional items being transported must also be secured for safety. The AHCCCS member must need to be transported by stretcher and must be physically unable to sit or stand and any other means of transportation is medically contraindicated.

5. **Wheelchair van** – the vehicle must be specifically equipped for the transportation of an individual seated in a wheelchair. Doors of the vehicle must be wide enough to accommodate loading and unloading of a wheelchair. Wheelchair vans must include electronic lifts for loading and unloading wheelchair bound transports. The vehicle must contain restraints for securing wheelchairs during transit. Safety features of wheelchair vans must be maintained as necessary. Any additional items being transported must also be secured for safety. The AHCCCS member must require transportation by wheelchair and must be physically unable to use other modes of ambulatory transportation.

6. **Taxi** – a vehicle that has been issued and displays a special taxi license plate pursuant to A.R.S. § 28-2515.

**A. EMERGENCY TRANSPORTATION**

1. **Emergency Transportation** - emergency ground and air ambulance services required to manage an emergency medical condition of an AHCCCS member at an emergency scene and transport to the nearest appropriate facility are covered for all members. Emergency transportation is needed due to a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could be expected to result in:

   a. Placing the member's health in serious jeopardy

   b. Serious impairment of bodily functions; or

   c. Serious dysfunction of any bodily organ or part.

   Emergency transportation may be initiated by an emergency response system call "9-1-1", fire, police, or other locally established system for medical emergency calls. Initiation of a designated emergency response system call by an AHCCCS member automatically dispatches emergency ambulance and Emergency Medical Technician (EMT) or Paramedic team services from the Fire Department. At the time of the call, emergency teams are required to respond; however, when they arrive on the scene, the services required at that time (based on field evaluation by the emergency team) may be determined to be:
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i. Emergent
   ii. Nonemergent, but medically necessary, or
   iii. Not medically necessary.

d. Maternal and Newborn Transportation - the Maternal Transport Program (MTP) and the Newborn Intensive Care Program (NICP) administered by the ADHS provides special training and education to designated staff in the care of maternity and newborn emergencies during transport to a perinatal center. The high risk transport team is dispatched after consultation with the MTP or NICP perinatologist or neonatologist. Only MTP or NICP Contractors may provide air transport.

Amount, Duration and Scope

Emergency transportation coverage is limited to those emergencies in which specially staffed and equipped ambulance transportation is required to safely manage the member's medical condition. Basic Life Support, Advanced Life Support, and air ambulance services are covered, depending upon the member's medical needs.

Emergency medical transportation includes the transportation of a member to a higher level of care for immediate medically necessary treatment, even after stabilization at an emergency facility. Emergency medical transportation is covered only to the nearest appropriate facility. The nearest appropriate facility for an AHCCCS Fee-For-Service (FFS) member is the nearest hospital medically equipped to provide definitive medical care. Contractor may establish preferred hospital arrangements, which must be communicated with emergency services providers. If the provider transports the member to the Contractor preferred hospital, the provider's claim must be honored even though that hospital may not be the nearest appropriate facility. However, the provider must not be penalized for taking the member to the nearest appropriate facility whether or not it is the Contractor preferred facility.

Acute conditions requiring emergency transportation to obtain immediate treatment include, but are not limited to the following:

1. Untreated fracture or suspected fracture of spine or long bones
2. Severe head injury or coma
3. Serious abdominal or chest injury
4. Severe hemorrhage
5. Serious complications of pregnancy
6. Shock, heart attack or suspected heart attack, stroke or unconsciousness

7. Uncontrolled seizures, and

8. Condition warranting use of restraints to safely transport to medical care.

For utilization review, the test for appropriateness of the request for emergency services is whether a prudent layperson, if in a similar situation, would have requested such services. Determination of whether a transport is an emergency is based on the member's medical condition at the time of transport.

Refer to the section of this policy regarding medically necessary transportation furnished by an ambulance provider for information related to transportation initiated by an emergency response system call.

Air ambulance services are covered under the following conditions:

1. The point of pickup is inaccessible by ground ambulance

2. Great distances or other obstacles are involved in getting the member to the nearest hospital with appropriate facilities, or

3. The medical condition of the member requires ambulance service and ground ambulance services will not suffice.

Air ambulance vehicles must meet ADHS licensing requirements and requirements set forth by the Federal Aviation Administration. Air ambulance companies must be licensed by the ADHS and be registered as a provider with AHCCCS.

**Emergency Transportation Provider Requirements for Emergency Transportation Services Provided for AHCCCS American Indian Health Program Members**

EmergencyTransportationServices: In addition to other requirements specified in this policy, emergency transportation providers rendering services on an Indian Reservation must meet the following requirements:

1. Tribal emergency transportation providers must be certified by the Tribe and Center for Medicare and Medicaid Services (CMS) as a qualified provider and registered as an AHCCCS provider.

2. If non-tribal emergency transportation providers render services under a contract with a Tribe either on-reservation or to and from an off-
reservation location the provider must be State licensed and certified, and
registered as an AHCCCS provider, or

3. Non-tribal transportation providers not under contract with a Tribe must meet requirements specified in this policy for emergency transport providers.

As with all emergency transportation, services are covered to manage an emergency medical condition at the emergency scene and in transport to the nearest appropriate facility.

B. MEDICALLY NECESSARY NON-EMERGENCY TRANSPORTATION FURNISHED BY NON-EMERGENCY TRANSPORTATION PROVIDERS FOR MEDICAL AND BEHAVIORAL HEALTH SERVICES

Amount, Duration and Scope

Non-emergency medically necessary transportation is transportation, as specified in A.A.C. R9-22-211, and furnished by providers included therein, to transport the member to and from a covered medical service. Such services may also be provided by emergency transportation providers after assessment by the EMT or Paramedic team that the member’s condition requires medically necessary transportation.

Medically Necessary Non-Emergency Transportation Services are Covered Under the Following Conditions:

1. The medical or behavioral health service for which the transportation is needed is a covered AHCCCS service.

2. The member is not able to provide, secure or pay for their own transportation, and free transportation is not available, and

3. The transportation is provided to and from the nearest appropriate AHCCCS registered provider.

The following must be adhered to:

1. The member must not require medical care en route
2. Passenger occupancy must not exceed the manufacturer's specified seating occupancy.

3. Members, escorts, and other passengers must follow state laws regarding passenger restraints for adults and children.

4. Vehicle must be driven by a licensed driver, following applicable State laws.

5. Vehicles must be insured.

6. Vehicles must be in good working order.

7. Members must be transported inside the vehicle.

8. School Based providers should follow the school based policies in effect (Chapter 700).

Medically Necessary Non-Emergency Transportation Furnished by Ambulance Providers

Medically necessary non-emergency transportation furnished by ambulance providers is appropriate if:

1. Documentation that other methods of transportation are contraindicated, and

2. The member’s medical condition, regardless of bed confinement, requires the medical treatment provided by the qualified staff in an ambulance.

3. For hospital patients only:

   a. Round-trip air or ground transportation services may be covered if an inpatient hospitalized member goes to another facility to obtain necessary specialized diagnostic and/or therapeutic services (such as a CT scan or cobalt therapy). Such transportation may be covered if services are not available in the hospital in which the member is an inpatient.

Transportation services to the nearest medical facility that can render appropriate services are also covered, when the transport was initiated through an emergency response system call and, upon examination by emergency medical personnel, the member’s condition is determined to be non-emergent but one which requires medically necessary transportation. At the Administration or Contractor’s discretion, medically necessary non-emergency ambulance transportation may not require prior authorization or notification, but
is subject to review for medical necessity. Medical necessity criteria is based upon the medical condition of the member and includes ground ambulance services provided because the member's medical condition was contradictory to any other means of transportation. This may include after hour calls.

Refer to Chapter 1200 for additional information regarding Arizona Long Term Care System (ALTCS) authorization requirements.

Refer to Chapter 800 for complete information regarding prior authorization for non-ALTCS FFS members.

Refer to the AHCCCS FFS Provider Manual or the AHCCCS Billing Manual for IHS/Tribal providers for billing information. These manuals are available on the AHCCCS Website at www.azahcccs.gov.

Refer to AHCCCS Contractors Operations Manual (ACOM) Policy 205, Ground Ambulance Transportation Reimbursement Guidelines for Non-Contracted Providers, for information regarding reimbursement.
310-CC  TRIAGE/SCREENING AND EVALUATION OF EMERGENCY MEDICAL CONDITIONS

Revision Dates: 10/01/06, 10/01/03, 10/01/01

Review Date: 05/01/2011

Initial Effective Date: 10/01/1995

Description

Covered services for managed care and FFS members not in the FESP (refer to Chapter 1100 for all requirements regarding the FESP), when provided by acute care hospitals, IHS facilities and urgent care centers to determine whether or not an emergency exists, assess the severity of the member's medical condition and determine what services are necessary to alleviate or stabilize the emergent condition.

Amount, Duration, and Scope

Triage/screening services must be reasonable, cost effective and meet the criteria for severity of illness and intensity of service.

Refer to Chapter 800 for PA and utilization review requirements for FFS members. Refer to Chapter 1100 for information and requirements regarding the FES Program.
Overview

Federal law 42 U.S.C. §1396b(i) and 42 CFR 441.35 describe general requirements for Title XIX coverage of transplants. For adults, organ transplant services are not mandatory covered services under Title XIX, and each State has the discretion to choose whether or not transplants will be available to members. The AHCCCS Administration, as the single State agency, has the authority under Federal law to determine which transplant procedures, if any, will be reimbursed as covered services.

In contrast to transplant coverage for persons age 21 years and older, the Early and Periodic Screening Diagnostic and Treatment (EPSDT) Program for individuals under age 21 covers all non-experimental transplants necessary to correct or ameliorate defects, illnesses and physical conditions. Transplants for EPSDT members are covered when medically necessary irrespective of whether or not the particular non-experimental transplant is specified as covered in the AHCCCS State Plan.

AHCCCS covers the specific medically necessary transplantation services and related immunosuppressant medications as described in this Policy.

The solid organ and tissue transplant services described in this policy, including the relevant standards of coverage, are referenced in the AHCCCS State Plan. The AHCCCS State Plan is the document approved by the Federal government which outlines the eligibility requirements and covered services for the AHCCCS program.

As with other AHCCCS-covered services, transplants must be medically necessary, cost effective, Federally reimbursable, and State reimbursable. Arizona State laws and regulations specifically address transplant services and related topics, as follows:

1. Specific non-experimental transplants which are approved for Title XIX reimbursement are covered services (A.R.S. §36-2907).

2. Services which are experimental, or which are provided primarily for the purpose of research are excluded from coverage (A.A.C. R9-22-202).
3. Medically necessary is defined as those covered services “provided by a physician or other licensed practitioner of the healing arts within the scope of practice under State law to prevent disease, disability or other adverse health conditions, or their progression, or prolong life” (A.A.C. R9-22-101).

4. Experimental services are as described in R9-22-203.

5. Standard of care is defined as “a medical procedure or process that is accepted as treatment for a specific illness, injury or medical condition through custom, peer review or consensus by the professional medical community” (A.A.C. R9-22-101).

In developing this Policy, the AHCCCS Administration has consulted with transplant experts to identify criteria for transplant coverage consistent with the current body of medical literature, including United Network for Organ Sharing (UNOS) clinical standards for solid organ transplant procedures, the Foundation for the Accreditation of Cellular Therapy (FACT) as well as peer-reviewed articles in medical journals published in the United States.

For persons ages 21 years and older, AHCCCS limits transplantation coverage to the specific transplant types set forth in this Policy. All other transplant types for persons ages 21 years and older are excluded from AHCCCS reimbursement. This policy includes criteria, indications as well as relative contraindications and absolute contraindications for each covered transplant type. Unless a contraindication is explicitly described as an absolute contraindication, the contraindication is a relative contraindication. However, these may change as a result of advances in medical treatment and technological innovation. The presence of an absolute contraindication precludes authorization for a transplant.

Each AHCCCS Contractor shall consult with the current authoritative medical sources to determine whether a transplant covered under this Policy is medically necessary, cost-effective, non-experimental, and not primarily for purposes of research. The AHCCCS Contractor shall provide the medical justification for the decision that is made. The Contractor has access to and may consult with the transplantation management entity (AHCCCS consultant) under contract with AHCCCS. Although the Contractor is encouraged to consult with the AHCCCS consultant for guidance in those cases requiring such medical determinations, the Contractor is not required to do so. Contractors not using the AHCCCS consultant must obtain their own expert opinion.

**Definitions**

Absolute contraindication – A condition or circumstance that if present precludes authorization of a transplant regardless of any other considerations.
Adult Caregiver - The adult caregiver is defined during the transplant psycho-social evaluation as the adult who will serve as the individual who will take responsibility for assuring that the member’s long term post-transplant care is provided in accordance with the transplant center guidelines, including administration of immunosuppressant therapy, enteral or parenteral therapy and adherence to immunosuppressant precautions. This is generally a family member and this person is not paid.

Close Proximity means within the geographic service area.

Emergent Fulminant Hepatic/Liver Failure - Liver failure that occurs suddenly in a previously healthy person. The most common causes are acute hepatitis, acetaminophen overdose, and liver damage from prescription drugs.

Experimental service – Refer to AHCCCS Rule R9-22-203. This rule provides, in part:
Experimental services are not covered. A service is not experimental if:

1. It is generally and widely accepted as a standard of care in the practice of medicine in the United States and is a safe and effective treatment for the condition for which it is intended or used.

2. The service does not meet the standard in (1), but the service has been demonstrated to be safe and effective for the condition for which it is intended or used based on the weight of the evidence in peer-reviewed articles in medical journals published in the United States.

3. The service does not meet the standard in (2) because the condition for which the service is intended or used is rare, but the service has been demonstrated to be safe and effective for the condition for which it is intended or used based on the weight of opinions from specialists who provide the service or related services.

Hematopoietic Stem Cell Transplants (HSCT) - The transplantation of blood stem cells derived from the bone marrow or peripheral blood, including cord blood. Conditioning therapy includes either myeloablative or non-myeloablative induction with or without Total Body Irradiation (TBI).

Relative Contraindications – A condition or circumstance that must be considered on a case-by-case basis to determine if a transplant will be authorized.

Description

The Transplant Policy sets forth criteria, including indications and contraindications, for determining whether transplant services are medically necessary, cost effective, non-experimental, and not primarily for purposes for research. Contraindications are
conditions which may significantly adversely impact the outcome of the transplant. They are not regarded as an absolute bar to transplantation. Contraindications must be evaluated along with all other relevant factors to determine whether the transplant service is medically necessary, non-experimental, and not primarily for purposes of research in each particular case.

1. Transplant Services and Settings

Transplant services are covered only when performed in specific settings:

   a. Solid organ transplantation services must be provided in a CMS certified and UNOS approved transplant center which meets the Medicare conditions for participation and special requirements for transplant centers delineated in 42 CFR Part 482.

   b. Hematopoietic stem cell transplant services must be provided in a facility that has achieved Foundation for the Accreditation of Cellular Therapy (FACT) accreditation. The facility must also satisfy the Medicare conditions of participation and any additional federal requirements for transplant facilities.

Transplantation related services and immunosuppressant drugs are not covered services for individuals in the Federal Emergency Services (FES) Program, pursuant to 42 U.S.C. 1396b(v)(3) and A.A.C. R9-22-206. Persons who qualify for transplant services, but who are later determined ineligible under A.R.S. 36-2907.10 due to excess income may qualify for extended eligibility (refer to Attachment A). For information about transplants and reinsurance, refer to the AHCCCS Contract and the Reinsurance Processing Manual.

2. Assessment for Transplant Consideration

The first step for transplant consideration is the initial assessment by the member’s Primary Care Provider (PCP) and/or the specialist treating the condition necessitating the transplant. In determining whether the member is appropriate for referral for transplant consideration, the PCP/specialist must determine that all of the following conditions are satisfied:

   a. The member will be able to attain an increased quality of life and chance for long-term survival as a result of the transplant
   b. There are no significant impairments or conditions that would negatively impact the transplant surgery, supportive medical services, or inpatient and outpatient post-transplantation management of the member
c. There are strong clinical indications that the member can survive the transplantation procedure and related medical therapy (e.g., chemotherapy, immunosuppressive therapy)

d. There is sufficient social support to ensure the member’s compliance with treatment recommendations such as, but not limited to, immunosuppressive therapy, other medication regimens and pre- and post-transplantation physician visits. For a pediatric/adolescent member, there is adequate evidence that the member and parent/guardian will adhere to the rigorous therapy, daily monitoring and re-evaluation schedule after transplant

e. The member has been adequately screened for potential co-morbid conditions that may impact the success of the transplant. When the member’s medical condition is such that the evaluation must proceed immediately, the screenings may be provided by the PCP concurrent with the transplant evaluation.

f. The member’s condition has failed to improve with all other conventional medical/surgical therapies. The likelihood of survival with transplantation, considering the member’s diagnosis, age and comorbidities, is greater than the expected survival rate with conventional therapies. This information must be documented and submitted to the Contractor at the time of request for evaluation.

3. AHCCCS Covered Solid Organ and Hematopoietic Stem Cell Transplants

The following solid organ and hematopoietic stem cell transplants are AHCCCS covered services when medically necessary, cost effective, non-experimental, and not primarily for purposes of research. Live donor/kidney transplants are covered for pediatric and adult members. The fiscal responsibility of AHCCCS and its Contractors for donor-related costs is limited to pediatric and adult kidney transplants as specified in this policy.

Live donor transplants may be considered on a case-by-case basis for solid organs other than kidney when medically appropriate and cost effective. However, in the event that a live donor transplant is approved for a non kidney transplant, any costs related to the donor shall not be separately reimbursed by AHCCCS or its Contractors, and no additional payment for the donor shall be made unless the donor is AHCCCS eligible. Payment by AHCCCS and its Contractors for both the transplant recipient and the donor associated with non kidney transplant services is limited to payment for the transplant and transplant-related services component during the 60 day post-transplant timeframe. Refer to the terms of the transplant contract for detailed information
about coverage and payment for transplants and transplant-related services. For any additional charges, the living donor must accept the terms of financial responsibility for the charges associated with the transplant in excess of any payments under the transplant contract. Detailed criteria regarding specific transplants are found under the heading “Solid Organ and Related Devices: Specific Indications and Contraindications/ Limitations.”

The following transplants are covered subject to the terms of this policy.

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<tr>
<td>Pancreas After Kidney (PAK)</td>
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<td>Pancreas Only</td>
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</tr>
<tr>
<td>Visceral Transplantation</td>
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<td>Not covered</td>
</tr>
<tr>
<td>• intestine alone</td>
<td></td>
<td></td>
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<tr>
<td>• intestine with pancreas</td>
<td>X</td>
<td>Not covered</td>
</tr>
<tr>
<td>• intestine with liver</td>
<td></td>
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<tr>
<td>• intestine, liver, pancreas en bloc</td>
<td>X</td>
<td>Not covered</td>
</tr>
<tr>
<td>Partial pancreas (including islet cell transplants)</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>HEMATOPOIETIC STEM CELL TRANSPLANTS</strong></td>
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<tr>
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<td>X</td>
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<td>• Allogeneic Unrelated</td>
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<tr>
<td>• Tandem Hematopoietic Stem Cell Transplant (HSCT)</td>
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*All other medically necessary, non-experimental transplants for members under the age of 21 are covered.

4. Other transplants and devices included in this policy are:
a. Circulatory Assist Device (CAD) is an AHCCCS covered service when used as a bridge to transplantation and other specific criteria are met. Refer to “Solid Organ Transplants and Related Devices: Specific Indications and Contraindications/ Limitations” within this Policy section for more details.

b. Bone grafts and corneal transplants are AHCCCS covered services.

**Amount, Duration, and Scope**

Coverage of transplantation services includes the following, as required by the specific type of transplant:

1. For the transplant candidate:

   a. Donor search, human Leukocyte Antigens (HLA) typing, and harvest as necessary for stem cell transplants

   b. Pre-transplant evaluation (inpatient or outpatient), which includes, but is not limited to, the following:

      i. Physical examination
      ii. Psychological and social service evaluations
      iii. Laboratory studies
      iv. X-ray and diagnostic imaging, and
      v. Biopsies

   c. Pre-transplant dental evaluation and treatment of oral infection as described in Policy 310-D, “Exception for Transplant and Cancer Cases.” Other dental services, including, but not limited to, restorative and cosmetic dentistry, will not be covered.

   d. Medically necessary post-transplant care (inpatient and outpatient), which may include, but is not limited to, the following:

      i. Laboratory studies
      ii. X-rays and diagnostic imaging
      iii. Biopsies
      iv. Home health
      v. Skilled Nursing Facility placement
      vi. All related medications, including immunosuppressants

**NOTE:** AHCCCS is the secondary payer of immunosuppressant medications if the member is also a Medicare beneficiary and is eligible to
receive the immunosuppressant medications under Medicare Part B. Drugs covered under Medicare Part D are not covered for AHCCCS members eligible for Medicare whether or not the member receives Medicare Part D coverage. Refer to Policy 310-V, Prescription Medication/Pharmacy Services.

e. Transportation, room, and board for the transplant candidate and, if needed, one adult care giver as identified by the transplant facility, to and from medical treatment during the time it is necessary for the member to remain in close proximity to the transplant center. This includes the evaluation, ongoing testing, transplantation, and post-transplant care by the transplant center.

2. For the donor:

Services are covered only when provided in the United States and are limited to the following:

a. Evaluation and testing for suitability

b. Kidney donor procurement or stem cell procurement, processing and storage.

c. Transportation, room and board to determine if the donor is a match or to donate either stem cells or organs under the transplant recipient’s benefit

Refer to the contract for detailed information regarding coverage and payment for transplants and transplant-related services. Transplants and transplant related services are limited to coverage through day 60 post-transplant surgery for non-kidney transplants or, in the case of kidney transplants, through day ten post kidney transplant. Complications for the transplant recipient or donor arising from the transplant surgery during the 60/10 post-transplant timeframe are considered transplant related and covered under the scope of the follow up care component(s). Payment for the 60/10 follow-up care component represents payment for services for both the recipient and the donor, and no additional reimbursement shall be made except as specified below for complications extending beyond the 60/10 timeframe. Complications extending beyond day 60/10 are covered for the recipient if the recipient is AHCCCS eligible and the services are medically necessary and covered. Complications for the donor beyond day 60/10 are covered only if the donor is AHCCCS eligible at the time the complication arises and the services are medically necessary and covered.
A. CONTRAINDICATIONS FOR ALL TRANSPLANTS

Contraindications to solid organ and hematopoietic stem cell transplantation include, but are not limited to:

1. History of non-compliance or psychiatric condition(s) such that there is an inability to comply with post-transplant protocol

2. HIV positive status and viral load – members whose HIV status makes them ineligible for AHCCCS coverage of transplantation have the potential to seek transplant in one of the National Institute of Health’s approved sites. These transplants are subject to the policy described in the section of this policy entitled “Medically Necessary Services for Members who Receive Transplants that are Not Covered by AHCCCS.”

3. For solid organ transplants, active malignancy or prior metastatic malignancy within the past five years, other than localized cutaneous basal cell or squamous cell cancers, is an absolute contraindication. The five year time frame for malignancy does not apply to liver transplants for hepatocellular carcinoma. For stem cell transplants, active or prior metastatic solid tumors malignancy within the past five years, other than localized cutaneous basal cell or squamous cell cancer, is a contraindication.

4. The failure of more than two organs. This does not include instances where the failure of one organ is secondary to the failure of another organ.

5. Presence of active uncontrolled infection or systemic infection (sepsis) at the time of transplant is an absolute contraindication.

6. Active substance abuse or history of substance abuse in the last six months (if there is an urgent need, evaluation may be allowed on a case-by-case basis).

7. Lack of a psychosocial support system, which, based on the member’s condition and general health, would place the success of the transplant at risk.

8. Non-adherence with previous or current treatment protocols that has resulted in the failure of a previously transplanted organ is a contraindication to retransplantation.

B. GENERAL MEDICAL CONDITIONS WHICH MUST BE CONSIDERED

The general medical conditions that must be evaluated prior to transplant to determine whether a particular transplant is medically necessary, cost effective, non-
experimental, and not primarily for purposes of research include, but are not limited to:

1. When a transplant consultation is requested, the Contractor will approve a drug and alcohol screen to be done at the requesting transplant center for all members 21 years of age and older.

2. For members with a history of substance abuse within the past three years, the member must provide a certificate of completion of a 12 month substance abuse program which has been approved by the Administration prior to determination for the transplant evaluation. For members with a history of substance abuse greater than three years from the date of the transplant consultation request, attendance in an approved substance abuse program may be waived. Members with a history of substance abuse within the past three years must have a total of three consecutive negative random screens prior to the evaluation. In addition, the member will be monitored with random and repeated alcohol and drug screenings during the assessment process up to the time of the transplant. At the time of transplant evaluation, members with a history of substance abuse within the prior three year timeframe must sign an agreement which states they will enroll in a post-transplant substance abuse program that will continue for a continuous 12 month timeframe. It is within the Contractor’s discretion to require a psychosocial assessment be completed prior to referral for transplant evaluation.

3. Any history of post-transplant substance abuse will exclude a member from further transplant procedures.

C. SOLID ORGAN TRANSPLANTS AND RELATED DEVICES: SPECIFIC INDICATIONS AND CONTRAINDICATIONS/LIMITATIONS

1. Heart

Prior to listing heart transplant, all other medical and/or surgical alternatives for correction and/or management of the underlying heart condition(s) must either have been optimized or ruled out as a viable treatment option(s).

   a. Indications

   Criteria for medical necessity of heart transplantation include, but are not limited to, the following indications:

      i. Left ventricular systolic dysfunction of any etiology
      ii. Valvular disease with left systolic dysfunction, unable to be surgically corrected
iii. Congenital cardiac disease that has failed prior correction  
iv. Sarcoidosis  
v. Drug-induced myocardial destruction due to prescription medication  
vi. Ischemic cardiomyopathy with a New York Heart Association Class III or IV cardiac disease when surgical or medical therapy is not likely to be effective and estimated survival is less than six to 12 months without a transplant.  
vii. Hypertrophic cardiomyopathy  
viii. Uncontrollable life-threatening arrhythmias  
ix. Refractory angina unresponsive to maximal medical and/or surgical therapy.

b. Contraindications

In addition to the contraindications noted in Section A of this Policy, the following are contraindications to heart transplantation:

i. Severe Pulmonary hypertension: inability to achieve Pulmonary Vascular Resistance (PVR) of <2.5 Wood units and/or a 15 mm Hg transpulmonary gradient on maximal medical therapy including vasodilators or inotropic medications. These patients may instead be candidates for heart-lung transplantation.  
ii. Acute severe hemodynamic compromise at the time of transplantation if accompanied by compromise or failure of one or more vital end-organs  
iii. Recent (within past six months) intracranial vascular disease or prior stroke with severe deficits  
iv. Severe peripheral vascular disease unable to be corrected surgically  
v. Chronic obstructive pulmonary disease or chronic bronchitis  
vi. Recent and/or unresolved pulmonary infarction or pulmonary embolus  
vii. The need for or prior transplantation of another organ such as lung, liver, kidney or hematopoietic transplants,  
viii. Autoimmune diseases or collagen vascular diseases are relative contraindications depending on the disease, severity, and predicted lifespan  
ix. Insulin-dependent diabetes mellitus with end-organ disease (e.g. peripheral vascular/arterial disease, retinopathy, neuropathy, or nephropathy)  
x. Active peptic ulcer disease  
xii. Chronic inflammatory bowel disease  
xii. Hepatic insufficiency
xiii. Amyloidosis
xiv. Age over 70
xv. HIV positive
xvi. Morbid obesity with Body Mass Index (BMI) of 35 kg/m².

2. Circulatory Assistive Device (CAD) formerly known as Ventricular Assist Devices (VAD) and Total Artificial Hearts (TAH)

AHCCCS covers Circulatory Assist Devices (CADs) that support heart function as a bridge to heart transplant only, for eligible members when medically necessary, cost effective, non-experimental, not primarily for purposes of research, and when the device is used in accordance with the Food and Drug Administration (FDA) approved labeling instructions.

For purposes of this Policy, Circulatory Assist Devices are defined as VADS and Total Artificial Hearts (TAH). TAH may be used in lieu of bi-VAD when clinically appropriate and cost effective.

AHCCCS-contracted transplant center surgeons use their skill and judgment to select the appropriate assist device, based on:

- Degree and presentation of cardiac insufficiency
- Size of recipient, and
- Device capability.

a. CAD criteria

Medical necessity for CADs as a bridge to transplant is based on the following criteria:

i. Adult Member

The potential adult recipient must meet all of the following:

(a) Is actively listed for cardiac transplantation and

**NOTE:** If a member is on the inactive transplant list due to a temporary medical complication (e.g. Status 7) and undergoes placement of a VAD or Total Heart, separate payment for those devices is only made if the patient returns to active status and is medically able to undergo a transplant should an organ become available. Medical records must indicate resolution of the temporary medical condition and show Active status for transplant with UNOS. If the patient
never returns to active status, the device is not paid for separately, but payment continues to be made for medical management of the patient.

(b) Is experiencing end stage heart failure with progressive failure to respond to medical management and meets the definition of cardiogenic shock according to the New York Heart Association (NYHA) functional classification system.

ii. Pediatric Member

The potential pediatric recipient must meet all of the following:

(a) Is actively listed for cardiac transplantation

NOTE: If a member is on the inactive transplant list due to a temporary medical complication (*e.g. Status 7) and undergoes placement of a VAD or Total Heart, separate payment for those devices is only made if the patient returns to active status and is medically able to undergo a transplant should an organ become available. Medical records must indicate resolution of the temporary medical condition and show active status for transplant with UNOS. If the patient never returns to active status, the device is not paid for separately, but payment continues to be made for medical management of the patient.

(b) Must meet the age restrictions established by the FDA for the particular device used
(c) Is in New York Heart Association class III or IV end-stage heart failure, and
(d) Is refractory to medical therapy.

b. Contraindications

Contraindications to successful CAD placement and subsequent recovery include, but are not limited to:

i. Severe lung disease, except as appropriate for heart-lung transplantation (refer to the sections pertaining to lung and heart-lung transplantation in this Policy)
ii. Malignant disease
iii. Stroke or refractory hypertension
iv. Chronic pulmonary embolism or recent pulmonary infarction, except as appropriate for heart-lung transplantation (refer to the sections pertaining to lung and heart-lung transplantation in this Policy)

v. Active infection

vi. Irreversible disease of a major organ system, or

vii. Critical psychosocial conditions, behaviors or problems in adherence to a disciplined medical regimen which preclude a positive transplant outcome.

3. Lung

a. Indications

Criteria for medical necessity for lung transplantation include, but are not limited to, the following indications:

i. Alpha-1 antitrypsin deficiency

ii. Primary pulmonary hypertension

iii. Pulmonary fibrosis, idiopathic pulmonary fibrosis

iv. Bilateral bronchiectasis

v. Cystic fibrosis (both lungs to be transplanted)

vi. Bronchopulmonary dysplasia

vii. Eisenmenger's syndrome

viii. Sarcoidosis lung involvement

ix. Scleroderma

x. Lymphangiomatomyomatosis

xi. Eosinophilic granuloma

xii. Pulmonary hypertension due to cardiac disease, or

xiii. Idiopathic fibrosing alveolitis.

b. Absolute Contraindications

In addition to the contraindications noted in Section A of this Policy, absolute contraindications to lung transplantation, include, but are not limited to:

i. Primary or metastatic malignancies of the lung

ii. Colonization with highly resistant or highly virulent microorganisms

iii. Untreatable, advanced dysfunction of any other organ (except the heart when a heart/lung transplant may be indicated

iv. Non-curable extra-pulmonary chronic infection
v. Inadequate biventricular cardiac function, significant coronary artery disease, or inadequate left ventricular function (these are not absolute contraindications if combined with a heart transplant)

vi. System-wide involvement of cystic fibrosis

vii. End Stage Renal Disease (ESRD)

viii. Active tuberculosis

c. Relative Contraindications

In addition to the absolute contraindications noted above, relative contraindications to lung transplantation, include, but are not limited to:

i. Acute respiratory insufficiency or failure requiring mechanical ventilation except adults with cystic fibrosis, where mechanical ventilation has not been shown to affect transplant survival

ii. Abscess of lung and mediastinum

iii. Significant chest wall and/or spinal deformity; prior thoracic surgery or other basis for pleural adhesions

iv. Current significant acute illness that is likely to contribute to a poor outcome if the member receives a lung transplant

v. Chronic, incurable pulmonary infection in candidates for single lung transplantation

vi. Continued cigarette smoking or failure to have abstained for a period of 12 months or longer.

vii. Chronic cortisone therapy with more than 20 mg prednisone daily or recent therapeutic use of systemic steroids.

viii. Severely limited functional status with low potential for rehabilitation

ix. HIV positive

x. Active infection with Hepatitis B or C with a detectable viral load

xi. Diabetes with end-organ dysfunction (e.g. peripheral vascular/arterial disease, retinopathy, neuropathy, or nephropathy)

xii. Osteoporosis with vertebral collapse compression fractures

xiii. Age over 65

xiv. Hepatic insufficiency

xv. Morbid obesity with 30 kg/ m²

4. Heart and Lung

a. Indications

Criteria for medical necessity for heart/lung transplantation include, but are not limited to, the following indications:
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i. Irreversible primary pulmonary hypertension with congestive heart failure

ii. Non-specific pulmonary fibrosis

iii. Eisenmenger’s complex with irreversible pulmonary hypertension and heart failure

iv. Cystic fibrosis with severe heart failure

v. Emphysema with severe heart failure, or

vi. Chronic Obstructive Pulmonary Disease (COPD) with severe heart failure

b. Contraindications

Refer to the individual heart and lung sections in this Policy for contraindications

5. Liver

a. Timing of referral:

Prior to referral to a transplant center for evaluation, the Contractor shall calculate the adult member’s Model for End stage Liver Disease (MELD) score. An adult member must have a MELD score greater than 10 to meet criteria for referral.

The Contractor shall calculate the pediatric member’s Pediatric End stage Liver Disease (PELD) score prior to transplant evaluation. The PELD score automatically assigns additional points for a child.

b. Indications for Adult and Pediatric Liver Transplants

Criteria for medical necessity for liver transplantation in adults and pediatric liver transplants (except as otherwise indicated) include, but are not limited to, the following indications:

i. Fulminant hepatic failure – This is an emergent basis for transplant (viral [A, B and Non-A-Non-B], toxins, drugs, Wilson’s Disease, idiopathic)

ii. Primary/secondary biliary cirrhosis

iii. Primary sclerosing cholangitis

iv. Cryptogenic or autoimmune cirrhosis

v. Chronic active hepatitis due to Hepatitis B, C or delta hepatitis.

vi. Alcoholic liver disease after a period of abstinence of six months or more

vii. Alpha-1 antitrypsin deficiency (non-acquired)
viii. Wilson’s Disease
ix. Primary hemochromatosis
x. Protoporphyria
xi. Familial Intrahepatic Cholestasis (Byler’s disease)
xii. Trauma
xiii. Drug-or toxin-induced liver disease (including but not limited to iatrogenic origin)
xiv. Extrahepatic biliary atresia, intrahepatic bile duct paucity (Alagille syndrome), as well as obstructive biliary disease
 xv. Budd-Chiari syndrome
xvi. Biliary dysplasia
xvii. Metabolic liver disorders
xviii. Cholangiocarcinoma (for adults: when a transplant center applies for a MELD exception for unresectable cholangiocarcinoma based on underlying liver disease or due to technical considerations, mass < 3 cm. and with intrahepatic and extrahepatic metastases excluded)
xix. Hepatocellular Carcinoma (HCC) when all of the following conditions are met:
   (a) The member is not a candidate for subtotal liver resection
   (b) The member has a single tumor less than or equal to 5 cm in diameter or up to 3 lesions each smaller than 3 cm
   (c) There is no macrovascular involvement or identifiable extrahepatic spread of tumor to surrounding lymph nodes, lungs, abdominal organs or bones, and
   (d) This is not a recurrence of previous resected or treated HCC.
xx. Retransplantation when any of the following occurs:
   (a) Chronic rejection with documented adherence to the post-transplant protocols
   (b) Biliary stricture
   (c) Hepatic artery thrombosis
   (d) Graft thrombosis
   (e) Sickle cell hepatopathy
   (f) Hepatic veno-occlusive disease

c. Reinfection with the Hepatitis C virus following a liver transplant is an absolute contraindication to retransplantation.

d. Additional Indications Limited to Pediatric Transplants

Criteria for medical necessity for liver transplantation limited to the pediatric population include, but are not limited to, the following indications:
i. Intractable cholestasis, intrahepatic (idiopathic neonatal hepatitis)
ii. Portal hypertension
iii. Multiple episodes of ascending cholangitis
iv. Failure of synthetic function
v. Failure to thrive, malnutrition
vi. Intractable ascites
vii. Encephalopathy
viii. Caroli’s with Congestive Heart Failure (CHF)
ix. Cystic fibrosis
x. Metabolic defects for which liver transplantation will reverse life threatening illness and prevent irreversible Central Nervous System (CNS) damage. The following may be underlying diagnoses/disorders that lead to pediatric liver transplantation:
   (a) Urea cycle defects
   (b) Selected organic acidemias
   (c) Crigler-Najjar Syndrome
   (d) Familial hypercholesterolemia
   (e) Neonatal iron storage disease
   (f) Hyperoxaluria Type I
   (g) Hemophilia A and B
   (h) Tyrosinemia
   (i) Glycogen storage disease (I, III, IV)
   (j) Glycogen debrancher deficiency 1B
   (k) Disorders of bile acid metabolism
   (l) Lipid storage disease, and
   (m) Protein C Deficiency
   (n) Malignancy including but not limited to:
      (o) Hepatoblastoma
      (p) Hepatocellular carcinoma
      (q) Hemangioendothelioma
      (r) Sarcomas, and
      (s) Neuroendocrine tumors when the tumor does not extend beyond the margins of the liver

e. Contraindications Limited to Adults

In addition to the contraindications noted in Section A of this Policy, contraindications to liver transplantation in adults, include, but are not limited to:

i. Malignancies, other than Hepatocellular Carcinoma (HCC) with the criteria previously stated in this Section
ii. Acute severe hemodynamic compromise at the time of transplant if accompanied by compromise or failure of one or more vital organs
iii. The need for prior transplantation of another organ such as lung, kidney, heart or blood or marrow if this represents a co-existence of significant disease
iv. Insulin-dependent diabetes mellitus with end-organ disease
v. Gross vascular invasion of hepatocellular carcinoma, or
vi. Systemic diseases that will result in member death regardless of liver transplant
vii. Morbid obesity with BMI >35 kg/m².

f. Contraindications Limited to Pediatric Liver Transplants

In addition to the contraindications noted in Section A of this Policy, contraindications to liver transplantation in the pediatric population include, but are not limited to:

i. Persistent viremia
ii. Active sepsis
iii. Severe cardio-pulmonary comorbidities
iv. Severe neurological disorder
v. Gross vascular invasion of hepatocellular carcinoma
vi. Malignancy extending beyond the margins of the liver with exception of neuro-endocrine tumors metastatic into the liver, and
vii. Systemic diseases that will result in member death despite liver transplant

6. Kidney

a. Indications

Criteria for medical necessity for live donor or cadaveric kidney transplantation includes, but is not limited to, the following indications:

i. All dialysis or advanced chronic kidney disease patients are transplant candidates until deemed unsuitable for transplant. Transplant is usually indicated when Glomerular Filtration Rate (GFR) falls below 20 ml/min.
ii. When the onset of dialysis is expected in the next six months (pre-emptive transplant)
iii. Symptomatic uremia at GFR above 20 ml/min.

b. Indications Limited to the Pediatric Population

For pediatric kidney transplants, additional criteria for transplantation include, but are not limited to:
i. Wilm’s tumor (non-metastatic), and
ii. Oxalosis (may also require a liver-kidney transplant and will be considered on a case-by-case basis)

c. Contraindications

In addition to the contraindications noted in Section A of this Policy, contraindications to kidney transplantation include, but are not limited to:

i. Potential complications from immunosuppressive regimens are unacceptable to the member (the benefits of remaining on dialysis outweigh the risks of transplantation)
ii. Structural problems or abnormalities with the lower urinary tract which interfere with normal renal function of the transplanted kidney
iii. Severe cardiomyopathy or ischemic heart disease that is not correctable
iv. Cardiac ejection fraction <30%
v. Hepatic cirrhosis
vi. Diffuse, pronounced vascular disease that is not correctable
vii. Active peptic ulcer disease
viii. Any chronic medical condition besides chronic kidney dysfunction where life expectancy is less than two years or
ix. Morbid Obesity with BMI > 35 kg/m²

d. Living Kidney Donor Exclusion Criteria

i. In order to qualify as a living kidney donor, the donor must be at least 18 but not more than 65 years of age and must be able to give informed consent.
ii. In addition, the donor will not be considered if he/she has any of the following:
   (a) Hypertension (>140/90 or requires medication)
   (b) Diabetes or abnormal glucose intolerance test
   (c) Proteinuria >250 mg/24 hours
   (d) Recent or recurrent kidney stones
   (e) Donors with a history of familial kidney disease such as Alport Syndrome, polycystic kidney disease, and nephrotic syndrome must be assessed for risk
   (f) Abnormal glomerular filtration rate, creatinine clearance <80 mL/min
   (g) Microscopic hematuria
   (h) Structural abnormalities in donor kidney
(i) History of prior malignancy other than cutaneous squamous or basal cell cancer
(j) Significant co-morbid medical conditions, (e.g., malignancy, COPD, etc.)
(k) Obesity (with BMI >35 kg/m²)
(l) History of thrombosis or thromboembolism, or
(m) Psychiatric contraindications including active substance abuse

7. Simultaneous Liver/Kidney (SLK)

a. Timing of referral:

Prior to referral to a transplant center for evaluation, the Contractor shall calculate the adult member’s Model for End stage Liver Disease (MELD) score. An adult member must have a MELD score greater than 10 to meet criteria for referral.

The Contractor shall calculate the pediatric member’s Pediatric End stage Liver Disease (PELD) score prior to transplant evaluation. The PELD score automatically assigns additional points for a child.

b. Indications for Simultaneous Liver/Kidney Transplants

Refer to the individual liver and kidney sections in this Policy for indications and general medical considerations.

c. Contraindications for Simultaneous Liver/Kidney Transplants

Refer to the individual liver and kidney sections in this Policy for contraindications and general medical considerations.

8. Simultaneous Pancreas/Kidney (SPK)

a. Indications for Simultaneous Pancreas/Kidney (SPK) Transplantation

Criteria for medical necessity for simultaneous pancreas/kidney transplantation include, but are not limited to, the following indications:

i. Insulin-dependent diabetes mellitus with impending renal failure, and

ii. The member is an acceptable candidate for pancreas transplantation
b. Contraindications

In addition to the general contraindications noted in Section A of this Policy, contraindications to SPK include, but are not limited to:

i. Uncorrectable cardiovascular or peripheral vascular disease
ii. Cardiac ejection fraction < 30%
iii. Peripheral vascular disease that is not correctable
iv. Active substance abuse, or
v. End-organ disease, in other than pancreas or kidney, secondary to insulin-dependent diabetes mellitus
vi. Morbid obesity with BMI >30 kg/m².

9. Pancreas After Kidney (PAK)

For EPSDT members, covered services are limited to total pancreas only after kidney transplant. Partial pancreas and islet cell transplantation are not covered for both EPSDT members and member’s age 21 years and older.

a. Indications for Pancreas After Kidney Transplantation

Criteria for medical necessity of pancreas after kidney transplantation include, but are not limited to:

i. Achievement of adequate renal function post kidney transplantation, and
ii. Extreme labile Type I diabetes that has not responded to conventional therapy including an insulin pump

b. Contraindications

In addition to the general contraindications noted in Section A of this Policy, contraindications to pancreas after kidney transplantation include, but are not limited to:

i. Uncorrectable cardiovascular or peripheral vascular disease
ii. Cardiac ejection fraction < 30%
iii. Peripheral vascular disease that is not correctable
iv. Active substance abuse
v. End-organ disease, in other than pancreas or kidney, secondary to insulin-dependent diabetes mellitus, or
vi. Morbid obesity with BMI >30 kg/m².
10. Pancreas Only

Pancreas only transplants are limited to EPSDT members and are covered when the member meets the criteria below.

a. Documented pancreas organ failure

b. Documented medically uncontrollable labile insulin-dependent diabetes mellitus with documented recurrent, severe, acutely life-threatening metabolic complications that require frequent (three or more emergency room visits or hospital admissions in a three-month period) hospitalization

c. Hospitalizations related to complications due to frequent hypoglycemia unawareness or recurring severe ketoacidosis, or recurring hypoglycemic attacks, and

d. Management by an endocrinologist for a minimum of 12 months with the most medically recognized advanced insulin formulations and delivery systems, including insulin pump therapy if appropriate.

NOTE: For individuals age 21 and older, AHCCCS covers pancreas after kidney and simultaneous pancreas/kidney transplants. Pancreas only transplants are not a covered benefit for adults unless the member has previously had a Pancreas after Kidney transplant or Simultaneous Pancreas/Kidney transplant and the pancreas is failing.

11. Visceral Transplants

NOTE: Visceral transplantation is limited to members who are under 21 years of age and meet the medical eligibility criteria.

Cadaveric en bloc visceral transplants involving pancreas/liver/small bowel are covered when clinically indicated.

a. Indications for EPSDT members

Criteria for visceral transplantation alone, and combined small bowel/liver/pancreas transplantation in any combination include, but are not limited to the following conditions:

i. Small bowel syndrome resulting from inadequate intestinal propulsion due to neuromuscular impairment

ii. Small bowel syndrome resulting from post-surgical conditions due to resections for:
(a) Intestinal cysts  
(b) Mesenteric cysts  
(c) Tumors involving small bowel  
(d) Crohn’s disease  
(e) Mesenteric thrombosis, or  
(f) Volvulus  

iii. Short-gut syndromes in which there is liver function impairment (usually secondary to Total Parenteral Nutrition [TPN])  
iv. Impending or overt liver or pancreas failure due to TPN-induced liver injury, with clinical manifestations including elevated serum bilirubin and/or liver enzymes, splenomegaly, thrombocytopenia, gastroesophageal varices, coagulopathy, stomal bleeding or hepatic fibrosis/cirrhosis  
v. Thrombosis of two or more major central venous channels (jugular, subclavian or femoral veins)  
vi. Two or more episodes per year of systemic sepsis secondary to line infection, which require hospitalization, indicating failure of TPN therapy  
vii. Frequent episodes of severe dehydration despite intravenous fluid supplement in addition to TPN, or  
viii. Gastrostomosis  

C. Contraindications for EPSDT members  

In addition to the general contraindications noted in Section A of this Policy, contraindications to visceral transplantation include, but are not limited to, the following conditions:  

i. Insufficient vascular patency, and  
ii. Life-threatening and non-correctable illness not related to the digestive system such as:  
   (a) Profound neurological disability, or  
   (b) Chronic cardio-pulmonary disease  

D. HEMATOPOIETIC STEM CELL TRANSPLANTS (HSCT)  

Hematopoietic Stem Cell Transplant (HSCT) is the transplantation of blood stem cells derived from the bone marrow or blood, including cord blood. Conditioning therapy includes either myeloablative or non-myeloablative induction with or without Total Body Irradiation (TBI).  

Medical necessity for Cord Blood Transplantation (CBT) in adults will be determined on a case-by-case basis. For any pediatric CBT, a single cord blood unit will be considered standard treatment.
E. AUTOLOGOUS HSCT

Criteria for medical necessity for autologous HSCT include, but are not limited to, the following indications:

1. **ADULTS**
   a. Acute Myelogenous Leukemia (AML) in remission
   b. Chronic Myelogenous Leukemia (CML) in remission
   c. Relapsed Hodgkin Lymphoma that is chemosensitive
   d. Mantle cell lymphoma that is chemosensitive
   e. Germ cell tumors (tandem)
   f. Multiple myeloma (tandem)
   g. Amyloidosis in patients with adequate organ function
   h. Waldenstrom’s macroglobulinemia
   i. Non-Hodgkin lymphoma subtypes where peer-reviewed data has confirmed safety and efficacy of the proposed transplant procedure.

2. **PEDIATRIC**
   a. Neuroblastoma (tandem appropriate if done per a clinical trial)
   b. Medulloblastoma
   c. Brain tumors, other than medulloblastoma, including central nervous system germ cell tumors, Peripheral Neuro-Ectodermal Tumor (PNET), atypical Teratoid/ Rhabdoid Tumor (AT/RT), oligodendroglioma, and pineoblastoma, where peer-reviewed data on safety and efficacy for the proposed transplant procedure have been successfully demonstrated.
   d. Relapsed chemo-sensitive Hodgkin lymphoma
   e. Relapsed chemo-sensitive Non-Hodgkin lymphoma
f. Other pediatric solid tumors (Wilm’s tumor, Ewings sarcoma, etc.) where peer-reviewed data on safety and efficacy for the proposed transplant have been successfully demonstrated.

Whether a specific disease meets the criteria for autologous HSCT is determined by current guidelines as published by specialty societies such as the American Society for Blood and Marrow Transplantation (ASBMT) and the Children’s Oncology Group (COG).

3. CONTRAINDICATIONS

In addition to the general contraindications noted in Section A of this Policy, contraindications to Autologous HSCT include, but are not limited to, the following conditions:

a. Evidence of cirrhosis or significant liver dysfunction, since this can be a factor for development of Sinusoidal Obstruction Syndrome (SOS) formerly called Veno-Occlusive Disease (VOD)

b. Uncontrolled, progressive or active systemic infection at the time of transplant is an absolute contraindication. Prior infection, or infection where there is relative control with a post-transplant plan of control, is not an absolute contraindication and must be considered on a case-by-case basis.

c. Prior malignancy, other than disease being treated by transplant, within the last five years. These must be considered on a case-by-case basis.

d. Cystic fibrosis (absolute) and other multi-system disease not correctable by hematopoietic stem cell transplantation

e. End-organ damage of either heart or lungs

f. Parenchymal brain disease that raises the risk of cerebrovascular hemorrhage

g. Prior allogeneic hematopoietic stem cell transplant is a relative contraindication depending on disease responsiveness, disease control, patient’s performance status, and presence of other co-morbidities. These must be considered on a case-by-case basis.
F. ALLOGENEIC HSCT

Criteria for medical necessity for Allogeneic HSCT include, but are not limited to, the following indications:

1. **ADULTS**
   
   a. **Acute Myelogenous Leukemia**
      
      i. Primary indication failure or slow to induce or refractory disease
      
      ii. In first complete remission, if patient at moderate risk for relapse per standard criteria and a match, related donor is available
      
      iii. In first complete remission, if patient at high-risk for relapse per standard criteria and has either a match, related donor or a well-matched unrelated donor available, or
      
      iv. In second complete remission.
   
   b. **Acute Lymphogenous Leukemia**, in remission
   
   c. **Chronic Myelogenous Leukemia**
      
      i. Unresponsive to tyrosine kinase inhibitor control with three prior lines of therapy or
      
      ii. Intolerance to tyrosine kinase inhibitors or has severe side effects
      
      iii. Accelerated phase or blast crisis.
   
   d. **Relapsed or progressive Hodgkin lymphoma** that is chemosensitive
   
   e. **Relapsed or progressive large cell Non-Hodgkin lymphoma** that is chemosensitive
   
   f. **Chemosensitive low-grade or follicular Non-Hodgkin lymphoma** when clinical evidence indicates transformation to more aggressive subtype (Richter transformation)
   
   g. **Relapsed or progressive Non-Hodgkin lymphoma** that is chemosensitive and there is peer-reviewed data demonstrating both safety and efficacy for the particular NHL subtype involved, or
   
   h. **Myelodysplastic Syndrome** with acceptable donor (either a matched, related donor or well, matched, unrelated donor)
      
      i. **Fanconi Anemia**
j. Other Hematological Disorders for which peer-reviewed data on safety and efficacy for proposed transplant have been successfully demonstrated including, but not limited to:
   i. Sickle cell disease
   ii. Severe congenital anemia
   iii. Thalassemia

2. **PEDIATRIC**

   a. Acute Myelogenous Leukemia

   b. Juvenile Myelomonocytic Leukemia, at any stage, with any donor type.

   c. Chronic Myelogenous Leukemia
      i. Unresponsive to tyrosine kinase inhibitor control (usually three prior lines of therapy).
      ii. Intolerance to tyrosine Kinase inhibitors, or
      iii. Accelerated phase or blast crisis

   d. Acute Lymphogenous Leukemia
      i. In first complete remission, if high-risk for relapse; or primary indication failures who subsequently achieve a first complete remission
      ii. T-cell Acute Lymphogenous Leukemia in first complete remission with early marrow relapse (<six months) or
      iii. In the second complete remission, if early relapse (less than 36 months remission)

   e. Relapsed or progressive Hodgkin Lymphoma that is chemosensitive.

   f. Relapsed or progressive Non-Hodgkin Lymphoma that is chemosensitive, and there is peer-reviewed data demonstrating safety and efficiency of the proposed procedure for the particular Non-Hodgkin Lymphoma subtype involved.

   g. Inborn errors of Metabolism in patients who have not yet suffered either significant or irreversible end-organ damage.

   **Example indications:**

   Hurler syndrome
Sly syndrome (MPSVII)
D-Mannosidosis
X-linked Adrenoleukodystrophy
Aspartylglucosaminuria
Wolman disease
Late infantile metachromatic leukodystrophy
Krabbe disease

h. Primary lethal immune deficiencies and hemophagocytic lymphohistiocytosis such as:
   i. Wiskott-Aldrich Syndrome
   ii. Severe combined immune deficiencies (SCID)

i. Fanconi Anemia

j. Other Hematological Disorders for which peer-reviewed data on safety and efficacy for the proposed transplant have been successfully demonstrated, including but not limited to:
   i. Sickle cell disease
   ii. Severe congenital anemia
   iii. Thalassemia

3. CONTRAINDICATIONS

In addition to the contraindications noted in Section A of this Policy, contraindications to allogeneic HSCT include, but are not limited to, the following conditions:

a. Evidence of cirrhosis or severe liver dysfunction

b. Cystic fibrosis is an absolute contraindication

c. Uncontrolled, progressive or active systemic infection at the time of transplant is an absolute contraindication

d. End-organ damage of either heart or lungs

e. Parenchymal brain disease that poses a risk for cerebrovascular hemorrhage

f. Prior hematopoietic stem cell transplant is a relative contraindication depending on disease responsiveness, disease control, patient’s
performance status, and presence of other co-morbidities. These must be considered on a case-by-case basis.

G. OUT-OF-NETWORK COVERAGE

AHCCCS provides out-of-network coverage for solid organ or hematopoietic stem cell transplants for those members who have current medical requirements that cannot be met by an appropriate in-network transplant center. These medical requirements must be manifested as requiring either a specific level of technical expertise or program coverage that is not currently provided by AHCCCS contracted facilities. A request for out-of-network coverage will not be approved if the member has already received a medical denial from an AHCCCS contracted transplant center. The use of out-of-network transplant centers is determined by the review of quality and outcome data as published by their accreditation organization as well as their cost containment standards.

When a member completes an AHCCCS approved transplantation at an out-of-network facility, the necessary follow-up services will be covered through an AHCCCS contracted in-network facility, if one is available. These services include, but are not limited to, travel, lodging, meals, medical testing and post-operative evaluation and apply to any transplant performed under AHCCCS coverage, another third-party payer or through self-pay.

H. MULTIPLE SITE LISTING FOR SOLID ORGAN/HEMATOPOIETIC TRANSPLANTATION

If a member seeks to be evaluated for solid organ, or hematopoietic stem cell transplantation and is "listed" with more than the primary AHCCCS contracted transplant center, AHCCCS will only pay for one center’s evaluation services.

In the event that a member becomes listed by a facility other than the primary AHCCCS contracted transplant center, AHCCCS will not provide coverage for any costs in excess of the state-contracted rate for the specific transplant procedure.

In addition, reimbursement will be available only to FACT accredited or UNOS approved facilities. Facilities must be CMS certified transplant centers and must meet the Medicare conditions of participation as well as the special requirements for transplant centers set forth in 42 CFR Part 482.

If a member chooses to make his/her own arrangements for travel, lodging and/or meals, then the member must notify the Contractor (or AHCCCS if they are a Fee-For-Service [FFS] member), of the arrangements they have made. In addition, the member, in such circumstances, is responsible for securing and sending appropriate medical records to the appropriate transplant case manager. If the member is receiving services on an FFS basis through AHCCCS Administration, appropriate
medical records must be sent to the transplant case manager in the AHCCCS Division of Health Care Management, Medical Management Unit.

I. Non Transplant Medically Necessary Services Covered by AHCCCS For Members Who Receive Non Covered Transplants

If a member receives a transplant that is not covered by AHCCCS, medically necessary, non-experimental services commence following discharge from the acute care hospitalization for the transplant.

1. Covered services include, but are not limited to:
   a. Transitional living arrangements appropriately ordered for post-transplant members when the member does not live in close proximity to the center
   b. Essential laboratory and radiology procedures
   c. Medically necessary post-transplant therapies
   d. Immunosuppressant medications, and
   e. Medically necessary transportation

2. Covered services do not include:
   a. Evaluations and treatments to prepare for transplant candidacy
   b. The actual transplant procedure and accompanying hospitalization, or
   c. Organ or tissue procurement

AHCCCS reimbursement of the Contractor for medically necessary services following non-covered organ transplantation is in accordance with the regular reinsurance guidelines found in the Reinsurance Processing Manual. AHCCCS-covered transplantation and its related medically necessary services are reimbursed in accordance with the transplant reinsurance guidelines found in the Reinsurance Processing Manual with the exception of kidney transplants, cornea transplants and bone grafts. These services are covered as part of regular capitation payments and any related services may be covered in accordance with the regular reinsurance guidelines.

Refer to Policy 320-B, AHCCCS Member Participation In Experimental Treatment for additional information regarding AHCCCS member participation in experimental treatment.
J. TRANSPLANTATION MANAGEMENT

The AHCCCS Administration has entered into a contract with a transplantation management entity (Consultant) to review developments, outcomes and respective changes in technology, as well as assist in the development and revision of this Policy. The Consultant will be available, as necessary, to provide expertise regarding clinical issues arising from transplant requests.

Although the contractor is encouraged to consult with the transplantation management entity (AHCCCS Consultant) under contract with AHCCCS for guidance in making medical determinations regarding transplants. Contractors are not required to use the AHCCCS Consultant in reaching their medical determination. Contractors have the option of obtaining their own expert opinion. A written medical justification for the Contractor’s decision is required in each case.

AHCCCS, in partnership with the Consultant, is available to assist with questions and issues concerning specific diagnoses and medical conditions that are covered for transplantation.

Consultation may include, but is not limited to:

1. Telephone access to the Consultant Medical Director. Access will be arranged by the DHCM Medical Management Unit.
2. Regular updates on changes in experimental status of selected transplants and advances in technology and devices
3. Analysis of transplantation and related technology developments with enough information, including cost projections, to assist AHCCCS in revising this Policy as necessary, and
4. Assistance in recommendation of approved/appropriate transplant facilities, as necessary, for out-of-network coverage.

REFERENCES

1. 42 U.S.C. 1396b(i)
2. Title 42, Code of Federal Regulations (42 CFR) 441.35
3. Title 42, Code of Federal Regulations (42 CFR) Parts 440, 482, and 488
4. Arizona Revised Statues (A.R.S.) §36-2907
5. Arizona State Plan


7. Attachment A of this Policy for extended eligibility process/procedure

8. Chapter 300 of this Manual, Policy 320-B for information regarding AHCCCS member participation in experimental treatment

9. Chapter 500 of this Manual, for information regarding care coordination for transplant candidates who experience an interruption of eligibility or enrollment

10. Chapter 800 of this Manual, for fee-for-service prior authorization requirements for providers

11. AHCCCS Division of Health Care Management - Reinsurance Processing Manual, for information regarding Contractor applications for transplantation reinsurance

12. The AHCCCS Contracts, including specialty contracts, for further information regarding transplants and reinsurance.
ATTACHMENT A

EXTENDED ELIGIBILITY PROCESS/PROCEDURE FOR COVERED SOLID ORGAN AND TISSUE TRANSPLANTS
ATTACHMENT A

EXTENDED ELIGIBILITY PROCESS/PROCEDURE FOR COVERED SOLID ORGAN AND TISSUE TRANSPLANTS

REVISION DATES: 03/01/09, 11/01/06, 06/01/05, 07/01/04

INITIAL
EFFECTIVE DATE: 09/05/2002

Individuals found eligible for a transplant who subsequently lose eligibility for AHCCCS due to excess income may become eligible for one of two extended eligibility options. This extended eligibility process is authorized only for those individuals who meet all of the following conditions:

- Have been determined ineligible due to excess income under one of the covered Title XIX acute care groups including the medical expense deduction category
- Have been approved for a medically necessary and appropriate transplant and have been placed on a donor waiting list before eligibility expired, and
- Have entered into a contractual arrangement with the transplant facility to pay the amount of income, which is in excess of the eligibility income standards (referred to as transplant share of cost)

CASE COORDINATION

Since eligible individuals receive as little as 10 days notification by mail that their eligibility will end, it is essential that all transplant candidates receive early instructions about what to do and where to go to have eligibility redetermined.

Once the AHCCCS Division of Health Care Management (DHCM) Transplant Coordinator has been notified by the Contractor and the transplant facility that an individual is approved as a candidate for a transplant, a transplant status letter is sent to that individual. The letter informs the individual to immediately contact the Contractor Transplant Coordinator and the Transplant Facility Social Worker should he/she receive notification of pending termination from AHCCCS. In addition, the AHCCCS DHCM Transplant Coordinator will work closely with the Contractor's Transplant Coordinator to monitor the member's eligibility status for any changes.

The Contractor's Transplant Financial Coordinator is responsible for discussing the available extended eligibility options for coverage.
ATTACHMENT A

EXTENDED ELIGIBILITY PROCESS PROCEDURE FOR COVERED SOLID ORGAN AND TISSUE TRANSPLANTS

The following two options for extended eligibility are available for these qualified individuals:

OPTION 1

This option is intended to extend all AHCCCS covered services.

- Extended eligibility is for one 12-month continuous period of time and is funded by Tobacco Tax funds.

- Tobacco Tax funds will be used to pay the state share of capitation, reinsurance and transplant reinsurance which is equal to the lesser of 100% of the AHCCCS contract amount for the transplantation services rendered, or the Contractor paid amount, less the transplant share of cost. For transplants received at a facility not contracted with AHCCCS, payment is made at the lesser of 100% of the lowest AHCCCS contracted amount for the transplantation services rendered, or the Contractor paid amount, less the transplant share of cost. Refer to the Reinsurance Processing Manual for further detail.

- The transplant share of cost will be determined based on the total unmet spend down requirement for the household divided by the number of individuals in the household and will be calculated by the AHCCCS Central Eligibility Unit (CEU).

- The contracting transplant facility must submit a copy of the individual’s contractual agreement with the facility to the AHCCCS Division of Member Services (DMS).

- The amount of transplant share of cost shall not change once the extended period of eligibility begins.

- If an individual elects Option 1, he or she cannot switch to Option 2.

At the end of the 12-month period, the individual must qualify for AHCCCS based on regular eligibility requirements, or they will lose AHCCCS eligibility. Or, if during the 12-month period, the individual is determined to be no longer medically eligible for a transplant, their coverage will terminate at the end of that month.

NOTE: If during the 12-month period the individual becomes eligible for Title XIX coverage, the 12-month period continues. However, if the transplant takes place while the person is Title XIX eligible, there is no share of cost.
ATTACHMENT A

EXTENDED ELIGIBILITY PROCESS/PROCEDURE FOR COVERED SOLID ORGAN AND TISSUE TRANSPLANTS

OPTION 2

In this option, the individual who loses Title XIX eligibility is allowed to retain their status on the transplant donor waiting list until such time as the transplant is scheduled or performed. The individual is not eligible for any health care services from AHCCCS while waiting for the transplant unless at any time the individual qualifies for AHCCCS based on regular eligibility requirements. If the transplant facility enters into the contractual agreement with the person, the facility must allow that person to retain their transplant candidacy status, as long as the person is medically eligible. The contracting transplant facility must submit a copy of the individual’s contractual agreement with the facility to DMS.

- Once the transplant is scheduled or performed, the individual must reapply for Title XIX eligibility. At re-application, if determined Title XIX ineligible solely due to excess income, the transplant share of cost will be recalculated based on current income and family size. The transplant candidate who signs a contract with the transplant facility to pay the transplant share of cost will be enrolled with an AHCCCS Contractor to receive covered services limited to applicable transplant services.

- Tobacco Tax funds will be used to pay the state share of capitation, reinsurance and transplant reinsurance which is equal to the lesser of 100% of the AHCCCS contract amount for the transplantation services rendered, or the Contractor paid amount, less the transplant share of cost. For transplants received at a facility not contracted with AHCCCS, payment is made at the lesser of 100% of the lowest AHCCCS contracted amount for the transplantation services rendered, or the Contractor paid amount, less the transplant share of cost. Refer to the Reinsurance Processing Manual for further detail.

While the person is enrolled with a Contractor, Tobacco Tax funds will be used to pay the medical cost associated with the transplant, less the transplant share of cost, if the transplant is performed within 30 days prior to the date of eligibility determination by the eligibility office.

At any time, the individual may qualify for AHCCCS based on regular eligibility requirements. If the transplant takes place while the person is Title XIX eligible, there is no share of cost.

Transplant Candidate Responsibility

When the transplant candidate receives notice of a pending termination, he/she must contact the Contractor’s Transplant Coordinator to discuss the available options. Once an option is chosen, the individual must sign the contract agreeing to pay the transplant share of cost.

If a transplant candidate who has chosen Option 2 receives notification of the need for eligibility re-determination, contact the CEU to submit all necessary documents to re-determine eligibility and a new share of cost as applicable.
ATTACHMENT A

EXTENDED ELIGIBILITY PROCESS/PROCEDURE FOR COVERED SOLID ORGAN AND TISSUE TRANSPLANTS

If an individual is too ill to complete the above process on their own, it is the responsibility of the Contractor’s Transplant Coordinator and Medical Director to coordinate with DHCM, DMS and the individual to ensure that the steps outlined to initiate the re-determination process are completed on behalf of the individual.

DES Responsibility

On a priority basis, DES, in coordination with the DMS representative, will determine if the person remains eligible for any Title XIX category; if not, then DES will transfer the case to the CEU.

AHCCCS CEU Responsibility

- Verify the individual’s current transplant status with DHCM
- Calculate a transplant share of cost
- Inform the individual of the need to contact the transplant facility so they may discuss the two options and the contract for the transplant share of cost
- Fax the amount of the transplant share of cost to the financial coordinator at the transplant facility
- Process the extended eligibility application on a priority basis once a copy of the signed contract has been received from the transplant facility, and
- Notify the AHCCCS Member File Integrity Section when Option 1 has been selected to ensure eligibility status is updated on the AHCCCS member eligibility file.

If Option 2 is chosen, CEU will be responsible for recalculating the transplant share of cost at the time the transplant organ becomes available.

Transplant Facility Responsibility

The transplant facility staff must discuss the two options with the transplant candidate, verify the option chosen and determine whether a transplant share of cost contract will be signed.

A copy of the signed contract indicating the option chosen must be faxed by the transplant facility to the CEU and the responsible Contractor.
When a hematopoietic transplant (bone marrow or hematopoietic stem cell) is performed or an appropriate solid organ is available for transplant, the transplant facility will notify the AHCCCS DHCM Transplant Coordinator, and, if the candidate is enrolled, the Contractor.

**Contractor Responsibility**

If the individual has chosen Option 1, enrollment with their current Contractor will continue for 12 months only.

If the individual has chosen Option 2, the individual is on a waiting list with the Transplant Facility, but is not on AHCCCS. At any time the individual may re-qualify for AHCCCS and at that time choose a Contractor or be auto-assigned to a new Contractor. The new Contractor will take responsibility for continuity of care.

Once the Contractor's Transplant Coordinator receives copies of the signed contract and the option chosen from the transplant facility, copies of the documents must be faxed to the AHCCCS DHCM Transplant Coordinator.

**AHCCCS DHCM Responsibility**

Once notified by the Contractor's Transplant Coordinator of the option chosen by the individual, the AHCCCS DHCM Transplant Coordinator will notify the CEU so that eligibility can be updated.

Once notified by the transplant facility of the transplant or the availability of an organ, the AHCCCS DHCM Transplant Coordinator will begin tracking all completed components of the transplant process for review and verification of dates of services for claims.

**Transplant Reinsurance**

Refer to the Reinsurance Processing Manual
CHAPTER 300
MEDICAL POLICY FOR AHCCCS COVERED SERVICES

POLICY 310
COVERED SERVICES

310-EE NEGATIVE PRESSURE WOUND THERAPY (NPWT)

REVISION DATE: 8/01/13

INITIAL

EFFECTIVE DATE: 10/01/2009

Description

AHCCCS covers negative pressure wound therapy as, specified in this policy.

Definitions

Licensed healthcare professional, for the purposes of this Policy, may be a physician, Physician’s Assistant (PA), Nurse Practitioner (NP), Registered Nurse (RN), Licensed Practical Nurse (LPN), or Physical Therapist (PT).

The Stages of pressure ulcers, for purposes of this Policy, are as follows:

Stage I - Observable pressure related alteration of intact skin whose indicators as compared to the adjacent or opposite area on the body may include changes in one or more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel) and/or sensation (pain, itching). The ulcer appears as a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues.

Stage II - Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.

Stage III - Full thickness skin loss involving damage to, or necrosis of, subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.

Stage IV - Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage IV pressure ulcers.

Chronic – Present for a minimum of 30 days.
**Amount, Duration and Scope**

AHCCCS covers Negative Pressure Wound Therapy (NPWT) pump and supplies in the home or alternative residential setting or nursing facility setting according to the guidelines provided in this Policy.

**A. Initial Coverage:**

AHCCCS covers NPWT (including NPWT pump and supplies) when both of the following criteria are met.

1. Member has one of the following eligible conditions:
   a. Chronic Stage III or IV pressure ulcer
   b. Chronic neuropathic (e.g. diabetic) ulcer
   c. Chronic venous or arterial insufficiency ulcer
   d. Chronic ulcer of mixed etiology
   e. Dehisced wound or wound with exposed hardware or bone
   f. Complications of a surgically created wound

   **and**

2. A wound care program as described below must have been tried or considered and ruled out prior to application of NPWT. Each of the following components of a wound therapy program must be addressed, applied, or considered and ruled out prior to application of NPWT:
   
   a. Documentation in the member’s medical record of evaluation, care, and wound measurements by a licensed health care professional, and
   
   b. Application of dressings to maintain a moist wound environment, and
   
   c. Debridement of necrotic tissue if present, and
   
   d. Evaluation of and provision for adequate nutritional status.
CHAPTER 300
MEDICAL POLICY FOR AHCCCS COVERED SERVICES

POLICY 310
COVERED SERVICES

B. CONTINUED COVERAGE:

For NPWT coverage to continue once initiated, a licensed health care professional must perform the following:

1. On at least a weekly basis,
   a. directly assess the wound(s) being treated with the NPWT, and
   b. supervise or directly perform the NPWT dressing changes, and

2. On at least a monthly basis, document changes in the ulcer's dimensions and characteristics.

C. WHEN COVERAGE ENDS:

A NPWT pump and supplies are not considered medically necessary if any one or more of the following occurs:

1. Criteria for continued coverage are no longer met.

2. Despite meeting initial coverage criteria, a provider with the necessary licensure to order NPWT (for the purposes of this paragraph, an MD, DO, NP, or PA) determines that adequate wound healing has occurred to the degree that NPWT may be discontinued.

3. Despite meeting initial coverage criteria, a provider with the necessary licensure to order NPWT determines that no measurable degree of wound healing has occurred during the prior month. Wound healing is defined as improvement occurring in either surface area or depth of the wound.

4. When equipment or supplies are no longer being used for the member.

Limitations

An NPWT pump and supplies will be denied if one or more of the following are present:

- Necrotic tissue with eschar in the wound, if debridement is not attempted;
- Untreated osteomyelitis within the vicinity of the wound;
- Cancer tissue in the wound;
- Untreated fistula to an organ or body cavity within the vicinity of the wound.
310-FF  MONITORING CONTROLLED AND NON-CONTROLLED MEDICATION UTILIZATION

INITIAL

EFFECTIVE DATE: 01/01/2016

Description

All Contractors and the AHCCCS Fee-For-Service program must engage in activities to monitor controlled and non-controlled medication use, as set for this in the policy. The policy also delineates minimum requirements to ensure members receive clinically appropriate prescriptions. These requirements are also referred to as interventions.

Definitions

Controlled Substance means drugs and other substances that are considered controlled substances under the Controlled Substance Act (CSA).

CSPMP means the Arizona State Board of Pharmacy Controlled Substance Prescription Monitoring Program

Drug Diversion means the redirection of prescription drugs for illicit purposes.

Exclusive Pharmacy means the individual pharmacy, which is chosen by the member or assigned by the Contractor to provide all medically necessary federally reimbursable pharmaceuticals to the member.

Amount, Duration and Scope

A. MINIMUM MONITORING REQUIREMENTS

1. Contractors and Fee-For-Service are required to monitor controlled and non-controlled medications on an ongoing basis. Monitoring must include, at a minimum, the evaluation of prescription utilization by members, prescribing patterns by clinicians and dispensing by pharmacies. Drug utilization data shall be used to identify and screen high-risk members and providers who may facilitate drug diversion. The monitoring requirements are to determine potential misuse of the drugs used in the following therapeutic classes. The list includes:

   a. Atypical Antipsychotics
   b. Benzodiazepines
   c. Hypnotics
d. Muscle Relaxants

e. Opioids

f. Stimulants

2. Contractors shall utilize the following resources, when available, for their monitoring activities.

   a. Prescription claims data

   b. Arizona State Board of Pharmacy CSPMP

   c. Indian Health Service (IHS) and Tribal 638 pharmacy data

   d. RBHA/TRBHA prescription claims data

   e. Other pertinent data

3. Contractors shall evaluate the prescription claims data at a minimum, quarterly, to identify:

   a. Medications filled prior to the calculated days-supply

   b. Number of prescribing clinicians

   c. Number of different pharmacies utilized by the member

   d. Other potential indicators of medication misuse

**B. Minimum Intervention Requirements**

Contractors and Fee-For-Service shall implement the following interventions to ensure members receive the appropriate medication, dosage, quantity and frequency. Contractor interventions required include:

1. Point-of-Sale (POS) safety edits and quantity limits

2. Care/case management

3. Referral to, or coordination of care with, a behavioral health service provider(s) or other appropriate specialist.

4. Assignment of members who meet any of the evaluation parameters in Table 1 to an exclusive pharmacy and/or single prescriber for a minimum 12-month period except for the following members. Members with one or more of the following conditions shall not be subject to the intervention requirements described in B 1-4.

   a. Members in treatment for an active oncology diagnosis,

   b. Members receiving hospice care, or

   c. Members residing in a skilled nursing facility.
Table 1: Program Evaluation Criteria

<table>
<thead>
<tr>
<th>Evaluation Parameter</th>
<th>Minimum Criteria for Initiating Interventions</th>
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| Over-utilization     | Member utilized the following in a 3 month time period:  
|                      | $\geq 4$ prescribers; and  
|                      | $\geq 4$ different abuse potential drugs; and  
|                      | $\geq 4$ Pharmacies.  
|                      | OR  
|                      | Member has received 12 or more prescriptions of the medications listed in section A-1 in the past 3 months. |
| Fraud                | Member has presented a forged or altered prescription to the pharmacy. |

5. A member who is assigned to an exclusive pharmacy and/or an exclusive prescriber for 12 months must be provided a written notice of action at least 30 days prior to the effective date of the assignment. The written notice must include the factual and legal bases for the restriction and must also inform the member of the opportunity to file a request for hearing and the timeframes and process for doing so. Contractors shall not implement the restriction before providing the member notice and opportunity for a hearing. If the member has filed a request for hearing, no restriction shall be imposed until such time that an administrative action through the Grievance System process, such as a Director’s Decision or voluntary withdrawal by the member, has affirmed the restriction.

6. At the end of the 12-month time period, the Contractor shall review the member’s prescription and other utilization data to determine whether the intervention will be continued or removed. The Contractor must notify the member in writing of the decision to continue or discontinue the assignment of the pharmacy and/or provider. If the decision is to continue the assignment, the Contractor is required to include instructions for the appeals/fair hearing process in the notification letter to the member.

7. The intervention of assigning an exclusive pharmacy and/or provider does not apply to emergency services furnished to the member. The Contractor must ensure that the member has reasonable access to AHCCCS covered services, taking into account the geographic location and reasonable travel time. Contractors are required to provide specific instructions to the member, the
assigned exclusive pharmacy and/or exclusive provider, and their Pharmacy Benefit Manager (PBM) on how to address the following:

a. Emergencies defined as medical services provided for non-FES members for the treatment of an emergency medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
   i. Placing the member's health in serious jeopardy,
   ii. Serious impairment to bodily functions, or
   iii. Serious dysfunction of any bodily organ or part.

b. The medication is out-of-stock at the exclusive pharmacy, or

c. The exclusive pharmacy is closed.

C. REPORTING REQUIREMENTS

1. Identified cases of member deaths due to medication poisoning/overdose or toxic substances must be referred to the Contractor’s Quality Management staff for research and review.

2. Contractors are responsible for reporting all suspected fraud, waste and abuse to the appropriate entity.

3. Contractors are required to report to AHCCCS, as specified in the Contract Chart of Deliverables, a report of members assigned to a pharmacy and/or prescribing clinician which includes the number of members which on the date of the report are assigned to using a exclusive pharmacy or Prescriber/Providers due to excessive use of prescriptive medications (narcotics and non-narcotics)

REFERENCES

1. Controlled Substance Act (CSA), Title 21- Food and Drugs, Chapter 13 Drug Abuse Prevention And Control, Subchapter 1 – Control and Enforcement


310-GG  NUTRITIONAL ASSESSMENTS AND NUTRITIONAL THERAPY

INITIAL

EFFECTIVE DATE: 10/01/2015

Description

Nutritional assessments and nutritional therapy apply to all members whose health status may improve or be maintained with nutrition intervention. Specific policy requirements related to nutritional assessments and nutritional therapy within this Manual are as follows:

1. Chapter 400, Policy 430, EPSDT Services – Provides language and requirements specific to nutritional assessments and nutritional therapy for all members 20 years of age and under (Acute and ALTCS members).

2. Chapter 300, Policy 320-H, Medical Foods – Provides language and requirements specific to members with specific metabolic diseases.

The following services described in this policy apply to all members 21 years of age and older.

NOTE: Refer to the CDC website at http://www.cdc.gov/healthyweight/assessing/bmi/ for Body Mass Index (BMI) related information and tools.

Amount, Duration and Scope

Nutritional Assessments – Nutritional assessments are conducted to assist members, 21 years of age and older, whose health status may improve with nutritional intervention. AHCCCS covers the assessment of nutritional status, as determined necessary and as a part of health risk assessment and screening services provided by the member’s Primary Care Provider (PCP). Nutritional assessment services provided by a registered dietitian also covered when ordered by the member’s PCP. To initiate the referral for nutritional assessment, the PCP must comply with Managed Care Contractor protocols or AHCCCS Administration protocols for FFS members.

AHCCCS covers nutritional therapy on an enteral, parenteral or oral basis when determined medically necessary to provide either complete daily dietary requirements, or to supplement a member’s daily nutritional and caloric intake.

1. Enteral Nutritional Therapy – Provides liquid nourishment directly to the digestive tract of a member who cannot ingest an appropriate amount of calories to maintain an acceptable nutritional status. Enteral nutrition is commonly provided by J-tube, G-tube or N/G tube.
Refer to the specific Managed Care Contractor for managed care members or to Chapter 800 of this Manual, as well as the AHCCCS Care Management Systems Unit (CMSU) Unit, for Fee-For-Service (FFS) members regarding information on prior authorization requirements.

2. Parenteral Nutritional Therapy – Provides nourishment through the venous system to members with severe pathology of the alimentary tract that does not allow absorption of sufficient nutrients to maintain weight and strength.

Refer to the specific Managed Care Contractor for managed care members or to Chapter 800 of this Manual, as well as the AHCCCS CMSU Unit, for FFS members regarding information on prior authorization requirements.

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

A. Authorization from the member’s Managed Care Contractor or the AHCCCS Administration for FFS members is required for commercial oral nutritional supplements, unless the member is also currently receiving nutrition through enteral or parenteral feedings.

B. Medical necessity for commercial oral nutritional supplements must be determined on an individual basis by the member’s PCP or specialty provider, using the criteria specified in this Policy. The PCP or specialty provider must use the AHCCCS approved form, Chapter 300 Attachment C, Certificate of Medical Necessity for Commercial Oral Nutritional Supplements (Members 21 Years of Age or Greater – Initial or Ongoing Requests) to obtain authorization from the member's Managed Care Contractor (and ALTCS case manager, if applicable) or the AHCCCS Administration for FFS members.

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

1. The Member is currently underweight with a BMI of less than 18.5, presenting serious health consequences for the member, or has already demonstrated a medically significant decline in weight within the past three months (prior to the assessment).

2. The member is able to consume/eat no more than 25% of his/her nutritional requirements from typical food sources.
3. The member has been evaluated and treated for medical conditions that may cause problems with weight gain (such as feeding problems, behavioral conditions or psychosocial problems, endocrine or gastrointestinal problems, etc.), and

4. The member has had a trial of higher caloric foods, blenderized foods, or commonly available products that may be used as dietary supplements for a period no less than 30 days in duration. If it is determined through clinical documentation and other supporting evidence that a trial of higher caloric foods would be detrimental to the member’s overall health, the provider may submit Exhibit 430-2, Certificate of Medical Necessity for Commercial Oral Nutritional Supplements along with supporting documentation demonstrating the risk posed to the member for the Contractor’s Medical Director or Designee’s consideration in approving the provider’s prior authorization request.

D. Supporting documentation must accompany Chapter 300, Attachment C, Certificate of Medical Necessity for Commercial Oral Nutritional Supplements. This documentation must demonstrate that the member meets all of the required criteria and includes:

1. Initial Requests
   a. Documentation demonstrating that nutritional counseling has been provided as a part of the health risk assessment and screening services provided to the member by the PCP or specialty provider, or through consultation with a registered dietitian.
   b. Clinical notes or other supporting documentation dated no earlier than three months prior to date of the request, providing a detailed history and thorough physical assessment and demonstrating evidence of the member meeting all of the required criteria, as indicated on the Certificate of Medical Necessity. The physical assessment must include the member’s current/past height, weight, and BMI.
   c. Documentation detailing alternatives that were tried in an effort to boost caloric intake and/or change food consistencies that have proven unsuccessful in resolving the nutritional concern identified, as well as member adherence to the prescribed dietary plan/alternatives attempted.

2. Ongoing Requests
   a. Subsequent submissions must include a clinical note or other supporting documentation dated no earlier than three months prior to the date of the request, that includes the members overall response to supplemental therapy and justification for continued supplement use. This must include the
member’s tolerance to formula, recent hospitalizations, current height, weight, and BMI.

**NOTE:** Members receiving nutritional therapy must be physically assessed by the member’s PCP, specialty provider, or registered dietitian at least annually.

b. Additionally, documentation demonstrating encouragement and assistance provided to the caregiver in weaning the member from supplemental nutritional feedings should be included, when appropriate.

Refer to the specific Managed Care Contractor for managed care members or to Chapter 800 of this Manual, as well as the AHCCCS CMSU Unit, for FFS members regarding information on prior authorization requirements.

**Contractor Requirements**

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

   a. Information necessary to obtain Prior Authorization for commercial oral nutritional supplements,

   b. Encouragement and assistance to the member and/or caregiver in weaning the member from the necessity for supplemental nutritional feedings, including consultation by a Registered Dietitian/Nutritionist when determined medically necessary, and

   c. Education and training regarding proper sanitation and temperatures to avoid contamination of foods that are blenderized or specially prepared for the member, if the member and/or caregiver elects to prepare the member’s food.

2. Contractors must implement protocols for transitioning a member who is receiving nutritional therapy, to or from another Contractor or another service program.

3. Contractors must implement a process for verifying medical necessity of nutritional therapy, through the receipt of supporting medical documentation dated within 3 months of the request, prior to giving initial or ongoing authorizations for nutritional therapy. Documentation must include clinical notes or other supporting documentation from the member’s PCP, specialty provider, or registered dietitian including a detailed history and thorough physical assessment that provides evidence of member meeting all of the required criteria, as indicated on the Certificate of Medical Necessity.
Provider Requirements

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

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

2. If the member/caregiver elects to prepare the member's food, education and training regarding proper sanitation and temperatures to avoid contamination of foods that are blended or specially prepared for the member is provided.

3. Ongoing monitoring is conducted to assess member adherence/tolerance to the prescribed nutritional supplement regimen and determine necessary adjustments to the prescribed amount of supplement are appropriate based on the member’s weight loss/gain.

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

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
CERTIFICATE OF MEDICAL NECESSITY FOR COMMERCIAL ORAL NUTRITIONAL SUPPLEMENTS
FOR MEMBERS 21 YEARS OF AGE OR GREATER - INITIAL OR ONGOING REQUESTS
ATTACHMENT C
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
CERTIFICATE OF MEDICAL NECESSITY FOR COMMERCIAL ORAL NUTRITIONAL SUPPLEMENTS
FOR MEMBERS 21 YEARS OF AGE OR GREATER -INITIAL OR ONGOING REQUESTS

MEMBER INFORMATION
Member’s AHCCCS ID Number: ___________________________ Contracted Health Plan: __________
Member’s Name: ___________________________________________ Date of Birth: ____________________
Last First Initial
Members’ Address: ___________________________________________________________________________

Assessment performed by: ____________________________________ AHCCCS Provider ID: _______________
Provider Specialty: ___________________ Telephone Number: _______________ Assessment Date: _____________

□ Initial □ Weaning from Tube Feeding □ Oral Feeding – Sole Source
□ Ongoing □ Oral Feeding – Supplemental □ Emergency Supplemental Nutrition

PREFERRED SUPPLEMENT
Type: _________________________________ Substitution Permissible: □ Yes □ No

ASSESSMENT: Supporting documentation dated within 3 months of this request must be submitted with the Certificate of Medical Necessity to support each of the criteria listed below.

<table>
<thead>
<tr>
<th>All of the Following Requirements Must be Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Member is currently underweight with a BMI of less than 18.5, presenting serious health consequences for the member, or has already demonstrated a medically significant decline in weight within the 3 month period prior to the assessment.</td>
</tr>
<tr>
<td>The member is able to consume/eat no more than 25% of his/her nutritional requirements from typical food sources.</td>
</tr>
<tr>
<td>The member has been evaluated and treated for medical conditions that may cause problems with weight gain (such as feeding problems, behavioral conditions or psychosocial problems, endocrine or gastrointestinal problems, etc.)</td>
</tr>
<tr>
<td>The member has had a trial of higher caloric foods, blenderized foods, or commonly available products that may be used as dietary supplements for a period no less than 30 days in duration. ** Refer to AMPM, Policy 310-GG.</td>
</tr>
</tbody>
</table>

Initial and Ongoing Certificate of Medical Necessity is valid for a period of 6 months. Subsequent submissions must include a current physical assessment in the form of a clinical note or other supporting documentation that includes the members overall response to supplemental therapy and justification for continued supplement use. This must include the member’s tolerance to formula, recent hospitalizations, current height, weight, and BMI. Documentation demonstrating encouragement and assistance provided to the caregiver in weaning the member from supplemental nutritional feedings should be included, when appropriate.

______________________________________________________       _______________________________
Submitting Provider Signature            Date

___________________________              _____________________       _______________________________
Printed Name           Provider Type        Contact Number

Effective Date: 10/01/2015
EXHIBIT 310-1

ARIZONA ADMINISTRATIVE CODE AHCCCS RULE
EMERGENCY MEDICAL AND BEHAVIORAL HEALTH SERVICES
FOR NON-FES MEMBERS
EXHIBIT 310-1

ARIZONA ADMINISTRATIVE CODE
TITLE 9. HEALTH SERVICES
CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
ADMINISTRATION
ARTICLE 2. SCOPE OF SERVICES

R9-22-210 Emergency Medical Services for Non-Federal Emergency Services (FES) Members
R9-22-210.01 Emergency Behavioral Health Services for Non-FES Members

R9-22-210. Emergency Medical Services for Non-FES Members

A. General provisions.

1. Applicability. This Section applies to emergency medical services for non-FES members. Provisions regarding emergency behavioral health services for non-FES members are in R9-22-210.01. Provisions regarding emergency medical and behavioral health services for FES members are in R9-22-217.

2. Definitions.

a. For the purposes of this Section, ‘‘contractor’’ has the same meaning as in A.R.S. § 36-2901. Contractor does not include ADHS/DBHS or a subcontractor of ADHS/DBHS, or Children’s Rehabilitative Services.

b. For the purposes of this Section and R9-22-210.01, ‘‘fiscal agent’’ means a person who bills and accepts payment for a hospital or emergency room provider.

3. Verification. A provider of emergency medical services shall verify a person’s eligibility status with AHCCCS, and if eligible, determine whether the person is enrolled with AHCCCS as non-FES FFS or is enrolled with a contractor.

4. Prior authorization.

a. Emergency medical services. A provider is not required to obtain prior authorization for emergency medical services.

b. Non-emergency medical services. If a non-FES member’s medical condition does not require emergency medical services, the provider shall obtain prior authorization as required by the terms of the provider agreement under R9-22-714(A) or the provider’s subcontract with the contractor, whichever is applicable.

5. Prohibition against denial of payment. Neither the Administration nor a contractor shall:

a. Limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms,

b. Deny or limit payment because the provider failed to obtain prior authorization for emergency services,

c. Deny or limit payment because the provider does not have a subcontract.

6. Grounds for denial. The Administration and a contractor may deny payment for emergency medical services for reasons including but not limited to:

a. The claim was not a clean claim;

b. The claim was not submitted timely; and

c. The provider failed to provide timely notification under subsection (B)(4) to the contractor or the Administration, as appropriate, and the contractor does not have actual notice from any other source that the member has presented for services.

B. Additional requirements for emergency medical services for non-FES members enrolled with a contractor.

1. Responsible entity. A contractor is responsible for the provision of all emergency medical services to non-FES members enrolled with the contractor.

2. Prohibition against denial of payment. A contractor shall not limit or deny payment for emergency medical services when an employee of the contractor instructs the member to obtain emergency medical services.

3. Contractor notification. A contractor shall not deny payment to a hospital, emergency room provider, or fiscal agent for an emergency medical service rendered to a non-FES member based on the failure of the hospital, emergency room provider, or fiscal agent to notify the member’s contractor within 10 days from the day that the member presented for the emergency medical service.

4. Contractor notification. A hospital, emergency room provider, or fiscal agent shall notify the contractor no later than the 11th day after presentation of the non-FES member for emergency inpatient medical services. A contractor may deny payment for a hospital’s, emergency room provider’s, or fiscal agent’s failure to provide timely notice, under this subsection.

C. Post-stabilization services for non-FES members enrolled with a contractor.

1. After the emergency medical condition of a member enrolled with a contractor is stabilized, a provider shall request prior authorization from the contractor for post-stabilization services.

2. The contractor is financially responsible for medical post-stabilization services obtained within or outside the network that have been prior authorized by the contractor.

3. The contractor is financially responsible for medical post-stabilization services obtained within or outside the network that are not prior authorized by the contractor, but are administered to maintain the member’s stabilized condition within one hour of a request to the contractor for prior authorization of further post-stabilization services;

4. The contractor is financially responsible for medical post-stabilization services obtained within or outside the network that are not prior authorized by the contractor, but are administered to maintain, improve, or resolve the member’s stabilized condition if:

a. The contractor does not respond to a request for prior authorization within one hour;

b. The contractor authorized to give the prior authorization cannot be contacted; or
c. The contractor representative and the treating physician cannot reach an agreement concerning the member’s care and the contractor physician is not available for consultation. In this situation, the contractor shall give the treating physician the opportunity to consult with a contractor physician. The treating physician may continue with care of the member until the contractor physician is reached. 
  i. A contractor physician with privileges at the treating hospital assumes responsibility for the member’s care,  
  ii. A contractor physician assumes responsibility for the member’s care through transfer,  
  iii. The contractor’s representative and the treating physician reach agreement concerning the member’s care, or  
  iv. The member is discharged.

5. Transfer or discharge. The attending physician or practitioner actually treating the member for the emergency medical condition shall determine when the member is sufficiently stabilized for transfer or discharge and that decision shall be binding on the contractor.

D. Additional requirements for FFS members.
1. Responsible entity. The Administration is responsible for the provision of all emergency medical services to non-FES FFS members.
2. Grounds for denial. The Administration may deny payment for emergency medical services if a provider fails to provide timely notice to the Administration.
3. Notification. A provider shall notify the Administration no later than 72 hours after a FFS member receiving emergency medical services presents to a hospital for inpatient services. The Administration may deny payment for failure to provide timely notice.

Historical Note

R9-22-210.01. Emergency Behavioral Health Services for Non-FES Members
A. General provisions.
1. Applicability. This Section applies to emergency behavioral health services for non-FES members. Provisions regarding emergency medical services for non-FES members are in R9-22-210. Provisions regarding emergency medical and behavioral health services for FES members are in R9-22-217.
2. Definition. For the purposes of this Section, “contractor” has the same meaning as in A.R.S. § 36-2901. Contractor does not include ADHS/DBHS, a subcontractor of ADHS/DBHS, or Children’s Rehabilitative Services.
3. Responsible entity for inpatient emergency behavioral health services.
   a. Members enrolled with a contractor.
      i. ADHS/DBHS. ADHS/DBHS or a subcontractor of ADHS/DBHS is responsible for providing all inpatient emergency behavioral health services to non-FES members with psychiatric or substance abuse diagnoses who are enrolled with the contractor, from one of the following time periods, whichever comes first:
         (1) The date on which the member becomes a behavioral health recipient, or  
         (2) The 73rd hour after admission for inpatient emergency behavioral health services.
      ii. Contractors. Contractors are responsible for providing inpatient emergency behavioral health services to non-FES members with psychiatric or substance abuse diagnoses who are enrolled with a contractor and are not behavioral health recipients, for the first 72 hours after admission.
   b. FFS members. ADHS/DBHS or a subcontractor of ADHS/DBHS is responsible for providing all inpatient emergency behavioral health services for non-FES FFS members with psychiatric or substance abuse diagnoses.
4. Responsible entity for non-inpatient emergency behavioral health services for non-FES members. ADHS/DBHS or a subcontractor of ADHS/DBHS is responsible for providing all non-inpatient emergency behavioral health services for non-FES members.
5. Verification. A provider of emergency behavioral health services shall verify a person’s eligibility status with AHCCCS, and if eligible, determine whether the person is a member enrolled with AHCCCS as non-FES FFS or is enrolled with a contractor, and determine whether the member is a behavioral health recipient as defined in R9-22-102.
6. Prior authorization.
   a. Emergency behavioral health services. A provider is not required to obtain prior authorization for emergency behavioral health services.
   b. Non-emergency behavioral health services. When a non-FES member’s behavioral health condition is determined by the provider not to require emergency behavioral health services, the provider shall follow the prior authorization requirements of a contractor and ADHS/DBHS or a subcontractor of ADHS/DBHS.
7. Prohibition against denial of payment. A contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS shall not limit or deny payment to an emergency behavioral health provider for emergency behavioral health services to a non-FES member for the following reasons:
   a. On the basis of lists of diagnoses or symptoms;
   b. Prior authorization was not obtained;
   c. The provider does not have a contract;
d. An employee of the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS instructs the member to obtain emergency behavioral health services; or
e. The failure of a hospital, emergency room provider, or fiscal agent to notify the member’s contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS within 10 days from the day the member presented for the emergency service.

8. Grounds for denial. A contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS may deny payment for emergency behavioral health services for reasons including but not limited to the following:
a. The claim was not a clean claim;
b. The claim was not submitted timely; or
c. The provider failed to provide timely notification under subsection (A)(9) to the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS.

9. Notification. A hospital, emergency room provider, or fiscal agent shall notify a contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, whichever is appropriate, no later than the 11th day from presentation of the non-FES member for emergency inpatient behavioral health services.

10. Behavioral health evaluation. An emergency behavioral health evaluation is covered as an emergency behavioral health service for a non-FES member under this Section if:
a. Required to evaluate or stabilize an acute episode of mental disorder or substance abuse, and
b. Provided by a qualified provider who is:
i. A behavioral health medical practitioner as defined in R9-22-112, including a licensed psychologist, a licensed clinical social worker, a licensed professional counselor, and a licensed marriage and family therapist; or
ii. An ADHS/DBHS-contracted provider.

11. Transfer or discharge. The attending physician or the provider actually treating the non-FES member for the emergency behavioral health condition shall determine when the member is sufficiently stabilized for transfer or discharge and that decision shall be binding on the contractor and ADHS/DBHS or a subcontractor of ADHS/DBHS.

B. Post-stabilization requirements for non-FES members.

1. A contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, as appropriate, is financially responsible for behavioral health post-stabilization services obtained within or outside the network that have been prior authorized by the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS.

2. The contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, as appropriate, is financially responsible for behavioral health post-stabilization services obtained within or outside the network that are not prior authorized by the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, but are administered to maintain the member’s stabilized condition within one hour of a request to the contractor, ADHS/DBHS, or a subcontractor for prior authorization of further post-stabilization services;

3. The contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, as appropriate, is financially responsible for behavioral health post-stabilization services obtained within or outside the network that are not prior authorized by the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, but are administered to maintain, improve, or resolve the member’s stabilized condition if:
a. The contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, does not respond to a request for prior authorization within one hour;
b. The contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS authorized to give the prior authorization cannot be contacted; or
c. The representative of the contractor, ADHS/DBHS, or the subcontractor and the treating physician cannot reach an agreement concerning the member’s care and the contractor’s, ADHS/DBHS’ or the subcontractor’s physician, is not available for consultation. The treating physician may continue with care of the member until ADHS/DBHS’, the contractor’s, or the subcontractor’s physician is reached, or:
i. A contractor physician with privileges at the treating hospital assumes responsibility for the member’s care;
ii. ADHS/DBHS’, a contractor’s, or a subcontractor’s physician assumes responsibility for the member’s care through transfer;
iii. A representative of the contractor, ADHS/DBHS, or the subcontractor and the treating physician reach agreement concerning the member’s care; or
iv. The member is discharged.

Historical Note
New Section made by final rulemaking at 11 A.A.R. 5480, effective December 6, 2005 (Supp. 05-4). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3).
320 SERVICES WITH SPECIAL CIRCUMSTANCES

320-A AFFILIATED PRACTICE DENTAL HYGIENIST POLICY

REVISION DATE: 10/01/09

INITIAL
EFFECTIVE DATE: 04/01/2007

Description

AHCCCS covers oral health care services as described in Chapter 400, Policy 430, EPSDT services. As allowed by State law, A.R.S. §32-1281 and §32-1289, and described in this policy, dental hygienists with an affiliated practice agreement, may provide dental hygiene services to AHCCCS members 18 years of age and younger.

Amount, Duration and Scope

AHCCCS covers dental hygiene services provided by Arizona licensed dental hygienists subject to the terms of the written affiliated practice agreement entered into between a dentist and a dental hygienist.

Each affiliated dental hygienist, when practicing under an affiliated practice relationship may perform only those duties specified within the terms of the affiliated practice relationship and they must maintain an appropriate level of contact, communication and consultation with the affiliated practice dentist.

In addition to the requirements specified in A.R.S. §32-1281 and §32-1289, AHCCCS requires the following:

1. Both the dental hygienist and the dentist in the affiliated practice relationship must be registered AHCCCS providers.

2. The affiliated practice dental hygienist must maintain individual medical records of AHCCCS members in accordance with the Arizona State Dental Practice Act. At a minimum this must include member identification, parent/guardian identification, signed authorization (parental consent) for services, member medical history and documentation of services rendered.
3. The affiliated practice dental hygienist must register with AHCCCS and bill for services under his or her individual AHCCCS provider identification number / NPI number.

4. The affiliated practice dental hygienist will only be reimbursed for providing services in accordance with State regulations, AHCCCS policy and provider agreement, and their affiliated practice agreement.

5. AHCCCS reimbursement for dental radiographs is restricted to providers who are qualified to perform both the exposure and the interpretation of dental radiographs.
320-B  AHCCCS MEMBER PARTICIPATION IN EXPERIMENTAL TREATMENT

REVISION DATES: 07/01/12, 03/01/09, 06/01/07, 07/01/04, 10/01/01

INITIAL EFFECTIVE DATE: 10/01/1994

Description

AHCCCS members who are enrolled with a Contractor, or are receiving services on a Fee-For-Service (FFS) basis, may participate in experimental treatment, but AHCCCS will not reimburse for the experimental treatment.

Amount, Duration and Scope

If the experimental treatment provided to an AHCCCS member requires laboratory tests, imaging services, inpatient services, or other medical services that would not otherwise be required for non-experimental treatments provided to the member, AHCCCS will not cover the additional services. Coverage of care associated with complications resulting from the experimental treatment will be considered on an individual basis. Participation in experimental treatment will not result in the loss of the member's other benefits.

The member's primary care provider must not have any financial interest in the experimental treatment and cannot accept a finder's fee for referral of a member to participate in the experiment.

Any individual expected to assess the appropriateness of services for the member cannot have a financial interest in conducting the experimental treatment, or its outcome.

Participation in a U.S. Food and Drug Administration Phase I or Phase II clinical trial must be approved by the member's Contractor, or by the AHCCCS Chief Medical Officer. If a Contractor approves participation of one or more members in an experimental trial, it must provide notice to AHCCCS/Division of Health Care Management (DHCM), Medical Management Unit, which includes assurance that the member's rights are protected. FFS member participation will be evaluated for approval by the AHCCCS Medical Director. The basis for approval will include:

1. Verification that full financial liability for the experimental treatment is taken by the researcher or the sponsor, and documentation indicates that the costs associated with the experimental treatment and direct complications will not be charged to, or paid by, AHCCCS
2. The experimental treatment regimen is well designed, and adequate protection of the member's welfare is assured. The trial provides adequate participant information, assures participant consent, and

3. AHCCCS Contractor employees or network providers cannot receive fees, finder's fees or other payment for referring members.
320-C  BREAST AND CERVICAL CANCER TREATMENT PROGRAM

REVISION DATES:  09/01/2011, 6/01/07, 07/01/04

INITIAL

EFFECTIVE DATE:  01/01/2002

Description

Effective January 1, 2002, the Breast and Cervical Cancer Treatment Program (BCCTP) was added as a new eligibility category under AHCCCS. The Native American Breast and Cervical Cancer Treatment technical amendment that was signed into law on January 15, 2002, made it possible for American Indian women to qualify for the BCCTP coverage group even if they are eligible for health services from the Indian Health Service (IHS) or a 638 Tribal Facility.

Requirements for the program specify that a woman must be screened and diagnosed as needing treatment for breast and/or cervical cancer. Any of the following Arizona programs of the National Breast and Cervical Cancer Early Detection Program funded by the Centers for Disease Control and Prevention (CDC) can provide such services:

1. The Well Woman Health Check Program (WWHP), administered by the Arizona Department of Health Services (ADHS),
2. The Hopi Women’s Health Program, and

Amount, Duration and Scope

A woman who is eligible for AHCCCS under the BCCTP receives the full range of AHCCCS covered services pursuant to Arizona Administrative Code Title 9, Chapter 22, Article 20. A woman who is eligible under this program will be enrolled with a Contractor of her choice. If she does not choose one, she will be automatically assigned to one.

Treatment Services and Eligibility

Breast Cancer - Eligibility for the breast cancer program shall conclude 12 months after the last provider visit for specific treatment of the cancer, or at the end of hormonal therapy for breast cancer, whichever is later.
Treatment includes any of the following:

1. Surgical removal of the breast cancer
2. Chemotherapy
3. Radiation therapy, or
4. A treatment that, as determined by the AHCCCS Medical Director or designee, is considered the standard of care as supported by a peer-reviewed study published in a medical journal.

Pre-cancerous cervical lesion(s) - Eligibility for the program for a pre-cancerous cervical lesion, including moderate or severe cervical dysplasia or carcinoma in situ, shall conclude four months after the last provider visit for specific treatment for the pre-cancerous lesion(s).

Treatment includes any of the following:

1. Conization
2. Loop Electrosurgical Excision Procedure
3. Cryotherapy, or
4. A treatment that, as determined by the AHCCCS Medical Director or designee, is considered the standard of care as supported by a peer-reviewed study published in a medical journal.

Cervical Cancer – Eligibility for the program for cervical cancer shall conclude 12 months after the last provider visit for specific treatment of the cancer.

Treatment includes any of the following:

1. Surgery
2. Chemotherapy
3. Radiation therapy, or
4. A treatment that, as determined by the AHCCCS Medical Director or designee, is considered the standard of care as supported by a peer-reviewed study published in a medical journal.
Metastasized Cancer - A woman’s eligibility and treatment under this program will continue if a metastasized cancer is found in another part of the woman’s body and the metastasized cancer is a known or presumed complication of the breast or cervical cancer.

Re-occurrence of the Cancer - A woman will have eligibility re-established, after eligibility under this program ends, if:

The woman is screened under the WWHP program or one of the American Indian programs, and

1. Additional breast or cervical cancer is found, or
2. There is re-occurrence of pre-cancerous lesion(s).

Exclusions

Males are precluded from receiving screening and diagnostic services under the National Breast and Cervical Cancer Early Detection Program and thus are ineligible under this program.

Responsibilities

The National Breast and Cervical Cancer Early Detection Program and staff shall:

1. Direct any woman whose screening shows a diagnosis of breast cancer, cervical cancer or pre-cancerous cervical lesion(s) to apply to AHCCCS for treatment. However, AHCCCS eligibility cannot be determined until a positive diagnosis is confirmed.
2. Assist the woman with a Title XIX application

A woman may apply for eligibility by completing an application for AHCCCS health insurance provided by National Breast and Cervical Cancer Early Detection Program staff. The National Breast and Cervical Cancer Early Detection Program mails or faxes the application directly to AHCCCS after receiving a positive diagnosis. A complete application contains all the information requested, including documentation verifying alien status if born outside the United States.

3. Provide AHCCCS with the diagnosis and date of diagnosis.
Responsibilities for Reporting

Background: This program is unique, in that continued eligibility is primarily determined by active treatment, and in that this program involves not only AHCCCS, but also ADHS and the CDC. The requirements for this program have created the need for special reporting by Contractors or the American Indian programs as follows:

1. AHCCCS Division of Member Services (DMS) must be notified when active treatment has ended.

2. ADHS must be notified of:
   a. Date the treatment began
   b. Tumor size
   c. Tumor stage, and
   d. Date treatment ended.

The Process for Reporting Clinical Information and Status of Treatment

1. AHCCCS Division of Member Services (DMS) will send forms to the appropriate Contractor that identify which women in the program require updated treatment information. The Contractor will complete the form and send it back to DMS.

2. For fee-for-service members, including American Indian program members, DMS will send forms to AHCCCS Division of Fee-For-Service Management/ Prior Authorization Unit (DFSM/PA) or the IHS/638 BCCTP clinic. DFSM/PA or the IHS/638 BCCTP clinic will complete the form and return it to DMS.

3. DMS will acquire the information they need from the forms and then send the forms on to ADHS.

REFERENCES

1. Breast and Cervical Cancer Prevention and Treatment Act
2. Arizona Administrative Code
3. Arizona Department of Health Services Well Woman Health Check Program
4. National Breast and Cervical Cancer Early Detection Program
320-D RESERVED
CHAPTER 300
MEDICAL POLICY FOR AHCCCS COVERED SERVICES

POLICY 320
SERVICES WITH SPECIAL CIRCUMSTANCES

320-E HEATH AND BEHAVIOR INTERVENTION

REVISION DATES: 03/01/14, 10/01/13, 05/01/07

INITIAL EFFECTIVE DATE: 10/01/2006

Description
Health and behavioral assessment procedures (CPT codes 96150-96155) are used to identify and treat the psychological, behavioral, emotional, cognitive and social factors important to the prevention, treatment and management of physical health problems. The focus of the assessment is not on mental health, but on the stresses, expectations, lifestyle and perceptions that are associated with the underlying medical condition. Codes 96150 - 96155 describe services offered to members who present with primary physical illnesses, diagnosis or symptoms and may benefit from assessments and interventions that focus on the biopsychosocial factors related to the member's health. These services do not represent preventative medicine counseling and risk factor reduction interventions. Therefore, evaluation and management services codes (including preventative medicine, individual counseling codes 99401-99404 and preventative medicine, group counseling codes 99411- 99412) should not be reported on the same day.

Amount, Duration and Scope
AHCCCS covers medically necessary health and behavioral assessment procedures (CPT codes 96150-96155). The focus of the assessment/interventions is not on mental health but the biopsychosocial factors important to physical health problems and treatment. The focus of the intervention is to improve the member's health and well-being utilizing cognitive, behavioral, social, and/or psychophysiological procedures designed to ameliorate specific disease-related problems.

Individuals requiring the service(s) described above must not be referred to the Integrated Regional Behavioral Health Authorities (Integrated RBHAs) or Regional Behavioral Health Authorities (RBHAs).

Codes
96150- Health and behavior assessment (e.g. health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment.
96151 - Re-assessment
96152 - Health and behavior intervention, each 15 minutes, face-to-face; individual
96153 - Group (2 or more patients)
96154 - Family (with the patient present)
The following professionals are approved by AHCCCS to provide health and behavioral assessments/interventions:

1. Psychologist
2. Licensed clinical social worker
3. Licensed marriage and family therapist
4. Licensed professional counselor, and
5. Psychiatric nurse practitioner

Health and behavior intervention services may be performed in the following places of service:

1. Federally Qualified Health Clinic (FQHC)
2. Rural Health Clinic
3. Provider Office
4. The member’s home
5. Indian Health Service (IHS) Freestanding Facility
6. IHS Provider Based Facility
7. Tribal 638 Freestanding Facility, and
8. Tribal 638 Provider Based Facility.
9. Integrated Behavioral Health Residential Facility

**Limitations**

1. Services are limited to 48 units annually (unit is equal to 15 minutes).

   Members with mental health treatment needs exceeding the scope or duration of services described (which are medical codes for behavioral health interventions) should be appropriately referred for behavioral health services that will require the specific use of behavioral health codes.

2. Services are limited to the providers and settings listed above.
**Description**

AHCCCS-covered medically necessary treatment services, rendered by qualified providers, are available for the treatment of members who have been diagnosed with HIV/AIDS. Members who are diagnosed with HIV/AIDS are also listed as members with special health care needs. Chapter 500 describes the requirements for special health care needs members. AHCCCS requires Contractors to follow the Centers for Disease Control and Prevention (CDC) guidelines for the treatment of HIV/AIDS. It is the responsibility of each Contractor to distribute these guidelines, and all updates, to HIV/AIDS treatment professionals included in their network.

As appropriate, AHCCCS shall review new technological advances in HIV/AIDS treatment, including recommended pharmacological regimens.

This review shall include the AHCCCS Chief Medical Officer, the AHCCCS Medical Director, Contractor Medical Directors and physician experts in the treatment of HIV/AIDS.

The review may include, but is not limited to, information regarding:

1. Established treatment and pharmaceutical regimens
2. Changes in technology and treatment protocols, and

**Contractor Monitoring**

Contractors must develop policies and protocols that document care coordination services provided to members with HIV/AIDS. This includes monitoring of member medical care in order to ensure that medical services, medication regimens and necessary support services (i.e., transportation) are provided within specified timelines, as defined in contractual arrangements with AHCCCSA, and that these services are utilized appropriately. Support services may be coordinated with existing community resources.
In addition, Contractors must ensure that the care for members diagnosed with HIV/AIDS, who are receiving services specified by and in accordance with the guidelines set by AHCCCS, is well coordinated and managed in collaboration with the member's treating physician.

If a conflict regarding treatment or denial of treatment arises between the member's treating physician and the Contractor Medical Director, the issue may be referred to the AHCCCS Medical Director or designee. However, this does not preclude the member's right to file an appeal.

**HIV/AIDS Treatment Professionals**

AHCCCS will compile, update and make available to Contractors, upon request, a listing of qualified HIV/AIDS treatment professionals (physicians, nurse practitioners and/or physician assistants). The listing will be based on information submitted by the Contractors as specified in contractor reporting requirements.

A qualified HIV/AIDS treatment professional, for the purpose of this policy, is defined as a physician or practitioner who:

1. Is recognized in the community as having a special interest, knowledge and experience in the treatment of HIV/AIDS,

2. Agrees to adhere to CDC treatment guidelines for HIV/AIDS,

3. Agrees to provide primary care services and/or specialty care to AHCCCS members with HIV/AIDS,

4. Demonstrates ongoing professional development by clinically managing at least five patients with HIV/AIDS during the last year, and

5. Meets one of the criteria below:

   a. Current Board Certification or Recertification in Infectious Diseases, or

   b. Annual completion of at least ten hours of HIV/AIDS-related Continuing Medical Education (CME), which meet the CME requirements under A.A.C. R4-16-101.
Limitations

A physician or practitioner not meeting the criteria to be a qualified HIV/AIDS treatment professional who wishes to provide primary care services to a member with HIV/AIDS must send documentation to the Contractor demonstrating that s/he has an established a consultative relationship with a physician who meets the criteria for a qualified HIV/AIDS treatment professional as identified in this policy.

This documentation should be maintained in the Contractor’s credentialing file. These practitioners may treat members with HIV/AIDS under the following circumstances:

- In geographic areas where the incidence of members with HIV/AIDS is low, and/or where there are no available AHCCCS-registered network HIV/AIDS treatment professionals meeting this criteria, or

- When a member with HIV/AIDS chooses a provider who does not meet the criteria.

Contractor Network

Contractors must include in their individual provider networks sufficient numbers of qualified HIV/AIDS treatment professionals (physicians, nurse practitioners and/or physician assistants). Contractors must also have policies and procedures to assure that provider requirements and standards specified in the AMPM are met. Each Contractor provider network of HIV/AIDS treatment professionals is subject to review and approval by AHCCCS, Division of Health Care Management (DHCM). Contractors must submit, annually by December 15, a list of HIV/AIDS treatment providers to AHCCCS/DHCM/Medical Management Unit (MM) which includes:

1. Name and location of all qualified HIV/AIDS treatment professionals treating members with HIV/AIDS, and

2. For each primary care provider (PCP) treating members with HIV/AIDS who is not a qualified HIV/AIDS treatment specialist, the name and location of the consulting HIV/AIDS treatment professional.

Contractors must also notify AHCCCS/DHCM/CQM of any material change to the HIV/AIDS provider network during the year.
Contractor policies must reflect that members with HIV/AIDS have freedom of choice to select an HIV/AIDS provider from the Contractor network. If the member selects a PCP in the Contractor network who is not a provider designated by the Contractor as a qualified HIV/AIDS disease treatment professional, the member must be informed that only those designated providers are authorized to render treatment regimens such as antiretroviral therapies. The selected PCP must consult with a qualified HIV/AIDS provider and follow the recommendations of the consultant in order for the treatment regimen (such as protease inhibitors) to be a covered service.
320-G LUNG VOLUME REDUCTION SURGERY (LVRS)

Revision Dates: 06/01/07, 04/01/04

Review Date: 08/01/2011

Initial Effective Date: 01/01/2004

Amount, Duration and Scope

AHCCCS covers LVRS, or reduction pneumoplasty, for persons with severe emphysema when performed at a facility approved by Medicare to perform this surgery and in accordance with all of the established Medicare guidelines. AHCCCS follows the Medicare National Coverage Decision as published on 11/17/05. In the event Medicare’s policy is revised, AHCCCS may reevaluate and/or revise our policy accordingly.

The member’s treating physician is responsible for providing appropriate documentation, establishing medical necessity, and verification of compliance with Medicare and AHCCCS guidelines. The documentation must be sent to the Contractor Medical Director or, to the AHCCCS Medical Director for fee-for-service members, when requesting authorization.

When possible, such surgeries, and the required pre- and post-operative therapies, will be performed at facilities approved by Medicare for LVRS reimbursement within the State of Arizona. However, AHCCCS may cover this procedure at out-of-state facilities if needed. All facilities must meet Medicare LVRS facility requirements as well as AHCCCS Provider Registration requirements.

If medically necessary, AHCCCS may pay for an adult caregiver to accompany members when out-of-state-travel is required. Transportation, lodging and board may be covered as appropriate.

Medicare Criteria

The Centers for Medicare and Medicaid Services (CMS) has issued a National Coverage Decision (NCD) for lung volume reduction surgery (reduction pneumoplasty) specifying covered and non-covered criteria. As stated above, AHCCCS will follow Medicare established guidelines for this procedure according to the NCD effective 11/17/2005. NCD for lung volume reduction surgery (reduction pneumoplasty) is included as Exhibit 320-1.
320-H  METABOLIC MEDICAL FOODS

REVISION DATES: 03/01/2016, 04/01/10, 05/01/06, 07/01/04, 10/01/01

INITIAL
EFFECTIVE DATE: 01/01/2001

Description of Benefit

Inherited metabolic disorders are rare genetic conditions in which normal metabolic function is inhibited by a deficiency in a crucial enzyme. To avoid toxic effects, treatment of the associated metabolic disorder depends on dietary restriction of foods containing the substances that cannot be metabolized by the affected member. Foods that restrict the offending amino acid(s) for disorders of amino acid metabolism are not generally available from the grocery store or health food store. Modified foods that are available in the grocery store or health food store are not covered by this policy. Treatment of inherited metabolic disorders is accomplished by use of specialized diets employing metabolic formula or medical foods.

AHCCCS covers metabolic formulas and medical foods, within the limitations specified in this policy, for member’s diagnosed with one of the following inherited metabolic conditions:

1. Phenylketonuria
2. Homocystinuria
3. Maple Syrup Urine Disease
4. Galactosemia (requires soy formula)
5. Beta Keto-Thiolase Deficiency
6. Citrullinemia
7. Glutaric Acidemia Type I
8. 3 Methylcrotonyl CoA Carboxylase Deficiency
9. Isovaleric Acidemia
10. Methylmalonic Acidemia
11. Propionic Acidemia

12. Arginosuccinic Acidemia

13. Tyrosinemia Type I

14. HMG CoA Lyase Deficiency

15. Cobalamin A, B, C Deficiencies

Definitions

1. Medical foods means metabolic formula or modified low protein foods that are produced or manufactured specifically for persons with a qualifying metabolic disorder and that are not generally used by persons in the absence of a qualifying metabolic disorder.

2. Metabolic nutritionist means an AHCCCS registered provider who is a registered dietitian specializing in nutritional assessment and treatment of metabolic conditions.

Conditions, Limitations and Exclusions

1. Contractors are responsible for:

   a. Initial and follow-up consultations by a genetics physician and/or a metabolic nutritionist,

   b. Lab tests and other services related to the provision of medical foods for enrolled members diagnosed with an inherited metabolic disorder listed below,

   c. Metabolic formula and modified medical foods for members who have been diagnosed with one of the inherited metabolic disorders listed in this policy.

2. Metabolic formula and modified low protein foods must be:

   a. Processed or formulated to be deficient in the nutrient(s) specific to the member's metabolic condition.

   b. Meet the member's distinctive nutritional requirements that are established through medical evaluations conducted by the member’s PCP, attending physician or appropriate specialist, and/or the metabolic nutritionist for the specific dietary management of the member’s
metabolic condition.

c. Determined to be essential to sustain the member’s optimal growth within nationally recognized height/weight or BMI (body mass index), health and metabolic homeostasis.

d. Obtained only under physician order, and

e. Supervised by the member’s PCP, attending physician or appropriate specialist for the medical and nutritional management of a member who has other specific nutritional requirements as established by medical evaluation.

3. Modified low protein foods must be formulated to contain less than one gram of protein per unit or serving. For purposes of this policy, modified low protein foods do not include foods that are naturally low in protein.

4. Soy formula is covered only for members receiving Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services and KidsCare members diagnosed with galactosemia and only until they are able to eat solid lactose-free foods.

5. Foods purchased through grocery or health food stores are not covered.
CHAPTER 300
MEDICAL POLICY FOR AHCCCS COVERED SERVICES

POLICY 320
SERVICES WITH SPECIAL CIRCUMSTANCES

320-I  TELEHEALTH AND TELEMEDICINE

REVISION DATES:  10/01/15, 04/01/12, 12/01/06, 10/01/06, 05/01/06, 07/01/04, 10/01/01

INITIAL
EFFECTIVE DATE:  01/01/2001

Description

AHCCCS covers medically necessary consultative and/or treatment telemedicine services for all eligible members within the limitations described in this policy when provided by an appropriate AHCCCS registered provider.

Definitions

1. **Asynchronous or "Store and Forward"** is the transfer of data from one site to another through the use of a camera or similar device that records (stores) an image that is sent (forwarded) via telecommunication to another site for consultation. Asynchronous or "store and forward" applications would not be considered telemedicine but may be utilized to deliver services.

2. **Consulting Provider** means any AHCCCS registered provider who is not located at the originating site who provides an expert opinion to assist in the diagnosis or treatment of a member.

3. **Distant or Hub site** is the site at which the physician or other licensed practitioner delivering the service is located at the time the service is provided via telecommunications system.

4. **Originating or Spoke site** is the location of the Medicaid patient at the time the service being furnished via a telecommunications system occurs. Telepresenters may be needed to facilitate the delivery of this service.

5. **Telecommunications Technology**, which includes store and forward, means the transfer of medical data from one site to another through the use of a camera, electronic data collection system such as an Electrocardiogram (ECG), or other similar device, that records (stores) an image which is then sent (forwarded) via telecommunication to another site for consultation. Services delivered using telecommunications technology, but **not** requiring the member to be present during their implementation, are **not** considered telemedicine. For information about coverage of these services, see Section B of the policy.
6. **Teledentistry** refers to the acquisition and transmission of all necessary subjective and objective diagnostic data through interactive audio, video or data communications by an AHCCCS registered dental provider to a distant dentist for triage, dental treatment planning, and referral.

   a. Teledentistry includes the provision of preventive and other approved therapeutic services by the AHCCCS registered Affiliated Practice Dental Hygienist, who provides dental hygiene services under an affiliated practice relationship with a dentist.

   b. Teledentistry does not replace the dental examination by the dentist; limited, periodic, and comprehensive examinations can not be billed through the use of teledentistry alone.

7. **Telehealth (or Telemonitoring)** is the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance.

   a. Telehealth includes such technologies as telephones, facsimile machines, electronic mail systems, and remote patient monitoring devices, which are used to collect and transmit patient data for monitoring and interpretation. While they do not meet the Medicaid definition of telemedicine they are often considered under the broad umbrella of telehealth services. Even though such technologies are not considered "telemedicine," they may nevertheless be covered and reimbursed as part of a Medicaid coverable service, such as laboratory service, x-ray service or physician services (under section 1905(a) of the Social Security Act).

8. **Telemedicine** means the practice of health care delivery, diagnosis, consultation and treatment and the transfer of medical data between the originating and distant sites through real time interactive audio, video or data communications that occur in the physical presence of the member.

9. **Telepresenter** means a designated individual who is familiar with the member’s case and has been asked to present the member’s case at the time of telehealth service delivery if the member’s originating site provider is not present. The telepresenter must be familiar, but not necessarily medically expert, with the member’s medical condition in order to present the case accurately.
A. Use of Telemedicine

For the services listed below, AHCCCS covers any medically necessary services provided via telemedicine. Services must be real-time visits otherwise reimbursed by AHCCCS.

The following medical services are covered:

1. Cardiology
2. Dermatology
3. Endocrinology
4. Hematology/oncology
5. Infectious diseases
6. Neurology
7. Obstetrics/gynecology
8. Oncology/radiation
9. Ophthalmology
10. Orthopedics
11. Pain clinic
12. Pathology
13. Pediatrics and pediatric subspecialties
14. Radiology
15. Rheumatology
16. Surgery follow-up and consultations
17. Behavioral Health
18. Diagnostic consultation and evaluation
   a. Psychotropic medication adjustment and monitoring
   b. Individual and family counseling
B. Use of Telecommunications

Services delivered using telecommunications are generally not covered by AHCCCS as a telemedicine service. The exceptions to this are described below:

1. A provider in the role of telepresenter may be providing a separately billable service under their scope of practice such as performing an ECG or an x-ray. In this case, that separately billable service would be covered, but the specific act of telepresenting would not be covered.

2. A consulting provider at the distant site may offer a service that does not require real time interaction with the member. Reimbursement for this type of consultation is limited to dermatology, radiology, ophthalmology, and pathology and is subject to review by AHCCCS Medical Management.

3. In the special circumstance of the onset of acute stroke symptoms within three hours of presentation, AHCCCS recognizes the critical need for a neurology consultation in rural areas to aid in the determination of suitability for thrombolytic administration. Therefore, when a member presents within three hours of onset of stroke symptoms, AHCCCS will reimburse the consulting neurologist if the consult is placed for assistance in determining appropriateness of thrombolytic therapy even when the patients’ condition is such that real-time video interaction cannot be achieved due to an effort to expedite care.

C. Use of Teledentistry Services

AHCCCS covers teledentistry for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) aged members when provided by an AHCCCS registered dental provider. Refer to Chapter 400, Policy 431 for more information on Oral Health Care for EPSDT aged members including covered dental services.

Conditions, Limitations and Exclusions

1. Both the referring and consulting providers must be registered with AHCCCS.

2. A consulting service delivered via telemedicine by other than an Arizona licensed provider must be provided to a specific member by an AHCCCS registered provider licensed to practice in the state or jurisdiction from which the consultation is provided or, if employed by an Indian Health Services (IHS), Tribal or Urban Indian health program, be appropriately licensed based on IHS and 638 Tribal facility requirements.
3. At the time of service delivery via real time telemedicine, the member's health care provider may designate a trained telepresenter to present the case to the consulting provider if the member's primary care provider or attending physician, or other medical professional who is familiar with the member's medical condition, is not present. The telepresenter must be familiar with the member's medical condition in order to present the case accurately. Medical questions may be submitted to the referring provider when necessary but no payment is made for such questions.

4. Nonemergency transportation to and from the telemedicine originating site to receive a medically necessary consultation or treatment service is covered.

D. ADDITIONAL INFORMATION

Refer to Policy 310 of this Chapter and to the Behavioral Health Services Guide for complete information regarding covered behavioral health services for Title XIX and Title XXI members.

AHCCCS Division of Fee-for-Service Management does not require Prior Authorization (PA) for medically necessary telemedicine services performed by Fee-For-Service (FFS) providers. Refer to Chapter 800 for complete information regarding PA requirements. Refer to the AHCCCS FFS Provider Billing Manual, the IHS/Tribal Provider Billing Manual and the AHCCCS Telehealth Training Manual for complete information regarding billing procedures. These manuals are available on the AHCCCS Web site at www.azahcccs.gov.
320-J  HIGH FREQUENCY CHEST WALL OSCILLATION (HFCWO) THERAPY

REVISION DATE: 10/01/10, 06/01/07

INITIAL EFFECTIVE DATE: 10/01/2004

High Frequency Chest Wall Oscillation therapy (HFCWO) is a form of chest physiotherapy that promotes airway clearance for retained pulmonary secretions. This form of therapy has been shown to be equally as effective as other forms of such therapy, such as postural drainage and clapping (CPT), flutter valve or blow glove, etc., in helping an individual with clearing secretions from the lungs. A HFCWO percussive vest will not replace a percussor, caregiver and/or self-administration of chest physiotherapy unless it is demonstrated that these forms of therapy are no longer effective. HFCWO therapy percussive vest are not covered for members who are age 21 and older.

HFCWO percussive vest requires prior authorization. All cases will be reviewed on a case-by-case basis. Requests for prior authorization must be accompanied by specific documentation in the individual's personal medical record that supports the medical necessity for HFCWO percussive vest. Criteria for medical necessity include, but are not limited to, all of the following:

1. Diagnosis of cystic fibrosis
2. Documentation of excessive sputum production combined with the member's inability to clear the sputum without assistance
3. Copy of chest x-ray report and pulmonary function tests showing findings consistent with moderate or severe Chronic Obstructive Pulmonary Disease (COPD)
4. Prescription signed by a M.D. or D.O. with a specialty in pulmonary disease, indicating the need for at least daily (or more frequent) chest physiotherapy
5. Age 2 years or older or 20 inch chest size, whichever comes first
6. Specific documentation of failure of other, more cost-effective, methods of chest physiotherapy, or airway clearance, including CPT and flutter valve
7. Specific documentation supporting why HFCWO therapy for the member is superior to other more cost-effective therapy methods, including at least one of the following:
a. Promotes independent self-care for the individual

b. Allows independent living or university or college attendance for the individual

c. Provides health stabilization in single adults or emancipated individuals without able partners to assist with CPT, or

d. Severe end-stage lung disease requiring complex or frequent chest physiotherapy

8. Evidence that the member can use the percussive vest effectively, including continuing compliance with all forms of prescribed therapy and treatment and member and family acceptance of HFCWO therapy, and

9. Coordination between the provider office or clinic and AHCCCS or other payer source, such as ADHS/CRS or AHCCCS Contractor, prior to implementation of HFCWO therapy for long-term use.

**Discontinuation Criteria for HFCWO**

Discontinuation criteria for the HFCWO percussive vest include, but are not limited to, the following:

1. Member and/or prescribing physician request

2. Member treatment compliance at a rate of less than 50% usage as prescribed in the medical treatment plan, to be checked at two (2) and six (6) months of usage.
320-K TOBACCO CESSATION PRODUCT POLICY

Description
AHCCCS covers tobacco cessation products, which include Nicotine Replacement Therapy (NRT) and tobacco use medications, for members who wish to stop using tobacco. AHCCCS encourages members to enroll in a tobacco cessation program offered by the Arizona Department of Health Services (ADHS).

Coverage is limited to Title XIX members (Acute Care, Arizona Long Term Care System [ALTCS] and Medicare Cost sharing members).

Amount, Duration and Scope
The following criteria apply to AHCCCS members choosing to receive a tobacco cessation product.

1. Members 18 years and older are encouraged to enroll in a tobacco cessation program through ADHS. To enroll in an ADHS cessation program the member must call 1-800-556-6222.

2. Members must contact their Primary Care Provider (PCP) for a prescription for a tobacco cessation product. The PCP will identify an appropriate tobacco cessation product. In order to be covered by AHCCCS, all tobacco use medications require a prescription. This includes all tobacco cessation products, including those that are available over-the-counter.

3. The maximum supply a member may receive of a tobacco cessation product is a 12 week supply in a six month time period. The six month period begins on the date the pharmacy fills the first tobacco cessation product.

4. The prior authorization protocol described in Exhibit 320-K-1 must be followed by all contractors.
EXHIBIT 320-K-1
PRIOR AUTHORIZATION PROTOCOL THERAPEUTIC CLASS:
SMOKING CESSATION AIDS

<table>
<thead>
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<tr>
<th>EDUCATION CLASSES</th>
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<tr>
<td>Nicotine Replacement Therapy (NRT) Products</td>
<td>Nicoderm CQ®</td>
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<td>Nicotine Patch</td>
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<td>Wellbutrin SR®, Zyban®</td>
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<td>Nicotine Receptor Agonist</td>
<td>Verenicline</td>
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<td>Chantix®</td>
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A. FEDERAL DRUG ADMINISTRATION (FDA) APPROVED INDICATIONS

All products are FDA approved as aids for smoking cessation treatment and to help reduce withdrawal symptoms, including nicotine craving.

B. GUIDELINES FOR APPROVAL

The following criteria apply to AHCCCS members choosing to receive a tobacco cessation product.

1. Members are encouraged to enroll in a tobacco cessation program through Arizona Department of Health Services (ADHS). To enroll in an ADHS cessation program the member must call 1-800-556-6222.

2. Members must contact their Primary Care Provider (PCP) to obtain a prescription for a tobacco cessation product. The PCP will identify an appropriate tobacco cessation product. In order to be covered by AHCCCS all tobacco use medications require a prescription. This includes all tobacco cessation products, including those that are available over-the-counter.

3. The maximum supply a member may receive of a tobacco cessation product is a 12-week supply in a six month time period. The six month time period begins the date the first prescription is filled for the tobacco cessation product.

Revision Date: 03/01/2012
Initial Effective Date: 06/01/2009
EXHIBIT 320-K-1
PRIOR AUTHORIZATION PROTOCOL THERAPEUTIC CLASS: SMOKING CESSATION AIDS

C. PRIOR AUTHORIZATION WILL BE REQUIRED FOR THE FOLLOWING:

1. Members under the age of 18 years old,
2. Brand name medications when a generic product is available, and
3. Bupropion 24 hour / Wellbutrin XL.

D. COVERAGE IS NOT AUTHORIZED FOR:

1. Non-Title XIX Members,
2. Indications other than for as an aid for smoking cessation,
3. Doses greater than the FDA Maximum Allowable,
4. Combination treatment with more than one of the above agents, or
5. Specific drug-disease condition contraindications.

E. COVERAGE FOR DUAL ELIGIBLES:

1. Medications that are available by prescription only and bear the federal legend, —Federal Law Prohibits Dispensing Without a Prescription— are to be obtained from and covered by the Medicare Part D Plan.

2. Medications that are available over-the-counter are to be covered by the AHCCCS Contracted Health Plans and ordered in accordance with Section B, Guidelines for Approval.

Revision Date: 03/01/2012
Initial Effective Date: 06/01/2009
## F. Therapeutic Alternatives

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<thead>
<tr>
<th>Smoking Cessation Product</th>
<th>Dosing Regimen</th>
<th>Maximum Daily Dose</th>
</tr>
</thead>
</table>
| **Nicotine Nasal Spray** *(Nicotrol® NS)* | 2-4 sprays per hour  
Minimum effective dose is 16 sprays per day | 40mg  
80 sprays per day  
80 sprays = ½ bottle |
| **Nicotine Inhaler** *(Nicotrol® Inhaler)* | 6-16 cartridges a day individualized dosing as needed. | 16 cartridges per day |
| **Nicotine Patch** *(Nicoderm® CQ, Nicotrol®, Habitrol®)* | 7 mg / 24 hours  
14 mg / 24 hours  
21 mg / 24 hours | 21mg per 24 hours |
| **Nicotine Gum** *(Nicorette®), OR Lozenge (Commit®)* | 1 piece every 1-2 hours weeks 1-6,  
than  
1 piece every 2-4 hours weeks 7-9,  
then  
1 piece every 4-8 hours weeks 10-12. | 24 pieces of gum or lozenges per day |
| **Bupropion HCl SR** *(Zyban® / Wellbutrin SR®)* | 150mg orally every day for the first 3 days, may increase to 150mg twice a day if tolerated. | 300mg per day |
| **Verenicline** *(Chantix®)* | Titration Schedule:  
0.5mg orally daily for 3 days, then  
0.5mg twice daily for 4 days,  
then 1mg twice daily to complete the 12 week course of therapy | 2mg per day |

## G. General Information

1. Nicotine Replacement Therapy (NRT)
   
   a. Dependence has been recognized as a chronic, relapsing disease
   
   b. Any form can be toxic and addictive
   
   c. Smoking-drug interactions are costly to the health care system
EXHIBIT 320-K-1
PRIOR AUTHORIZATION PROTOCOL THERAPEUTIC CLASS: SMOKING CESSATION AIDS

2. Bupropion (Wellbutrin, Wellbutrin XL & Zyban)
   a. Mechanism of action is unknown
   b. In comparative data trials, efficacy is superior to NRT
   c. Reduces weight gain after smoking cessation
   d. Has several contraindications, precautions and warnings
   e. The study, *A Controlled Trial of Sustained-Release Bupropion, a Nicotine Patch, or Both for Smoking Cessation* (1999), found that sustained release bupropion alone or in combination with a nicotine patch resulted in significantly higher long-term rates of smoking cessation as compared to the use of either the nicotine patch alone or placebo. Abstinence rates were higher with combination therapy than with bupropion alone but the difference was not statistically significant.

3. Verenilone (Chantix)
   a. Represents a new class for smoking cessation therapy and acts as a nicotine partial receptor agonist.
   b. Dose dependent nausea has been reported in up to 40% of utilizing patients.
   c. Long-term safety is unknown.
   d. Does not reduce weight gain after smoking cessation.
   e. Efficacy of Verenilone as compared to NRT is currently unknown.
   f. In comparative trials following 12 weeks of treatment, bupropion naïve patients receiving Verenilone were more likely to quit smoking than patients on bupropion.
   g. In one Verenilone study, an additional 12-week course of therapy was given to abstinent patients immediately after the first 12-week course had elapsed. There is currently no data to support the efficacy of re-starting Verenilone after a lapse in therapy following the initial 12-week course.
   h. No contraindications (other than drug allergy).
   i. Extreme caution should be taken when evaluating a person with serious mental illness for a trial of Verenilone.

4. Abstinence rates were consistently higher with all products when combined with a behavioral modification program.
320-L NEUROPSYCHOLOGICAL TESTING

Description

AHCCCS covers medically necessary neuropsychological evaluation services within certain limits for all members, with the exception of the Federal Emergency Services (FES) population (Refer to Chapter 1100 for FES coverage). It may be covered due to a medical condition or a behavioral health condition dependent on the member presentation. The purpose of this policy is to clarify under what circumstances, whether due to a medical condition or a behavioral health condition, neuropsychological evaluation is reimbursable and by whom.

Neuropsychological testing is specialized psychological testing. Neuropsychological testing seeks to establish presence or absence of organic brain dysfunction or damage and to make inferences concerning brain function. Neuropsychological testing can be an important tool in determining localization of brain dysfunction or damage, or in determining effects of toxic substances, medical conditions or traumatic injury on brain function, or in evaluating progress in individuals undergoing treatment or rehabilitation from a brain insult.

By contrast, psychological testing, in general, (excluding neuropsychological testing) may measure mental functioning such as intelligence, achievement, ability, thought process, perception and personality. Psychological testing is performed in a variety of settings, including schools and employment agencies, and is performed in behavioral health settings when questions arise concerning the individual's psychiatric diagnosis or impact of an individual's intelligence, thought, perception, or personality on behavioral health care.

Neuropsychological evaluation is considered medically necessary when a member has exhibited a change in cognitive function, mental status, memory or behavior due to a confirmed brain disorder, or when a differential diagnosis includes brain dysfunction (damage, disease or trauma). Members referred to a neuropsychologist for assessment may be classified into one of three groups:

1. Members who have known brain damage. Examples include but are not limited to cerebrovascular disorders, head injury, hydrocephalus, Alzheimer’s disease, Parkinson’s disease, Multiple Sclerosis, Huntington’s chorea, tumors, seizures, and infections.
2. Members who have a recognized risk factor for brain damage and who demonstrate a change in behavior that might be the result of disease or injury to the brain. Examples include but are not limited to: systemic illnesses, endocrinopathies, metabolic and electrolyte disturbances, diseases of the kidney, liver, and pancreas, nutritional deficiencies, toxins, including substance abuse (particularly alcohol), conditions producing decreased blood supply to the brain (e.g. trauma, vascular disorders, cardiac disease, pulmonary disease, anemia, carbon monoxide exposure, and complications of anesthesia or surgery).

3. Members in which brain disease or trauma is suspected but no specific etiology or risk factor has been identified. Examples include but are not limited to: members with observed and well-documented changes in behavior or mental deterioration; lack of identifiable risk factors for brain injury; and other potential medical illnesses have been excluded.

Additionally, the results of neuropsychological evaluation must be expected to resolve questions about the member's condition necessary to contribute to a diagnostic or functional determination that will contribute to a change in the treatment plan anticipated to improve the member’s condition.

**Reimbursement**

The condition of the member determines whether the test is for medical or behavioral health purposes. Tests performed for medical reasons are the responsibility of the medical Contractors. Tests performed for behavioral health reasons are the responsibility of the behavioral health Contractors. Arizona Long Term Care System (ALTCS) Contractors are fiscally responsible for both medical and behavioral health conditions.

If the neuropsychological evaluation is requested for medical conditions as described in Section A, Medical Condition and Neuropsychological Evaluation, the reimbursement is the responsibility of the following entities:

1. Acute Care Contractors
2. ALTCS Contractors
3. AHCCCS Administration for Fee-For-Service (FFS) members (Tribal ALTCS, American Indian Health Plan (AIHP) and other FFS members, with the exception of Federal Emergency Services [FES] members)
If the neuropsychological evaluation is requested for behavioral health conditions as described in Section B, Behavioral Health Condition and Neuropsychological Evaluation, the reimbursement is the responsibility of the following entities:

1. Integrated Regional Behavioral Health Authorities (Integrated RBHAs) or Regional Behavioral Health Authorities (RBHAs) including Tribal/RBHA (TRBHA).

2. ALTCS Contractors

3. AHCCCS Administration for Tribal ALTCS members or AIHP members treated in an Indian Health Services [IHS] or 638 facility

Once prior authorization approval is given for neuropsychological evaluation, the results of those tests cannot be used to retroactively deny reimbursement for the tests.

**Amount, Duration and Scope**

**A. Medical Condition and Neuropsychological Evaluation**

1. Conditions for Coverage/Reimbursement

   Neuropsychological evaluation is a covered medical service and reimbursable by Acute Care and ALTCS Contractors as well as the AHCCCS Administration for FFS members if both:

   a. The evaluation is necessary to assess the extent of dysfunction and determine an effective medical treatment plan and outcome goals or the evaluation is necessary to effect an expected change in the current medical treatment plan and outcome goals; and

   b. The evaluation is expected to provide additional information regarding the nature and severity of functional problems involving higher mental functions that may be the result of organic brain damage (damage, disease or trauma). Conditions associated with organic brain dysfunction affecting higher mental function include, but are not limited to the following:

      i. Traumatic Brain Injury/Head Injury
      ii. Cerebral Vascular Disorders/Stroke
      iii. Hydrocephalus
      iv. Epilepsy
      v. Brain Tumors (Primary or Metastatic; Malignant or Benign)
      vi. Cerebral Anoxia or Hypoxia
vii. Exposure to toxic chemicals, substances or treatments that are known to cause toxic effects on the brain (acute or chronic) such as lead poisoning, intrathecal methotrexate, cranial irradiation.

viii. Exposure to infectious diseases that affect brain functions or cause brain damage (e.g., Herpes Encephalitis, Human Immunodeficiency Virus [HIV]).

ix. Chronic and progressive toxic/metabolic encephalopathic states resulting from systemic medical illnesses or conditions.

x. Neurological conditions resulting in chronic deteriorating course of illness affecting brain functions and behavior, including. Multiple Sclerosis, Parkinson’s disease, Alzheimer’s Disease, Huntington’s Chorea, Acquired Immune Deficiency Syndrome (AIDS), and others.

xi. Prenatal, perinatal, or infant exposure to alcohol or drugs of abuse.

Refer to section C of this policy for limitations.

B. Behavioral Health Condition and Neuropsychological Evaluation

1. Conditions for Coverage/Reimbursement

   Neuropsychological evaluation is a covered behavioral health service and reimbursable by the Integrated RBHA/RBHA/TRBHA, ALTCS Contractor or the AHCCCS Administration for Tribal ALTCS or AIHP members treated in an IHS OR 638 facility if both:

   a. Possible organic brain damage or dysfunction is suspected of contributing to the member's behavioral health disorder (e.g., Mood Disorder, depression with psychosis secondary to traumatic brain injury; Mood Disorder due to Cerebrovascular Accident (CVA) with Major Depressive- Like episode; Inhalant-Induced Persisting Dementia) and

   b. A behavioral health treatment decision rests on the clarification of the possible organic brain damage or dysfunction or other results of the neuropsychological testing.

   Refer to section C of this Policy for limitations.

C. Limitations

1. A neuropsychological evaluation is not a covered service by either the medical or behavioral health Contractors when:
a. The objective of evaluation is educational planning. The school district is responsible for the cost of evaluation to evaluate conditions such as learning disabilities.

b. The individual has permanent, persistent, and static organic brain dysfunction, and it is unlikely that evaluation results would provide new information that would be utilized to alter the course of treatment or treatment planning.

c. The current condition of the member may render evaluation results invalid due to such conditions as:
   i. Present substance use/abuse or withdrawal
   ii. Medication regimen that may affect evaluation performance or

d. The primary purpose of evaluation is not related to a treatment plan

2. Neuropsychological evaluation is not a covered service under the medical condition category when a member has behavioral health disorders that are primarily attributable to organic brain damage that results in higher-level mental organic brain dysfunction. Examples include Mood Disorder, depression with psychosis secondary to traumatic brain injury; Mood Disorder due to Cerebrovascular Accident (CVA) with Major Depressive-Like episode; Inhalant-Induced Persisting Dementia. The service is not reimbursable by Acute Care Contractors. However, ALTCS Contractors or the AHCCCS Administration for FFS members as noted in B (1) may be financially responsible if it is determined that the neuropsychological service is medically necessary and covered under behavioral health.

   NOTE: If the basis of the referral for the neuropsychological evaluation is to obtain treatment recommendations for use of psychotropic medications for these conditions, a direct referral to the Integrated RBHA/RBHA/TRBHA for psychiatric consultation should be made for Acute Care members. Tribal ALTCS members and ALTCS members should be referred to a behavioral health specialist within their system/network. Reimbursement is the responsibility of the Integrated RBHA/RBHA/TRBHA, AHCCCS Administration or ALTCS Contractor as appropriate.

3. Neuropsychological evaluation is not a covered service under the behavioral health condition category when

   a. Organic brain damage or dysfunction is not suspected of contributing to the member's behavioral health disorder, or
b. Behavioral health treatment is not expected to change due to results of neuropsychological testing.

D. REQUEST FOR PRIOR AUTHORIZATION OF NEUROPSYCHOLOGICAL EVALUATION

The requesting provider (AHCCCS Contractor provider or Integrated RBHA/RBHA/TRBHA Provider) must submit a request for prior authorization for a neuropsychological evaluation in writing to the appropriate entity (AHCCCS Acute Care Health Plan, Integrated RBHA/RBHA/TRBHA, ALTCS Program Contractor AHCCCS Administration for FFS members) that will include, at a minimum, the following information:

1. The specific reasons why the evaluation is being requested. The specific diagnostic or treatment-related question(s) to be answered by the evaluation must be included or the request will be returned to the requesting physician/clinician for completion.

2. The complete list of current diagnoses and medications.

3. The most recent complete history and physical examination and pertinent findings, including laboratory tests and diagnostic procedures that may be relevant to the evaluation request.

4. Results of any consultations from sub-specialists in neurology or psychiatry/behavioral health, if available.

5. Results of any prior psychological evaluation that may be available.

6. The specific areas of concern for evaluation that could improve the proposed course of treatment or treatment planning.

7. The desired or expected outcome of treatment identified by the referring practitioner/provider, which may result from the evaluation. Address how this evaluation could benefit or improve the overall treatment approach for the member.

Refer to the following policies for adjunct information related to this Policy:


ACOM Policy 409, Intra-Agency Care Coordination.

ACOM Policy 414, Content of Notices of Action for Service Authorization.
320-M  MEDICAL MARIJUANA

INITIAL

EFFECTIVE DATE:  08/01/2011

Description

Under 42 CFR §440.120 marijuana does not qualify as a federally reimbursable medication.

AHCCCS does not currently cover and has never covered medical marijuana as a medical or pharmacy benefit. AHCCCS will not provide reimbursement for an office visit or any other services that are primarily for the purpose of determining if a member would benefit from medical marijuana.

AHCCCS covers medically necessary federally reimbursable medications prescribed by physician, physician’s assistant, nurse practitioner, dentist or other AHCCCS approved practitioner and dispensed by a licensed AHCCCS registered pharmacy, as defined in 9 A.A.C. 22, Article 2.

AHCCCS recognizes that registered providers operating within the scope of their license may recommend the use of medical marijuana although it is not a covered benefit.

REFERENCES

1.  9 A.A.C. 22, Article 2
2.  42 CFR §440.120
3.  Title 21 United States Code 812
EXHIBIT 320-K-1
PRIOR AUTHORIZATION PROTOCOL THERAPEUTIC CLASS:
SMOKING CESSATION AIDS
5. Based on the clinical trials of all of the products, an assumption can be drawn that Varenicline is superior to Bupropion and NRT.

References

1. AHCCCS Smoking Cessation Policy, October 2009.
320-N  **HEPATITIS C DRUG PRIOR AUTHORIZATION CRITERIA POLICY**

**EFFECTIVE DATE:** 03/15/15, 08/01/14

**INITIAL EFFECTIVE DATE:** 07/17/2014

**MEMBER COVERAGE CRITERIA:**

1. **Age ≥18 years**

   **AND**

2. Diagnosis of hepatitis C confirmed by detectable serum HCV RNA by quantitative assay completed within the past 90 days

   **AND**

3. Prescribed by or in consultation with a gastroenterologist, hepatologist, or infectious disease physician

   **AND**

4. Liver fibrosis/cirrhosis

   a. Imaging evidence of cirrhosis or severe fibrosis based upon ultrasound, CT or MRI of the abdomen describing a nodular-appearing liver, generally in combination with evidence of splenomegaly and portal hypertension.

      **OR**

   b. Elastrography Score ≥ 11 kPa

      **OR**
c. Liver biopsy with METAVIR score ≥ F3

OR

d. FibroSure (e.g. FibroTest) ≥ 0.58

OR

e. Extrahepatic manifestations including leukocytoclastic vasculitis, membranoproliferative glomerulonephritis, or symptomatic cryoglobulinemia despite mild liver disease.

AND

5. Member has received Hepatitis A and B vaccinations or has laboratory evidence of immunity.

AND

6. If member has history of substance use disorder, in past 12 months, he/she must be in remission for six months prior to initiating treatment.

AND

7. If member has HIV-1:

   a. CD4 count >500 cells/mm$^3$ if member is not taking antiretroviral therapy, OR

   b. CD4 count >200 cells/mm$^3$ if member is virologically suppressed (e.g. HIV RNA < 200 copies/mL)

8. Interferon ineligibility will be considered for the following:

   a. Autoimmune hepatitis or other autoimmune disorders

   b. Previous intolerance to IFN leading to treatment discontinuation

   i. Pre-existing hematological disease as evidenced by:
      (a) Baseline neutrophil count < 1500/µL, or
      (b) Baseline platelet count < 90,000/µL, or
      (c) Baseline hemoglobin of < 10g/dL

   ii. History of psychiatric disorders:
      (a) Schizophrenia
      (b) Bipolar Disorder
(c) Previous inpatient psychiatric admission
(d) History of a suicide attempt within the past two years
(e) Unstable major depressive disorder

iii. Ischemic heart disease

9. Monitoring requirements during treatment:

a. HCV viral load laboratory results must be submitted to the Contractor/PBM after completion of 4 weeks of a 12-week Sofosbuvir therapy regimen.

i. Viral loads must be undetectable after 4 weeks of therapy by sensitive assay testing.
ii. If the viral load is very low, but detectable, (<100 IUs), the test must be repeated.
iii. If the viral load is still detectable (>100 IUs), treatment shall be discontinued.

b. HCV viral load laboratory results must be submitted to the Contractor/PBM after completion of 4 and 12 weeks of a 24-week Sofosbuvir therapy regimen.

i. Viral loads must be undetectable after 4 weeks of therapy by sensitive assay testing.
ii. If the viral load is very low, but detectable, (<100 IUs), the test must be repeated.
iii. If the viral load is still detectable (>100 IUs), treatment shall be discontinued.
iv. Viral loads must be undetectable after 12 weeks of therapy by sensitive assay testing.
v. If the viral load is very low, but detectable, (<100 IUs), the test must be repeated
vi. If the viral load is still detectable (>100 IUs), treatment shall be discontinued.

c. For members with a history of substance use disorder, within the past 12 months, random drug/alcohol screens must be completed during HCV treatment.

d. Members prescribed Sofosbuvir or Simeprevir must participate in a treatment adherence program.

10. Coverage is not provided for:

a. Monotherapy of Simeprevir (Olysio).
b. Monotherapy of Sofosbuvir (Sovaldi).
c. Sofosbuvir for greater than 12 weeks of therapy except for interferon ineligible genotype 3 members.
d. Sofosbuvir doses greater than 400mg/day.
e. Simprevir doses greater than 150mg/day.
f. Harvoni doses greater than 90mg Ledipsavir / 400mg Sofosbuvir / day
g. Viekira doses greater than one Viekira Pak / day.
h. Previous therapy with Sofosbuvir or Simeprevir.
i. HCV genotypes 5 and 6.
j. Documented non-adherence to prior HCV medications, HCV medical treatment, or failure to complete HCV disease evaluation appointments and procedures.
k. Members declining to participate in a treatment adherence program.
l. Decompensated liver disease (i.e., Child-Pugh score >9).
m. Elastography score < 11 kPa.

St. John’s wart, rifampin, carbamazepine, ritonavir, tipranavir, etc.)
r. Members with severe renal impairment or end stage renal disease defined as CrCl ≤ 30mL/min
s. Members who do not meet the CD4 counts as stated in Section I #7.
u. Greater than one course of therapy per lifetime.
v. Lost or stolen medication absent good cause.
w. Fraudulent use of HCV medications

Checklist of required documentation to be submitted with the prior authorization request:

☐ Evidence of liver fibrosis as referenced in section I

☐ HCV treatment history and responses

☐ Evidence of Hepatitis A & B vaccinations or laboratory evidence of immunity

☐ Current medication list

☐ Evidence of contraception counseling for all members prescribed ribavirin
Evidence of birth control treatment for female members prescribed ribavirin

Evidence of remission for \( \geq 6 \) months for members with a history of a substance use disorder in past 12 months

Evidence of psychiatric clearance for members with a serious mental illness

Evidence of HIV specialist clearance for members with HIV-1

Evidence of cardiac clearance for members with ischemic heart disease

Laboratory results

- **All members:**
  - HCV screen, genotype and current baseline viral load, total bilirubin, albumin, INR, CrCl or GFR, LFTs, and CBC completed within the past 90 days
  - Baseline drug/alcohol screen completed within the past 30 days

- **Members with HIV-1:**
  - CD4 count

- **Members with a history of substance use disorder in past 12 months:**
  - Random drug/alcohol screens

- **Female members:**
  - Pregnancy test

- **Null or partial responders:**
  - HCV RNA levels at baseline, prior to IFN/RBV or IFN/RBV/PI treatment, and at the time of treatment discontinuation, if available

**REFERENCES**


2. Treatment Considerations from the Department of Veterans Affairs National Hepatitis C Resource Center Program and the Office of Public Health: March 2014.


CHAPTER 300
MEDICAL POLICY FOR AHCCCS COVERED SERVICES

POLICY 320
SERVICES WITH SPECIAL CIRCUMSTANCES

320-O RESERVED
320-P  RESERVED
320-Q RESERVED
320-R  SPECIAL ASSISTANCE FOR PERSONS DETERMINED TO HAVE A SERIOUS MENTAL ILLNESS

INITIAL

EFFECTIVE DATE: 07/01/2016

Background

Contractors and Tribal Regional Behavioral Health Authorities (TRBHA), the Arizona State Hospital (AzSH) and subcontracted providers must identify and report to the AHCCCS Office of Human Rights (OHR) persons determined to have a Serious Mental Illness (SMI) who meet the criteria for Special Assistance. If the person’s Special Assistance needs appear to be met by an involved family member, friend, designated representative or guardian, the Contractor, TRBHA or behavioral health provider must still submit a notification to the OHR. Contractors, TRBHAs, AzSH, subcontracted providers and the Behavioral Health Office of Grievances and Appeals (BHOGA) must ensure that the person designated to provide Special Assistance is involved at key stages.

Amount, Duration and Scope

The purpose of this policy is to establish uniform guidelines for:

1. Identifying persons determined to have a Serious Mental Illness (SMI) who are in need of Special Assistance,

2. Ensuring that persons in need of Special Assistance have their Special Assistance needs met, and

3. Maintaining and disseminating required reports on persons in need of Special Assistance.

As applicable, RBHAs must ensure that all subcontracted providers adhere to the requirements of this Policy.

A. GENERAL REQUIREMENTS

1. Criteria to deem a person to be in need of Special Assistance are as follows:

   a. A person determined to have a Serious Mental Illness (SMI) is in need of Special Assistance if he/she is also unable to do any of the following:

      i. Communicate preferences for services,

      ii. Participate effectively in individual service planning (ISP) or inpatient treatment discharge planning (ITDP),
iii. Participate effectively in the appeal, grievance or investigation processes, and
iv. The person’s limitations described in i–iii above must also be due to any of the following:
   (a) Cognitive ability/intellectual capacity (i.e. cognitive impairment, borderline intellectual functioning, or diminished intellectual capacity),
   (b) Language barrier (an inability to communicate, other than a need for an interpreter/translator), and/or
   (c) Medical condition (including, but not limited to traumatic brain injury, dementia, or severe psychiatric symptoms).

A person who is subject to general guardianship has been found to be incapacitated under A.R.S. § 14-5304, and therefore automatically satisfies the criteria for Special Assistance.

b. For a person determined to have a SMI, the existence of any of the following circumstances should prompt the Contractor, TRBHA, AzSH, or subcontracted provider to more closely review whether the person is in need of Special Assistance:
   i. Developmental disability involving cognitive ability,
   ii. Residence in a 24 hour setting,
   iii. Limited guardianship, or the Contractor, TRBHA or subcontracted provider is recommending and/or pursuing the establishment of a limited guardianship, or
   iv. Existence of a serious medical condition, that affects his/her intellectual and/or cognitive functioning (such as, dementia or traumatic brain injury).

2. The following may deem a person to be in need of Special Assistance:
   a. A qualified clinician providing treatment for the person,
   b. A case manager of a Contractor, TRBHA or subcontracted provider,
   c. A clinical team of a Contractor, TRBHA or subcontracted provider,
   d. A Contractor or TRBHA,
   e. A program director of a subcontracted provider (including AzSH),
   f. The Deputy Director of AHCCCS or designee, or
g. A hearing officer assigned to an appeal involving a person determined to have a SMI.

3. When to Screen for Special Assistance: Contractors, TRBHAs, AzSH and subcontracted providers must on an ongoing basis screen whether persons determined to have a SMI are in need of Special Assistance in accordance with the criteria set out in Section A of this Policy. Minimally, this must occur at the following stages:

a. Assessment and annual updates,

b. Development of or update to the Individual Service Plan (ISP),

c. Upon admission to a psychiatric inpatient facility,

d. Development of or update to an Inpatient Treatment and Discharge Plan (ITDP),

e. Initiation of the grievance or investigation processes,

f. Filing of an appeal, and

g. Existence of a condition which may be a basis for a grievance, investigation or an appeal

4. Documentation

a. Contractors, TRBHAs, AzSH and subcontracted providers shall document in the clinical record each time a staff member screens a person for Special Assistance, indicating the factors reviewed and the conclusion. If the conclusion is that the person is in need of Special Assistance, they shall notify the OHR using Exhibit 320-8, Notification of Person In Need of Special Assistance in accordance with the procedures below.

b. Before submitting Exhibit 320-8, Contractors, TRBHAs and their subcontracted providers shall check if the person is already identified as in need of Special Assistance. A notation of Special Assistance designation and a completed Exhibit 320-8 should already exist in the clinical record. However, if it is unclear, subcontracted providers must review Contractor or TRBHA data or contact the Contractor or TRBHA to inquire about current status. Contractors and TRBHAs are required to maintain a database on persons in need of Special Assistance and share data with providers on a regular basis (at a minimum quarterly).
B. Notification Requirements to the Office of Human Rights

1. If a person is not correctly identified as Special Assistance, Contractors, TRBHAs, AzSH and subcontracted providers must submit Part A of Exhibit 320-8 to the OHR within five working days of identifying a person in need of Special Assistance. If the person has a Special Assistance need requiring immediate assistance, the notification form must be submitted immediately with a notation indicating the urgency. Contractors, TRBHAs, AzSH and subcontracted providers should inform the person of the notification and explain the benefits of having another person involved who can provide Special Assistance, if able.

2. If the person is under a guardianship or one is in process, the documentation of such must also be submitted to OHR However, if the documentation is not available at the time of submission of the Exhibit 320-8 notification, the form should be submitted within the required timeframes, followed by submittal of the guardianship documentation.

3. The OHR (reviews the notification form to ensure that it contains sufficient information detailing the criteria and responds to the Contractor, TRBHA and subcontracted providers by completing Part B of Exhibit 320-8 within five working days of receipt of the form. In the event the necessary information is not provided on the form, OHR contacts the staff member submitting the notification for clarification. In the event the notification is urgent, OHR will respond as soon as possible, but generally within one working day of receipt of the notification.

4. The notification process is not complete until OHR completes Part B of the form and sends it back to the Contractor or TRBHA and subcontracted providers. The Contractors, TRBHAs and subcontracted providers should follow up with OHR if no contact is made or Part B is not received within five working days.

5. OHR designates which agency/person will provide Special Assistance when processing Exhibit 320-8. When the agency/person providing Special Assistance changes, OHR processes an “updated Part B” to document the change.

6. In the event the person or agency currently identified as providing Special Assistance is no longer actively involved, the Contractor, TRBHA or subcontracted provider must notify DHCAA. If a DHCAA advocate is also assigned, notification to the advocate is sufficient.
C. PERSONS NO LONGER IN NEED OF SPECIAL ASSISTANCE

1. Contractors, TRBHAs, AzSH or subcontracted providers must notify the OHR within 10 days of an event or determination that a person in need of Special Assistance no longer meets criteria by completing Part C of the original notification form (with Parts A & B completed when first identified), noting:

   a. The reason(s) why Special Assistance is no longer required,
   
   b. The effective date,
   
   c. The name, title, phone number and e-mail address of the staff person completing the form, and
   
   d. The date the form is completed.

2. The following are instances that should prompt Contractors, TRBHAs, AzSH or subcontracted providers to submit a Part C:

   a. The original basis for the person meeting Special Assistance criteria is no longer applicable and the person does not otherwise meet criteria,
      i. Contractors, TRBHA, AzSH or subcontracted provider must first discuss the determination with the person or agency providing Special Assistance to obtain any relevant input, and
      ii. This includes when a person is determined to no longer be a person with a SMI (proper notice and appeal rights must be provided and the period to appeal must have expired).
   
   b. The person passes away.
   
   c. The person’s episode of care is ended with the Contractor or TRBHA (Non-Title XIX persons with a SMI will also be disenrolled) and the person is not transferred to another Contractor or TRBHA. Contractors, TRBHAs or subcontracted providers must first perform all required re-engagement efforts, which includes contacting the person providing Special Assistance, per AMPM Policy 1040, Engagement, Re-engagement and Closure. Proper notice and appeal rights must be provided and the period to appeal must have expired prior to submission of Part C.

NOTE: Submission of a Part C is not needed when a person transfers to another Contractor or TRBHA, as the Special Assistance designation follows the person.
Upon receipt of Part C of the Exhibit 320-8, OHR -reviews content to confirm accuracy and completeness and returns it to the agency that submitted it, copying any involved Contractors, TRBHAs or subcontracted provider.

D. Requirement of Contractors, TRBHAs, AZSH, Subcontracted Providers and Behavioral Health Office of Grievances and Appeals (BHOGA) to Help Ensure the Provision of Special Assistance.

1. Contractors, TRBHAs, AzSH, subcontracted providers and BHOGA must maintain open communication with the person (guardian, family member, friend, OHR advocate, etc.) assigned to meet the person’s Special Assistance needs. Minimally, this involves providing timely notification to the person providing Special Assistance to ensure involvement in the following:

   a. ISP planning and review: Includes any instance when the person makes a decision regarding service options and/or denial/modification/termination of services (service options include not only a specific service but also potential changes to provider, site, -physician and case manager assignment).

   b. ISP development and updates: Must be in accordance with AMPM Policy 320-O, Service Planning, Assessments, and Discharge Planning.

   c. ITDP planning: Includes any time a person is admitted to a psychiatric inpatient facility and involvement throughout the stay and discharge.

   d. Appeal process: Includes circumstances that may warrant the filing of an appeal, so all Notices of Action (NOA) or Notices of Decision (NOD) issued to the person/guardian must also be copied to the person designated to meet Special Assistance needs; and

   e. Investigation or Grievance: Includes when an investigation/grievance is filed and circumstances when initiating a request for an investigation/grievance may be warranted.

2. In the event that such procedures are delayed in order to ensure the participation of the person providing Special Assistance, the Contractors, TRBHAs, AzSH, subcontracted providers and BHOGA must document the reason for the delay in the clinical record, or the investigation, grievance or appeal file. If an emergency service is needed Contractors, TRBHAs, AzSH, and/or subcontracted providers must, ensure that the person receives the needed services in the interim and promptly notify the agency/person providing Special Assistance.
3. Contractors, TRBHAs and subcontracted providers shall timely provide relevant details and a copy of the original Exhibit 320-8 (both Parts A and B) to the receiving entity and when applicable, Case Manager, when a person in need of Special Assistance is:

   a. Admitted to an inpatient facility,

   b. Admitted to a residential treatment setting, or

   c. Transferred to a different Contractor, TRBHA, Case Management Provider Site, or Case Manager.

4. Contractors, TRBHAs and subcontracted providers must periodically review whether the person’s needs are being met by the person or agency designated to meet the person’s Special Assistance needs. If a concern arises, they should first address it with the person or agency providing Special Assistance. If the issue is not promptly resolved, they must take further action to address the issue, which may include contacting OHR administration for assistance.

E. Behavioral Health Office of Grievances and Appeals (BHOGA) and RBHA Office of Grievance and Appeals Reporting Requirements (OGA)

1. Upon receipt of a request for investigation, grievance or an appeal, the Contractor’s or TRBHAs’ OGA and the BHOGA must review whether the person is already identified as in need of Special Assistance.

2. If so, the Contractor, TRBHA or BHOGA must ensure that:

   a. A copy of the request for investigation or grievance is sent to OHR within five days of receipt of the request. The Contractor, TRBHA or BHOGA must also forward a copy of the final grievance/investigation decision to the OHR within five days of issuing the decision.

   b. A copy of an appeal for a person with Special Assistance are sent to OHR.

   c. The results of the Informal Conference (IC) regarding appeals are sent to OHR. The Contractor, TRBHA or BHOGA shall also forward a copy of any subsequent notice of hearing.

F. Contractor and TRBHA Reporting Requirements

1. Contractors and TRBHAs must maintain a copy of completed Exhibit 320-8, Parts A, B and updated if any.
2. Contractors and TRBHAs must maintain a database on persons in need of Special Assistance to ensure compliance with this Policy and the reporting requirements described in this section. This cannot be delegated to Contractor or TRBHA providers.

3. The Contractor and TRBHA must, by the 10th calendar day of each month, provide the OHR with a comprehensive report listing:
   a. All persons in need of Special Assistance who are active as of the end of the previous month,
   b. Any Part C notifications during the previous month that a person no longer needs Special Assistance.
   c. Any persons transferred to the Contractor or TRBHA during the previous month who were Special Assistance in the previous Contractor or TRBHA, and
   d. Any person in need of Special Assistance transferred from the Contractor or TRBHA to another Contractor or TRBHA.

4. The monthly reports must contain the following information:
   a. CIS Number
   b. Name
   c. Date of Birth
   d. Guardian (yes or no)
   e. Current address
   f. Current phone number
   g. Type of residence
   h. Whether currently at AzSH & unit name
   i. AzSH Identification Number
   j. Name of Provider
   k. Name/location of Provider site
l. Name of Case Manager

m. Name of Clinical Supervisor

n. GSA (for RBHAs serving more than one)

o. Title XIX (AHCCCS) enrollment status (yes or no)

p. Effective Date (date Part B was completed)

q. Person/relationship or agency meeting Special Assistance needs

r. Name, address and phone number of person meeting the Special Assistance needs

s. If applicable, the Date of Discharge from AzSH

t. If applicable, the Date of the Removal (when Part C of the notification was sent to OHR) or the event and event date that prompted the removal

u. If applicable, information on any updated Part B (indicating change in person meeting needs), and

v. If applicable, the Date of the Inter-RBHA transfer including the name of the receiving Contractor or TRBHA.

5. By the 25th day of the month following the end of a quarter, OHR provides Contractors and TRBHAs with a comprehensive report for the previous quarter.

6. The Contractors and TRBHAs in response to OHR’s quarterly report must update the Contractors or TRBHA’s database with data updates contained in the quarterly report for persons assigned to an OHR advocate and submit an updated report to OHR by the 10th day of the next month, as specified in the RBHA Contract, Exhibit-9, Deliverables. The report must identify any changes in client information, for persons not assigned to an OHR Advocate, that occurred during the previous quarter. Examples include change in Title XIX enrollment, changes in the person’s residence, case management provider or case manager assignment, etc. Contractors, TRBHAs and OHR shall work together to rectify any data discrepancies in a timely manner to ensure that the data maintained is accurate.

7. The - OHR, utilizing data it maintains on all persons in need of Special Assistance, must provide a list of persons in each region to each Human Rights Committee (HRC) by the 25th calendar day of each month. The OHR
customarily provides a courtesy copy of the report to the corresponding Contractor or TRBHA.

8. By the 10th calendar day of each month, AzSH must provide the OHR with a comprehensive report listing of persons in need of Special Assistance that were receiving services at AzSH during the previous month. OHR provides the final report to the AzSH HRC and a copy to AzSH by the 25th of the month.

9. Contractors must share Special Assistance data with its subcontracted providers that provide case management to persons determined to have a SMI and verify that a process exists at each case management provider to ensure this data is accessible by front-line provider staff (at a minimum quarterly). Contractors must also establish a process with such providers to obtain quarterly updates on persons currently identified as Special Assistance to support the Contractors or TRBHAs quarterly data updates process with the OHR.

G. CONFIDENTIALITY REQUIREMENTS

1. Contractors, TRBHAs, AzSH and subcontracted providers shall grant access to clinical records of persons in need of Special Assistance to the OHR in accordance with federal and state confidentiality laws (see AMPM Policy 550, Medical Records and Confidentiality).

2. HRCs and their members shall safeguard the monthly list that contains the names of those persons in need Special Assistance regarding any Protected Health Information (PHI). HRCs must inform AHCCCS annually in writing of how it will maintain the confidentiality of the Special Assistance lists. If HRCs request additional information that contains PHI that is not included in the monthly report, they must do so in accordance with the requirements set out in ACOM Policy 447, Disclosure of Confidential Information to Human Rights Committees.

H. OTHER PROCEDURES

1. Contractors, TRBHAs, AzSH and subcontracted providers must maintain a copy of the completed Exhibit 320-8, (Parts A and B and updated B, if any) in the person’s comprehensive clinical record. In the event a person was identified as no longer needing Special Assistance and a Part C of the notification form was completed, the Contractors, TRBHAs, AzSH, and subcontracted providers must maintain a copy of the form in the comprehensive clinical record.

2. Contractors, TRBHAs, AzSH and subcontracted providers must clearly document in the clinical record (i.e. on the assessment, ISP, ITDP, face sheet) and case management/client tracking system if a person is identified as in need
of Special Assistance, the person assigned currently to provide Special Assistance, the relationship, contact information including phone number and mailing address.

3. The HRCs must make regular visits to the residential environments of persons in need of Special Assistance to determine whether the services meet their needs and their satisfaction with the residential environment.

4. Contractors must implement quality management measures to ensure the subcontracted providers implement the requirements of this Policy. Audit tools and procedures must be shared with the AHCCCS/OHR Administration prior to use to ensure they address:

   a. The screening requirements,

   b. The documentation requirements, and

   c. The provisions of Special Assistance requirements.

5. Contractors and TRBHAs must ensure that all applicable TRBHA and provider staff are trained regarding the requirements of Special Assistance. (See AMPM Policy 1060, Training Requirements).

REFERENCES

1. Refer to Policy 320-O of this Manual for Behavioral Health Assessments, Service Planning, and Inpatient Discharge Planning

2. Refer to Policy 320-P of this Manual for Serious Mental Illness Eligibility Determination

3. Refer to Chapter 500 of this Manual for Member Records and Confidentiality

4. Refer to Chapter 1000 of this Manual for Training Requirements and Outreach, Engagement, Reengagement and Closure

5. AHCCCS Contractors Operations Manual

6. A.R.S. §§ 36-107,

7. A.R.S. 36-501,

8. A.R.S. 36-504,
9. A.R.S. 36-509,

10. A.R.S. 36-517.01

11. A.R.S. §§ 41-3803,

12. A.R.S. 41-3804

13. 9 A.A.C 21

14. AHCCCS/RBHA Contracts

15. AHCCCS/TRBHA
EXHIBIT 320-1

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID
NATIONAL COVERAGE DECISION FOR LUNG VOLUME REDUCTION SURGERY
(REDUCTION PNEUMOPLASTY)
EXHIBIT 320-1
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID
NATIONAL COVERAGE DETERMINATION (NCD) FOR LUNG VOLUME REDUCTION SURGERY
(REDUCTION PNEUMOPLASTY) (240.1)

Effective Date of this Version: 11/17/2005

A. GENERAL

Lung Volume Reduction Surgery (LVRS) or reduction pneumoplasty, also referred to as lung shaving or lung contouring, is performed on patients with severe emphysema in order to allow the remaining compressed lung to expand, and thus, improve respiratory function. Medicare-covered LVRS approaches are limited to bilateral excision of a damaged lung with stapling performed via median sternotomy or video-assisted thoracoscopic surgery.

Indications and Limitations of Coverage

B. NATIONALLY COVERED INDICATIONS

Effective for services performed on or after January 1, 2004 Medicare will only consider LVRS reasonable and necessary when all of the following requirements are met (note varying dates for facility criteria in section 3. below):

1. The patient satisfies all the criteria outlined below:

<table>
<thead>
<tr>
<th>ASSESSMENT</th>
<th>CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>HISTORY AND PHYSICAL EXAMINATION</td>
<td>Consistent with emphysema</td>
</tr>
<tr>
<td></td>
<td>BMI, ≤31.1 kg/m$^2$ (men) or ≤32.3 kg/m$^2$ (women)</td>
</tr>
<tr>
<td></td>
<td>Stable with ≤ 20 mg prednisone (or equivalent) qd</td>
</tr>
<tr>
<td>RADIOGRAPHIC</td>
<td>High Resolution Computer Tomography (HRCT) scan evidence of bilateral emphysema</td>
</tr>
<tr>
<td>PULMONARY FUNCTION (PRE-REHABILITATION)</td>
<td>Forced Expiratory Volume in one second (FEV$_1$) ≤ 45% predicted ≥ 15% predicted if age ≥ 70 years</td>
</tr>
<tr>
<td></td>
<td>Total lung capacity (TLC) ≥ 100% predicted post-bronchodilator</td>
</tr>
<tr>
<td></td>
<td>Residual Volume (RV) ≥ 150% predicted post-bronchodilator</td>
</tr>
<tr>
<td>ARTERIAL BLOOD GAS LEVEL (PRE-REHABILITATION)</td>
<td>PCO$_2$, ≤ 60 mm Hg (PCO$_2$, ≤ 55 mm Hg if 1-mile above sea level)</td>
</tr>
<tr>
<td></td>
<td>PO$_2$, ≥ 45 mm Hg on room air (PO$_2$, ≥ 30 mm Hg if 1-mile above sea level)</td>
</tr>
<tr>
<td>CARDIAC ASSESSMENT</td>
<td>Approval for surgery by cardiologist if any of the following are present: Unstable angina; Left-Ventricular Ejection Fraction (LVEF) cannot be estimated from the echocardiogram; LVEF &lt;45%; dobutamine-radionuclide cardiac scan indicates coronary artery disease or ventricular dysfunction; arrhythmia (&gt;5 premature ventricular contractions per minute; cardiac rhythm other than sinus; premature ventricular contractions on EKG at rest)</td>
</tr>
</tbody>
</table>
EXHIBIT 320-1
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID
NATIONAL COVERAGE DETERMINATION (NCD) FOR LUNG VOLUME REDUCTION SURGERY
(REDUCTION PNEUMOPLASTY) (240.1)

<table>
<thead>
<tr>
<th>ASSESSMENT</th>
<th>CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>SURGICAL ASSESSMENT</td>
<td>Approval for surgery by pulmonary physician, thoracic surgeon, and</td>
</tr>
<tr>
<td></td>
<td>anesthesiologist post-rehabilitation</td>
</tr>
<tr>
<td>EXERCISE</td>
<td>Post-rehabilitation 6-min walk of ≥ 140 m; able to complete 3 min</td>
</tr>
<tr>
<td></td>
<td>unloaded pedaling in exercise tolerance test (pre- and post-</td>
</tr>
<tr>
<td></td>
<td>rehabilitation)</td>
</tr>
<tr>
<td>CONSENT</td>
<td>Signed consents for screening and rehabilitation</td>
</tr>
<tr>
<td>SMOKING</td>
<td>Plasma cotinine level ≤ 13.7 ng/mL (or arterial carboxyhemoglobin ≤</td>
</tr>
<tr>
<td></td>
<td>2.5% if using nicotine products)</td>
</tr>
<tr>
<td></td>
<td>Nonsmoking for 4 months prior to initial interview and throughout</td>
</tr>
<tr>
<td></td>
<td>evaluation for surgery</td>
</tr>
<tr>
<td>PREOPERATIVE DIAGNOSTIC AND</td>
<td>Must complete assessment for and program of preoperative services in</td>
</tr>
<tr>
<td>THERAPEUTIC PROGRAM ADHERENCE</td>
<td>preparation for surgery</td>
</tr>
</tbody>
</table>

2. In addition, the patient must have:

- Severe upper lobe predominant emphysema (as defined by radiologist assessment of upper lobe predominance on CT scan), or
- Severe non-upper lobe emphysema with low exercise capacity.

Patients with low exercise capacity are those whose maximal exercise capacity is at or below 25 watts for women and 40 watts (w) for men after completion of the preoperative therapeutic program in preparation for LVRS. Exercise capacity is measured by incremental, maximal, symptom-limited exercise with a cycle ergometer utilizing 5 or 10 watt/minute ramp on 30% oxygen after 3 minutes of unloaded pedaling.

3. Effective for services performed on or after November 17, 2005, CMS determines that LVRS is reasonable and necessary when performed at facilities that are:

   (1) Certified by the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission) under the LVRS Disease Specific Care Certification Program (program standards and requirements as printed in the Joint Commission’s October 25, 2004, Disease Specific Care Certification Program packet); or
   (2) approved as Medicare lung or heart-lung transplantation hospitals.

In addition, LVRS performed between January 1, 2004, and May 17, 2007, is reasonable and necessary when performed at facilities that:

   (1) were approved by the National Heart Lung and Blood Institute to participate in the National Emphysema Treatment Trial (NETT); or
   (2) are approved as Medicare lung or heart-lung transplantation hospitals.

A list of approved facilities and their approval dates will be listed and maintained on the CMS Web site at http://www.cms.hhs.gov/MedicareApprovedFacilities/04_lvrs.asp#TopOfPage.
The surgery must be preceded and followed by a program of diagnostic and therapeutic services consistent with those provided in the NETT and designed to maximize the patient's potential to successfully undergo and recover from surgery. The program must include a 6- to 10-week series of at least 16, and no more than 20, preoperative sessions, each lasting a minimum of 2 hours. It must also include at least 6, and no more than 10, postoperative sessions, each lasting a minimum of 2 hours, within 8 to 9 weeks of the LVRS. This program must be consistent with the care plan developed by the treating physician following performance of a comprehensive evaluation of the patient's medical, psychosocial and nutritional needs, be consistent with the preoperative and postoperative services provided in the NETT, and arranged, monitored, and performed under the coordination of the facility where the surgery takes place.

C. NATIONALLY NON-COVERED INDICATIONS

1. **LVRS is not covered in any of the following clinical circumstances:**
   a. Patient characteristics carry a high risk for perioperative morbidity and/or mortality;
   b. The disease is unsuitable for LVRS;
   c. Medical conditions or other circumstances make it likely that the patient will be unable to complete the preoperative and postoperative pulmonary diagnostic and therapeutic program required for surgery;
   d. The patient presents with FEV₁ <20% of predicted value, and either homogeneous distribution of emphysema on CT scan, or carbon monoxide diffusing capacity of <20% of predicted value (high-risk group identified October 2001 by the NETT); or
   e. The patient satisfies the criteria outlined above in section B(1), and has severe, non-upper lobe emphysema with high exercise capacity. High exercise capacity is defined as a maximal workload at the completion of the preoperative diagnostic and therapeutic program that is above 25 w for women and 40 w for men (under the measurement conditions for cycle ergometry specified above).

2. **All other indications for LVRS not otherwise specified remain noncovered.**
EXHIBIT 320-2

RESERVED
EXHIBIT 320-6
NOTIFICATION OF PERSON IN NEED OF SPECIAL ASSISTANCE
A Contractor, TRBHA, provider, or other person qualified to make the determination that determines a person with a Serious Mental Illness (SMI) is in need of Special Assistance, in accordance with AMPM Policy 320-R, must notify the AHCCCS Office of Human Rights within five days of the determination. If the person is not already identified as Special Assistance, notification is required even if someone is involved and assisting the person.

**Part A: Notification** (to be completed by the Contractor, TRBHA, provider or other person qualified and sent to the Office of Human Rights at (602) 364-4590 or via secure e-mail toOHRts@azahcccs.gov)

The following person, **who is a person determined to have a Serious Mental Illness (SMI)**, is in need of Special Assistance.

<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
<th>DOB</th>
<th>Residence Type</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Arizona</th>
<th>Zip code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<table>
<thead>
<tr>
<th>Phone</th>
<th>Guardian (If none, list N/A)</th>
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</table>

**Title XIX?**

- [ ] Yes
- [ ] No

<table>
<thead>
<tr>
<th>CIS ID</th>
<th>T/RBHA</th>
<th>GSA (N/A for T/RBHAs)</th>
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<tr>
<td></td>
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<table>
<thead>
<tr>
<th>SMI Provider Name</th>
<th>Site Name/Location</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>SMI Case Manager</th>
<th>Site Phone</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>SMI Clinical Supervisor</th>
<th>Site Fax</th>
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**Indicate the areas of Special Assistance need. Please check all that may apply, regardless of whether a process is currently pending**

- Service Planning
- Discharge Planning Process
- Grievance Process
- Appeal process

Provide the clinical basis to support that the person is in need of Special Assistance. Please detail the specific circumstances and how they affect the person's ability to communicate preferences and/or participate effectively in the ISP, discharge planning, grievance/investigation, and/or appeal processes.

**Grievance or Appeal Pending:**

- [ ] Yes
- [ ] No

**Currently Inpatient?**

- [ ] Yes
- [ ] No

<table>
<thead>
<tr>
<th>Inpatient Facility &amp; Unit</th>
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</table>

**Indicate a guardian, relative, or a friend is regularly involved with the person and Behavioral Health provider.**

- [ ] Yes
- [ ] No

<table>
<thead>
<tr>
<th>If so, by Who (Name)</th>
<th>Relationship</th>
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<table>
<thead>
<tr>
<th>Phone</th>
<th>Address</th>
<th>City</th>
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</tbody>
</table>

**Is the person in need of Special Assistance aware that you are submitting this notification?**

- [ ] Yes
- [ ] No

Please Explain:

<table>
<thead>
<tr>
<th>Date Completed</th>
<th>By Name</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Phone Number</th>
<th>E-mail</th>
<th>Title</th>
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<tr>
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</tbody>
</table>
**EXHIBIT 320-6**  
**NOTIFICATION OF PERSON IN NEED OF SPECIAL ASSISTANCE**

**PART B: Response (to be completed by the Office of Human Rights Administration (OHR)):**

<table>
<thead>
<tr>
<th>Re: NAME</th>
<th>DOB</th>
<th>Original Part A Notification Date</th>
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<tbody>
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</table>

Per the information provided/supplemental information obtained, the person meets the criteria for Special Assistance  

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

The person requires Special Assistance in the following areas

- [ ] Service Planning
- [ ] Discharge Planning
- [ ] Grievance Process
- [ ] Appeal Process

The following person/agency is designated to provide Special Assistance

- [ ] OHR Assigned Advocate

Phone

Date (as of)

**PART C: Notification of Change (to be completed by the T/RBHA, Provider or other person qualified)**

Please indicate the date when the need for Special Assistance was no longer required and the reason(s) why. Submit Part C to OHR within ten (10) days of the determination.

As of, Date

The above referenced person no longer meets the criteria for Special Assistance for the following reason(s):

The person was informed, due to a change in circumstances, he/she no longer meets the criteria for Special Assistance and OHR is being notified  

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

Please explain:

First Name | Last Name | Agency | Phone | E-mail | Title |
|-----------|-----------|--------|-------|--------|-------|

Date Completed
330 COVERED CONDITIONS AND SERVICES FOR THE CHILDREN’S REHABILITATIVE SERVICES (CRS) PROGRAM

Revision Dates: 09/01/14, 10/01/13

Initial Effective Date: 03/11/2011 (Medical Content from the ADHS Contractor Policy & Procedures Manual transitioned to the AMPM)

Description

AHCCCS enrolls EPSDT members who require treatment for medically disabling or potentially disabling conditions, as defined in A.A.C. R9-22-1303 (refer to Exhibit 330-1), into the Children’s Rehabilitative Services (CRS) program. Enrollment in CRS is based upon a member’s qualifying condition and the need for active treatment of the CRS conditions in A.A.C. R9-22-1303 through medical, surgical, or therapy modalities. The AHCCCS Division of Member Services will provide information to the CRS Contractor related to the CRS qualifying condition(s) that are identified during the eligibility determination process. The AHCCCS Division of Member Services may also provide information received for purposes of eligibility determination for the CRS Program regarding care, services or procedures that may have been approved or authorized by the member’s current health plan. It will be the responsibility of the CRS Contractor to ensure that the information provided by the AHCCCS Division of Member Services is made available to the appropriate areas and staff within its organization who may need the information. It remains the responsibility of the CRS Contractor and the AHCCCS Acute Care, Division of Developmental Disabilities (DDD), and Comprehensive Medical Dental Program (CMDP) Contractors to also appropriately transition the member utilizing established transition processes.

The CRS Contractor provides services through an approach to service delivery that is family-centered, coordinated and culturally competent, in a manner that considers the unique medical and behavioral holistic needs of the member.

CRS members may be seen for care and specialty services by CRS contracted network providers within the community that are qualified or trained in the care of the member’s condition. CRS members may also benefit from treatment in clinic-based multi-specialty/interdisciplinary care settings when active treatment is required, in addition to care and services provided by community based providers in independent offices. The CRS Contractor also provides community based services, including services provided in field clinics.

CRS services are covered within the state of Arizona. When medically necessary services are not available in state, the CRS Contractor is required to provide services...
Covered benefits for CRS Partially Integrated members are the same as those provided by the Acute Contractors and the Behavioral Health Contactors including any necessary placement settings such as skilled nursing facilities, chemotherapy, hospice, transplant services, and behavioral health placement settings, as determined to be medically necessary and resulting from the CRS qualifying condition or a condition that is related to, or the result of, a CRS condition.

CRS Fully Integrated members receive all care and services through the CRS Contractor, including physical health and behavioral health services. For those Partially Integrated - Acute and Fully Integrated members with an acute condition that is not a CRS qualifying condition, the member will continue to remain enrolled in and eligible for CRS services; thereby, receiving services for the Acute condition from the CRS Contractor.

Definitions

Active Treatment means there is a current need for treatment or evaluation for continuing treatment of the CRS qualifying condition(s) or it is anticipated that treatment or evaluation for continuing treatment of the CRS qualifying condition(s) will be needed within the next 18 months from the last date of service for treatment of any CRS qualifying condition (A.A.C. R9-22-1301).

Chronic means expected to persist over an extended period of time.

CRS condition means any of the covered medical conditions in A.A.C. R9-22-1303. Refer to Exhibit 330-1.

CRS Fully Integrated refers to members receiving all services from the CRS Contractor including acute health, behavioral health and CRS-related services.

CRS Partially-Integrated - Acute refers to American Indian Health Plan members receiving all acute health and CRS-related services from the CRS Contractor and receiving behavioral health services from a Tribal RHBA.

CRS Partially-Integrated - Behavioral Health refers to CMDP or DDD members receiving all behavioral health and CRS-related services from the CRS Contractor and receiving acute health services from the primary program of enrollment.

CRS Only refers to those members receiving CRS-related services from the CRS Contractor, receiving acute health services from the primary program of enrollment, and receiving behavioral health services as follows:
AIHP members from a T/RBHA

CRS Only also includes ALTCS/EPD AI Fee For Service members.

**CRS provider** means a person who is authorized by employment or written agreement with the CRS Contractor to provide covered CRS services to a member or covered support services to a member or a member's family.

**Functionally limiting** means a restriction having a significant effect on an individual's ability to perform an activity of daily living as determined by a CRS provider.

**Medically eligible** means meeting the medical eligibility requirements of A.A.C. R9-22-1303.

The CRS fully integrated plan is responsible for all Title XIX and XXI covered services described throughout this Chapter, including those described in this section of the policy.

The following services described in this policy apply to Comprehensive Medical and Dental Program (CMDP), Division of Developmental Disabilities (DDD), and American Indian Health Plan (AIHP) [Fee-For-Service (FFS)] CRS Partially Integrated members.

**Amount, Duration and Scope**

The CRS Contractor provides covered medical, surgical, or therapy modalities only for CRS enrolled members. The CRS Contractor provides CRS covered services for CRS qualifying conditions (Refer to Exhibit 330-1) and conditions arising as a result of or related to the CRS qualifying condition when medically necessary. The CRS Contractor does not cover routine, preventive, or other non-CRS related covered services for Comprehensive Medical and Dental Program (CMDP), Division of Developmental Disabilities (DDD), Fee-For-Service (FFS) or third party payers. Members who are 21 years of age and older are subject to all limitations and exclusions applicable to the adult population.

The CRS Contractor may elect to provide AHCCCS or CRS non-covered services. In such instances, the CRS Contractor acknowledges that the provision of these services will not be considered in rate development and will not be reimbursable through Medicaid funds.

The CRS Contractor or authorized subcontractors provide medically necessary CRS services in both inpatient and outpatient settings, including contracted hospitals, CRS clinics, community based field clinics, community based provider offices, behavioral health and skilled nursing facilities. Certain services may be available
only in limited types of service settings or may be medically appropriate only for members with a particular clinical presentation. Services may require prior authorization from the CRS Contractor and may require additional documentation to determine the medical necessity of the service requested for treating the CRS qualifying condition or a condition that is related to, or the result of, a CRS condition.

COVERAGE DISPUTE RESOLUTION PROCESS

In the event that the CRS Contractor and the DDD Contractor, CMDP Contractor, or AIHP disagree on the financial responsibility or coverage decision of the CRS Contractor, the Medical Director for each Contractor shall review and discuss the request for services to determine appropriate financial responsibility or coverage. If agreement is not reached, the DDD Contractor, CMDP Contractor, or AIHP shall provide the medically necessary service and initiate a Request for Review with the AHCCCS Medical Management Unit. The following shall be the process for resolving the Request for Review:

a. The DDD, CMDP Contractor or the AIHP shall submit the service request and all accompanying/relevant documentation to the AHCCCS Medical Management Manager with a request for secondary review and determination if the CRS Contractor coverage decision was appropriate; within 30 Calendar Days of the receipt of the CRS coverage decision.

b. The AHCCCS Medical Management Manager shall issue a written decision to the CMDP Contractor, DDD Contractor, AIHP and the CRS Contractor no later than 30 Calendar Days from the date of the receipt of the Request for Review.

c. If the AHCCCS Medical Management Manager determines that the service should have been provided by the CRS Contractor, the CRS Contractor shall be financially responsible for the costs incurred by the DDD Contractor, CMDP Contractor or the AIHP in providing the service.

d. All AHCCCS Medical Management decisions shall advise the Contractor that the Contractor may file a request for review with the Office of Administrative Legal Services (OALS) at AHCCCS within thirty (30) Days of receipt of the AHCCCS Medical Management responsible Contractor decision in the event that the Contractor continues to disagree with the decision.

MEDICAL SERVICES

The CRS program provides medical services in accordance with R9-22, Article 2. The following services described in this policy apply strictly to Comprehensive Medical and Dental Program (CMDP), Division of Developmental Disabilities
(DDD), and AIHP Fee-For-Service (FFS) CRS Partially Integrated members, as the CRS fully integrated plan is responsible for all Title XIX and XXI covered services, including those described in this policy. Coverage limitations and exclusions for members 21 years of age and older apply.

Below is the responsibility of the CRS Contractor:

A. AUDIOLGY SERVICES

Audiology is an AHCCCS covered service as described in Policy 310-A of this Chapter, within certain limitations, to evaluate and rehabilitate members with hearing loss. For purposes of CRS, the following applies:

1. Audiologic Assessments
   a. Audiologic assessments must be consistent with accepted standards of audiolodic practice.

2. Hearing Aid Fittings and Evaluations The following are covered:
   a. Hearing aids.
      i. The CRS member may have the hearing aid reevaluated annually.
      ii. A hearing aid may be replaced once every three years, unless the member experiences a change in hearing levels or is determined by a CRS contracted audiologist to require a hearing aid replacement due to the hearing aid being lost, broken, or non-functioning.
   b. Implantable bone conduction devices.
   c. Cochlear implants. (For further information, please refer to Policy 430, EPSDT Services.)

B. DENTAL AND ORTHODONTIA SERVICES

Dental and Orthodontia Services are AHCCCS covered services, with certain limitations as described in AMPM, Chapter 400, Policy 430, EPSDT Services. For purposes of the CRS program, the following applies:

1. Dental Services
   Full ranges of dental services are covered by the CRS Contractor for CRS members having at least one of the following:
a. Cleft lip and/or cleft palate

b. A cerebral spinal fluid diversion shunt where the member is at risk for subacute bacterial endocarditis

c. A cardiac condition where the member is at risk for subacute bacterial endocarditis

d. Dental complications arising as a result of treatment for a CRS condition

e. Documented significant functional malocclusion
   i. when the malocclusion is defined as functionally impairing in a CRS member with a craniofacial anomaly or
   ii. when one of the following criteria is present:
      (a) Masticatory and swallowing abnormalities that affect the nutritional status of the individual resulting in growth abnormalities,
      (b) The malocclusion induces clinically significant respiratory problems such as dynamic or static airway obstruction, or
      (c) Serious speech impairment, determined by a speech therapist, that indicates the malocclusion as the primary etiology for the speech impairment and that speech cannot be further improved by speech therapy alone.

2. Orthodontia Services

Medically necessary Orthodontia Services are covered for a CRS member with a diagnosis of cleft palate or documented significant functional malocclusion as described in 1.e. above.

C. DIAGNOSTIC TESTING AND LABORATORY SERVICES

AHCCCS covers medically necessary diagnostic testing and laboratory services as described in Policy 310 of this Chapter. For purposes of the CRS program, the following applies:

Limitations

1. Genetic testing is only covered when the results of such testing are
necessary to differentiate between treatment options as described in Policy 310, Covered Services and when related to a CRS condition.

2. Follow-up laboratory evaluations for conditions unrelated to the CRS condition are excluded. The member must be referred to his or her primary care provider for follow-up care.

D. DURABLE MEDICAL EQUIPMENT (DME)

AHCCCS covers medically necessary DME, as described in Policy 310-P Medical Supplies, Durable Medical Equipment and Orthotic/Prosthetic Devices of this Chapter. For CRS qualifying conditions, the CRS program covers:

- Durable medical equipment for rehabilitative care
- Equipment repairs, and
- Equipment modifications.

1. Exclusion and limitations of Durable Medical Equipment Services
(Refer to #4 and #5 of this section for specific information related to wheelchair and ambulation devices)

   a. Members are eligible for equipment only when ordered by a CRS contracted provider and/or authorized by the CRS Contractor.

   b. Cranial modeling bands are excluded except for members who are 24 months of age or younger who have undergone CRS-approved cranial modeling surgery and demonstrate postoperative progressive loss of surgically achieved correction and that without intervention would most likely require additional surgery.

2. Equipment Maintenance for Durable Medical Equipment Services

   CRS covered services include equipment modifications necessary due to the member's growth or due to a change in the member's orthopedic or health needs. The request for modification must come from a CRS contracted provider.

3. Equipment Replacement or Repair for Durable Medical Equipment Services

   The CRS Contractor must ensure that Durable Medical Equipment found to be unsatisfactory due to imperfect or faulty construction is corrected, adjusted, or replaced.
4. Wheelchairs and Ambulation Devices

   a. The CRS program provides routine or custom wheelchairs and/or ambulation assistive devices (crutches, canes, and walkers) for CRS members, based on medical necessity.

   b. The CRS program provides initial wheelchair fittings within 20 business days of the order being written. Modifications, and repairs must be completed according to the medical needs of the member (Completion not to exceed 30 business days from the date ordered by the member's provider unless there are documented extenuating circumstances).

   c. The CRS program provides final fittings for ambulation assistive/adaptive devices from the date ordered within:

      i. 20 working days for routine fittings.

      ii. Three working days for repairs ordered by a physician as urgent.

      iii. Same day service shall be provided for emergency adjustments or repairs for members unable to undertake their normal daily activities safely without the repair/adjustment.

         Note: In order to meet the timeframes in items b and c, as found above, the Contractor may provide temporarily appropriate and safe ambulation assistive/adaptive devices while waiting for routine fittings, repairs and/or adjustments.

   d. The CRS program covers medically necessary equipment modifications and replacement.

   e. Custom fit standards and parapodiums are covered for CRS members with spinal cord defects who have walking potential.

   f. Trays for wheelchairs are provided when documentation indicates that the need is directly related to improvement in functional skill.

   g. The member and/or his family must demonstrate that they can safely use all equipment provided to the member, as verified and documented by the treating provider or wheelchair fitting provider. Practical and functional use of the equipment must be documented in the CRS medical record.
5. **Limitations and Exclusions Related to Wheelchairs and Ambulation Devices**

   a. Replacement of wheelchairs and ambulation devices is not a covered service when the equipment is functional and can be repaired such that the equipment is safe to operate.

   b. Physical or structural modifications to a home are excluded.

   c. After initial delivery, care and transportation of the equipment, including vehicle modifications, is the responsibility of the member and/or the member's guardian.

   Note: The CRS program repairs or provides maintenance to equipment that was not provided to the member by the CRS Contractor, when a CRS provider has determined the equipment to be safe and appropriate.

E. **HIGH FREQUENCY CHEST WALL OSCILLATION (HFCWO) THERAPY**

High Frequency Chest Wall Oscillation (HFCWO) therapy is an AHCCCS covered service, for members under 21 years of age, as described in Policy 320 of this Chapter. HFCWO is covered by CRS when there is:

1. A diagnosis of cystic fibrosis

2. Documentation of excessive sputum production combined with the member's inability to clear the sputum without assistance

3. Copy of chest x-ray report and pulmonary function tests showing findings consistent with moderate or severe Chronic Obstructive Pulmonary Disease (COPD)

4. Prescription signed by M.D. or D.O. with a specialty in pulmonary disease, indicating the need for at least daily chest physiotherapy

5. Member is two years of age or older, or has a documented chest size of 20 inches or greater, whichever comes first

6. Specific documentation supporting why HFCWO therapy for the member is superior to other more cost-effective therapy methods, including at least one of the following:

   a. Promotes independent self-care for the individual
b. Allows independent living or university or college attendance for the individual

c. Provides stabilization in single adults or emancipated individuals without able partners to assist with Chest Physical Therapy (CPT), or

d. Severe end-stage lung disease requiring complex or frequent CPT.

7. Evidence that the member can use the vest effectively, including continuing compliance with all forms of prescribed therapy and treatment and member and family acceptance of HFCWO therapy, and

8. Coordination prior to implementation of HFCWO therapy for long-term use between the CRS provider office/clinic and AHCCCS (AIHP), CMDP or DDD Contractor, or other payer source has occurred.

**DISCONTINUATION CRITERIA FOR HFCWO**

HFCWO services will be discontinued if there is:

1. Member and/or prescribing physician request, or

2. Patient treatment compliance at a rate of less than 50% usage, as prescribed in the medical treatment plan, that is verified at two and six months of use.

**F. HOME HEALTH CARE SERVICES**

AHCCCS covers medically necessary home health care services, as described in Policy 310 of this Chapter. For purpose of the CRS program, home health care services include professional nurse visits, therapies, equipment, and medications. Home health care services must be ordered by a CRS contracted provider. The home health care service is covered for a CRS member when the home health service is specifically for the treatment of a CRS or CRS related condition.

**G. INPATIENT SERVICES**

The CRS Contractor covers medically necessary inpatient services, as described in Policy 310 of this Chapter. The hospitalization is covered for a member when the hospitalization is for the treatment of a CRS condition or a condition that is
related to, or the result of, the CRS condition. 

CRS requirements for admission and coverage for an inpatient acute care stay are as follows:

1. CRS authorized providers with admitting privileges can admit and treat CRS members for CRS qualifying conditions or those conditions related to, or the result of, a CRS condition. Providers must have a contract with a CRS Contractor or receive an authorization from the CRS Contractor.

2. The admitting provider must obtain prior authorization from the CRS Contractor for all non-emergency hospital CRS related admissions.

3. Prior authorization is not required for an emergency service.

4. The primary reason for hospitalization must be related to, or the result of, the CRS condition.

H. GROWTH HORMONE THERAPY

The CRS program covers growth hormone therapy only for members with panhypopituitarism.

I. NUTRITION SERVICES

CRS covers medically necessary nutritional services, as described in Chapter 400, Policy 430, EPSDT Services. For purposes of the CRS program, nutrition services include screening, assessment, intervention, and monitoring of nutritional status. CRS Contractors must cover nutrition services for CRS members with special nutritional needs when the nutritional need is related to a CRS condition or resulting from the CRS condition. The CRS program covers nutritional supplements upon referral from CRS providers with consultation by a registered dietician.

NOTE: Covered services also include special formula to meet the nutritional needs of members with metabolic needs.

Limitations

1. A registered dietitian must provide nutrition services.

2. The CRS program covers Total Parenteral Nutrition (TPN) for long-term nutrition if medical necessity is related to, or resulting from, the CRS condition.
J. OUTPATIENT SERVICES

The CRS Contractor is responsible for outpatient services where the diagnosis is a CRS qualifying condition or a condition that is related to, or the result of, a CRS condition.

CRS outpatient services include:

1. Ambulatory/outpatient surgery
2. Outpatient diagnostic and laboratory services
3. Ancillary services, and
4. Clinic services

   a. CRS members may benefit from multi-specialty, interdisciplinary care teams, in addition to community-based providers. The CRS Contractor shall make available these care teams throughout the state.

   b. Community-based field clinics are specialty clinics that are held periodically in outlying towns and communities in Arizona, or on Indian Reservations.

   c. CRS members may be seen by CRS Contracted community based providers in independent offices for CRS qualifying conditions or conditions that are related to, or the result of, a CRS condition.

LIMITATIONS

The member's primary health care system must be used for routine and acute medical care that is not related to the CRS condition, such as periodic visits for scheduled immunizations and periodic physical examinations and check-ups.

K. PHARMACEUTICAL SERVICES

The CRS Contractor covers medically necessary prescription medication and pharmacy services, as described in Policy 310 of this Chapter. Under the CRS program, pharmaceuticals are covered when appropriate for the treatment of the CRS condition or a condition that is related to, or the result of, a CRS condition, when ordered by the CRS provider, and provided through a CRS contracted pharmacy. The CRS Contractor is required to provide community-based pharmacy services.
LIMITATIONS

1. Pharmaceuticals or supplies that would normally be ordered by the primary care provider for the non-CRS covered condition(s) are not covered.

2. Medications covered under Medicare Part D for CRS members who are dual eligible (AHCCCS/Medicare) enrollees are not covered by the CRS program.

L. PHYSICAL AND OCCUPATIONAL THERAPY SERVICES

AHCCCS covers medically necessary physical and occupational therapy services, as described in Policy 310 of this Chapter. For purposes of the CRS program, physical therapy and occupational therapy services are provided when the service is medically necessary and prescribed to treat the CRS condition and other conditions arising as a result of the CRS qualifying condition. Limitations listed for members age 21 and older in Policy 310, Covered Services apply.

M. PHYSICIAN SERVICES

AHCCCS covers medically necessary physician services, as described in Policy 310 of this Chapter. For purposes of the CRS program, physician services must be furnished by an AHCCCS registered, licensed physician and must be covered for members when rendered within the physician's scope of practice under A.R.S Title 32. The CRS Contractor is responsible for contracting with physician specialists with expertise in pediatrics to provide CRS covered services.

Medically necessary physician services may be provided in an inpatient or outpatient setting.

N. PROSTHETIC AND ORTHOTIC DEVICES

AHCCCS covers medically necessary prosthetic and orthotic services, as described in Policy 310 of this Chapter. Under the CRS program, prosthetic and orthotic devices are provided when medically necessary to treat the CRS condition and other conditions arising as a result of the CRS qualifying condition.

1. Maintenance and Replacement
   a. The CRS program covers prosthetic and orthotic modifications or repairs that are related to the CRS condition and medically necessary.
b. The CRS program covers ocular prostheses and replacements when medically necessary and when related to a CRS condition.

c. Prior authorization is required for replacement of lost or stolen prosthetic and orthotic devices.

d. The CRS program must provide or fabricate orthotic/prosthetic devices that assist CRS members in performing normal living activities and skills. Requirements include:

i. All orthotic/prosthetic devices shall be constructed or fabricated using high quality products

ii. All orthotics shall be completed, modified or repaired, and delivered to the CRS member within 15 working days of the provider's order

iii. All prosthetics shall be completed, modified or repaired, and delivered to the CRS member within 20 working days following the member's provider order

iv. Orthotic/prosthetic repairs ordered by a CRS provider as 'urgent' shall be delivered within five working days, and

v. Same day service shall be provided for emergency adjustments for members unable to undertake their normal daily activities without the repairs and/or modifications.

e. The CRS program will assure there will be no additional charge for modifications and/or repairs during the normal life expectancy of the device, except as required to accommodate a documented change in the member’s physical size, functional level, or medical condition.

LIMITATIONS AND EXCLUSION

1. Myoelectric prostheses are excluded.

2. Limitations for members age 21 and older apply as described in Policy 301, Covered Services.

O. PSYCHOLOGY /BEHAVIORAL HEALTH SERVICES

For discussion of behavioral health services, please see Policy 310-B, Behavioral Health Services.
P. SECOND OPINIONS

The CRS program covers second opinions by other CRS contracted physicians, when available. If not available, CRS will provide a second opinion by a contracted specialty provider able to treat the condition or a same specialty non-CRS contracted provider.

Q. SPEECH THERAPY SERVICES

AHCCCS covers medically necessary speech therapy services, as described in policy 310 of this Chapter. Speech therapy services are provided by the CRS program when the service is medically necessary and prescribed to treat the CRS diagnosed or a related condition. Limitation for members age 21 and older apply as per Policy 310, Covered Services.

R. TRANSPLANT SERVICES

The CRS program covers transplant services for CRS qualifying conditions or those conditions related to, or resulting from, the CRS condition.

S. TELEMEDICINE

AHCCCS covers telemedicine, as described in Policy 320 of this Chapter. The CRS program covers telemedicine when it is related to the member's CRS condition. The purpose of telemedicine is to provide clinical and therapeutic services by means of telemedicine technology. This technology is used to deliver care and services directly to the member and to maximize the provider network.

T. TRANSPORTATION

AHCCCS covers medically necessary transportation services, as described in Policy 310 of this Chapter. The CRS program covers transportation for a member who is receiving services for a CRS condition or a CRS related service.

U. VISION SERVICES

The CRS program covers vision services including examinations, eyeglasses, and/or contact lenses for the treatment of a CRS or CRS related condition.
REFERENCES:

Refer to Chapter 500 for Coordination of Care and Transition.
Refer to Chapter 1000 for Medical Management.
Refer to the AHCCCS Contracts.
EXHIBIT 330-1

COVERED CONDITIONS IN THE CRS PROGRAM

MEDICAL ELIGIBILITY PURSUANT TO A.A.C. R9-22-1303

R9-22-1303 Medical Eligibility

The following lists identify those medical conditions that qualify for the CRS Program, as well as those that do not qualify for the CRS program. While, the covered conditions list is all inclusive, the list of conditions not covered by CRS is not an all-inclusive list.

1. Cardiovascular System

   a. CRS conditions:

      i. Congenital heart defect,
      ii. Cardiomyopathy,
      iii. Valvular disorder,
      iv. Arrhythmia,
      v. Conduction defect,
      vi. Rheumatic heart disease,
      vii. Renal vascular hypertension,
      viii. Arteriovenous fistula, and
      ix. Kawasaki disease with coronary artery aneurysm;

   b. Conditions not medically eligible for CRS:

      i. Essential hypertension;
      ii. Premature atrial, nodal or ventricular contractions that are of no hemodynamic significance;
      iii. Arteriovenous fistula that is not expected to cause cardiac failure or threaten loss of function; and
      iv. Benign heart murmur;

2. Endocrine system:

   a. CRS conditions:

      i. Hypothyroidism,
      ii. Hyperthyroidism,
      iii. Adrenogenital syndrome,
      iv. Addison's disease,
      v. Hypoparathyroidism,
      vi. Hyperparathyroidism,
      vii. Diabetes insipidus,
      viii. Cystic fibrosis, and
      ix. Panhypopituitarism;

Initial Effective Date: 03/01/2011 (Medical content from the ADHS Contractor Policy & Procedures Manual)
b. Conditions not medically eligible for CRS:
   i. Diabetes mellitus,
   ii. Isolated growth hormone deficiency,
   iii. Hypopituitarism encountered in the acute treatment of a malignancy, and
   iv. Precocious puberty;

3. Genitourinary system medical conditions:
   a. CRS conditions:
      i. Vesicoureteral reflux, with at least mild or moderate dilatation and tortuosity of the ureter and mild or moderate dilatation of renal pelvis;
      ii. Ectopic ureter;
      iii. Ambiguous genitalia;
      iv. Ureteral stricture;
      v. Complex hypospadias;
      vi. Hydronephrosis;
      vii. Deformity and dysfunction of the genitourinary system secondary to trauma after the acute phase of the trauma has passed;
      viii. Pyelonephritis when treatment with drugs or biologicals has failed to cure or ameliorate and surgical intervention is required;
      ix. Multicystic dysplastic kidneys;
      x. Nephritis associated with lupus erythematosus; and
      xi. Hydrocele associated with a ventriculo-peritoneal shunt;
   
   b. Conditions not medically eligible for CRS:
      i. Nephritis, infectious or noninfectious;
      ii. Nephrosis;
      iii. Undescended testicle;
      iv. Phimosis;
      v. Hydrocele not associated with a ventriculo-peritoneal shunt;
      vi. Enuresis;
      vii. Meatal stenosis; and
      viii. Hypospadias involving isolated glandular or coronal aberrant location of the urethral meatus without curvature of the penis;

4. Ear, nose, or throat medical conditions:
   a. CRS conditions:
      i. Cholesteatoma;
      ii. Chronic mastoiditis;
      iii. Deformity and dysfunction of the ear, nose, or throat secondary to trauma, after the acute phase of the trauma has passed;
      iv. Neurosensory hearing loss;
EXHIBIT 330-1

COVERED CONDITIONS IN THE CRS PROGRAM

MEDICAL ELIGIBILITY PURSUANT TO A.A.C. R9-22-1303

v. Congenital malformation;
vi. Significant conductive hearing loss due to an anomaly in one ear or both ears equal to or greater than a pure tone average of 30 decibels, that despite medical treatment, requires a hearing aid;
vii. Craniofacial anomaly that requires treatment by more than one CRS provider; and
viii. Microtia that requires multiple surgical interventions;

b. Conditions not medically eligible for CRS

i. Tonsillitis,
ii. Adenoiditis,
iii. Hypertrophic lingual frenum,
iv. Nasal polyp,
v. Cranial or temporal mandibular joint syndrome,
vi. Simple deviated nasal septum,
vii. Recurrent otitis media,
viii. Obstructive apnea,
ix. Acute perforation of the tympanic membrane,
x. Sinusitis,
xi. Isolated preauricular tag or pit, and
xii. Uncontrolled salivation;

5. Musculoskeletal system medical conditions:

a. CRS conditions:

i. Achondroplasia;
ii. Hypochondroplasia;
iii. Diastrophic dysplasia;
iv. Chondrodysplasia;
v. Chondroectodermal dysplasia;
vi. Spondyloepiphyseal dysplasia;
vii. Metaphyseal and epiphyseal dysplasia;
viii. Larsen syndrome;
ix. Fibrous dysplasia;
x. Osteogenesis imperfecta;
xi. Rickets;
xii. Enchondromatosis;
xiii. Juvenile rheumatoid arthritis;
xiv. Seronegative spondyloarthropathy;
xv. Orthopedic complications of hemophilia;
xvi. Myopathy;
xvii. Muscular dystrophy;
xviii. Myoneural disorder;
xix. Arthrogryposis;
xx. Spinal muscle atrophy;
EXHIBIT 330-1

COVERED CONDITIONS IN THE CRS PROGRAM

MEDICAL ELIGIBILITY PURSUANT TO A.A.C. R9-22-1303

xxi. Polyneuropathy;
xxii. Chronic stage bone infection;
xxiii. Chronic stage joint infection;
xxiv. Upper limb amputation;
xxv. Syndactyly;
xxvi. Kyphosis;
xxvii. Scoliosis;
xxviii. Congenital spinal deformity;
xxix. Congenital or developmental cervical spine abnormality;
xxx. Hip dysplasia;
xxxi. Slipped capital femoral epiphysis;
xxxii. Femoral anteversion and tibial torsion;
xxxiii. Legg-Calve-Perthes disease;
xxiv. Lower limb amputation, including prosthetic sequelae of cancer;
xxv. Metatarsus adductus;
xxvi. Leg length discrepancy of five centimeters or more;
xxvii. Metatarsus primus varus;
xxviii. Dorsal bunions;
xxix. Collagen vascular disease;
xx. Benign bone tumor;
xxi. Deformity and dysfunction secondary to musculoskeletal trauma;
xxii. Osgood Schlatter's disease that requires surgical intervention;
xxiii. Complicated flat foot, such as rigid foot, unstable subtalar joint, or significant calcaneus deformity; and
xxiv. Club foot

b. Conditions not medically eligible for CRS

i. Ingrown toenail;
ii. Back pain with no structural abnormality;
iii. Ganglion cyst;
iv. Flat foot other than complicated flat foot;
v. Fracture;
vi. Popliteal cyst;
vi. Simple bunion; and
vii. Carpal tunnel syndrome;
ix. Deformity and dysfunction secondary to trauma or injury if:
   (a) Three months have not passed since the trauma or injury; and
   (b) Leg length discrepancy of less than five centimeters at skeletal maturity.

6. Gastrointestinal system medical conditions:

a. CRS conditions:

i. Tracheoesophageal fistula;
ii. Anorectal atresia;
EXHIBIT 330-1

COVERED CONDITIONS IN THE CRS PROGRAM

MEDICAL ELIGIBILITY PURSUANT TO A.A.C. R9-22-1303

iii. Hirschsprung's disease;
iv. Diaphragmatic hernia;
v. Gastroesophageal reflux that has failed treatment with drugs or biologicals and requires surgery;
vi. Deformity and dysfunction of the gastrointestinal system secondary to trauma, after the acute phase of the trauma has passed;
vii. Biliary atresia;
viii. Congenital atresia, stenosis, fistula, or rotational abnormalities of the gastrointestinal tract;
ix. Cleft lip;
x. Cleft palate;
xi. Omphalocele; and
xii. Gastrochisis;

b. Conditions not medically eligible for CRS

i. Malabsorption syndrome, also known as short bowel syndrome,
ii. Crohn's disease,
iii. Hernia other than a diaphragmatic hernia,
iv. Ulcer disease,
v. Ulcerative colitis,
vi. Intestinal polyp,
vii. Pyloric stenosis, and
viii. Celiac disease;

7. Nervous system medical conditions:

a. CRS conditions:

i. Uncontrolled seizure disorder, in which there have been more than two seizures with documented adequate blood levels of one or more medications;
ii. Cerebral palsy;
iii. Muscular dystrophy or other myopathy;
iv. Myoneural disorder;
v. Neuropathy, hereditary or idiopathic;
vi. Central nervous system degenerative disease;
vii. Central nervous system malformation or structural abnormality;
viii. Hydrocephalus;
ix. Craniosynostosis of a sagittal suture, a unilateral coronal suture, or multiple sutures in a child less than 18 months of age;
x. Myasthenia gravis, congenital or acquired;
xi. Benign intracranial tumor;
xii. Benign intraspinal tumor;
xiii. Tourette's syndrome;
xiv. Residual dysfunction after resolution of an acute phase of vascular accident, inflammatory condition, or infection of the central nervous system;
EXHIBIT 330-1

COVERED CONDITIONS IN THE CRS PROGRAM

MEDICAL ELIGIBILITY PURSUANT TO A.A.C. R9-22-1303

xv. Myelomeningocele, also known as spina bifida;
xvi. Neurofibromatosis;
xvii. Deformity and dysfunction secondary to trauma in an individual;
xviii. Residual dysfunction after acute phase of near drowning; and
xix. Residual dysfunction after acute phase of spinal cord injury;

b. Conditions not medically eligible for CRS

i. Headaches;
ii. Central apnea secondary to prematurity;
iii. Near sudden infant death syndrome;
iv. Febrile seizures;
v. Occipital plagiocephaly, either positional or secondary to lambdoidal synostosis;
vi. Trigonocephaly secondary to isolated metopic synostosis;
vii. Spina bifida occulta;
viii. Near drowning in the acute phase; and
ix. Spinal cord injury in the acute phase;
x. Chronic vegetative state;

8. Ophthalmology:

a. CRS conditions:

i. Cataracts;
ii. Glaucoma;
iii. Disorder of the optic nerve;
iv. Non-malignant enucleation and post-enucleation reconstruction;
v. Retinopathy of prematurity; and
vi. Disorder of the iris, ciliary bodies, retina, lens, or cornea;

b. Conditions not medically eligible for CRS

i. Simple refraction error,
ii. Astigmatism,
iii. Strabismus, and
iv. Ptosis;

9. Respiratory system medical conditions:

a. CRS conditions:

i. Anomaly of the larynx, trachea, or bronchi that requires surgery; and
ii. Nonmalignant obstructive lesion of the larynx, trachea, or bronchi;

b. Conditions not medically eligible for CRS:

i. Respiratory distress syndrome,
ii. Asthma,
EXHIBIT 330-1

COVERED CONDITIONS IN THE CRS PROGRAM

MEDICAL ELIGIBILITY PURSUANT TO A.A.C. R9-22-1303

iii. Allergies,
iv. Bronchopulmonary dysplasia,
v. Emphysema,
vi. Chronic obstructive pulmonary disease, and
vii. Acute or chronic respiratory condition requiring venting for the neuromuscularly impaired;

10. Integumentary system medical conditions:

a. CRS conditions:

   i. A craniofacial anomaly that is functionally limiting,
   ii. A burn scar that is functionally limiting,
   iii. A hemangioma that is functionally limiting,
   iv. Cystic hygroma, and
   v. Complicated nevi requiring multiple procedures;

b. Conditions not medically eligible for CRS:

   i. A deformity that is not functionally limiting,
   ii. A burn other than a burn scar that is functionally limiting;
   iii. Simple nevi,
   iv. Skin tag,
   v. Port wine stain,
   vi. Sebaceous cyst,
   vii. Isolated malocclusion that is not functionally limiting,
   viii. Pilonidal cyst,
   ix. Ectodermal dysplasia, and
   x. A craniofacial anomaly that is not functionally limiting;

11. Metabolic CRS conditions:

   a. Amino acid or organic acidopathy,

   b. Inborn error of metabolism,

   c. Storage disease,

   d. Phenylketonuria,

   e. Homocystinuria,

   f. Maple syrup urine disease,

   g. Biotinidase deficiency,
EXHIBIT 330-1
COVERED CONDITIONS IN THE CRS PROGRAM
MEDICAL ELIGIBILITY PURSUANT TO A.A.C. R9-22-1303

12. Hemoglobinopathies CRS conditions:
   a. Sickle cell anemia,
   b. Thalassemia.

13. Medical/behavioral conditions which are not medically eligible for CRS:
   a. Allergies;
   b. Anorexia nervosa or obesity;
   c. Autism;
   d. Cancer;
   e. Depression or other mental illness;
   f. Developmental delay;
   g. Dyslexia or other learning disabilities;
   h. Failure to thrive;
   i. Hyperactivity;
   j. Attention deficit disorder; and
   k. Immunodeficiency, such as AIDS and HIV.