CHAPTER 400
MEDICAL POLICY FOR MATERNAL AND CHILD HEALTH

400 CHAPTER OVERVIEW ........................................................................................................ 400-1

- REFERENCES ......................................................................................................................... 400-2
- Exhibit 400-1 Maternal and Child Health Reporting Requirements (Due To AHCCCS/DHCM)
- Exhibit 400-2A Maternity/Family Planning Services Annual Plan Checklist
- Exhibit 400-2B EPSDT Annual Plan Checklist
- Exhibit 400-2C Dental Annual Plan Checklist
- Exhibit 400-3 AHCCCS Maternal Child Health/EPSDT Member Outreach

410 MATERNITY CARE SERVICES ...................................................................................... 410-1

A. Maternity Care Service Definitions ............................................................................. 410-1
B. Contractor Requirements For Providing Maternity Care Services ............................. 410-3
C. Contractor Requirements For The Maternity/Family Planning Services Annual Plan ......................................................................................................................... 410-6
D. Maternity Care Provider Requirements ....................................................................... 410-8
E. Additional Covered Related Services .......................................................................... 410-9
   1. Circumcision Of Newborn Male Infants, Is A Covered Service When It Is Determined To Be Medically Necessary ................................................................. 410-9
   2. Extended Stays for Normal Newborns Related to Status of Mother’s Stay .................. 410-10
   3. Home Uterine Monitoring Technology ...................................................................... 410-11
   4. Labor And Delivery Services Provided In Freestanding Birthing Centers .......... 410-11
   5. Labor And Delivery Services Provided In A Home Setting .................................. 410-12
   6. Licensed Midwife Services ......................................................................................... 410-13
   7. Supplemental Stillbirth Payment .............................................................................. 410-15
   8. Pregnancy Termination (Including Mifepristone [Mifeprrex Or RU-486]) .......... 410-16

- Exhibit 410-1 Semiannual Report of Number of Pregnant Women Who Are HIV/AIDS Positive
- Exhibit 410-2 AHCCCS Maternity Care Risk Screening Guidelines
- Exhibit 410-3 AHCCCS Request for Stillbirth Supplement
- Exhibit 410-4 Certificate of Necessity For Pregnancy Termination
CHAPTER 400
MEDICAL POLICY FOR MATERNAL AND CHILD HEALTH

410  MATERNITY CARE SERVICES (CONTINUED) ........................................
    • EXHIBIT 410-5 VERIFICATION OF DIAGNOSIS BY CONTRACTOR FOR
      PREGNANCY TERMINATION REQUEST
    • EXHIBIT 410-6 MONTHLY PREGNANCY TERMINATION REPORT

411  WOMEN’S PREVENTATIVE CARE SERVICES .......................................
    A. WELL-WOMAN PREVENTATIVE CARE SERVICES DEFINITIONS ...........
    B. CONTRACTOR REQUIREMENTS FOR WELL-WOMAN PREVENTATIVE CARE
       SERVICES ..........................................................................
    C. WELL-WOMAN PREVENTATIVE CARE SERVICES PROVIDER REQUIREMENTS ..
    D. ADDITIONAL COVERED RELATED SERVICES ..................................

420  FAMILY PLANNING ............................................................................
    A. FAMILY PLANNING DEFINITIONS .............................................
    B. CONTRACTOR REQUIREMENTS FOR PROVIDING FAMILY PLANNING SERVICES
    C. PROTOCOL FOR MEMBER NOTIFICATION OF FAMILY PLANNING CONTRACTOR
       REPORTING REQUIREMENTS ..................................................
    D. FEE-FOR-SERVICE (FFS) FAMILY PLANNING PROVIDER REQUIREMENTS ......
    E. STERILIZATION ...........................................................................
       • EXHIBIT 420-1 STERILIZATION CONSENT FORM
       • EXHIBIT 420-2 ARIZONA HEALTH CARE COST CONTAINMENT
         SYSTEM STERILIZATION REPORTING FORM FOR
         MEMBERS UNDER 21 YEARS OF AGE

430  EPSDT SERVICES ................................................................................
    A. EPSDT DEFINITIONS ..................................................................
    B. COVERED SERVICES DURING AN EPSDT VISIT ..............................
    C. EPSDT SERVICE STANDARDS .................................................
       1. IMMUNIZATIONS ..................................................................
       2. EYE EXAMINATIONS AND PRESCRIPTIVE LENSES ......................
       3. BLOOD LEAD SCREENING ....................................................
       4. ORGAN AND TISSUE TRANSPLANTATION SERVICES ..................
       5. TUBERCULOSIS SCREENING ............................................... 
       6. NUTRITIONAL ASSESSMENT AND NUTRITIONAL THERAPY ......

CHAPTER 400
MEDICAL POLICY FOR MATERNAL AND CHILD HEALTH

430  EPSDT SERVICES (CONTINUED) ................................................................. 430-16

7. ORAL HEALTH SERVICES ................................................................. 430-16
8. COCHLEAR AND OSSEINTEGRATED IMPLANTATION .......................... 430-16
9. CONSCIOUS SEDATION ................................................................. 430-18
10. BEHAVIORAL HEALTH SERVICES .................................................. 430-19
11. RELIGIOUS NON-MEDICAL HEALTH CARE INSTITUTION SERVICES ......... 430-21
12. CARE MANAGEMENT SERVICES ...................................................... 430-21
13. CHIROPRACTIC SERVICES ............................................................. 430-22
14. PERSONAL CARE SERVICES .......................................................... 430-22
15. INCONTINENCE BRIEFS ................................................................. 430-22
16. MEDICALLY NECESSARY THERAPIES ............................................. 430-23

D. SICK VISIT PERFORMED IN ADDITION TO AN EPSDT VISIT ................. 430-23
E. CONTRACTOR REQUIREMENTS FOR PROVIDING EPSDT SERVICES .......... 430-24
F. CONTRACTOR REQUIREMENTS FOR THE EPSDT ANNUAL PLAN ............. 430-30
G. FEE-FOR-SERVICE/EPSDT PROVIDER REQUIREMENTS .................... 430-31
H. CLAIM FORMS .................................................................................. 430-32

• EXHIBIT 430-1  EPSDT PERIODICITY SCHEDULE
• EXHIBIT 430-2  ARIZONA HEALTH CARE COST CONTAINMENT
SYSTEM CERTIFICATE OF MEDICAL NECESSITY FOR
COMMERCIAL ORAL NUTRITIONAL SUPPLEMENTS
(EPSDT AGED MEMBERS - INITIAL OR ONGOING
REQUESTS)
• EXHIBIT 430-3  PROCEDURES FOR THE COORDINATION OF SERVICES
UNDER EARLY PERIODIC SCREENING DIAGNOSTIC
AND TREATMENT AND EARLY INTERVENTION
• EXHIBIT 430-4  THE ARIZONA EARLY INTERVENTION PROGRAM
(AzEIP) AHCCCS MEMBER SERVICE REQUEST

431  ORAL HEALTH CARE (EPSDT AGE MEMBERS) .............................. 431-1

A. COVERED SERVICES ......................................................................... 431-3
B. PROVIDER REQUIREMENTS ............................................................ 431-5
C. CONTRACTOR REQUIREMENTS ....................................................... 431-6
D. CONTRACTOR REQUIREMENTS FOR THE DENTAL ANNUAL PLAN ....... 431-8
CHAPTER 400
MEDICAL POLICY FOR MATERNAL AND CHILD HEALTH

431  ORAL HEALTH CARE (EPSDT AGE MEMBERS) (CONTINUED)………
       •  EXHIBIT 431-1  DENTAL PERIODICITY SCHEDULE

440  KIDS CARE SERVICES ........................................................................ 440-1

       A.  COVERED SERVICES ................................................................. 440-1
       B.  EXCLUDED SERVICES UNDER THE KIDS CARE PROGRAM .......... 440-2
       C.  CARE COORDINATION RESPONSIBILITIES ............................... 440-2
       D.  MONITORING AND ASSESSING THE QUALITY OF CARE RECEIVED BY KIDS CARE MEMBERS ........................................... 440-2
       E.  SERVICE DELIVERY REQUIREMENTS FOR IHS AND 638 TRIBAL FACILITIES .... 440-2

450  RESERVED ........................................................................ 450-1
AHCCCS covers a comprehensive package of services for women, newborns and children that includes:

1. Maternity care services
2. Family planning services
3. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services for eligible children under 21 years of age.

While these service programs are closely intertwined, this Chapter discusses the policy and procedural guidelines for each of them separately. The discussion for each component includes: a service description, criteria for coverage, services with special policies, and procedural guidelines for Contractors and/or Fee-For-Service providers.

Contractors must promote improvement in the quality of care provided to enrolled members receiving maternity care, family planning, and EPSDT services. Contractors must participate in community initiatives and/or quality initiatives within the communities they serve.

Contractors must attend and participate in maternal and child health related meetings when requested or scheduled by AHCCCS.

Refer to Chapter 900 for quality management and performance improvement requirements. These requirements apply to all AHCCCS covered services, including maternal and child health.

Refer to Chapter 500 for a discussion of care coordination and requirements.

Refer to Chapter 600 for a discussion of provider and network requirements.
REFERENCES

2. 42 C.F.R. 441.306 [Maternal and Child Health]
3. 42 C.F.R. 438.10 (f)(6)(v) and (VII) [Information Requirements]
4. 42 C.F.R. 50.203 [Sterilization]
5. 42 USC 1396d(r) [EPSDT]
6. 42 USC 1396 a(a)(43)
7. 42 USC 1396d(a) [Mandatory and Optional Medicaid Services]
8. Social Security Act, Title V, Parts 1 and 4 [Maternal and Child Health]
9. Arizona Revised Statutes (A.R.S.) 36-2907 [Covered Health and Medical Services]
10. A.R.S. Title 36, Chapter 2, Article 3 [Children’s Rehabilitative Services]
11. A.R.S. Title 36, Chapter 29, Article 4 [KidsCare]
12. Arizona Administrative Code (A.A.C.) Title 9, Chapter 22, Article 2 [EPSDT]
13. A.A.C., Title 9, Chapter 31 [KidsCare]
14. A.A.C., Title 9, Chapter 13, Article 2 [Newborn Infant Screening]
15. A.R.S. Title 36, Chapter 6, Article 5 [Maternal and Child Health]
16. AHCCCS Acute Care Contract, Section D
17. AHCCCS ALTCS Contract, Section D
18. AHCCCS CMDP Contract, Section D
19. AHCCCS CRS Contract, Section D
20. AHCCCS Contractor Operations Manual (ACOM),

21. AHCCCS Online Provider Website, Newborn Reporting,
https://azweb.statemedicaid.us/Home.asp


http://www.aapd.org/media/Policies_Guidelines/P_DentalHome.pdf


26. Centers for Medicare and Medicaid Services (CMS), Guide to Children’s Dental Care in Medicaid,

27. Centers for Disease Control and Prevention (CDC), Immunization Schedules,
http://www.cdc.gov/vaccines/schedules/index.html
EXHIBIT 400-1

MATERNAL AND CHILD HEALTH REPORTING REQUIREMENTS
(DUE TO AHCCCS/DHCM)
<table>
<thead>
<tr>
<th>REPORT</th>
<th>DUE DATE</th>
<th>REPORTS DIRECTED TO:</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHCCCS MONTHLY PREGNANCY TERMINATION REPORT (INCLUDING USE OF</td>
<td>Monthly, no later than 30 days following the end of the month.</td>
<td>SFTP server, password protected, with email notification to the CQM Administrator</td>
</tr>
<tr>
<td>Mifepristone Mifeprrex or RU-486) (EXHIBIT 410-6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AHCCCS STERILIZATION REPORTING FORM (EXHIBIT 420-2)</td>
<td>Monthly, no later than 30 days following the end of the month.</td>
<td>SFTP server, password protected, with email notification to the CQM Administrator</td>
</tr>
<tr>
<td>EPSDT/ADULT MONITORING AND PERFORMANCE MEASURE QUARTERLY REPORT</td>
<td>Quarterly, within 15 days of the end of each quarter (see Appendix A</td>
<td>SFTP server with email notification to the CQM Administrator</td>
</tr>
<tr>
<td>(APPENDIX A)</td>
<td>for report template and instructions).</td>
<td></td>
</tr>
<tr>
<td>AHCCCS SEMIANNUAL REPORT OF NUMBER OF PREGNANT WOMEN WHO ARE HIV/AIDS</td>
<td>Semianually, no later than 30 days after the end of the 2nd and 4th</td>
<td>SFTP server with email notification to the CQM Administrator</td>
</tr>
<tr>
<td>POSITIVE (EXHIBIT 410-1)</td>
<td>quarters of each contract year. (April 30 and October 30)</td>
<td></td>
</tr>
<tr>
<td>MATERNITY/FAMILY PLANNING SERVICES ANNUAL PLAN (EXHIBIT 400-2A)</td>
<td>Annually, by December 15.</td>
<td>SFTP server with email notification to the CQM Administrator</td>
</tr>
<tr>
<td>EPSDT ANNUAL PLAN (EXHIBIT 400-2B)</td>
<td>Annually, by December 15.</td>
<td>SFTP server with email notification to the CQM Administrator</td>
</tr>
<tr>
<td>DENTAL ANNUAL PLAN (EXHIBIT 400-2C)</td>
<td>Annually, by December 15.</td>
<td>SFTP server with email notification to the CQM Administrator</td>
</tr>
<tr>
<td>ADDITIONAL REPORTING (AS NEEDED)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AHCCCS REQUEST FOR STILLBIRTH SUPPLEMENT (EXHIBIT 410-3)</td>
<td>Within six months of delivery date.</td>
<td>SFTP server, password protected, with email notification to the CQM Administrator</td>
</tr>
<tr>
<td>AHCCCS CERTIFICATE OF NECESSITY FOR PREGNANCY TERMINATION &amp; AHCCCS</td>
<td>Monthly, no later than 30 days following the end of the month.</td>
<td>SFTP server, password protected, with email notification to the CQM Administrator</td>
</tr>
<tr>
<td>VERIFICATION OF DIAGNOSIS BY CONTRACTOR FOR PREGNANCY TERMINATION</td>
<td></td>
<td></td>
</tr>
<tr>
<td>REQUESTS</td>
<td></td>
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</tbody>
</table>

* An extension of time to complete a report may be requested by contacting DHCM/CQM Administrator.

* If experiencing difficulty with a submission, please contact the DHCM/CQM Administrator via email or telephone.

EXHIBIT 400-2A

MATERNITY/FAMILY PLANNING SERVICES
ANNUAL PLAN CHECKLIST
## EXHIBIT 400-2A
### MATERNITY/FAMILY PLANNING SERVICES ANNUAL PLAN CHECKLIST

<table>
<thead>
<tr>
<th>BBA(^1) SECTION AND AMPM(^2) SECTION</th>
<th>MATERNITY/FAMILY PLANNING SERVICES ANNUAL PLAN CHECKLIST</th>
<th>PLAN PAGE #(^3)</th>
<th>YES</th>
<th>NO</th>
<th>EXPLANATION OF “NO” ANSWER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity/Family Planning Services Narrative Plan</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>AMPM: 410-C</strong></td>
<td>1. A written description of all planned activities to address the Contractor’s minimum requirements, as specified in the Contractor Requirements for Providing Maternity Care and Family Planning Services, including participation in community and/or quality initiatives within the communities served by the Contractor. The narrative description must also include Contractor activities to identify member needs, coordination of care, and follow-up activities to ensure appropriate and medically necessary treatment is received in a timely manner.</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td><strong>AMPM: 410-B</strong></td>
<td>a. Description of activities that ensure prenatal care, labor/delivery, and postpartum care services provided by licensed midwives are in adherence to the requirements contained within AHCCCS policy, procedures, and contracts.</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>AMPM: 410-B</strong></td>
<td>b. Description of activities, which ensure that all maternity care services are delivered by qualified physicians and non-physician practitioners, according to and in compliance with the most current American Congress of Obstetrics and Gynecology (ACOG) Standards for Obstetric and Gynecologic Services.</td>
<td></td>
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<tr>
<td><strong>AMPM: 410-B</strong></td>
<td>c. Appropriately qualified personnel, in sufficient numbers to carry out the components of the maternity care program for eligible enrolled members and achieve contractual compliance.</td>
<td></td>
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</tbody>
</table>

\(^1\)BBA = Balanced Budget Act of 1997

\(^2\)AMPM = AHCCCS Medical Policy Manual

\(^3\)Plan Page # = Page Number in Contractor’s MCH/EPSDT Plan

Revision Date: 10/01/15, 10/01/13, 02/01/11, 10/01/09   Initial Publication Date: 10/01/2008
<table>
<thead>
<tr>
<th>BBA&lt;sup&gt;1&lt;/sup&gt; SECTION AND AMPM&lt;sup&gt;2&lt;/sup&gt; SECTION</th>
<th>MATERNITY/FAMILY PLANNING SERVICES ANNUAL PLAN CHECKLIST</th>
<th>PLAN PAGE #&lt;sup&gt;3&lt;/sup&gt;</th>
<th>YES</th>
<th>NO</th>
<th>EXPLANATION OF “NO” ANSWER</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMPM: 410-B</td>
<td>d. Process to conduct outreach activities to identify currently enrolled pregnant women and enter them into prenatal care as soon as possible.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AMPM: 410-B</td>
<td>e. Process by which service providers notify the Contractor of case finding activities and members who have tested positive for pregnancy.</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>AMPM: 410-B</td>
<td>f. Description of activities to inform all enrolled AHCCCS pregnant women and maternity care providers of voluntary prenatal HIV testing, and of the availability of counseling, if the test is positive.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AMPM: 410-B</td>
<td>g. Process to ensure designation of a maternity care provider for each enrolled pregnant woman for the duration of her pregnancy and postpartum care.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>AMPM: 410-B</td>
<td>h. Process to provide information, regarding the opportunity to change Contractors to ensure continuity of prenatal care, to newly-assigned pregnant members and those currently under the care of a non-network provider.</td>
<td></td>
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</tr>
<tr>
<td>AMPM: 410-B</td>
<td>i. Process to ensure mandatory availability of maternity care coordination services are available and management of enrolled pregnant women who are determined to be medically/socially at-risk by the maternity care provider or Contractor.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>AMPM: 410-B</td>
<td>j. Description of activities to assure network providers adhere to AHCCCS requirements defined in Policy 410- B – 10, a through f (Including prenatal care, return visits, and postpartum visits).</td>
<td></td>
<td></td>
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<td></td>
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</tbody>
</table>

<sup>1</sup>BBA = Balanced Budget Act of 1997

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<th>YES</th>
<th>NO</th>
<th>EXPLANATION OF “NO” ANSWER</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMPM: 410-B k.</td>
<td>Process to document written intake procedures for the provider, which includes identifying risk factors through the use of a comprehensive tool that covers psychosocial, nutritional, medical, and educational factors (i.e. ACOG, MICA).</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>AMPM: 410-B l.</td>
<td>Process for referral of members to support services such as WIC, and process for notifying members that in the event they lose eligibility, they may contact the Arizona Department of Health Services Hotline for a referral to a low or no-cost service/agency.</td>
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<td></td>
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</tr>
<tr>
<td>AMPM: 410-B m.</td>
<td>Process that ensures all providers maintain complete medical records documenting all aspects of maternity care.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>AMPM: 410-B n.</td>
<td>Description of activities to ensure mandatory provision of initial prenatal care appointments within established timeframes.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AMPM: 410-B o.</td>
<td>A process to monitor and evaluate cesarean section and elective induction rates prior to 39 weeks gestation, and implement interventions to decrease the incidence of occurrence.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>AMPM: 410-B p.</td>
<td>Process to monitor and evaluate Low Birth Weight/Very Low Birth Weight (LBW/VLBW) and implement interventions to decrease LBW/VLBW.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AMPM: 410-B q.</td>
<td>Process to ensure that all enrolled pregnant women receive transportation services as needed and as described in Chapter 300, Policy 310-BB, Transportation.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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<th>YES</th>
<th>NO</th>
<th>EXPLANATION OF “NO” ANSWER</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMPM: 420-A</td>
<td>r. Process to implement an outreach program to notify members of reproductive age of the specific covered family planning services available to them and how to request these services.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AMPM: 410-B</td>
<td>s. Establishment of a specific objective for postpartum visit utilization rate provided to members within 60 days of delivery.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AMPM: 410-B</td>
<td>t. Process to monitor and evaluate postpartum activities and interventions to increase postpartum utilization.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>AMPM: 410-B</td>
<td>u. Process to identify postpartum depression and refer members to the appropriate health care providers.</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

### Maternity/Family Planning Services Work Plan Evaluation

| AMPM: 410-C                               | 2. An evaluation of the previous year’s Work Plan to determine the effectiveness of strategies and interventions used toward meeting stated objectives. |             |     |    |                            |

### Maternity/Family Planning Services Work Plan

| AMPM: 410-C                               | 3. A work plan that formally documents the Maternity and Family Planning program objectives, strategies and activities directed at achieving optimal birth outcomes, as based on the Contractor Requirements outlined in the Maternity/Family Planning Services sections of Chapter 400, Medical Policy for Maternal and Child Health. |             |     |    |                            |

---

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### Maternity/Family Planning Services Work Plan

<table>
<thead>
<tr>
<th>BBA: 438.240 (c)-# 1</th>
<th>a. Specific measurable objectives. These objectives must be based on AHCCCS established minimum performance standards.</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMPM: 410-C</td>
<td>b. In cases where AHCCCS minimum performance standards have been met, other generally accepted benchmarks that continue the Contractor’s improvement efforts will be used to establish the program’s measurable objectives. These may include benchmarks established by the National Committee on Quality Assurance, Healthy People 2020 standards, or other national standards. Contractors may also develop additional specific measurable goals and objectives aimed at enhancing the maternity program.</td>
</tr>
<tr>
<td>AMPM: 410-C</td>
<td>c. Strategies and activities to accomplish objectives.</td>
</tr>
<tr>
<td>AMPM: 410-C</td>
<td>d. Targeted implementation and completion dates of work plan activities.</td>
</tr>
<tr>
<td>AMPM: 410-C</td>
<td>e. A listing of local staff positions responsible and accountable for meeting established goals and objectives.</td>
</tr>
</tbody>
</table>

#### Relevant Policies and Procedures

| AMPM: 410-C | 4. Contractors must attach all referenced relevant policies and procedures addressed in the Maternity/Family Planning Services Annual Plan (i.e., medically necessary pregnancy termination, including administration of RU 486, family planning, maternity care, etc.). |

---

1. **BBA** = Balanced Budget Act of 1997
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3. **Plan Page #** = Page Number in Contractor’s MCH/EPSDT Plan

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EXHIBIT 400-2B

EPSDT ANNUAL PLAN CHECKLIST
## EXHIBIT 400-2B
EPSDT ANNUAL PLAN CHECKLIST

<table>
<thead>
<tr>
<th>BBA¹ SECTION AND AMPM² SECTION</th>
<th>EPSDT ANNUAL PLAN CHECKLIST</th>
<th>PLAN PAGE #³</th>
<th>YES</th>
<th>NO</th>
<th>EXPLANATION OF “NO” ANSWER</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EPSDT Narrative Plan</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>AMPM: 430-F</strong></td>
<td>1. A written description of all planned activities to address the Contractor’s minimum requirements for EPSDT services, (Contractor Requirements for Providing EPSDT Services) including, but not limited to, informing providers and members that EPSDT is a comprehensive child health program of prevention, treatment, correction, and improvement (amelioration) of physical and behavioral health problems for AHCCCS members under the age of 21 and description of process related to developmental screening tools and childhood obesity.</td>
<td></td>
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</tr>
<tr>
<td><strong>AMPM: 430-E</strong></td>
<td>a. Process for completion and submission of EPSDT/Adult Monitoring and Performance Measure Quarterly Report to AHCCCS (refer to Appendix A).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>AMPM: 430-E</strong></td>
<td>b. Description of activities that inform all participating Primary Care Providers (PCPs) about EPSDT requirements and monitor compliance with these requirements. This must include informing PCPs of Federal, State and AHCCCS policy requirements for EPSDT and updates of new information as they become available.</td>
<td></td>
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</tr>
<tr>
<td><strong>AMPM: 430-E</strong></td>
<td>c. A description of activities that inform members that an EPSDT visit is synonymous with a well-child visit and identifies all EPSDT screenings and services in detail, and how to access the services.</td>
<td></td>
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</tr>
<tr>
<td><strong>AMPM: 430-E</strong></td>
<td>d. Description of activities used to identify the needs of EPSDT age members, coordinate their care, provide care management, conduct appropriate follow-up, and ensure members receive timely and appropriate treatment.</td>
<td></td>
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</table>

¹BBA = Balanced Budget Act of 1997
²AMPM = AHCCCS Medical Policy Manual
³Plan Page # = Page Number in Contractor’s MCH/EPSDT Plan

Revision Date: 10/01/15, 04/01/15, 10/01/13, 02/01/11, 10/01/09  Initial Publication Date: 10/01/2008
### EXHIBIT 400-2B
EPSDT ANNUAL PLAN CHECKLIST

<table>
<thead>
<tr>
<th>BBA(^1) SECTION AND AMPM(^2) SECTION</th>
<th>EPSDT ANNUAL PLAN CHECKLIST</th>
<th>PLAN PAGE #(^3)</th>
<th>YES</th>
<th>NO</th>
<th>EXPLANATION OF “NO” ANSWER</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AMPM: 430-E</strong></td>
<td>e. Description of activities that ensure written notification of all members/caretakers of EPSDT/Dental visits required by the AHCCCS EPSDT and Dental Periodicity Schedules. Second written notices must be sent, if visit is not completed. Additional notices may be necessary to ensure required schedule is met.</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td><strong>AMPM: 430-E</strong></td>
<td>f. Process to reduce no-show appointment rates for EPSDT services and a description of outreach activities targeted to those members who did not attend scheduled appointments.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>AMPM: 430-E</strong></td>
<td>g. Process for distributing and requiring use of the AHCCCS EPSDT and Dental Periodicity Schedules and AHCCCS approved, standardized EPSDT tracking forms by all contracted providers.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>AMPM: 430-E</strong></td>
<td>h. Process for monitoring that providers use the EPSDT tracking forms at every EPSDT visit and that age appropriate screening and services are conducted during each EPSDT visit, in accordance with the AHCCCS EPSDT and Dental Periodicity Schedules.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>AMPM: 430-E</strong></td>
<td>i. Develop processes to ensure PCPs providing care to children are trained to use implemented developmental screening tools. This will also include monitoring the utilization of AHCCCS approved developmental screening tools for members at 9, 18 and 24 months of age.</td>
<td></td>
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<tr>
<td><strong>AMPM: 430-E</strong></td>
<td>j. Process for coordinating care and services with the appropriate state agencies for EPSDT eligible members, and ensure that members are referred to support services, as well as other community-based resources to support good health outcomes. (CRS, AzEIP, WIC, VFC, ASIIS, Head Start)</td>
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</tbody>
</table>

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\(^1\)BBA = Balanced Budget Act of 1997  
\(^2\)AMPM = AHCCCS Medical Policy Manual  
\(^3\)Plan Page # = Page Number in Contractor’s MCH/EPSDT Plan  
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Initial Publication Date: 10/01/2008
<table>
<thead>
<tr>
<th>BBA(^1) SECTION AND AMPM(^2) SECTION</th>
<th>EPSDT ANNUAL PLAN CHECKLIST</th>
<th>PLAN PAGE #(^3)</th>
<th>YES</th>
<th>NO</th>
<th>EXPLANATION OF “NO” ANSWER</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMPM: 410-B AMPM: 430-E</td>
<td>k. Process to provide outreach related to dangers of lead poisoning to EPSDT age members as specified in policy and implementation of strategies for appropriate follow-up care for members who have abnormal blood lead test results.</td>
<td></td>
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</tr>
<tr>
<td>AMPM: 430-E</td>
<td>l. Process for providing necessary supplemental nutrition to eligible members of EPSDT age.</td>
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</tr>
<tr>
<td>AMPM: 430-E</td>
<td>m. Process to assist members in navigating the healthcare system, as well as inform members of any other community-based resources that support optimal health outcomes, to ensure that members receive appropriate support services.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>AMPM: 430-E</td>
<td>n. Process for internal coordination to reimburse all AHCCCS-registered Arizona Early Intervention Program (AzEIP) providers, regardless of their contract status with the Contractor, when the Contractor has authorized the AzEIP provider to provide medically necessary EPSDT covered services.</td>
<td></td>
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</tr>
<tr>
<td>AMPM: 430-E</td>
<td>o. Process for educating providers to comply with the AHCCCS/AzEIP Procedures for the coordination of services under early periodic screening diagnostic and treatment and early intervention (Exhibit 430-3), when the need for medically necessary services are identified for members birth to 3 three years of age, and ensuring medically necessary services are initiated within 45 days of a completed Individual Family Service Plan (IFSP) when services are requested by the AzEIP service coordinator.</td>
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</tbody>
</table>

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Revision Date: 10/01/15, 04/01/15, 10/01/13, 02/01/11, 10/01/09 Initial Publication Date: 10/01/2008
**EXHIBIT 400-2B**
**EPSDT ANNUAL PLAN CHECKLIST**

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<tr>
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<th>PLAN PAGE (^3)</th>
<th>YES</th>
<th>NO</th>
<th>EXPLANATION OF “NO” ANSWER</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EPSDT WORK PLAN EVALUATION</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>AMPM: 430-F</td>
<td>2. An evaluation of the previous year’s Work Plan to determine the effectiveness of strategies, interventions, and activities used toward meeting stated objectives.</td>
<td></td>
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<tr>
<td><strong>EPSDT WORK PLAN</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>AMPM: 430-F</td>
<td>3. A work plan that formally documents the EPSDT program objectives, strategies and activities and demonstrates how these activities will improve the quality of services, the continuum of care, and health care outcomes (including processes related to developmental screening tools and childhood obesity).</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>BBA: 438.240 (c )-# 1 AMPM: 430-F</td>
<td>a. Specific measurable objectives. These objectives must be based on AHCCCS established minimum performance standards.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>AMPM: 430-F</td>
<td>b. In cases where AHCCCS minimum performance standards have been met, other generally accepted benchmarks that continue the Contractor’s improvement efforts will be used (e.g., National Committee on Quality Assurance, Healthy People 2020 standards). The Contractors may also develop their own specific measurable goals and objectives aimed at enhancing the EPSDT program.</td>
<td></td>
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</tr>
<tr>
<td>AMPM: 430-F</td>
<td>c. Strategies and activities to accomplish objectives.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>AMPM: 430-F</td>
<td>d. Targeted implementation and completion dates of work plan activities.</td>
<td></td>
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</tr>
<tr>
<td>AMPM: 430-F</td>
<td>e. A listing of local staff positions responsible and accountable for meeting established goals and objectives for EPSDT activities.</td>
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\(^3\)Plan Page # = Page Number in Contractor’s MCH/EPSDT Plan

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<th>NO</th>
<th>EXPLANATION OF “NO” ANSWER</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AMPM: 430-F</strong></td>
<td>4. Contractors must attach all referenced relevant policies and procedures addressed in the EPSDT Annual Plan (i.e. EPSDT, dental, developmental screenings, AzEIP, childhood obesity, supplemental nutrition, and coordination of care and services with appropriate state agencies).</td>
<td></td>
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</tbody>
</table>
EXHIBIT 400-2 C

DENTAL ANNUAL PLAN CHECKLIST
### Dental Annual Plan Checklist

<table>
<thead>
<tr>
<th>BBA(^1) Section and AMPM(^2) Section</th>
<th>Dental Annual Plan Checklist</th>
<th>Plan Page #</th>
<th>Yes</th>
<th>No</th>
<th>Explanation of “No” Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dental Narrative Plan</strong></td>
<td></td>
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</tr>
<tr>
<td>AMPM: 410-C</td>
<td>1. A written description of all planned activities to address the Contractor’s minimum requirements for Dental services, as specified in the Contractor Requirements found in the Dental Section of this Policy.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>AMPM: 410-B</td>
<td>a. Process for completion and submission of EPSDT/Adult Monitoring and Performance Measure Quarterly Report, using report template (refer to Appendix A) to AHCCCS.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AMPM: 430-E</td>
<td>b. Description of activities that inform all participating Dental Providers and PCPs about Dental requirements and how to monitor compliance with the requirements. This must include informing Dental Providers of Federal, State and AHCCCS policy requirements for Dental services and updates of new information as it becomes available.</td>
<td></td>
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</tr>
<tr>
<td>AMPM: 430-E</td>
<td>c. Description of activities used to identify the needs of Dental age members, coordinate their care, provide care management, conduct appropriate follow-up, and ensure members receive timely and appropriate treatment.</td>
<td></td>
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</tr>
<tr>
<td>AMPM: 430-E</td>
<td>d. Description of activities that ensure written notification of all members/caretakers of Dental visits required by the AHCCCS Dental Periodicity Schedules. Second written notices must be sent if visit is not completed. Additional notices may be necessary to ensure required schedule is met.</td>
<td></td>
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### DENTAL ANNUAL PLAN CHECKLIST

<table>
<thead>
<tr>
<th>BBA¹ SECTION AND AMPM² SECTION</th>
<th>DENTAL ANNUAL PLAN CHECKLIST</th>
<th>PLAN PAGE #</th>
<th>YES</th>
<th>NO</th>
<th>EXPLANATION OF “NO” ANSWER</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMPM: 430-E</td>
<td>e. Process to reduce no-show appointment rates for Dental services and a description of outreach activities targeted to those members who did not attend scheduled appointments.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>AMPM: 430-E</td>
<td>f. Process for distributing and requiring use of the AHCCCS Dental Periodicity Schedules by all contracted providers.</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>AMPM: 430-E</td>
<td>g. Process for monitoring that age appropriate screenings and services are conducted during each Dental visit, in accordance with the AHCCCS Dental Periodicity Schedule.</td>
<td></td>
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</tr>
<tr>
<td>AMPM: 431-C</td>
<td>h. Process for connecting all EPSDT/Dental age members to a dental home before one year of age or upon assignment to the Contractor, informing members of the selected or assigned dental home, and providing relevant contact information and recommended dental visit schedule.</td>
<td></td>
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<tr>
<td>AMPM: 431-C</td>
<td>i. Process for monitoring provider efforts of dental home providers in engaging members to obtain ongoing care as recommended by the AHCCCS Dental Periodicity Schedule.</td>
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</tbody>
</table>

### DENTAL WORK PLAN EVALUATION

| AMPM: 430-F | 2. An evaluation and assessment that documents the effectiveness of Dental program strategies, interventions, and activities directed at achieving healthy outcomes, at least annually (report on the last year). | | | |

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³Plan Page # = Page Number in Contractor’s MCH/EPSDT Plan  
Revision Date: 10/01/15, 10/01/13, 02/01/11, 10/01/09   Initial Publication Date: 10/01/2008
### EXHIBIT 400-2 C
### DENTAL ANNUAL PLAN CHECKLIST

<table>
<thead>
<tr>
<th>BBA(^1) SECTION AND AMPM(^2) SECTION</th>
<th>DENTAL ANNUAL PLAN CHECKLIST</th>
<th>PLAN PAGE (^3)</th>
<th>YES</th>
<th>NO</th>
<th>EXPLANATION OF “NO” ANSWER</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DENTAL WORK PLAN</strong></td>
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</tr>
<tr>
<td>AMPM: 430-F</td>
<td>3. A work plan that formally documents the Dental program objectives, strategies and activities and demonstrates how these activities will improve the quality of services, the continuum of care, and health care outcomes.</td>
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<tr>
<td><strong>AMPM: 430-F</strong></td>
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</tr>
<tr>
<td>BBA: 438.240 (c )-# 1 AMPM: 430-F</td>
<td>a. Specific measurable objectives. These objectives must be based on AHCCCS established minimum performance standards.</td>
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<tr>
<td>AMPM: 430-F</td>
<td>b. In cases where AHCCCS minimum performance standards have been met, other generally accepted benchmarks that continue the Contractor’s improvement efforts will be used (e.g., National Committee on Quality Assurance, Healthy People 2020 standards). The Contractors may also develop their own specific measurable goals and objectives aimed at enhancing the Dental program.</td>
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</tr>
<tr>
<td><strong>AMPM: 430-F</strong></td>
<td>c. Strategies and activities to accomplish objectives.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>AMPM: 430-F</strong></td>
<td>d. Targeted implementation and completion dates of work plan activities.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>AMPM: 430-F</strong></td>
<td>e. A listing of local staff positions responsible and accountable for meeting established goals and objectives for Dental activities.</td>
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</tr>
<tr>
<td><strong>RELEVANT POLICIES AND PROCEDURES</strong></td>
<td></td>
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</tr>
<tr>
<td>AMPM: 430-F</td>
<td>4. Contractors must attach all referenced relevant policies and procedures addressed in the Dental Annual Plan.</td>
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</tbody>
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Initial Publication Date: 10/01/2008
EXHIBIT 400-3

AHCCCS MATERNAL CHILD HEALTH/EPSDT MEMBER OUTREACH
EXHIBIT 400-3
AHCCCS MATERNAL CHILD HEALTH/EPSDT MEMBER OUTREACH

- This exhibit serves as an easy reference guide for required member outreach, as outlined in AHCCCS AMPM - Chapter 400, Medical Policy for Maternal and Child Health.

- Unless marked with an asterisk, the medium for distribution is considered a suggestion and may be distributed through other approved means, outside of the Member Handbook or Contractor Website, in efforts to meet the stated requirements. Those marked with an asterisk are considered a required means for distribution.

- For full details pertaining to the requirement related to Maternal Child Health and EPSDT member outreach, please refer to policies 410-450 within this Chapter.

- For information pertaining to the requirements for Member Handbooks or member-focused materials posted on the Contractor’s Website, please refer to the AHCCCS Compliance Operations Manual, as these items are not referenced or discussed within this appendix.

All informational materials developed by the Contractor and disseminated to its own members must be submitted to AHCCCS for approval, prior to dissemination, unless otherwise specified in contract. Unless otherwise indicated, proposed materials must be submitted 30 days before the intended publication date. (For more details, refer to AHCCCS Compliance Operations Manual)

1New Member Information: All Contractor(s) shall produce and provide the following information to each member/representative or household within twelve (12) business days of receipt of notification of the enrollment date. Contractors have the option of providing the Member Handbook and Network Description/Provider Directory with the new member packet, or providing written notification that the information is available on the Contractor’s website, by electronic mail or by postal mailing.

Revision Date: 10/01/15, 04/01/14 Initial Effective Date: 04/01/2014
**AHCCCS Maternal Child Health/EPSTD Member Outreach**

<table>
<thead>
<tr>
<th>Maternity Care</th>
<th>Frequency of Outreach Dissemination</th>
<th>Date(s)</th>
<th>Mechanism for Member Dissemination</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Educational Outreach</strong></td>
<td></td>
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</tbody>
</table>
| • **HIV Testing** – Information encouraging pregnant women to be tested providing instructions on where testing is available and the availability of counseling, if testing is positive. | Annually | New Member Enrollment | • New Member Welcome Packet¹  
• Member Newsletter  
• Maternity Packets |
| • **Opportunity to Change Contractors** – Information to newly assigned pregnant members, and those currently under the care of a non-network provider, regarding the opportunity to change contractors to ensure continuity of prenatal care. | Once | New Pregnant Member Enrollment | • New Member Welcome Packet¹  
• Member Newsletter  
• Maternity Packets |
| • **Low/Very Low Birth Weight** – Information to new pregnant members of interventions to decrease the incidence of infants born with low/very low birth weight. | Once | New Pregnant Member Enrollment  
Identification of Member Pregnancies (Initial and Subsequent) | • New Member Welcome Packet¹  
• Member Newsletter  
• Maternity Packets |

All informational materials developed by the Contractor and disseminated to its own members must be submitted to AHCCCS for approval, prior to dissemination, unless otherwise specified in contract. Unless otherwise indicated, proposed materials must be submitted 30 days before the intended publication date. (For more details, refer to AHCCCS Compliance Operations Manual)

¹New Member Information: All Contractor(s) shall produce and provide the following information to each member/representative or household within twelve (12) business days of receipt of notification of the enrollment date. Contractors have the option of providing the Member Handbook and Network Description/Provider Directory with the new member packet, or providing written notification that the information is available on the Contractor’s website, by electronic mail or by postal mailing.

Revision Date: 10/01/15, 04/01/14  
Initial Effective Date: 04/01/2014
## Maternity Care

<table>
<thead>
<tr>
<th>Topics</th>
<th>Frequency of Outreach Dissemination</th>
<th>Date(s)</th>
<th>Mechanism for Member Dissemination</th>
</tr>
</thead>
<tbody>
<tr>
<td>EDUCATIONAL OUTREACH</td>
<td></td>
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<tr>
<td><strong>Postpartum Services</strong> – Information related to postpartum services provided to members within 60 days of delivery.</td>
<td>Once</td>
<td>New Pregnant Member Enrollment Identification of Member Pregnancies (<em>Initial and Subsequent</em>)</td>
<td>• New Member Welcome Packet¹ • Maternity Packets</td>
</tr>
<tr>
<td><strong>Available Support Services</strong> - Information to members of available support services to the special supplemental nutrition program for Women, Infants and Children (WIC), as well as other community-based resources, in order to support healthy pregnancy outcomes.</td>
<td>Once</td>
<td>New Pregnant Member Enrollment Identification of Member Pregnancies (<em>Initial and Subsequent</em>)</td>
<td>• New Member Welcome Packet¹ • Maternity Packets • Member Newsletter</td>
</tr>
</tbody>
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All informational materials developed by the Contractor and disseminated to its own members must be submitted to AHCCCS for approval, prior to dissemination, unless otherwise specified in contract. Unless otherwise indicated, proposed materials must be submitted 30 days before the intended publication date. (For more details, refer to AHCCCS Compliance Operations Manual)

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**Maternity Care**

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<tr>
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<tr>
<td><strong>EDUCATIONAL OUTREACH</strong></td>
<td></td>
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</tbody>
</table>
| • Risks Associated with Elective Inductions and Cesarean Sections Prior to 39 Weeks Gestation | Contractors must conduct written member educational outreach at a minimum of **once every 12 months**. These topics may be addressed separately or combined into one written outreach material; however, each topic must be covered during the twelve month period. | Previous Date of Outreach Distribution Relating to Each Topic Area | • New Member Welcome Packet
• Maternity Packets
• Member Newsletter |
| • Healthy Pregnancy Measures (Addressing Nutrition, Sexually Transmitted Infections, Substance Abuse and Other Risky Behaviors) | | | |
| • Dangers of Lead Exposure to Mother and Baby During Pregnancy | | | |
| • Importance of Timely Prenatal and Postpartum Care | | | |
| • Postpartum Depression | | | |
| • Safe Sleep | | | |

**REQUIRED MEMBER NOTIFICATIONS**

Notification to members identifying postpartum services available to the member, advising of the importance for scheduling a postpartum visit, and the availability of assistance in scheduling, if needed.

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</thead>
<tbody>
<tr>
<td>Once</td>
<td>Delivery Date</td>
<td>• Member Mailing*</td>
</tr>
</tbody>
</table>

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1New Member Information: All Contractor(s) shall produce and provide the following information to each member/representative or household within twelve (12) business days of receipt of notification of the enrollment date. Contractors have the option of providing the Member Handbook and Network Description/Provider Directory with the new member packet, or providing written notification that the information is available on the Contractor’s website, by electronic mail or by postal mailing.
## Family Planning Services

<table>
<thead>
<tr>
<th>Topics</th>
<th>Frequency of Outreach Dissemination</th>
<th>Date (s)</th>
<th>Mechanism for Member Dissemination</th>
</tr>
</thead>
<tbody>
<tr>
<td>EDUCATIONAL OUTREACH</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• AHCCCS Acute Care, ALTCS AND FFS Members - Notification to AHCCCS Acute Care, ALTCS AND FFS Members that screening and treatment of Sexually Transmitted Diseases (STDs) are a covered benefit.</td>
<td>Annually</td>
<td>Enrollment Date</td>
<td>• Member Newsletters</td>
</tr>
<tr>
<td>• Covered Family Planning Services – Information advising members of reproductive age of the specific covered family planning services available and how to request them.</td>
<td>Annually</td>
<td>Enrollment Date</td>
<td>• Member Newsletter</td>
</tr>
<tr>
<td>• HIV Testing – Information encouraging pregnant women to be tested providing instructions on where testing is available and the availability of counseling, if testing is positive.</td>
<td>Annually</td>
<td>New Member Enrollment Date</td>
<td>• New Member Welcome Packet¹</td>
</tr>
</tbody>
</table>

¹New Member Information: All Contractor(s) shall produce and provide the following information to each member/representative or household within twelve (12) business days of receipt of notification of the enrollment date. Contractors have the option of providing the Member Handbook and Network Description/Provider Directory with the new member packet, or providing written notification that the information is available on the Contractor’s website, by electronic mail or by postal mailing.

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</tr>
</thead>
<tbody>
<tr>
<td>REQUIRED MEMBER NOTIFICATIONS</td>
<td>Annually</td>
<td>Notifications Must Be Completed By November 1st (or Time of Enrollment if Enrolled after November 1st)</td>
<td>• Member Mailing*</td>
</tr>
</tbody>
</table>

Note: AHCCCS Administration will provide information about AHCCCS covered family planning services to members who receive services on a fee-for-service basis. Notification is to be given at least once a year and must be completed by November 1. For Contractor members who enroll after November 1, notification will be sent at the time of enrollment.

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## EXHIBIT 400-3

**AHCCCS MATERNAL CHILD HEALTH/EPSDT MEMBER OUTREACH**

### EPSDT

<table>
<thead>
<tr>
<th>Topics</th>
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<th>Date (s)</th>
<th>Mechanism for Member Dissemination</th>
</tr>
</thead>
<tbody>
<tr>
<td>EDUCATIONAL OUTREACH</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>EPSDT Coverage</strong> - Inform members EPSDT includes, but is not limited to, coverage of: inpatient and outpatient hospital services, laboratory and x-ray services, physician services, nurse practitioner services, medications, dental services, therapy services, behavioral health services, medical supplies, prosthetic devices, eyeglasses, transportation, and family planning services. EPSDT also includes diagnostic, screening, preventive and rehabilitative services. However, EPSDT services do not include services that are experimental, that are solely for cosmetic purposes, or that are not cost effective when compared to other interventions.</td>
<td>Annually</td>
<td>Enrollment Date</td>
<td>• Member Handbook</td>
</tr>
<tr>
<td><strong>Required Health Screenings</strong> - Information to members of required health screenings in compliance with the AHCCCS EPSDT Periodicity Schedule.</td>
<td>Annually</td>
<td>Enrollment Date</td>
<td>• Member Newsletters</td>
</tr>
<tr>
<td><strong>Components of the EPSDT Visit</strong> - Information to members describing what is included in an EPSDT visit (including Oral Health and Nutritional Screenings and Developmental Surveillance) and the importance of attending EPSDT visits as recommended in the AHCCCS Periodicity schedule. Information should include that EPSDT visit is synonymous with a well-child visit.</td>
<td>Annually</td>
<td>Enrollment Date</td>
<td>• Member Newsletters</td>
</tr>
</tbody>
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**Note:** Contractors must inform members about EPSDT services within 30 days of enrollment.

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Revision Date: 10/01/15, 04/01/14  
Initial Effective Date: 04/01/2014
<table>
<thead>
<tr>
<th>Topics</th>
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</thead>
<tbody>
<tr>
<td><strong>EDUCATIONAL OUTREACH</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Immunizations</td>
<td>Contractors Must Conduct Written Member Educational Outreach At A Minimum Of Once Every 12 Months.</td>
<td>Date Last Outreach Distributed Related to Each Topic Area</td>
<td>• Member Newsletters</td>
</tr>
<tr>
<td>• Available Community Resources (WIC, AzEIP, CRS, Behavioral Health, and Head Start)</td>
<td>These Topics May Be Addressed Separately Or Combined Into One Written Outreach Material; However, Each Topic Must Be Covered During The Twelve Month Period.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Dangers Of Lead Exposure And Recommended/Mandatory Testing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Childhood Obesity And Prevention Measures</td>
<td></td>
<td></td>
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<tr>
<td>• Age Appropriate Risk Prevention Efforts (Addressing Injury And Suicide Prevention, Bullying, Violence, And Risky Sexual Behavior)</td>
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<td></td>
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<tr>
<td>• Education On Importance Of Utilizing Primary Care Provider In Place Of ER Visits For Non-Emergent Concerns</td>
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Note: Contractors must inform members about EPSDT services within 30 days of enrollment.

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<tr>
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<th>Mechanism for Member Dissemination</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>At Each Age Dictated by the AHCCCS Periodicity Schedule</td>
<td>Member’s Age Meeting that Dictated by the AHCCCS Periodicity Schedule</td>
<td>• Member Mailing*</td>
</tr>
<tr>
<td></td>
<td>Annually &amp; Each Age as Dictated by the Recommended Immunization Schedule</td>
<td>Enrollment Date &amp; Each Age Recommended in the Immunization Schedule</td>
<td>• Member Mailing*</td>
</tr>
</tbody>
</table>

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## Dental

<table>
<thead>
<tr>
<th>Topics</th>
<th>Frequency of Outreach Dissemination</th>
<th>Date (s)</th>
<th>Mechanism for Member Dissemination</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EDUCATIONAL OUTREACH</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Importance of Oral Health Care</td>
<td>Contractors Must Conduct Written Member Educational Outreach At A Minimum Of <strong>Once Every 12 Months</strong>.</td>
<td>Date Last Outreach Distributed Related to Each Topic Area</td>
<td><strong>Member Newsletters</strong></td>
</tr>
<tr>
<td>• Dental Decay Prevention Measures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Fluoride Varnish Applications</td>
<td>These Topics May Be Addressed Separately Or Combined Into One Written Outreach Material; However, Each Topic Must Be Covered During The Twelve Month Period.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Dental Home Information</td>
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Revision Date: 10/01/15, 04/01/14    Initial Effective Date: 04/01/2014
### Exhibit 400-3

AHCCCS Maternal Child Health/EPSDT Member Outreach

<table>
<thead>
<tr>
<th>Dental</th>
<th>Topics</th>
<th>Frequency of Outreach Dissemination</th>
<th>Date(s)</th>
<th>Mechanism for Member Dissemination</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>REQUIRED MEMBER NOTIFICATION</strong></td>
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</tr>
<tr>
<td>Notification of assignment to a dental home with the provider’s contact information, importance of being seen by a dentist for routine preventative care (in accordance with the AHCCCS Dental Periodicity Schedule). Notification should include the availability of assistance with scheduling and arrangements of transportation, if needed.</td>
<td>Annually</td>
<td>Birthdate</td>
<td>• Member Mailings*</td>
<td></td>
</tr>
<tr>
<td>Notification to members or responsible parties regarding due dates of biannual (one visit every six months) dental visits.</td>
<td>Biannual</td>
<td>Birthdate</td>
<td>• Member Mailings*</td>
<td></td>
</tr>
<tr>
<td><strong>To Members Receiving Oral Health Care through School-Based or Mobile Unit Providers</strong> - Outreach ensuring members are aware of their dental home provider and contact information, as well as understand the availability of ongoing-access to care through the dental home provider, when school-based or mobile unit providers are not accessible.</td>
<td>Annually</td>
<td>Birthdate</td>
<td>• Member Mailings*</td>
<td></td>
</tr>
</tbody>
</table>

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Revision Date: 10/01/15, 04/01/14  Initial Effective Date: 04/01/2014
410  MATERNITY CARE SERVICES

REVISION DATES: 10/01/15, 10/01/14, 03/01/14, 10/01/13, 10/01/11, 09/01/11, 02/01/11,
10/01/09, 10/01/08, 04/01/07, 08/01/05, 04/01/04, 02/14/03, 10/01/01,
08/07/01, 02/01/01, 06/27/00, 10/01/97

INITIAL EFFECTIVE DATE: 01/01/1997

Description

AHCCCS covers a full continuum of maternity care services for all eligible, enrolled
members of childbearing age.

Amount, Duration and Scope

Maternity care services include, but are not limited to, medically necessary preconception
counseling, identification of pregnancy, medically necessary education and prenatal
services for the care of pregnancy, the treatment of pregnancy-related conditions, labor and
delivery services, and postpartum care. In addition, related services such as outreach and
family planning services (Policy 420) are provided, whenever appropriate, based on the
member's current eligibility and enrollment.

All maternity care services must be delivered by qualified physicians and non-physician
practitioners, and must be provided in compliance with the most current American
Congress of Obstetricians and Gynecologists (ACOG) standards for obstetrical and
gynecological services. Prenatal care, labor/delivery, and postpartum care services may be
provided by licensed midwives within their scope of practice, while adhering to AHCCCS
risk-status consultation/referral requirements. According to ACOG guidelines, cesarean
section deliveries must be medically necessary. Inductions and cesarean section deliveries
performed prior to 39 weeks must be medically necessary. Cesarean sections and inductions
performed prior to 39 weeks that are not found to be medically necessary based on
nationally established criteria are not eligible for payment.

A. MATERNITY CARE SERVICE DEFINITIONS

1. Certified Nurse Midwife (CNM) is certified by the American College of Nursing
Midwives (ACNM) on the basis of a national certification examination and
licensed to practice in Arizona by the State Board of Nursing. CNMs practice
independent management of care for pregnant women and newborns, providing
antepartum, intrapartum, postpartum, gynecological, and newborn care, within a
health care system that provides for medical consultation, collaborative
management, or referral.
2. **High-risk pregnancy** refers to a pregnancy in which the mother, fetus, or newborn is, or is anticipated to be, at increased risk for morbidity or mortality before or after delivery. High-risk is determined through the use of the Medical Insurance Company of Arizona (MICA) or American Congress of Obstetricians and Gynecologists (ACOG) standardized medical risk assessment tools.

3. **Licensed Midwife** means an individual licensed by the Arizona Department of Health Services to provide maternity care pursuant to Arizona Revised Statutes (A.R.S.) Title 36, Chapter 6, Article 7 and Arizona Administrative Code Title 9, Chapter 16 (This provider type does not include certified nurse midwives licensed by the Board of Nursing as a nurse practitioner in midwifery or physician assistants licensed by the Arizona Medical Board).

4. **Maternity care** includes identification of pregnancy, prenatal care, labor/delivery services, and postpartum care.

5. **Maternity care coordination** consists of the following maternity care related activities: determining the member's medical or social needs through a risk assessment evaluation; developing a plan of care designed to address those needs; coordinating referrals of the member to appropriate service providers and community resources; monitoring referrals to ensure the services are received; and revising the plan of care, as appropriate.

6. **Practitioner** refers to certified nurse practitioners in midwifery, physician's assistants and other nurse practitioners. Physician's assistants and nurse practitioners are defined in A.R.S. Title 32, Chapters 25 and 15 respectively.

7. **Postpartum care** is the health care provided for a period of up to 60 days post-delivery. Family planning services are included, if provided by a physician or practitioner, as addressed in Policy 420 of this Chapter.

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

9. **Prenatal care** is the health care provided during pregnancy and is composed of three major components:
   a. Early and continuous risk assessment,
   b. Health education and promotion, and
c. Medical monitoring, intervention, and follow-up.

B. CONTRACTOR REQUIREMENTS FOR PROVIDING MATERNITY CARE SERVICES

Contractors must establish and operate a maternity care program with program goals directed at achieving optimal birth outcomes. The minimum requirements of the maternity care program are:

1. Employ sufficient numbers of appropriately qualified local personnel in order to meet the requirements of the maternity care program for eligible enrolled members and achieve contractual compliance.

2. Provide written member educational outreach related to risks associated with elective inductions and cesarean sections prior to 39 weeks gestation, healthy pregnancy measures (addressing nutrition, sexually transmitted infections, substance abuse and other risky behaviors), dangers of lead exposure to mother and baby during pregnancy, postpartum depression, importance of timely prenatal and postpartum care, and other Contractor selected topics at a minimum of once every 12 months. These topics may be addressed separately or combined into one written outreach material; however, each topic must be covered during the twelve month period. Contractors may utilize multiple different venues to meet these requirements.

3. Conduct outreach and education activities to identify currently enrolled pregnant members, and enter them into prenatal care as soon as possible. The program must include protocols for service providers to notify the Contractor promptly when members have tested positive for pregnancy. In addition, Contractors must have an ongoing process to monitor and evaluate the effectiveness of outreach activities for all pregnant members. If activities prove to be ineffective, the Contractor must implement different activities.

4. Participate in community and quality initiatives within the communities served by the Contractor.

5. Implement written protocols to inform pregnant women and maternity care providers of voluntary prenatal HIV testing and the availability of counseling, if the test is positive.

   a. Each Contractor must include information to encourage pregnant women to be tested and provide instructions on where testing is available at least annually in the member newsletter, new member welcome packet, maternity packet, provider instructions, and the member handbook.
b. Semiannually, each Contractor must report to AHCCCS the number of pregnant women who have been identified as HIV positive. The AHCCCS Semiannual Report of Number of Pregnant Women Who Are HIV Positive (Exhibit 410-1) is due no later than 30 days after the end of the second and fourth quarters of the federal fiscal year (contract year).

6. Designation of a maternity care provider for each enrolled pregnant woman for the duration of her pregnancy and postpartum care. Such designations must be consistent with AHCCCS Acute Care and Long Term Care contract requirements, allowing freedom of choice, while not compromising the continuity of care. Members who transition to a new Contractor or become enrolled during their third trimester must be allowed to complete maternity care with their current AHCCCS registered provider, regardless of contractual status, to ensure continuity of care.

7. Provision of information, regarding the opportunity to change Contractors to ensure continuity of prenatal care, to newly-assigned pregnant members and those currently under the care of a non-network provider.

8. Written new member assessment procedures for the provider that include identifying risk factors through the use of a comprehensive assessment tool covering psychosocial, nutritional, medical and educational factors (available from the American Congress of Obstetricians and Gynecologists [ACOG] or the Mutual Insurance Company of Arizona [MICA]).

9. Mandatory availability of maternity care coordination services for enrolled pregnant women, who are determined to be medically or socially at-risk/high-risk by the maternity care provider or the Contractor. This includes identified difficulties with navigating the health care system, evident by missed visits, transportation difficulties, or other perceived barriers.

10. Demonstration of an established process for assuring:

a. Network physicians, practitioners, and licensed midwives adhere to the highest standards of care, including the use of a standardized medical risk assessment tool for initial and ongoing risk assessments, and appropriate consults/referrals for increased-risk or high-risk pregnancies using ACOG or MICA criteria.

b. Maternity care providers educate members about healthy behaviors during pregnancy, including the importance of proper nutrition; dangers of lead exposure to mother and child; tobacco cessation; avoidance of alcohol and other harmful substances, including illegal drugs; screening for sexually transmitted infections; the physiology of pregnancy; the process of labor
CHAPTER 400
MEDICAL POLICY FOR MATERNAL AND CHILD HEALTH

POLICY 410
MATERNITY CARE SERVICES

and delivery; breast-feeding; other infant care information; and postpartum follow-up.

c. Members are referred for support services to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), as well as other community-based resources to support healthy pregnancy outcomes. In the event where a member loses eligibility, the member must be notified where they may obtain low-cost or no-cost maternity services.

d. Maternity care providers maintain a complete medical record, documenting all aspects of maternity care.

e. High-risk pregnant members have been referred to and are receiving appropriate care from a qualified physician, and

f. Postpartum services are provided to members within 60 days of delivery.

11. Mandatory provision of initial prenatal care appointments within the established timeframes. The established timeframes are as follows:

a. First trimester -- within 14 days of a request for an appointment

b. Second trimester -- within seven days of a request for an appointment

c. Third trimester -- within three days of a request for an appointment, or

d. High-risk pregnancy care must be initiated within three days of identification to the member’s Contractor or maternity care provider, or immediately, if an emergency exists.

12. Primary verification of pregnant members, to ensure that the above mentioned timeframes are met, and to effectively monitor members are seen in accordance with those timeframes.

13. Monitoring and evaluation of infants born with low/very low birth weight, and implementation of interventions to decrease the incidence of infants born with low/very low birth weight.

14. Monitoring and evaluation of cesarean section and elective induction rates prior to 39 weeks gestation, as well as implementation of interventions to decrease occurrence.

15. Identification of postpartum depression and referral of members to the appropriate health care providers.
NOTE: Contractors may refer to AMPM, Exhibit F, Tool Kit for the Management of Adult Postpartum Depression, which is intended to assist the provider in assessing the postpartum needs of women regarding depression and decisions regarding health care services provided by the PCP or subsequent referral to the Regional Behavioral Health Authority (RBHA) if clinically indicated.

16. Process for monitoring provider compliance for perinatal/postpartum depression screenings being conducted at least once during the pregnancy and then repeated at the postpartum visit, with appropriate counseling and referrals made, if a positive screening is obtained.

17. Return visits in accordance with ACOG standards. A process, with primary verification, must be in place to monitor these appointments and ensure timeliness. Contractors must include the first and last prenatal care dates of service and the number of obstetrical visits that the member had with the provider on claim forms to AHCCCS regardless of the payment methodology.

Contractors must continue to pay obstetrical claims upon receipt of claim after delivery, and must not postpone payment to include the postpartum visit. Rather, Contractors must require a separate “zero-dollar” claim for the postpartum visit.

18. Timely provision of medically necessary transportation services, as described in Chapter 300, Policy 310-BB, Transportation.

19. Postpartum activities must be monitored and evaluated, and interventions to improve the utilization rate implemented, where needs are identified.

20. Participation of Contractors in reviews of the maternity care services program conducted by AHCCCS as requested, including provider visits and audits.

C. CONTRACTOR REQUIREMENTS FOR THE MATERNITY/FAMILY PLANNING SERVICES ANNUAL PLAN

Each Contractor must have a written Maternity/Family Planning Services Annual Plan that addresses minimum Contractor requirements as specified in the prior section (numbers 1 through 20), as well as the objectives of the Contractor’s program that are focused on achieving AHCCCS requirements. It must also incorporate monitoring and evaluation activities for these minimum requirements (see Exhibit 400-2A, Maternity/Family Planning Services Annual Plan Checklist). The Maternity/Family Planning Services Annual Plan must be submitted no later than December 15th to the AHCCCS Division of Health Care Management/Clinical Quality Management Unit and is subject to approval (see Exhibit 400-1, Maternal and Child Health Reporting Requirements).
The Maternity/Family Planning Services Annual Plan must contain, at a minimum, the following:

1. Maternity/Family Planning Services Care Plan – A written, narrative description of all planned activities to address the Contractor’s minimum requirements as specified in the prior section (Contractor Requirements for Providing Maternity Care Services- Numbers 1 through 20) for maternity care and family planning services, including participation in community and/or quality initiatives within the communities served by the Contractor. The narrative description must also include Contractor activities to identify member needs, coordination of care, and follow-up activities to ensure appropriate and medically necessary treatment is received in a timely manner.

2. Maternity/Family Planning Services Work Plan Evaluation – An evaluation of the previous year’s Work Plan to determine the effectiveness of strategies and interventions used toward meeting stated objectives.

3. Maternity/Family Planning Services Work Plan that includes:
   a. Specific measurable objectives. These objectives must be based on AHCCCS established minimum performance standards. In cases where AHCCCS minimum performance standards have been met, other generally accepted benchmarks that continue the Contractor’s improvement efforts must be used (e.g., National Committee on Quality Assurance, Healthy People 2020 standards). The Contractor may also develop additional specific measurable goals and objectives aimed at enhancing the maternity program when AHCCCS Minimum Performance Standards have been met.
   b. Strategies and specific measurable interventions to accomplish objectives (e.g., member outreach, provider education and provider compliance with mandatory components of the Maternity/Family Planning Services program).
   c. Targeted implementation and completion dates of work plan activities.
   d. Assigned local staff position(s) responsible and accountable for meeting each established goal and objective.
   e. Identification and implementation of new interventions, continuation of or modification to existing interventions, based on analysis of the previous year’s Work Plan Evaluation.

4. Relevant policies and procedures, referenced in the Maternity/Family Planning Services Annual Plan, submitted as separate attachments.
D. MATERNITY CARE PROVIDER REQUIREMENTS

1. Physicians and practitioners must follow the American Congress of Obstetricians and Gynecologists standards of care, including the use of a standardized medical risk assessment tool and ongoing risk assessment.

2. Licensed midwives, if included in the Contractor’s provider network, adhere to the requirements contained within AHCCCS policy, procedures, and contracts.

3. All maternity care providers will ensure that:
   a. High-risk members have been referred to a qualified provider and are receiving appropriate care.
   b. Members are educated about health behaviors during pregnancy, including the importance of proper nutrition; dangers of lead exposure to mother and child; tobacco cessation; avoidance of alcohol and other harmful substances, including illegal drugs; screening for sexually transmitted infections; the physiology of pregnancy; the process of labor and delivery; breastfeeding; other infant care information; and postpartum follow-up.
   c. Perinatal/Postpartum depression screenings are conducted at least once during the pregnancy and then repeated at the postpartum visit with appropriate counseling and referrals made, if a positive screening is obtained. Postpartum depression screening is considered part of the global service and is not a separately reimbursable service.

   NOTE: Providers should refer to AMPM, Exhibit F, Tool Kit for the Management of Adult Postpartum Depression, which is intended to assist the provider in assessing the postpartum needs of women regarding depression and decisions regarding health care services provided by the PCP or subsequent referral to the Regional Behavioral Health Authority (RBHA) if clinically indicated.
   d. Member medical records are appropriately maintained and document all aspects of the maternity care provided.
   e. Members must be referred for support services to the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), as well as other community-based resources, in order to support healthy pregnancy outcomes.
f. Members must be notified that in the event they lose eligibility for services, they may contact the Arizona Department of Health Services Hotline for referrals to low-cost or no-cost services.

g. The first and last prenatal care dates of service, as well as the number of obstetrical visits that the member had with the provider, are recorded on all claim forms submitted to the Contractor regardless of the payment methodology used.

h. Postpartum services must be provided to members within 60 days of delivery utilizing a separate “zero-dollar” claim for the postpartum visit.

E. ADDITIONAL COVERED RELATED SERVICES

AHCCCS covered related services with special policy and procedural guidelines for Fee-For-Service and Contractor providers include, but are not limited to:

1. Circumcision of newborn male infants, is a covered service when it is determined to be medically necessary

2. Extended stays for normal newborns related to status of mother’s stay

3. Home uterine monitoring technology

4. Labor and delivery services provided in freestanding birthing centers

5. Labor and delivery services provided in a home setting

6. Licensed Midwife services

7. Supplemental stillbirth payment

8. Pregnancy termination (including Mifepristone [Mifeprex or RU-486])

1. CIRCUMCISION OF NEWBORN MALE INFANTS, IS A COVERED SERVICE WHEN IT IS DETERMINED TO BE MEDICALLY NECESSARY

Description

Pursuant to A.R.S. 36-2907, routine circumcision for newborn males is not a covered service.
Amount, Duration and Scope

Circumcision is a covered service under EPSDT for males when it is determined to be medically necessary. The procedure requires prior authorization by the Contractor Medical Director or designee for enrolled members, or the AHCCCS Chief Medical Officer or designee for Fee-For-Service members.

2. Extended Stays for Normal Newborns Related to Status of Mother’s Stay

Description

AHCCCS covers up to 48 hours of inpatient hospital care for a normal vaginal delivery and up to 96 hours of inpatient hospital care for a cesarean delivery.

Effective with dates of discharge on or after October 1, 2014, there is no 25 day limit for inpatient hospital services per benefit year for members who are 21 years and older.

CYE 2014 Limitations

AHCCCS covers up to 48 hours of inpatient hospital care for a normal vaginal delivery and up to 96 hours of inpatient hospital care for a cesarean delivery. The attending health care provider, in consultation with the mother, may discharge the mother or newborn prior to the minimum length of stay. A newborn may be granted an extended stay in the hospital of birth when the mother’s stay in the hospital is medically necessary beyond a 48/96 hour stay.

Amount, Duration and Scope

The mother of the newborn may be discharged prior to the minimum 48/96 hour stay if agreed upon by the mother in consultation with the physician or practitioner. In addition, if the mother's stay is to extend beyond 48/96 hours, an extended stay for the newborn should be granted if the mother's condition allows for mother-infant interaction and the child is not a ward of the State or is not to be adopted. Prior authorization is required for extended stays for newborn infants for the Fee-For-Service population.
3. **HOME UTERINE MONITORING TECHNOLOGY**

**Description**

AHCCCS covers medically necessary home uterine monitoring technology for members with premature labor contractions before 35 weeks gestation, as an alternative to hospitalization.

If the member has one or more of the following conditions, home uterine monitoring may be considered:

a. Multiple gestation, particularly triplets or quadruplets,

b. Previous obstetrical history of one or more births before 35 weeks gestation, or

c. Hospitalization for premature labor before 35 weeks gestation with a documented change in the cervix, controlled by tocolysis and ready to be discharged for bed rest at home.

These guidelines refer to home uterine activity monitoring technology and do not refer to daily provider contact by telephone or home visit.

4. **LABOR AND DELIVERY SERVICES PROVIDED IN FREESTANDING BIRTHING CENTERS**

**Description**

For members who meet medical criteria specified in this policy, AHCCCS covers freestanding birthing centers when labor and delivery services are provided by licensed physicians or certified nurse practitioners in midwifery (a.k.a. certified nurse midwives).

Freestanding birthing centers are defined as out-of-hospital, outpatient obstetrical facilities, licensed by the Arizona Department of Health Services and certified by the Commission for the Accreditation of Free Standing Birth Centers. These facilities are staffed by registered nurses to provide assistance with labor and delivery services. They are equipped to manage uncomplicated, low-risk labor and delivery. These facilities must be affiliated with, and in close proximity to, an acute care hospital for the management of complications, should they arise.

**Amount, Duration and Scope**

a. Labor and delivery services rendered through freestanding birthing centers must be provided by a physician, (i.e., the member's primary care provider
or an obstetrician with hospital admitting privileges) or by a registered nurse who is accredited/certified by the American College of Nurse Midwives and has hospital admitting privileges for labor and delivery services.

b. Only pregnant AHCCCS members, for whom an uncomplicated prenatal course and a low-risk labor and delivery can be anticipated, may be scheduled to deliver at a free standing birthing center. Risk status must be determined by the attending physician or certified nurse midwife using the standardized assessment tools for high-risk pregnancies (American Congress of Obstetricians and Gynecologists, Mutual Insurance Company of Arizona, or National Association of Childbearing Centers). In any area of the risk assessment where standards conflict, the most stringent will apply. The age of the member must also be a consideration in the risk status evaluation; members younger than 18 years of age are generally considered high risk.

Refer to the AHCCCS Maternity Care Risk Screening Guidelines (Exhibit 410-2) for more detailed explanation of what AHCCCS does not consider as low-risk deliveries, nor appropriate for planned home-births or births in freestanding birthing centers.

5. **Labor and Delivery Services Provided in the Home Setting**

**Description**

For members who meet medical criteria specified in this policy, AHCCCS covers labor and delivery services provided in the home by licensed physicians, practitioners (physician assistants or certified nurse practitioners in midwifery), and licensed midwives.

**Amount, Duration and Scope**

Only AHCCCS members, for whom an uncomplicated prenatal course and a low-risk labor and delivery can be anticipated, may be scheduled to deliver in the member’s home. Refer to the AHCCCS Maternity Care Risk Screening Guidelines (Exhibit 410-2) for more detailed explanation of what AHCCCS does not consider as low-risk deliveries, nor appropriate for planned home-births or births in freestanding birthing centers.

Risk status must initially be determined at the time of the first visit, and each trimester thereafter, by the member’s attending physician, practitioner or licensed midwife, using the current standardized assessment criteria and protocols for high-risk pregnancies from the American Congress of Obstetrics and Gynecology or Mutual Insurance Company of Arizona.
A risk assessment must be conducted when a new presenting complication or concern arises to ensure appropriate care and referral to a qualified provider, if necessary.

Physicians and practitioners who render home labor and delivery services must have admitting privileges at an acute care hospital in close proximity to the site where the services are provided in the event of complications during labor and/or delivery.

For each anticipated home labor and delivery, licensed midwives who render home labor and delivery services must have an established plan of action, including methods of obtaining services at an acute care hospital in close proximity to the site where services are provided. In addition, referral information to an AHCCCS registered physician who can be contacted immediately, in the event that management of complications is necessary, must be included in the plan.

Upon delivery of the newborn, the physician, practitioner, or licensed midwife is responsible for conducting newborn examination procedures, including a mandatory Bloodspot Newborn Screening Panel and referral of the infant to an appropriate health care provider for a mandatory hearing screening, as well as a second mandatory Bloodspot Newborn Screening Panel and second newborn hearing screening (if infant refers on first testing). Refer the infant and/or member to an appropriate health care provider for follow-up care of any assessed problematic conditions (Refer to Exhibit 410-2, AHCCCS Maternity Care Risk Screening Guidelines).

In addition, the physician, practitioner, or licensed midwife must notify the mother’s Contractor or the AHCCCS Newborn Reporting Line of the birth for infants born to Fee-For-Service mothers. Notification may also be made using the AHCCCS web site reporting form. Notification must be given no later than three days after the birth in order to enroll the newborn with AHCCCS.

### 6. LICENSED MIDWIFE SERVICES

**Description**

AHCCCS covers maternity care and coordination provided by licensed midwives for Fee-For-Service (FFS) members or enrolled members, if licensed midwives are included in the Contractor’s provider network. In addition, members who choose to receive maternity services from this provider type must meet eligibility and medical criteria specified in this policy.
**Amount Duration and Scope**

Licensed midwife services may be provided only to members for whom an uncomplicated prenatal course and a low-risk labor and delivery can be anticipated. The age of the member must be included as a consideration in the risk status evaluation. Refer to the AHCCCS Maternity Care Risk Screening Guidelines (Exhibit 410-2) for more detailed explanation of what AHCCCS does not consider as low-risk deliveries, nor appropriate for planned home-births or births in freestanding birthing centers.

Risk status must initially be determined at the time of the first visit, and each trimester thereafter, using the current standardized assessment criteria and protocols for high-risk pregnancies from the American Congress of Obstetrics and Gynecology or Mutual Insurance Company of Arizona.

A risk assessment from the American Congress of Obstetrics and Gynecology or Mutual Insurance Company of Arizona must be conducted when a new presenting complication or concern arises to ensure proper care and referral to a qualified physician if necessary.

Before providing licensed midwife services, documentation certifying the risk status of the member’s pregnancy must be submitted to the member’s Contractor or the AHCCCS Division of Fee-For-Service Management (DFSM) Utilization Management/Care Management (UM/CM) Unit for FFS members. In addition, a consent form signed and dated by the member must be submitted, indicating that the member has been informed and understands the scope of services that will be provided by the licensed midwife. Members initially determined to have a high-risk pregnancy, or members whose physical condition changes to high-risk during the course of pregnancy, must immediately be referred to an AHCCCS registered physician within the provider network of the member’s Contractor for maternity care services. The AHCCCS DFSM UM/CM Unit must be notified of all FFS members determined to be high risk and the name of the physician to whom the member was referred.

Labor and delivery services provided by a licensed midwife cannot be provided in a hospital or other licensed health care institution. Licensed midwives must have a plan of action, including the name and address of an AHCCCS registered physician and an acute care hospital in close proximity to the planned location of labor and delivery for referral, in the event that complications should arise. This plan of action must be submitted to the AHCCCS Chief Medical Officer or designee for FFS members, or to the Contractor Medical Director or designee for members enrolled with a Contractor.

Upon delivery of the newborn, the licensed midwife is responsible for conducting newborn examination procedures, including a mandatory Bloodspot Newborn Screening Panel and referral of the infant to an appropriate health care provider.
for a mandatory hearing screening, as well as a second mandatory Bloodspot Newborn Screening Panel and a second newborn hearing screening (if infant refers on first testing). Refer the infant and/or member to an appropriate health care provider for follow-up care of any assessed problematic conditions (Refer to Exhibit 410-2, AHCCCS Maternity Care Risk Screening Guidelines).

In addition, the licensed midwife must notify the mother’s Contractor, or the AHCCCS Newborn Reporting Line for infants born to FFS mothers, of the birth no later than three days after the birth, in order to enroll the newborn with AHCCCS.

7. SUPPLEMENTAL STILLBIRTH PAYMENT

Description

A supplemental payment package was implemented for Contractors to cover the cost of delivery services. The supplemental payment (“kick”) applies to all births to women enrolled with Contractors. AHCCCS also pays this supplement to Contractors when the infant is stillborn.

Stillbirth refers to those infants, either pre-term or term, delivered in the third trimester of a documented pregnancy, who were deemed a fetal demise. In order for Contractors to be eligible to receive this payment, criteria must be met. The stillborn infant must have:

a. Attained a weight of at least 600 grams, or

b. Attained a gestational age of at least 24 weeks, as verified by Provider’s obstetrical prenatal records (History & Physical) including an Estimated Date of Confinement (EDC). An ultrasound report may also be used to verify EDC, when completed prior to 20 weeks gestation. A Ballard Assessment, done at delivery by nursing and/or physician staff to determine physical maturity of the infant, confirming a gestational age of at least 24 weeks may also be used.

For stillbirths meeting one of the above medical criteria, Contractors must submit medical documentation to confirm infant’s weight and/or gestational age, as well as the date/time of delivery and zero APGARs, using the AHCCCS Request for Stillbirth Supplement form (Exhibit 410-3). The request must be submitted to AHCCCS using secure email to CQM@azahcccs.gov or by mailing it to the address indicated below.

AHCCCS
Division of Health Care Management
Clinical Quality Management Unit/MCH Manager
Exclusions

No supplemental payment is provided for labor and delivery services rendered during the prior period coverage timeframe, or if the member was not assigned to the Contractor at the time labor and delivery services were rendered.

Contractor requests for the payment must be made within six months of the delivery date, unless an exemption is granted by the AHCCCS Clinical Quality Management Unit. Exemptions will be considered on a case-by-case basis.

8. PREGNANCY TERMINATION
(INCLUDING MIFEPRISTONE [MIFEPR EX OR RU-486])

Description

AHCCCS covers pregnancy termination if one of the following criteria is present:

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

b. The pregnancy is a result of incest.

c. The pregnancy is a result of rape.

d. The pregnancy termination is medically necessary according to the medical judgment of a licensed physician, who attests that continuation of the pregnancy could reasonably be expected to pose a serious physical or behavioral health problem for the pregnant member by:

   i. Creating a serious physical or behavioral health problem for the pregnant member,

   ii. Seriously impairing a bodily function of the pregnant member,

   iii. Causing dysfunction of a bodily organ or part of the pregnant member,

   iv. Exacerbating a health problem of the pregnant member, or
v. Preventing the pregnant member from obtaining treatment for a health problem.

**Conditions, Limitations and Exclusions**

The attending physician must acknowledge that a pregnancy termination was necessary based on the above criteria by submitting the AHCCCS Certificate of Necessity for Pregnancy Termination (Exhibit 410-4) and supporting clinical documentation.

This form must be submitted to the appropriate assigned Contractor Medical Director or designee for enrolled pregnant members, or the AHCCCS Chief Medical Officer or designee for Fee-For-Service (FFS) members. The Certificate must certify that, in the physician's professional judgment, one of the above criteria has been met.

**Additional Required Documentation**

a. A written informed consent must be obtained by the provider and kept in the member’s chart for all pregnancy terminations. If the pregnant member is younger than 18 years of age, or is 18 years of age or older and considered an incapacitated adult (as defined in A.R.S. § 14-5101), a dated signature of the pregnant member's parent or legal guardian indicating approval of the pregnancy termination procedure is required.

b. When the pregnancy is the result of rape or incest, documentation must be obtained that the incident was reported to the proper authorities, including the name of the agency to which it was reported, the report number (if available), and the date the report was filed.

**Additional Considerations Related to Use of Mifepristone**

Mifepristone (also known as Mifeprex or RU-486) is not a post-coital emergency oral contraceptive. The administration of Mifepristone, for the purposes of inducing intrauterine pregnancy termination, is covered by AHCCCS when a minimum of one AHCCCS required criterion is met for pregnancy termination, as well as the following conditions specific to Mifepristone:

a. Mifepristone can be administered through 49 days of pregnancy.

b. If the duration of pregnancy is unknown or if ectopic pregnancy is suspected, ultrasonography should be used for confirmation.

c. Any Intrauterine Device (“IUD”) should be removed before treatment with Mifepristone begins.
d. 400 mg of Misoprostol must be given two days after taking Mifepristone unless a complete abortion has already been confirmed.

e. Pregnancy termination by surgery is recommended in cases when Mifepristone and Misoprostol fail to induce termination of the pregnancy.

When Mifepristone is administered, the following documentation is also required:

a. Duration of pregnancy in days,

b. The date IUD was removed if the member had one,

c. The date Mifepristone was given,

d. The date Misoprostol was given, and

e. Documentation that pregnancy termination occurred.

NOTE: Contractors must submit a standardized AHCCCS Monthly Pregnancy Termination Report (Exhibit 410-6) to AHCCCS/Division of Health Care Management Clinical Quality Management Unit, which documents the number of pregnancy terminations performed during the month (including pregnancy terminations resulting from the use of Mifepristone). If no pregnancy terminations were performed during the month, the monthly report must still be submitted to attest to that information.

When pregnancy terminations have been authorized by the Contractor, the following information must be provided with the monthly report:

a. A copy of the completed AHCCCS Certificate of Necessity for Pregnancy Termination form, which has been signed by the Contractor’s Medical Director,

b. A copy of the completed AHCCCS Verification of Diagnosis by Contractor for Pregnancy Termination Request (Exhibit 410-5) confirming requirements for pregnancy termination have been met,

c. A copy of the official incident report, in the case of rape or incest,

d. A copy of documentation confirming pregnancy termination occurred, and

e. A copy of the clinical information supporting the justification/necessity for pregnancy termination.
(See Exhibit 410-6, *AHCCCS Monthly Pregnancy Termination Report* for the reporting form and Exhibit 400-1, *Maternal and Child Health Reporting Requirements* for submission timeframes.)

**Prior Authorization (PA)**

Except in cases of medical emergencies, the provider must obtain a Prior Authorization (PA) for all covered pregnancy terminations from the Contractor’s Medical Director. PA for Fee-For-Service (FFS) pregnant members must be obtained from the AHCCCS Chief Medical Officer or designee. A completed AHCCCS Certificate of Necessity for Pregnancy Termination (Exhibit 410-4) and the AHCCCS Verification of Diagnosis by Contractor for Pregnancy Termination Request (Exhibit 410-5) forms must be submitted with the request for PA, along with the lab, radiology, consultation or other testing results that support the justification/necessity for pregnancy termination. The Contractor’s Medical Director or AHCCCS Chief Medical Officer or designee will review the PA request, the AHCCCS Certificate of Necessity for Pregnancy Termination, and the AHCCCS Verification of Diagnosis by Contractor for Pregnancy Termination Request forms and expeditiously authorize the procedure, if the documentation meets the criteria for justification of pregnancy termination.

In cases of medical emergencies, the provider must submit all documentation of medical necessity to the Contractor, or AHCCCS/Division of FFS Management UM/CM Unit, within two working days of the date on which the pregnancy termination procedure was performed.

**The following references apply to all information contained in this policy:**

Refer to Chapter 500 for AHCCCS policy on the transfer of a neonate between acute care centers.

Refer to Chapter 800 for AHCCCS/DFSM FFS policy regarding extended stays for normal newborns.

Refer to Chapter 900 for quality management for all covered services.
EXHIBIT 410-1

SEMIANNUAL REPORT OF NUMBER OF PREGNANT WOMEN WHO ARE HIV/AIDS POSITIVE
SEMIANNUAL REPORT OF NUMBER OF PREGNANT WOMEN WHO ARE HIV/AIDS POSITIVE

Each Contractor must report to AHCCCS the number of pregnant women who have been identified as HIV/AIDS positive. This report is due no later than 30 days after the end of the second and fourth quarters of each federal fiscal year (due by April 30 and October 30).

Contractor Name: __________________________________________________________

Reporting Period: _____ October 1 through March 31, ________

____ April 1 through September 30, ________

Name of Person Completing Form: ____________________________________________

Name

___________________________________________

Title

Please report the number of new cases of pregnant women enrolled with your Contractor who have been identified as HIV/AIDS positive during this reporting period (not cumulatively).

____________________________

Information must be submitted using the SFTP server with notification to the CQM Administrator.
EXHIBIT 410-2

AHCCCS MATERNITY CARE RISK SCREENING GUIDELINES
HOME BIRTHS AND BIRTHS IN FREESTANDING BIRTH CENTERS

The following are not considered low-risk deliveries by AHCCCS and are not appropriate for planned home-births or births in freestanding birthing centers. These include members with:

1. Age less than 16 years regardless of parity; primiparous over 40 years of age or multiparous over 45 years of age
2. Previous uterine surgery or cesarean section
3. Drug addiction, current use of drugs, or therapy for drug abuse
4. Current severe psychiatric illness or severe psychiatric illness evident during assessment of recipient’s preparation for birth
5. Significant hematological disorders/coagulopathies/hemolytic disease
6. History of severe postpartum bleeding, of unknown cause, which required transfusion
7. Isoimmunization, including evidence of Rh sensitization/platelet sensitization
8. Congenital heart defects or cardiovascular disease causing functional impairment
9. Chronic or severe hypertension, eclampsia (current or previous pregnancy)
10. History or current diagnosis of deep venous thrombosis or pulmonary embolism
11. Significant pulmonary disease/disorder (including active tuberculosis)
12. Renal, or collagen-vascular disease
13. Significant endocrine disorders including pre-existing diabetes (type I or type II)
14. Hepatic disorders including uncontrolled intrahepatic cholestasis of pregnancy and/or abnormal liver function tests
15. Neurologic disorders or active seizure disorders
16. Positive HIV antibody test
17. Active syphilis, gonorrhea or hepatitis, until treated and recovered
18. Primary genital herpes simplex infection in first trimester or active genital herpes at onset of labor
19. Previous placenta previa, current placental abnormalities, or significant 3rd trimester bleeding
20. Known multiple gestation
21. Abnormal presentation after 36 weeks gestation
22. Gestational age >34 weeks with no prenatal care
23. Pelvis that will not safely allow a baby to pass through during labor
24. Cancer affecting site of delivery or previous breast surgery for malignancy
25. Other significant deviations from normal as assessed by the provider

Initial Effective Date 10/01/2013
Maternity care provided by the licensed midwife

Transfer of care is indicated for, but not limited to, the following maternal and newborn-related conditions:

**Maternal (refers to the antepartum, intrapartum and postpartum care of the mother)**

1. Prematurity or labor beginning before 36 weeks gestation
2. Gestation beyond 42 weeks
3. Presence of ruptured membranes without onset of labor within 24 hours
4. Abnormal fetal heart rate below 120 beats per minute or above 160 beats per minute
5. Presence of thick meconium, blood-stained amniotic fluid or abnormal fetal heart tone;
6. Umbilical cord prolapse
7. Non-bleeding placenta retained more than 24 hours
8. Consistent non-attendance at prenatal visits, lack of available support in the home for first three postpartum days, unsafe location for delivery
9. Postpartum hemorrhage of greater than 500 cc in the current pregnancy
10. Anaphylaxis or shock
11. Uterine prolapse or inversion
12. Sustained maternal vital sign instability and/or shock
13. Maternal seizure
14. Respiratory distress
15. Development of any of the conditions listed in previous section
16. Other significant deviations from normal as assessed by the provider

**Newborn (refers to the infant’s care during the first 24 hours following birth)**

1. Birth weight less than 2000 grams
2. Pale blue or gray color after ten minutes
3. Excessive edema
4. Major congenital anomalies
5. Respiratory distress
6. Cardiac abnormalities or irregularities
7. Prolonged glycemic instability
8. Neonatal seizure
9. Other significant deviations from normal as assessed by the provider

Licensed midwives are required to use professional judgment in assessing and determining the need for implementation of appropriate transfer of care in cases of adverse situations.

Initial Effective Date 10/01/2013
EXHIBIT 410-3

AHCCCS REQUEST FOR STILLBIRTH SUPPLEMENT
## ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

### REQUEST FOR STILLBIRTH SUPPLEMENT

<table>
<thead>
<tr>
<th>CONTRACTOR:</th>
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<tbody>
<tr>
<td>Representative’s Name:</td>
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<table>
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<tr>
<th>MOTHER’S NAME:</th>
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<tr>
<td>Date of Birth:</td>
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</table>

| INFANT’S NAME: | ________________________________ | Date of Delivery: | __________ |
|----------------|-----------------------------------------------|
| Place of Delivery: | ________________________________ | Time of Delivery: | __________ |
| Weight (Grams): | ______ | Gestational Age: | ______ | Apgars: | ______/_______ |
| Cause of Stillbirth (If Known): | __________________________________________ |

**REQUESTS MUST BE ACCOMPANIED BY DOCUMENTATION SUPPORTING THE ABOVE ITEMS, WHICH INCLUDES:**

Maternal and/or Newborn Delivery Record, **and**

One of the following to confirm gestational age:

- Obstetrical prenatal records (history and physical)
- Ultrasound report conducted prior to 20 weeks gestation
- Ballard assessment completed at delivery to assess physical maturity

**SEND THE REQUEST AND SUPPORTING DOCUMENTATION TO EITHER OF THE FOLLOWING:**

<table>
<thead>
<tr>
<th>MAILED SUBMISSION</th>
<th>ELECTRONIC SUBMISSION</th>
</tr>
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<tbody>
<tr>
<td>AHCCCS Administration Division of Health Care Management/CQM Maternal &amp; Child Health Manager 701 E. Jefferson, MD 6700 Phoenix, AZ 85034</td>
<td>Upload of password protected submission to the SFTP server, with email notification to the CQM Administrator</td>
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EXHIBIT 410-4

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
CERTIFICATE OF NECESSITY FOR PREGNANCY TERMINATION
## AHCCCS Member Information

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<thead>
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<td>Procedure Code(s)</td>
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## Justification for Pregnancy Termination (Check one and provide additional rationale):

- **Life of Mother Endangered**

- **Incest**
  - [ ] Police Report Attached
  - Yes [ ] No [ ]
  - If yes, to what Agency? [Space for agency] Report #: [Space for report number] Date Filed: [Space for date]

- **Rape**
  - [ ] Police Report Attached
  - Yes [ ] No [ ]
  - If yes, to what Agency? [Space for agency] Report #: [Space for report number] Date Filed: [Space for date]

- **Medically Necessary** (Check one)
  - [ ] Creating a serious physical or behavioral health problem for the pregnant member
  - [ ] Seriously impairing a bodily function of the pregnant member
  - [ ] Causing dysfunction of a bodily organ or part of the pregnant member
  - [ ] Preventing the pregnant member from obtaining treatment for a health problem

## Complete only with the use of Mifepristone (Mifeprax or RU-486)

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<td>(if applicable)</td>
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<td>Date Mifepristone Given</td>
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<td>Date Misoprostol Given</td>
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<td>Documentation of Confirmed Termination is Attached</td>
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## Physician Information

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## Prior Authorization Information

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## Denial Reason

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## Contractor Medical Director/AHCCCS Chief Medical Officer Signature

[Signature]
EXHIBIT 410-5

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
VERIFICATION OF DIAGNOSIS BY CONTRACTOR
FOR PREGNANCY TERMINATION REQUEST
This page must be submitted by the Contractor with the AHCCCS Certificate of Necessity for Pregnancy Termination along with the clinical information as specified below for each member included in the AHCCCS Monthly Pregnancy Termination Report.

The Contractor must make every reasonable effort to contact the provider to confirm the qualifying diagnosis/condition within 24 hours of receiving the prior authorization request for a pregnancy termination. Except for circumstances beyond the control of the Contractor, a failure to confirm the diagnosis/condition within 24 hours may result in corrective actions and/or sanctions.

Requesting Provider is the provider confirming the qualifying diagnosis/condition:

☐ Laboratory Results
☐ Diagnostic Testing Results
☐ Written Provider Consultation Report

When Requesting Provider is NOT the provider confirming the qualifying diagnosis/condition, Contractor must contact and request documentation from the provider that determined the member had the qualifying diagnosis condition. Contractor requested and received the following:

☐ Laboratory Results
☐ Diagnostic Testing Results
☐ Written Provider Consultation Report

PROVIDER INFORMATION:

NAME OF PROVIDER CONTACTED: ______________________________________________

FACILITY/PRACTICE NAME: _______________ TELEPHONE NUMBER: ______________

ADDRESS: ____________________________________________________________________

An authorization decision must be made after contact is made with the provider that determined that the member had the qualifying diagnosis/condition and the supporting documentation has been received.

NAME OF PLAN REPRESENTATIVE COMPLETING VERIFICATION: ______________________

SIGNATURE: ___________________________ DATE: ___________________________
EXHIBIT 410-6

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
MONTHLY PREGNANCY TERMINATION REPORT
CONTRACTOR NAME: ________________________________________________________________

REPORTING PERIOD: ________________________________________________________________

NAME OF INDIVIDUAL COMPLETING FORM: _____________________________________________

If the Contractor has not authorized any termination of pregnancies for the month, indicate with a zero here ______

When terminations have been authorized by the Contractor, the following information must be provided:

<table>
<thead>
<tr>
<th>* AHCCCS MEMBER ID</th>
<th>**AGE:</th>
<th>*REASON</th>
<th>RATE CODE</th>
<th>PROCEDURE CODE</th>
<th>DATE OF SERVICE</th>
<th>AMOUNT PAID</th>
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Choose one of the following codes:

*Reasons for Termination:  **Age/Condition
A. Life of Mother Endangered (a) Under 18 years of age
B. Result of Incest (b) Incapacitated, over 18 years of age
C. Result of Rape (c) 18 years of age and older
D. Medically Necessary

For each approved pregnancy termination, attach to this report:

- A copy of the AHCCCS Certificate of Necessity for Pregnancy Termination form,
- A copy of the Verification of Diagnosis by Contractor for Pregnancy Termination request,
- Clinical reports and medical documentation supporting justification for pregnancy termination, and
- A copy of the official incident report, when rape or incest is involved.

Reports and supporting documentation must be sent via secure e-mail to: CQM@AZAHCCCS.GOV

Any additional information discovered after submission must be presented to AHCCCS upon receipt, review, and consideration

Revision Date: 10/2013
WOMEN’S PREVENTATIVE CARE SERVICES

INITIAL
EFFECTIVE DATE:  10/01/2015

Description

An annual well-woman preventative care visit is a covered benefit for women to obtain the recommended preventive services, including preconception counseling.

Amount, Duration and Scope

A well-woman preventative care visit is covered on an annual basis when clinically indicated.

A. WELL-WOMAN PREVENTATIVE CARE SERVICES DEFINITIONS

1. Human Papillovirus (HPV) - A sexually transmitted infection for which a series of immunizations are available for both males and females beginning at a recommended age of 11 years up to 26 years of age. Refer to Chapter 300 Medical Policy for AHCCCS Covered Services, Policy 310-M, Immunizations for further information related to immunization coverage.

2. Family Planning Counseling - The provision of accurate information and discussion with a health care provider to allow members to make informed decisions about the specific family planning methods available that align with the member’s lifestyle.

3. Mammogram - An x-ray of the breast used to look for early signs of breast cancer. Coverage does not include genetic testing.

4. Clinical Breast Exam - A physical examination of the breasts by a health care provider used as a primary diagnostic procedure for early detection of breast cancer.

5. Preconception Counseling - Counseling aimed at identifying/reducing behavioral and social risks, through preventive and management interventions, in women of reproductive age who are capable of becoming pregnant, regardless of whether she is planning to conceive. This counseling focuses on the early detection and management of risk factors before pregnancy and includes efforts to influence behaviors that can affect a fetus prior to conception. The purpose of preconception counseling is to ensure that a woman is healthy prior to pregnancy.
NOTE: Preconception counseling is considered included in the well-woman preventative care visit and does not include genetic testing.

6. Well Exam - A physical examination in the absence of any known disease, symptom, or specific medical complaint by the member precipitating the examination.

B. CONTRACTOR REQUIREMENTS FOR WELL-WOMAN PREVENTATIVE CARE SERVICES

Contractors must develop policies and procedures to monitor, evaluate, and improve women’s participation in preventative care services.

Contractors must:

1. Inform all participating Primary Care Providers (PCPs) and Obstetrician/Gynecologist (OB/GYN) providers of the availability of women’s preventative care services, detailing the covered services included as part of the well-woman preventative care visit, as outlined in Section C-1 of this policy.

2. Develop and implement a process for monitoring compliance with well-woman preventative care services provider requirements.

3. Develop, implement, and maintain a process to inform members about women’s preventative health services annually and within 30 days of enrollment with the Contractor for newly enrolled members. This information must be provided in a second language, in addition to English, in accordance with the requirements of the AHCCCS Division of Health Care Management (DHCM) “Cultural Competency” policy available in the AHCCCS Contractor Operations Manual (available online at http://www.azahcccs.gov/shared/ACOM/default.aspx).

   a. This information must include:

      i. The benefits of preventive health care,

      ii. A complete description of the services available as described in this section,

      iii. Information on how to obtain these services. This must include a statement that assistance with medically necessary transportation and scheduling appointments is available to obtain well-woman preventative care services, and

      iv. A statement that there is no copayment or other charge for women’s preventative care visit.
C. WELL-WOMAN PREVENTATIVE CARE SERVICES PROVIDER REQUIREMENTS

Provider requirements for well-woman preventative care services include the following:

1. COVERED SERVICES INCLUDED AS PART OF A WELL-WOMAN PREVENTATIVE CARE VISIT

An annual well-woman preventative care visit is intended for the identification of risk factors for disease, identification of existing medical/mental health problems, and promotion of healthy lifestyle habits essential to reducing or preventing risk factors for various disease processes. As such, the well-woman preventative care visit is inclusive of a minimum of the following:

a. A physical exam (well exam) that assesses overall health.

b. Clinical breast exam.

c. Pelvic exam (as necessary, according to current recommendations and best standards of practice).

d. Review and administration of immunizations, screenings and testing as appropriate for age and risk factors. Refer to 310-H, Health Risk Assessment and Screening Tests for further information pertaining to health risk assessments and associated screening tests.

NOTE: Genetic screening and testing is not covered, except as described in Chapter 300, Medical Policy for Covered Services.

e. Screening and counseling is included as part of the well-woman preventive care visit and is focused on maintaining a healthy lifestyle and minimizing health risks, that addresses at a minimum the following:

   i. Proper nutrition

   ii. Physical activity

   iii. Elevated BMI indicative of obesity

   iv. Tobacco/substance use, abuse, and/or dependency

   v. Depression screening

   vi. Interpersonal and domestic violence screening, that includes counseling involving elicitation of information from women and adolescents about current/past violence and abuse, in a culturally
sensitive and supportive manner to address current health concerns about safety and other current or future health problems

vii. Sexually transmitted infections

viii. Human Immunodeficiency Virus (HIV)

ix. Family planning counseling

x. Preconception counseling that includes discussion regarding a healthy lifestyle before and between pregnancies that includes:

(a) Reproductive history and sexual practices

(b) Healthy weight, including diet and nutrition, as well as the use of nutritional supplements and folic acid intake

(c) Physical activity or exercise

(d) Oral health care

(e) Chronic disease management

(f) Emotional wellness

(g) Tobacco and substance use (caffeine, alcohol, marijuana and other drugs), including prescription drug use

(h) Recommended intervals between pregnancies

NOTE: Preconception counseling does not include genetic testing.

f. Initiation of necessary referrals when the need for further evaluation, diagnosis, and/or treatment is identified.

2. **Well-Woman Preventative Care Service Standards**

**Immunizations** - AHCCCS will cover the Human Papilloma Virus (HPV) vaccine for female members 11 to 26 years of age. For adult immunizations, refer to Policy 310-M, **Immunizations**. Providers must coordinate with The Arizona Department of Health Services (ADHS) Vaccines for Children (VFC) Program in the delivery of immunization services if providing vaccinations to Early and Periodic Screening, Diagnostic and Treatment (EPSDT) aged members less than 19 years of age. Immunizations must be provided according to the Advisory Committee on Immunization Practices Recommended Schedule. (Refer to the CDC website at [http://www.cdc.gov/vaccines/schedules/index.html](http://www.cdc.gov/vaccines/schedules/index.html) where this information is included). Providers must enroll and re-enroll annually with the
VFC program, in accordance with AHCCCS contract requirements in providing immunizations for EPSDT aged members less than 19 years of age, and must document each EPSDT age member’s immunizations in the Arizona State Immunization Information System (ASIIS) registry. In addition, the Contractor shall not utilize AHCCCS funding to purchase vaccines covered through the VFC program for members younger than 19 years of age.

**Screenings** - Refer to Policy 310-H, *Health Risk Assessment and Screening Tests* for further details pertaining to specific screening and limitations related to health risk assessments and associated screening tests for those members over 21 years of age. Refer to Policy 430, *EPSDT Services* for further details related to covered services for members less than 21 years of age.

### D. ADDITIONAL COVERED RELATED SERVICES

Refer to Policy 310-H, *Health Risk Assessment and Screening Tests* for further details pertaining to specific screening and limitations related to health risk assessments and associated screening tests.

Refer to Policy 420, *Family Planning* for further details related to the family planning covered services.
FAMILY PLANNING

Description

Family planning services are covered when provided by physicians or practitioners to members who voluntarily choose to delay or prevent pregnancy. Family Planning services include covered medical, surgical, pharmacological, and laboratory benefits specified in this policy. Covered services also include the provision of accurate information and counseling to allow members to make informed decisions about specific family planning methods available. Members may choose to obtain family planning services and supplies from any appropriate provider within the Contractor’s network.

Amount, Duration and Scope

Members (male and female), who are eligible to receive full health care coverage and are enrolled with a Contractor or receiving services on a Fee-For-Service (FFS) basis, may elect to receive family planning services in addition to other covered services.

Members who are enrolled with a Contractor at the time their SOBRA eligibility expires will remain with their Contractor, if member continues to be eligible for AHCCCS coverage. Members, whose eligibility continues, may remain with their assigned maternity provider or exercise their option to select another provider for family planning services. Members receiving services on a FFS basis may elect to remain with their attending FFS physician, or select a new FFS provider.

Family planning services for members eligible to receive full health care coverage may receive the following medical, surgical, pharmacological, and laboratory services:

1. Contraceptive counseling, medication, and/or supplies, including, but not limited to: oral and injectable contraceptives, subdermal implantable contraceptives, intrauterine devices, diaphragms, condoms, foams and suppositories,

2. Associated medical and laboratory examinations and radiological procedures, including ultrasound studies related to family planning,

3. Treatment of complications resulting from contraceptive use, including emergency treatment,
4. Natural family planning education or referral to qualified health professionals, and

5. Post-coital emergency oral contraception within 72 hours after unprotected sexual intercourse (RU 486 is not post-coital emergency oral contraception).

Coverage for the following family planning services are as indicated in the matrix below.

<table>
<thead>
<tr>
<th>SERVICES</th>
<th>AHCCCS ACUTE CARE, ALTCS AND FFS MEMBERS</th>
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<tbody>
<tr>
<td>PREGNANCY SCREENING</td>
<td>Covered service.</td>
</tr>
<tr>
<td>PHARMACEUTICALS</td>
<td>Covered service when associated with medical conditions related to family planning or other medical conditions.</td>
</tr>
<tr>
<td>SCREENING AND TREATMENT FOR SEXUALLY TRANSMITTED INFECTIONS (STIs)</td>
<td>Both screening and treatment for STIs are covered services for male and female members.</td>
</tr>
<tr>
<td>STERILIZATION</td>
<td>Services are covered for both male and female members when the requirements specified in this policy for sterilization services are met (including hysteroscopic tubal sterilizations effective 7-1-08).</td>
</tr>
<tr>
<td>PREGNANCY TERMINATION AND HYSTERECTOMY</td>
<td>Covered as specified in this Policy [including Mifepristone (Mifeprex or RU 486)].</td>
</tr>
</tbody>
</table>

**LIMITATIONS**

The following are not covered for the purpose of family planning services:

1. Infertility services including diagnostic testing, treatment services and reversal of surgically induced infertility

2. Pregnancy termination counseling, and

3. Pregnancy terminations [(including Mifepristone (Mifeprex or RU 486)] and hysterectomies.

Refer to Chapter 800 - FFS Quality and Utilization Management for prior authorization requirements for FFS providers.
A. **Family Planning Services Definitions**

1. **Hysterosalpingogram** - An X-ray procedure used to confirm sterility (occlusion of the fallopian tubes) approximately three months following a hysteroscopic tubal sterilization.

2. **Long-Acting Reversible Contraceptives (LARC)** – Methods for family planning that provide effective contraception for an extended period of time with little or no maintenance or user actions required, including intrauterine devices and contraceptive implants.

3. **Reproductive Age** – AHCCCS members, male or female, from twelve to 55 years of age.

B. **Contractor Requirements For Providing Family Planning Services**

Contractors must ensure that service delivery, monitoring, and reporting requirements are met.

Contractors must:

1. Plan and implement an outreach program to notify members of reproductive age of the specific covered family planning services available and how to request them. Notification must be in accordance with A.R.S. §36.2904(L). The information provided to members must include, but is not limited to:
   a. A complete description of covered family planning services available,
   b. Information advising how to request/obtain these services,
   c. Information that assistance with scheduling is available, and
   d. A statement that there is no charge for these services.

2. Have policies and procedures in place to ensure that maternity care providers are educated regarding covered and non-covered services, including family planning services, available to AHCCCS members.

3. Have family planning services that are:
   a. Provided in a manner free from coercion or behavioral/mental pressure,
   b. Available and easily accessible to members,
C. Protocol for Member Notification of Family Planning Services and Contractor Reporting Requirements

Contractors are responsible for providing family planning services and notifying their members regarding the availability of these AHCCCS covered services. Contractors must establish processes to ensure sterilization reports submitted follow the procedural guidelines for encounters’ submissions.

AHCCCS will notify all SOBRA members, who become ineligible for full health care coverage. In addition, AHCCCS will provide information about AHCCCS covered family planning services to members who receive services on a Fee-For-Service basis.
Annual member notification of these covered services must meet the following minimum requirements:

1. Notification shall be in accordance with A.R.S. § 36-2904(L).

2. The requirement for written notification is in addition to the member handbook and the member newsletter. Communications and correspondence dealing specifically with notification of family planning services are acceptable methods of providing this information. The communications and correspondence must be approved by AHCCCS and conform to confidentiality requirements. (Refer to the AHCCCS Contractor Operations Manual: Member Information Policy, Policy 404).

3. Notification is to be given at least once a year and must be completed by November 1. For members who enroll with a Contractor after November 1, notification must be sent at the time of enrollment.

4. Notification must include all of the family planning services covered through AHCCCS, as well as instructions to members regarding how to access these services.

5. Notification must be written at an easily understood reading level.


7. Monitor compliance to ensure that primary care providers (PCPs) verbally notify members of the availability of family planning services during office visits.

8. Contractors must report to AHCCCS Division of Health Care Management, Clinical Quality Management unit (DHCM/CQM), all members under 21 years of age, undergoing a procedure that renders the member sterilized, using Exhibit 420-2, Arizona Health Care Cost Containment System Sterilization Reporting Form for Members Under 21 Years of Age, according to the timeframe specified in Exhibit 400-1, Maternal and Child Health Reporting Requirements. Documentation supporting the medical necessity for the procedure must be submitted with the reporting form.

**Clarification Related to Hysteroscopic Tubal Sterilization**

Hysteroscopic tubal sterilization is not immediately effective upon insertion of the sterilization device. It is expected that the procedure will be an effective sterilization
procedure three months following insertion. Therefore, during the first three months the member must continue using another form of birth control.

At the end of the three months, it is expected that a hysterosalpingogram will be performed confirming that the member is sterile. After the confirmatory test the member is considered sterile.

D. **Fee-For-Service (FFS) Family Planning Provider Requirements**

FFS providers of family planning services must comply with the following:

1. Register as an AHCCCS provider and obtain an AHCCCS provider identification number.

2. Comply with AHCCCS policy for family planning services.

3. Comply with AHCCCS Division of Fee-For-Service Management Prior Authorization (PA) requirements for prescriptions and/or related family planning supplies.

4. Make referrals to appropriate medical professionals for services that are beyond the scope of family planning services. Such referrals are to be made at the family planning provider's discretion. If the member is eligible for full health care coverage, the referral must be made to an AHCCCS registered provider.

E. **Sterilization**

The following AHCCCS requirements regarding member consent for covered sterilization services apply to Contractors and Fee-For-Service (FFS) providers (For more information refer to 42 C.F.R. §50.203).

The following criteria must be met for the sterilization of a member to occur:

1. The member is at least 21 years of age at the time the consent is signed (See Exhibit 420-1, AHCCCS Consent for Sterilization),

2. Mental competency is determined,

3. Voluntary consent was obtained without coercion, and

4. Thirty days, but not more than 180 days, have passed between the date of informed consent and the date of sterilization, except in the case of a premature delivery or emergency abdominal surgery. Members may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since they gave informed consent for the sterilization. In the
case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

Any member requesting sterilization must sign an appropriate consent form (Exhibit 420-1, Consent for Sterilization) with a witness present when the consent is obtained. Suitable arrangements must be made to ensure that the information in the consent form is effectively communicated to members with limited English proficiency or reading skills and those with diverse cultural and ethnic backgrounds, as well as members with visual and/or auditory limitations. Prior to signing the consent form, a member must first have been offered factual information that includes all of the following:

1. Consent form requirements,
2. Answers to questions asked regarding the specific procedure to be performed,
3. Notification that withdrawal of consent can occur at any time prior to surgery without affecting future care and/or loss of federally funded program benefits,
4. A description of available alternative methods,
5. A full description of the discomforts and risks that may accompany or follow the performing of the procedure, including an explanation of the type and possible effects of any anesthetic to be used,
6. A full description of the advantages or disadvantages that may be expected as a result of the sterilization, and
7. Notification that sterilization cannot be performed for at least 30 days post consent.

Sterilization consents may **NOT** be obtained when a member:

1. Is in labor or childbirth,
2. Is seeking to obtain, or is obtaining, a pregnancy termination, or
3. Is under the influence of alcohol or other substances that affect that member's state of awareness.
EXHIBIT 420-1

CONSENT FOR STERILIZATION
EXHIBIT 420-1
CONSENT FOR STERILIZATION

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY
BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS

**CONSENT TO STERILIZATION**

I have asked for and received information about sterilization from __________________________. When I first asked __________________________
for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Temporary Assistance for Needy Families (TANF) or Medicaid that I am now getting or for which I may become eligible. I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN. I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as __________________________________________.

Specify Type of Operation

The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction. I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on:___________________________ Date

I, ____________________________, hereby consent of my own free will to be sterilized by ____________________________

Doctor or Clinic

Specify Type of Operation

by a method called __________________________________________________________.

My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to: Representatives of the Department of Health and Human Services or Employees of programs or projects funded by the Department but only for determining if Federal laws were observed.

I have received a copy of this form.

Signature __________________________ Date __________________________

You are requested to supply the following information, but it is not required:

( Ethnicity and Race Designation) (please check)

- Hispanic or Latino
- Not Hispanic or Latino
- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

**INTERPRETER’S STATEMENT**

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

Interpreter’s Signature __________________________ Date __________________________

**STATEMENT OF PERSON OBTAINING CONSENT**

Before ____________________________ signed the consent form, I explained to him/her the nature of sterilization operation ____________________________, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

Signature of Person Obtaining Consent __________________________ Date __________________________

**PHYSICIAN’S STATEMENT**

Shortly before ____________________________ performed a sterilization operation upon ____________________________

Doctor or Clinic

Specify Type of Operation

I explained to him/her the nature of the sterilization operation ____________________________, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I informed the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

( INSTRUCTIONS FOR USE OF ALTERNATIVE FINAL PARAGRAPH: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

1) At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- Premature delivery

Individual's expected date of delivery: __________________________

- Emergency abdominal surgery (describe circumstances):

________________________________________________________

________________________________________________________

________________________________________________________

________________________________________________________

________________________________________________________

Physician’s Signature __________________________ Date __________________________
EXHIBIT 420-2

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
STERILIZATION REPORTING FORM FOR MEMBERS UNDER 21 YEARS OF AGE
**EXHIBIT 420-2**

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM**  
**STERILIZATION REPORTING FORM FOR MEMBERS UNDER 21 YEARS OF AGE**

<table>
<thead>
<tr>
<th>CONTRACTOR NAME:</th>
<th>REPORTING PERIOD:</th>
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Name of Individual Completing Form: ____________________________  
Contact Number: ____________________________

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<thead>
<tr>
<th>DATE OF SERVICE</th>
<th>Member Name</th>
<th>Member ID#</th>
<th>Date of Birth</th>
<th>Date of Confirmatory Testing (If Required)</th>
<th>Medical Necessity Confirmed and Supporting Documentation Attached</th>
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Total number of sterilizations being reported during the referenced reporting period: ______________

**ALL STERILIZATIONS FOR AHCCCS MEMBERS UNDER 21 YEARS OF AGE MUST BE REPORTED BY CONTRACTORS USING SECURE EMAIL, NO LATER THAN THE 30TH OF THE MONTH, FOLLOWING AN ADJUDICATED STERILIZATION CLAIM OR COMPLETED CONFIRMATORY TESTING (WHEN SUCH TESTING IS REQUIRED). PLEASE REFER TO REPORTING INSTRUCTIONS FOR MORE DETAIL RELATED TO THE USE OF THIS FORM.**

**EFFECTIVE DATE:** 4/1/2014
Chapter 400
Medical Policy for Maternal and Child Health

Policy 430
EPSDT Services

430 Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services

Revision Dates: 10/01/15, 04/01/15, 12/15/14, 11/01/14, 09/01/14, 04/01/14, 10/01/13, 08/01/11, 02/01/11, 10/01/10, 04/01/10, 10/01/09, 05/01/09, 10/01/08, 04/01/07, 12/01/06, 09/01/06, 07/01/06, 06/01/06, 04/21/06, 03/03/06, 11/01/05, 08/01/05, 04/01/04, 10/01/04, 10/01/01, 10/01/99

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Description

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is a comprehensive child health program of prevention, treatment, correction, and improvement (amelioration) of physical and behavioral/mental health conditions for AHCCCS members under 21 years of age. The purpose of EPSDT is to ensure the availability and accessibility of health care resources, as well as to assist Medicaid members in effectively utilizing these resources. EPSDT services provide comprehensive health care through primary prevention, early intervention, diagnosis, medically necessary treatment, and follow-up care of physical and behavioral health conditions for AHCCCS members under 21 years of age. EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary, mandatory, and optional services listed in Federal Law 42 USC 1396d (a) to correct or ameliorate defects and physical and behavioral/mental illnesses and conditions identified in an EPSDT screening, whether or not the services are covered under the AHCCCS State Plan. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness, do not apply to EPSDT services.

A well child visit is synonymous with an EPSDT visit. EPSDT services include all screenings and services described in the AHCCCS EPSDT section of this Chapter, as well as referenced EPSDT Periodicity Schedule (Exhibit 430-1) and AHCCCS Dental Periodicity Schedule (Exhibit 431-1).

Refer to Appendix B for the AHCCCS EPSDT Tracking Forms, which are to be used by providers to document all age-specific, required information related to EPSDT screenings and visits.

Providers must use the EPSDT Tracking Forms provided by AHCCCS Contractors (or electronic equivalent that includes all components found in the hard copy form) at every EPSDT visit.
Amount, Duration and Scope

The Medicaid Act defines EPSDT services to include screening services, vision services, dental services, hearing services and “such other necessary health care, diagnostic services, treatment and other measures described in Federal Law Subsection 42 USC 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the (AHCCCS) State Plan.” This means that EPSDT covered services include services that correct or ameliorate physical and mental defects, conditions, and illnesses discovered by the screening process when those services fall within one of the optional and mandatory categories of “Medical Assistance”, as defined in the Medicaid Act. Services covered under EPSDT include all 29 categories of services in the Federal Law, even when they are not listed as covered services in the AHCCCS State Plan, AHCCCS statutes, rules, or policies, as long as the services are medically necessary and cost effective.

EPSDT includes, but is not limited to, coverage of: inpatient and outpatient hospital services, laboratory and x-ray services, physician services, nurse practitioner services, medications, dental services, therapy services, behavioral health services, medical supplies, prosthetic devices, eyeglasses, transportation, and family planning services. EPSDT also includes diagnostic, screening, preventive and rehabilitative services. However, EPSDT services do not include services that are experimental, that are solely for cosmetic purposes, or that are not cost effective when compared to other interventions or treatments.

EPSDT screening services are provided in compliance with the periodicity requirements of Title 42 of the Code of Federal Regulations (42 C.F.R. 441.58). Contractors must ensure members receive required health screenings in compliance with the AHCCCS EPSDT Periodicity Schedule and the AHCCCS Dental Periodicity Schedule. The AHCCCS Periodicity Schedule for EPSDT and dental services are intended to meet reasonable and prevailing standards of medical and dental practice and specifies screening services at each stage of the child’s life (see Exhibits 430-1, AHCCCS EPSDT Periodicity Schedule and 431-1, AHCCCS Dental Periodicity Schedule). The service intervals represent minimum requirements, and any services determined by a Primary Care Provider (PCP) to be medically necessary must be provided, regardless of the interval. The requirements and reporting forms for an EPSDT screening service are described in this Policy. EPSDT focuses on continuum of care by: assessing health needs, providing preventive screening, initiating needed referrals, and completing recommended medical treatment and appropriate follow-up.
A. EPSDT DEFINITIONS

1. Early means, in the case of a child already enrolled with an AHCCCS Contractor, as early as possible in the child's life, or in other cases, as soon after the member's eligibility for AHCCCS services has been established.

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

3. Screening means regularly scheduled examinations and evaluations of the general physical and behavioral health, growth, development, and nutritional status of infants, children and adolescents, and the identification of those in need of more definitive evaluation. For the purpose of the AHCCCS EPSDT program, screening and diagnosis are not synonymous.

4. Diagnostic means the determination of the nature or cause of a condition, illness, or injury through the combined use of health history, physical, developmental and psychological examination, laboratory tests, and X-rays, when appropriate.

5. Treatment means any of the 29 mandatory or optional services described in Federal Law 42 USC 1396d(a), even if the service is not covered under the (AHCCCS) State Plan, when necessary to correct or ameliorate defects and physical and mental illnesses and conditions detected by screening or diagnostic procedures.

B. COVERED SERVICES DURING AN EPSDT VISIT

Comprehensive periodic screenings must be performed by a clinician, according to the timeframes identified in the AHCCCS EPSDT Periodicity Schedule and the AHCCCS Dental Periodicity Schedule, as well as inter-periodic screenings, as appropriate, for each member. Contractors must implement processes to ensure age appropriate screening and care coordination when member needs are identified. The Contractor must ensure providers utilize AHCCCS approved standard developmental screening tools and complete training in the use of these tools, as indicated by the American Academy of Pediatrics. The Contractor must monitor providers and implement interventions for non-compliance. Contractors must ensure that the Bloodspot Newborn Screening Panel and hearing tests are conducted, including initial and secondary screenings, in accordance with 9 A.A.C. 13, Article 2.

The AHCCCS EPSDT Periodicity Schedule is based on recommendations by the Arizona Medical Association and is closely aligned with the guidelines of the American Academy of Pediatrics. The service intervals represent minimum requirements, and any services determined by a PCP to be medically necessary must be provided, regardless of the interval.
EPSDT visits are all-inclusive visits. The payment for the EPSDT visit is intended to cover all elements outlined in the AHCCCS EPSDT Periodicity Schedule (Exhibit 430-1). Exceptions to payments are noted in each of the paragraphs listed below. Only those services specifically identified below as a separately billable service may be billed separately or in addition to the EPSDT visit.

EPSDT/Well Child visits must include the following:

1. A comprehensive health and developmental history, including growth and development screening [42 C.F.R. 441.56(B)(1)] which includes physical, nutritional and behavioral health assessments. (Refer to the Centers for Disease Control and Prevention website at http://www.cdc.gov/growthcharts/ for Body Mass Index (BMI) and growth chart resources.)

2. Nutritional Assessment provided by a PCP - Nutritional assessments are conducted to assist EPSDT members whose health status may improve with nutritional intervention. Payment for the assessment of nutritional status provided by the member’s PCP is part of the EPSDT screening specified in the AHCCCS EPSDT Periodicity Schedule (Exhibit 430-1), and on an inter-periodic basis as determined necessary by the member’s PCP. Payment for nutritional assessments are included in the EPSDT visit and are not a separately billable service.

3. Behavioral Health Screening and Services provided by a PCP - AHCCCS covers behavioral health services for members eligible for EPSDT. EPSDT behavioral health services include the services listed in Federal Law 42 USC 1396d(a) necessary to correct or ameliorate mental illnesses and conditions discovered by the screening services, whether or not the services are covered under the (AHCCCS) State Plan. PCPs may treat Attention Deficit Hyperactivity Disorder (ADHD), depression and anxiety. All other behavioral health conditions must be referred to the Regional Behavioral Health Authority (RBHA). American Indian members may receive behavioral health services through an Indian Health Service or Tribally operated 638 facility, with the exclusion of ALTCS, Maricopa Integrated RBHA and CRS programs. PCPs that elect to prescribe medications to treat ADHD, depression, or anxiety disorders must complete an annual assessment of the member’s behavioral health condition and treatment plan. Payment for behavioral health screenings and assessments are included as part of an EPSDT visit and are not separately billable services.

**NOTE:** CPT code 96101 - PSYCHOLOGICAL TESTING (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology) is not a separately billable service. The code may be billed on the claim to indicate the service was performed, but payment will be included in the fee paid for the EPSDT visit.
4. Developmental Screening Tools used by a PCP - AHCCCS approved developmental screening tools should be utilized for developmental screening by all participating PCPs who care for EPSDT-age members. PCPs must be trained in the use and scoring of the developmental screening tools, as indicated by the American Academy of Pediatrics (A list of available training resources may be found in the Arizona Department of Health Services website at www.azdhs.gov/clinicians/training-opportunities/developmental/index.php). The developmental screening should be completed for EPSDT members from birth through three years of age during the 9 month, 18 month and 24 month EPSDT visits. A copy of the screening tool must be kept in the medical record. Use of AHCCCS approved developmental screening tools may be billed separately using CPT-4 code 96110 (Developmental screening, with interpretation and report, per standardized instrumentation) for the 9 month, 18 month and 24 month visit when the developmental screening tool is used. A developmental screening CPT code (with EP modifier) must be listed in addition to the preventive medicine CPT codes. Other CPT-4 codes, such as 96111 – Developmental Testing (includes assessment of motor, language, social, adaptive) are not considered screening tools and are not separately billable. To receive the developmental screening tool payment, the modifier EP must be added to the 96110. For claims to be eligible for payment of code 96110; the provider must have satisfied the training requirements, the claim must be a 9, 18, or 24-month EPSDT visit, and an AHCCCS approved developmental screening tool must have been completed.

AHCCCS approved developmental screening tools include:

a. The Parent’s Evaluation of Developmental Status (PEDS) tool which may be obtained from www.pedstest.com or www.forepath.org.

b. Ages and Stages Questionnaire (ASQ) tool which may be obtained from www.agesandstages.com.

c. The Modified Checklist for Autism in Toddlers (MCHAT) may be used only as a screening tool by a primary care provider, for members 16-30 months of age, to screen for autism when medically indicated. Copies of the completed tools must be retained in the medical record.

5. A comprehensive unclothed physical examination.

6. Appropriate immunizations according to age and health history (administration of the immunizations may be billed in addition to the EPSDT visit using the CPT-4 code appropriate for the immunization with an SL modifier). Combination vaccines are paid as one vaccine. Providers must be registered as Vaccines for Children (VFC) providers and VFC vaccines must be used.
7. Laboratory tests including blood lead screening assessment and blood lead testing appropriate to age and risk, anemia testing and diagnostic testing for sickle cell trait (if a child has not been previously tested with sickle cell preparation or a hemoglobin solubility test).

EPSDT covers blood lead screening. Required blood lead screening for children under six year of age is based on the child’s risk as determined by either the member’s residential zip code or presence of other known risk-factors, as specified in the Arizona Department of Health Services Targeted Lead Screening Plan for the Prevention of Childhood Lead Poisoning. For more information refer to Section C, EPSDT Service Standards, Item 3 – Blood Lead Screening of this policy for more information.

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

8. Health education, counseling, and chronic disease self-management are not separately billable services and are considered part of the EPSDT visit payment.

9. Appropriate oral health screening, intended to identify oral pathology, including tooth decay and/or oral lesions, and the application of fluoride varnish conducted by a physician, physician’s assistant or nurse practitioner. Application of fluoride varnish may be billed separately from the EPSDT visit using CPT Code 99188. Fluoride varnish is limited in a primary care provider’s office to once every six months, during an EPSDT visit for children who have reached six months of age with at least one tooth erupted, with recurrent applications up to two years of age.

Appropriate vision, hearing, and speech screenings are covered during an EPSDT visit. EPSDT covers eye examinations as appropriate to age according to the AHCCCS EPSDT Periodicity Schedule (Exhibit 430-1) and as medically necessary using standardized visual tools. Payment for vision and hearing exams, (including, but not limited to CPT codes 92015, 92081, 92285, 92551, 92552, 92553, 92567, 92568, 92285, 92286, 92587, 92588, 95930, and 99173) or any other procedure that may be interpreted as fulfilling the vision and hearing requirements provided in a PCP’s office during an EPSDT visit, are considered part of the EPSDT visit and are not a separately billable services.

Ocular photoscreening with interpretation and report, bilateral (CPT code 99174) is covered for children ages three to five as part of the EPSDT visit due to challenges with a child’s ability to cooperate with traditional vision screening techniques. Ocular photoscreening is limited to a lifetime coverage limit of one.
This procedure, although completed during the EPSDT visit, is a separately billable service.

**NOTE:** Automated visual screening, described by CPT code 99174, is not recommended for or covered by AHCCCS when used to determine visual acuity for purposes of prescribing glasses or other corrective devices.

Vision CPT codes with the EP modifier must be listed on the claim form in addition to the preventive medicine CPT codes for visit screening assessment. With the exception of CPT code 99174, no additional reimbursement is allowed for these codes.

Hearing CPT codes with the EP modifier must be listed on the claim form, in addition to the preventive medicine CPT codes, for a periodic hearing screening assessment. With the exception of CPT code 99174, no additional reimbursement is allowed for these codes.

Contractors must ensure that:

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

b. Each hospital or birthing center provides outpatient re-screening for babies who were missed or are referred from the initial screening. Outpatient re-screening must be scheduled at the time of the initial discharge and completed between two and six weeks of age.

c. When there is an indication that a newborn or infant may have a hearing loss or congenital disorder, the family must be referred to the PCP for appropriate assessment, care coordination and referral(s), and

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

10. Tuberculin skin testing as appropriate to age and risk. Children at increased risk of Tuberculosis (TB) include those who have contact with persons:

a. Confirmed or suspected as having TB,

b. In jail or prison during the last five years,

c. Living in a household with an HIV-infected person or the child is infected with HIV, and
d. Traveling/emigrating from, or having significant contact with persons indigenous to, endemic countries.

C. EPSDT SERVICE STANDARDS

EPSDT services must be provided according to community standards of practice and the AHCCCS EPSDT and Dental Periodicity Schedules. The AHCCCS EPSDT Tracking Forms must be used to document services provided and be in compliance with AHCCCS standards (see Appendix B). The tracking forms must be signed by the clinician who performs the screening. Contractors are responsible for monitoring PCPs use of and submission of EPSDT Tracking Forms, whether hard copy or electronic, to the Contractor’s Maternal and Child Health Unit.

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

1. Immunizations - EPSDT covers all child and adolescent immunizations, as specified in the Centers for Disease Control and Prevention (CDC) recommended childhood immunization schedules. All appropriate immunizations must be provided to establish, and maintain, up-to-date immunization status for each EPSDT age member. (Refer to the CDC website at http://www.cdc.gov/vaccines/schedules/index.html for current immunization schedules.)

AHCCCS will cover the human papilloma virus (HPV) vaccine for female and male EPSDT members age 11 through 20 years. AHCCCS will cover members nine and ten years of age, if the member is deemed to be in a high-risk situation. For adult immunizations, refer to Policy 310-M, Immunizations. Providers must coordinate with the Arizona Department of Health Services (ADHS) Vaccines for Children (VFC) program in the delivery of immunization services. Immunizations must be provided according to the Advisory Committee on Immunization Practices Recommended Schedule. (Refer to the CDC website at http://www.cdc.gov/vaccines/schedules/index.html where this information is included). Contractors must ensure providers enroll and re-enroll annually with the VFC program, in accordance with AHCCCS Contract requirements. The Contractor shall not utilize AHCCCS funding to purchase vaccines covered through the VFC program for members younger than 19 years of age.

Contractors must ensure providers document each EPSDT age member’s immunizations in the Arizona State Immunization Information System (ASIIS) registry. In addition, Contractors must ensure providers maintain the ASIIS immunization records of each EPSDT member in ASIIS, in accordance with A.R.S. Title 36, Section 135. Contractors are required to monitor provider’s compliance with immunization registry reporting requirements and take action to improve reporting when issues are identified.
2. **Eye Examinations and Prescriptive Lenses** - EPSDT covers eye examinations as appropriate to age, according to the AHCCCS EPSDT Periodicity Schedule, and as medically necessary using standardized visual tools. Vision exams provided in a PCP’s office during an EPSDT visit are not a separately billable service. Prescriptive lenses and frames are provided to correct or ameliorate defects, physical illness and conditions discovered by EPSDT screenings, subject to medical necessity. Frames for eyeglasses are also covered.

3. **Blood Lead Screening** - EPSDT covers blood lead screening. Required blood lead screening for children under six year of age is based on the child’s risk as determined by either the member’s residential zip code or presence of other known risk-factors, as specified in the Arizona Department of Health Services Targeted Lead Screening Plan for the Prevention of Childhood Lead Poisoning.

   a. Children living in a targeted high-risk zip code: All children living in a high risk zip code as identified by the Arizona Department of Health Services Targeted Lead Screening Plan for the Prevention of Childhood Lead Poisoning must have a blood lead test at 12 and 24 months of age. Children between 36 and 72 months of age must receive a screening blood lead test, if they have not been previously screened for lead poisoning.

   b. Children living outside of the targeted high-risk zip codes: Children living in Arizona, but not in a targeted high-risk zip code must receive an individual risk assessment according to the AHCCCS periodicity schedule (when the child is 6, 9, 12, 18, and 24 months of age and then annually through age 6 years), with appropriate follow-up action taken for those children who are determined to be at high risk based on criteria included within the Arizona Department of Health Services Targeted Lead Screening Plan for the Prevention of Childhood Lead Poisoning.

   A blood lead test result, equal to or greater than 10 micrograms of lead per deciliter of whole blood obtained by capillary specimen or fingerstick, must be confirmed using a venous blood sample. A verbal blood lead screening risk assessment must be completed at each EPSDT visit for children six through 72 months of age (six years of age) to assist in determining risk.

   Contractors must ensure that providers report blood lead levels equal to or greater than ten micrograms of lead per deciliter of whole blood to ADHS (A.A.C. R9-4-302).

   Contractors must implement protocols for:

   a. Care coordination for members with elevated blood lead levels (parents, PCP and ADHS) to ensure timely follow-up and retesting.
b. Appropriate care coordination for an EPSDT child, who has an elevated blood lead level and is transitioning to or from another AHCCCS Contractor, and

c. Referral of members who lose AHCCCS eligibility to low-cost or no-cost follow-up testing and treatment for those members that have a blood lead test result equal to or greater than ten micrograms of lead per deciliter of whole blood.

Refer to Chapter 500, Care Coordination Requirements for more information related to transitioning members.

4. **Organ and Tissue Transplantation Services** - Refer to Chapter 300 (Policy 310-DD with Attachment A) in this Manual for a discussion of AHCCCS-covered transplantations.

5. **Tuberculosis (TB) Screening** - EPSDT covers TB screening. Contractors must implement protocols for care and coordination of members who received TB testing to ensure timely reading of the TB skin test and treatment, if medically necessary.

6. **Nutritional Assessment and Nutritional Therapy**

**Nutritional Assessments**  Nutritional assessments are conducted to assist EPSDT members whose health status may improve with nutritional intervention. AHCCCS covers the assessment of nutritional status provided by the member's PCP as a part of the EPSDT screenings, as specified in the AHCCCS EPSDT Periodicity Schedule and on an inter-periodic basis, as determined necessary by the member’s PCP. AHCCCS also covers nutritional assessments provided by a registered dietitian when ordered by the member's PCP. This includes EPSDT eligible members who are underweight or overweight.

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

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

a. Infant formulas above the amount provided through the WIC program or formula types deemed medically necessary that are not provided through the WIC program. **NOTE:** This does not include formulas outside of those offered through the WIC program that are not medically necessary, such as formula types selected based on brand preference.
i. For AHCCCS members, infants and children under the age of five, requiring formula types deemed medically necessary that are not provided through the WIC program, an AHCCCS Certificate of Medical Necessity for Commercial Oral Nutritional Supplements (Exhibit 430-3) is to be submitted directly to the member’s Contracted Health Plan, as WIC is considered a secondary payor of specialty exempt formulas.

ii. For AHCCCS members, infants (0-1 year), requiring infant formulas above the amount provided through the WIC program, an AHCCCS Certificate of Medical Necessity for Commercial Oral Nutritional Supplements (Exhibit 430-3) is to be submitted directly to the member’s Contracted Health Plan for the amount of formula that exceeds that provided through the WIC program.

**NOTE:** WIC is considered a secondary payor of infant formulas above the amount provided through the WIC program.

b. Medical foods
c. Parenteral feedings
d. Enteral feedings

If an AHCCCS covered member has a congenital metabolic disorder identified through the Bloodspot Newborn Screening Panel (such as Phenylketonuria, Homocystinuria, Maple Syrup Urine Disease or Galactosemia), refer to Chapter 300, Policy 320-H, *Metabolic Medical Foods*.

**Nutritional Therapy**  
AHCCCS covers nutritional therapy for EPSDT eligible members on an enteral, parenteral or oral basis when determined medically necessary to provide either complete daily dietary requirements, or to supplement a member’s daily nutritional and caloric intake. AHCCCS Contractors are the primary payor for parenteral and enteral feedings, unless nutritional therapy is covered by a member’s primary insurance.

a. Enteral nutritional therapy: Provides liquid nourishment directly to the digestive tract of a member who cannot ingest an appropriate amount of calories to maintain an acceptable nutritional status. Enteral nutrition is commonly provided by Jejunostomy tube (J-tube), Gastrostomy Tube (G-tube) or Nasogastric (N/G) tube. Refer to the specific AHCCCS Contractor for managed care members, and the AHCCCS Utilization Management/Care Management (UM/CM) Unit for Fee-For-Service members regarding PA requirements.
b. Parenteral nutritional therapy: Provides nourishment through the venous system to members with severe pathology of the alimentary tract, which does not allow absorption of sufficient nutrients to maintain weight and strength. Refer to the specific AHCCCS Contractor for managed care members, and the AHCCCS UM/CM Unit for Fee-For-Service members regarding PA requirements.

c. Commercial Oral Supplemental Nutritional Feedings: Provides nourishment and increases caloric intake as a supplement to the member's intake of other age appropriate foods, or as the sole source of nutrition for the member. Nourishment is taken orally and is generally provided through commercial nutritional supplements available without prescription.

i. Prior Authorization (PA) is required from the member’s Managed Care Contractor or Tribal Case Manager or the AHCCCS UM/CM Unit for Fee-For-Service members for commercial oral nutritional supplements, unless the member is also currently receiving nutrition through enteral or parenteral feedings.

ii. Medical necessity for commercial oral nutritional supplements must be determined on an individual basis by the member’s PCP or specialty provider, using the criteria specified in this policy. An example of a nutritional supplement is an amino acid-based formula used by a member for eosinophilic gastrointestinal disorder. The PCP or specialty provider must use the AHCCCS approved form, Exhibit 430-2, AHCCCS Certificate of Medical Necessity for Commercial Oral Nutritional Supplements to obtain authorization from the member's Managed Care Contractor or the AHCCCS Administration for FFS members.

iii. The Certificate of Medical Necessity for Commercial Oral Nutritional Supplements must indicate which criteria were met when assessing the medical necessity of providing commercial oral nutritional supplements.

(a) The member has been diagnosed with a chronic disease or condition, is below the recommended BMI percentile (or weight-for-length percentile for members less than two years of age) for the diagnosis per evidence-based guidance as issued by the American Academy of Pediatrics, and there are no alternatives for adequate nutrition.
At least two of the following criteria have been met for the basis of establishing medical necessity:

(a) The member is at or below the 10th percentile for weight-for-length or BMI on the appropriate growth chart for age and gender, as recommended by the CDC, for three months or more.

(b) The member has reached a plateau in growth and/or nutritional status for more than six months, or more than three months if member is an infant less than one year of age.

(c) The member has already demonstrated a medically significant decline in weight within the three month period prior to the assessment.

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

Additionally, each of the following requirements must be met:

(a) The member has been evaluated and treated for medical conditions that may cause problems with growth (such as feeding problems, behavioral conditions or psychosocial problems, endocrine or gastrointestinal problems, etc.), and

(b) The member has had a trial of higher caloric foods, blenderized foods, or commonly available products that may be used as dietary supplements for a period no less than 30 days in duration. If it is determined through clinical documentation and other supporting evidence that a trial of higher caloric foods would be detrimental to the member’s overall health, the provider may submit Exhibit 430-2, Certificate of Medical Necessity for Commercial Oral Nutritional Supplements along with supporting documentation demonstrating the risk posed to the member for the Contractor’s Medical Director or Designee’s consideration in approving the provider’s prior authorization request.

d. Supporting documentation must accompany the Certificate of Medical Necessity for Commercial Oral Nutritional Supplements (Members 21 Years of Age or Greater- Initial or Ingoing Requests). This documentation must demonstrate that the member meets all of the required criteria and includes:
i. Initial Requests

(a) Documentation demonstrating that nutritional counseling has been provided as a part of the health risk assessment and screening services provided to the member by the PCP or specialty provider, or through consultation with a registered dietitian.

(b) Clinical notes or other supporting documentation dated within three months of the request, providing a detailed history and thorough physical assessment demonstrating evidence of member meeting all of the required criteria, as indicated on the Certificate of Medical Necessity. The physical assessment must include the member’s current/past weight-for-length and BMI percentiles (if member is two years of age or older).

(c) Documentation detailing alternatives that were tried in an effort to boost caloric intake and/or change food consistencies that have proven unsuccessful in resolving the nutritional concern identified, as well as member adherence to the prescribed dietary plan/alternatives attempted.

ii. Ongoing Requests

(a) Subsequent submissions must include a clinical note or other supporting documentation dated within three months of the request, that includes the members overall response to supplemental therapy and justification for continued supplement use. This must include the member’s tolerance to formula, recent hospitalizations, current weight-for-length or BMI percentile (if member is two year of age or older).

NOTE: Members receiving nutritional therapy must be physically assessed by the member’s PCP, specialty provider, or registered dietitian at least annually.

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

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

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

   i. Information necessary to obtain PA for commercial oral nutritional supplements,

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

   iii. Education and training, if the member's parent or guardian elects to prepare the member's food, regarding proper sanitation and temperatures to avoid contamination of foods that are blended or specially prepared for the member.

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

c. Contractors must implement a process for verifying medical necessity of nutritional therapy, through the receipt of supporting medical documentation dated within three months of the request, prior to giving initial or ongoing authorizations for nutritional therapy. Documentation must include clinical notes or other supporting documentation from the member’s PCP, specialty provider, or registered dietitian including a detailed history and thorough physical assessment that provides evidence of member meeting all of the required criteria, as indicated on the Certificate of Medical Necessity.

PROVIDER REQUIREMENTS

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

a. Documents are submitted with the completed Certificate of Medical Necessity to support all of the necessary requirements for Commercial Oral Nutritional Supplements as detailed above.

b. If the member's parent or guardian elects to prepare the member's food, education and training regarding proper sanitation and temperatures to avoid contamination of foods that are blended or specially prepared for the member is provided.
c. Ongoing monitoring is conducted to assess member adherence/tolerance to the prescribed nutritional supplement regimen and determine necessary adjustments to the prescribed amount of supplement are appropriate based on the member’s weight loss/gain.

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

Refer to Chapter 500, Policy 520, Member Transitions for more information related to transitioning members.

7. **Oral Health Services** – As part of the physical examination, the physician, physician’s assistant or nurse practitioner must perform an oral health screening. A screening is intended to identify gross dental or oral lesions, but is not a thorough clinical examination and does not involve making a clinical diagnosis resulting in a treatment plan. Referral to a dentist or dental home must be made as outlined in policy. Refer to Policy 431-1, AHCCCS Dental Periodicity Schedule, of this Chapter for more details pertaining to covered services, provider and Contractor requirements.

8. **Cochlear and Osseointegrated Implantation**

   a. Cochlear implantation

   Cochlear implantation provides an awareness and identification of sounds and facilitates communication for persons who have profound, sensorineural hearing loss (nerve deafness). Deafness may be prelingual/perilingual or postlingual. AHCCCS covers medically necessary services for cochlear implantation solely for EPSDT age members. Cochlear implantation is limited to one functioning implant per member. AHCCCS will not cover cochlear implantation in instances where individuals have one functioning cochlear implant.

   i. Candidates for cochlear implants must meet criteria for medical necessity, including but not limited to, the following indications:

      (a) A diagnosis of bilateral profound sensorineural deafness (using age-appropriate standard testing), with little or no benefit from a hearing (or vibrotactile) aid, as established by audiologic and medical evaluation,

      (b) Presence of an accessible cochlear lumen structurally suited to implantation, with no lesions in the auditory nerve and acoustic
areas of the central nervous system, as demonstrated by CT scan or other appropriate radiologic evaluation,

(c) No known contraindications to surgery,

(d) Demonstrated age appropriate cognitive ability to use auditory clues, and

(e) The device must be used in accordance with the FDA approved labeling.

ii. Coverage of cochlear implantation includes the following treatment and service components:

(a) Complete auditory testing and evaluation by an otolaryngologist, speech-language pathologist or audiologist

(b) Pre-surgery inpatient/outpatient evaluation by a board certified otolaryngologist

(c) Diagnostic procedures and studies, including CT scan or other appropriate radiologic evaluation, for determining candidacy suitability

(d) Pre-operative psychosocial assessment/evaluation by psychologist or counselor

(e) Prosthetic device for implantation (must be non-experimental/non-investigational and be Food and Drug Administration approved and used according to labeling instructions)

(f) Surgical implantation and related services

(g) Post-surgical rehabilitation, education, counseling and training

(h) Equipment maintenance, repair and replacement of the internal/external components or both if not operating effectively and is cost effective. Examples include but are not limited to: the device is no longer functional or the used component compromises the member’s safety. Documentation which establishes the need to replace components not operating effectively must be provided at the time prior authorization is sought.
Cochlear implantation requires PA from the Contractor Medical Director, or from the AHCCCS Medical Director or designee for FFS members. Refer to Chapter 800 PA requirements for FFS providers.

b. Osseointegrated implants (Bone Anchored Hearing Aid [BAHA])

AHCCCS coverage of medically necessary services for osseointegrated implantation is limited to EPSDT members. Osseointegrated implants are devices implanted in the skull that replace the function of the middle ear and provide mechanical energy to the cochlea via a mechanical transducer. These devices are indicated only when hearing aids are medically inappropriate or cannot be utilized due to congenital malformation, chronic disease, severe sensorineural hearing loss or surgery. Osseointegrated implantation requires PA from the Contractor Medical Director, or from the AHCCCS Medical Director or designee for FFS members. Maintenance is the same as in Item 8.a.(1)(i) above.

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

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

a. Bone marrow biopsy with needle or trocar

b. Bone marrow aspiration

c. Intravenous chemotherapy administration, push technique

d. Chemotherapy administration into central nervous system by spinal puncture

e. Diagnostic lumbar spinal puncture, and

f. Therapeutic spinal puncture for drainage of cerebrospinal fluid.

Additional applications of conscious sedation for members receiving EPSDT services are considered on a case by case basis and require medical review and prior authorization by the Contractor Medical Director for enrolled members or by the AHCCCS Chief Medical Officer or designee for FFS members.
10. Behavioral Health Services – AHCCCS covers behavioral health services for members eligible for EPSDT services as described in Chapter 300, Policy 310, and the Behavioral Health Services Guide. EPSDT behavioral health services include the services listed in Federal Law 42 USC 1396d(a) necessary to correct or ameliorate mental illnesses and conditions discovered by the screening services whether or not the services are covered under the (AHCCCS) State Plan.

There are two appendices, Appendix E for children and adolescents and Appendix F for adults. For the diagnosis of Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADHD), depression (including postnatal depression), and/or anxiety disorders, there are clinical guidelines that include assessment tools and algorithms. The clinical guidelines are to be used by the PCPs as an aid in treatment decisions. PCPs that elect to prescribe medications to treat ADHD, depression, or anxiety disorders must complete an annual assessment of the member’s behavioral health condition and treatment plan. Contractors must establish a medication management process that results in the annual assessment being completed by the PCP in order for ADHD, depression, and anxiety medication prescriptions to continue beyond a 12 month period. To ensure there is not a gap in medications for these conditions, Contractors are required to identify and conduct outreach to members approaching the 12 month re-assessment timeframe and provide assistance in scheduling the appointment with the member’s PCP.

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

Principles:

1. Collaboration with the child and family: Respect for and active collaboration with the child and parents is the cornerstone to achieving positive behavioral health outcomes. Parent and children are treated as partners in the assessment process, and the planning, delivery, and evaluation of behavioral health services, and their preferences are taken seriously.

2. Functional Outcomes: Behavioral health services are designed and implemented to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Implementation of the behavioral health services plan stabilizes the child’s condition and minimizes safety risks.

3. Collaboration with Others: When children have multi-agency, multi-system involvement, a joint assessment is developed and a jointly established
behavioral health services plan is collaboratively implemented. Client centered teams plan and deliver services. Each child’s team includes the child, parents, any foster parent, and any individual important in the child’s life who is invited to participate by the child or parents. The team also includes all other persons needed to develop an effective plan, including as appropriate, the child’s teacher, the child’s Child Protective Service and/or Division of Developmental Disabilities case worker, and the child’s probation officer. The team develops a common assessment of the child’s and family’s strengths and needs, develops an Individualized Service Plan and monitors the implementation of the plan and makes adjustments in the plan if it is not succeeding.

4. Accessible Services: Children have access to a comprehensive array of behavioral health services, sufficient to ensure that they receive the treatment they need. Case management is provided as needed. Behavioral health services plans identify transportation the parents and the child need to access behavioral health services, and how transportation assistance will be provided. Behavioral health services are adapted or created when they are needed but not available.

5. Best Practices: Behavioral health services are provided by competent individuals who are adequately trained and supervised. Behavioral health service plans identify and appropriately address behavioral symptoms that are reactions to death of a family member, abuse or neglect, learning disorders, and other similar traumatic or frightening circumstances, substance abuse problems, the specialized behavioral health needs of children are developmentally disabled, maladaptive sexual behavior, including abusive conduct and risky behavior, the need for stability and the need to promote permanency in the class members’ lives, especially class members in foster care. Behavioral health services are continuously evaluated and modified if ineffective in achieving desired outcomes.

6. Most appropriate setting: Children are provided behavioral health services in their home and community to the extent possible. Behavioral health services are provided in the most integrated setting appropriate to meet the child’s needs. When provided in a residential setting, the setting is the most integrated and most home-like setting that is appropriate to the child’s needs.

7. Timeliness: Children identified as needing behavioral health services are assessed and served promptly.

8. Services tailored to the child and family: The unique strengths and needs of children and their families dictate the type, mix, and intensity of behavioral health services provided. Parents and children are encouraged and assisted
to articulate their own strengths and needs, the goals they are seeking, and what services they think are required to meet these goals.

9. Stability: Behavioral health service places strive to minimize multiple placements. Service plans identify whether a class member is at risk of experiencing a placement disruption and, if so, identify the steps to be taken to minimize or eliminate the risk. Behavioral health service plans anticipate crisis that might develop and include specific strategies and services that will be employed if a crisis develops. In responding to crises, the behavioral health system uses all appropriate behavioral health services to help the child remain at home, minimize placement disruptions, and avoid the inappropriate use of the police and the criminal justice system. Behavioral health service plans anticipate and appropriately plan for transition in children’s lives, including transitions to new schools and new placements, and transitions to adult services.

10. Respect for the child and family’s unique cultural heritage: Behavioral health services are provided in a manner that respects the cultural tradition and heritage of the child and family. Services are provided in Spanish to children and parents whose primary language is Spanish.

11. Independence: Behavioral health services include support and training for parents in meeting their child’s behavioral health needs, and support and training for children in self-management. Behavioral health service plans identify parents’ and children’s needs for training and support to participate as partners in the assessment process, and in the planning and delivery, and evaluation of services, and provide that such training and support, including transportation assistance, advance discussions, and help with the understanding of written materials, will be made available.

12. Connection to natural supports: The behavioral health system identifies and appropriately utilizes natural supports available from the child and parents’ own network of associates, including friends and neighbors, and from community organizations, including service and religious organizations.

**NOTE:** PCPs are encouraged to implement postpartum depression screenings to identify and refer mothers who would benefit from additional treatment due to concerns related to postpartum depression during EPSDT visits for infants up to one year of age.

11. **Religious Non-Medical Health Care Institution Services** – AHCCCS covers religious non-medical health care institution services for members eligible for EPSDT services as described in Chapter 300, Policy 310.
12. **Care Management Services** – AHCCCS covers care management services for both physical and behavioral health care, as appropriate for members eligible for EPSDT services. In EPSDT, care management involves identifying the health needs of a child, ensuring necessary referrals are made, maintaining health history, and initiating further evaluation/diagnosis and treatment when necessary.

13. **Chiropractic Services** – AHCCCS covers chiropractic services to members eligible for EPSDT services, when ordered by the member’s PCP and approved by the Contractor in order to ameliorate the member’s medical condition.

14. **Personal Care Services** – AHCCCS covers personal care services, as appropriate, for members eligible for EPSDT services.

15. **Incontinence Briefs** – Incontinence briefs, including pull-ups and incontinence pads, are covered in order to prevent skin breakdown and to enable participation in social, community, therapeutic and educational activities under the following circumstances:

   a. The member is over three years and under 21 years of age
   
   b. The member is incontinent due to a documented disability that causes incontinence of bowel and/or bladder
   
   c. The PCP or attending physician has issued a prescription ordering the incontinence briefs
   
   d. Incontinence briefs do not exceed 240 briefs per month unless the prescribing physician presents evidence of medical necessity for more than 240 briefs per month for a member diagnosed with chronic diarrhea or spastic bladder
   
   e. The member obtains incontinence briefs from vendors within the Contractor’s network
   
   f. Prior authorization has been obtained as required by the Administration, Contractor, or Contractor’s designee. Contractors may require a new prior authorization to be issued no more frequently than every twelve months. Prior authorization for a renewal of an existing prescription may be provided by the physician through telephone contact with the member rather than an in-person physician visit.

Prior authorization will be permitted to ascertain that:

   i. The member is over three years and under 21 years of age,
ii. The member has a disability that causes incontinence of bladder and/or bowel,

iii. A physician has prescribed incontinence briefs as medically necessary. A physician prescription supporting medical necessity may be required for specialty briefs or for briefs different from the standard briefs supplied by the Contractor, and

iv. The prescription is for 240 briefs or fewer per month, unless evidence of medical necessity for over 240 briefs is provided

16. **Medically Necessary Therapies** — AHCCCS covers medically necessary therapies including physical therapy, occupational therapy and speech therapy, necessary to correct or ameliorate defects, physical and mental illnesses, and conditions discovered by the screening services. Therapies are covered under both an inpatient and outpatient basis when medically necessary. For children identified by the PCP as needing early intervention services, Contractors are required to provide services in the natural environment whenever possible. Refer to Procedures for the Coordination of Services under Early Periodic Screening, Diagnostic and Treatment, and Early Intervention (Exhibit 430-3), for more information related to the coordination and referral process for early interventions services.

**D. SICK VISIT PERFORMED IN ADDITION TO AN EPSDT VISIT**

Billing of a “sick visit” (CPT Codes 99201-99215) at the same time as an EPSDT is a separately billable service if:

1. An abnormality is encountered or a preexisting problem is addressed in the process of performing an EPSDT service and the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service.

2. The “sick visit” is documented on a separate note.

3. History, Exam, and Medical Decision Making components of the separate “sick visit” already performed during the course of an EPSDT visit are not to be considered when determining the level of the additional service (CPT Code 99201-99215).

4. The current status (not history) of the abnormality or preexisting condition is the basis of determining medical necessity.
Modifier 25 must be added to the Office/Outpatient code to indicate that a significant, separately identifiable evaluation and management service was provided by the same physician on the same day as the preventive medicine service.

Acute diagnosis codes not applicable to the current visit should not be billed.

An insignificant or trivial problem/abnormality that is encountered in the process of performing the preventive medicine evaluation and management service, and which does not require additional work and the performance of the key components of a problem-oriented E/M service is included in the EPSDT visit and should not be reported.

E. CONTRACTOR REQUIREMENTS FOR PROVIDING EPSDT SERVICES

This section provides the procedural requirements for Contractors.

The Contractor must develop policies and procedures to identify the needs of EPSDT age members, inform members of the availability of EPSDT services, coordinate their care, provide care management, conduct appropriate follow up, and ensure members receive timely and appropriate treatment.

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

Contractors must:

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

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

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

3. Ensure PCPs providing care to children are trained to use implemented developmental screening tools. This will also include a process to monitor the utilization of AHCCCS approved developmental screening tools (ASQ and PEDS Tool) for members at 9, 18, and 24 months of age. The MCHAT may be used for members 16-30 months of age to assess the risk of autism spectrum disorders in place of the ASQ or PEDS Tool when medically indicated. Providers are expected to be trained as specified by the American Academy of Pediatrics, in order for the PCP to obtain additional reimbursement for use of one AHCCCS approved developmental screening tool during an EPSDT visit.
**NOTE:** Approved developmental screening tool training resources may be found on the Arizona Department of Health Services website [http://www.azdhs.gov/clinicians/training-opportunities/developmental/index.php](http://www.azdhs.gov/clinicians/training-opportunities/developmental/index.php)

4. Develop, implement, and maintain a program to inform members about EPSDT services within 30 days of enrollment with the Contractor. This information must include:

   a. The benefits of preventive health care

   b. Information that an EPSDT visit is a well child visit

   c. A complete description of the services available as described in this section

   d. Information on how to obtain these services and assistance with scheduling appointments

   e. Availability of care management assistance in coordinating EPSDT covered services

   f. A statement that there is no copayment or other charge for EPSDT screening and resultant services, and

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

5. Contractors must conduct written and other member educational outreach related to immunizations, available community resources (WIC, AzEIP, CRS, Behavioral Health, and Head Start), dangers of lead exposure and recommended/mandatory testing, childhood obesity and prevention measures, age appropriate risk prevention efforts (addressing injury and suicide prevention, bullying, violence, and risky sexual behavior), education on importance of utilizing primary care provider in place of ER visits for non-emergent concerns, recommended periodicity schedule, and other Contractor selected topics at a minimum of once every 12 months. These topics may be addressed separately or combined into one written outreach material; however, each topic must be covered during the twelve month period. EPSDT related outreach material, must include a statement informing members that an EPSDT visits is synonymous to a well child visit. (Refer to Exhibit 400-3, *AHCCCS Maternal Child Health/EPSDT Member Outreach.*)

Outreach requirements for Contractors are included in ACOM Policy 404.
6. Provide EPSDT information (as defined in paragraphs #4 and #5 above), in a second language, in addition to English, in accordance with the requirements of the AHCCCS Division of Health Care Management (DHCM) “Cultural Competency” policy available in the AHCCCS Contractor Operations Manual (available online at http://www.azahcccs.gov/shared/ACOM/default.aspx).

7. Develop and implement processes to assist members and their families regarding community health resources, including but not limited to WIC, AzEIP, and Head Start.

8. Develop and implement processes to ensure the identification of member’s needing care management services and the availability of care management assistance in coordinating EPSDT covered services.

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

10. Attend EPSDT related meetings when requested by AHCCCS.

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

12. Develop, implement, and maintain a procedure for ensuring timeliness and care coordination of re-screening and treatment for all conditions identified, including behavioral health services, as a result of examination, screening, and diagnosis. Treatment, if required, must occur on a timely basis, generally initiating services no longer than six months beyond the request for screening services, unless stated otherwise in this policy (Refer to the Contractor Requirements section within this Policy).

13. Develop, implement, and maintain a process to provide appropriate follow-up care for members who have abnormal blood lead test results.

14. Develop and implement a process for monitoring that providers use the most current EPSDT Tracking Forms at every EPSDT visit and that all age appropriate screenings and services are conducted during each visit. If an electronic medical record is utilized, the electronic medical record must include all of the elements of the most current age appropriate EPSDT Tracking Form.

15. Develop, implement, and maintain a procedure to notify all members/responsible parties of visits required by the AHCCCS EPSDT and Dental Periodicity Schedules. Processes other than mailings must be pre-approved by AHCCCS Clinical Quality Management. This procedure must include:
a. Notification to members or responsible parties regarding due dates of each EPSDT visit. If an EPSDT visit has not taken place, a second written notice must be sent.

b. Notification to members or responsible parties regarding due dates of biannual (one visit every six months) dental visits. If a dental visit has not taken place, a second notice must be sent.

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

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

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

18. Implement processes to print two part carbonless EPSDT Tracking Forms (a copy for the medical record and a copy for providers to send to the Contractor Maternal Child Health/EPSDT Coordinator).

19. Distribute EPSDT Tracking Forms to contracted providers who do not use and submit electronic EPSDT forms to the Contractor.

20. Require the use of the AHCCCS EPSDT and Dental Periodicity Schedules and AHCCCS approved, standardized EPSDT Tracking Forms (see Appendix B) by all contracted providers. The AHCCCS EPSDT and Dental Periodicity Schedules give providers necessary information regarding timeframes in which age-related required screenings and services must be rendered by providers.

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

a. Use the EPSDT Tracking Forms (or electronic equivalent) at every EPSDT visit. Contractors must monitor the anticipated volume of EPSDT Tracking Forms received based on the number and age of the PCPs EPSDT age member panel.

b. Perform all age appropriate screening and services during each EPSDT visit in accordance with the AHCCCS EPSDT and Dental Periodicity Schedules, including, but not limited to, utilizing the AHCCCS approved developmental screening tools, as described in this Chapter.

c. Sign EPSDT Tracking Forms and place them in the member’s medical record. If an electronic medical record is used, an electronic signature by the provider must be included.
d. Send copies of the EPSDT Tracking Forms (or electronic equivalent) to the Contractor. Providers are not required to submit EPSDT Tracking Forms to AHCCCS.

e. Providers of Fee-For-Service members must maintain a copy of the EPSDT Tracking Forms (or electronic equivalent), per AHCCCS policy, in the medical record. Providers do not need to send copies to AHCCCS. If an electronic medical record is used, an electronic signature by the provider must be included.

21. Submit the EPSDT/Adult Monitoring and Performance Measure Quarterly Report to AHCCCS DHCM CQM, a detailed progress report that describes the activities of the quarter and the progress made in reaching the established goals of the plan, within 15 days of the end of each reporting quarter (see Exhibit 400-1, Maternal and Child Health Reporting Requirements). Quarterly reports must include documentation of monitoring and evaluation of EPSDT requirements, and implementation of improvement processes. The quarterly report must include results of Contractor’s ongoing monitoring of performance rates, in a format that will facilitate comparison of rates in order to identify possible need for interventions to improve or sustain rates. The report must also identify the Contractor’s established goals (see Appendix A, EPSDT/Adult Monitoring and Performance Measure Quarterly Report, for report template and requirements/instructions).

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

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

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

   b. Agree to utilize the standardized AHCCCS EPSDT Tracking Forms or, if electronic medical records are utilized, they must contain all the elements of the current AHCCCS EPSDT Tracking Forms.

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

   d. Implement protocols to ensure that health problems are diagnosed and treated early, before they become more complex and the treatment more
costly (including follow-up related to blood lead screening and tuberculosis screening).

e. Have a process for assisting members in navigating the healthcare system, as well as inform members of any other community-based resources that support optimal health outcomes, to ensure that members receive appropriate support services.

f. Implement protocols for coordinating care and services with the appropriate state agencies for EPSDT eligible members, and ensure that members are referred to support services, as well as other community-based resources to support good health outcomes.

g. Refer eligible members to Head Start and the special supplemental nutrition program for Women, Infants and Children (WIC), for WIC approved formula and support services. Ensure that medically necessary nutritional supplements are covered by the Contractor (For more information, refer to Section C, EPSDT Service Standards, Item 6 - Nutritional Assessment and Nutritional Therapy of this policy).

h. Utilize the criteria specified in this policy when requesting medically necessary nutritional supplements (Refer to Section C, EPSDT Service Standards, Item 6 - Nutritional Assessment and Nutritional Therapy of this policy and Exhibit 430-2, AHCCCS Certificate of Medical Necessity for Commercial Oral Nutritional Supplements).

i. Coordinate with Arizona Early Intervention Program (AzEIP) to identify children 0-3 years of age with developmental disabilities needing services, including family education and family support needs focusing on each child’s natural environment, to optimize child health and development (EPSDT services, as defined in 9 A.A.C. 22, Article 2, must be provided by the Contractors). Contractors must require their providers to communicate results of assessments and services provided to AzEIP enrollees within 45 days of the member’s AzEIP enrollment. Refer to Procedures for the Coordination of Services under EPSDT and Early Intervention (Exhibit 430-3) for more information related to the coordination and referral process for early interventions services.

24. Educate providers to comply with AHCCCS/AzEIP Procedures for the Coordination of Services under Early Periodic Screening, Diagnostic and Treatment, and Early Intervention (Exhibit 430-3), when the need for medically necessary services are identified for members birth to three years of age. This includes:
a. Ensuring medically necessary services are initiated within 45 days of a completed Individual Family Service Plan (IFSP), when services are requested by the AzEIP service coordinator.

b. Reimbursing all AHCCCS registered AzEIP providers, whether or not they are contracted with the AHCCCS Contractor. Non-Contracted AHCCCS registered AzEIP providers will be reimbursed for authorized services at the Fee-For-Service (FFS) rates. IFSP services must be reviewed for medical necessity prior to reimbursement.

25. Provide education and assists with referrals of eligible members to the special supplemental nutrition program for Women, Infants and Children (WIC), for WIC approved formula and support services and ensures medically necessary nutritional supplements are covered. (Refer to Section C, EPSDT Service Standards, and Item 6 - Nutritional Assessment and Nutritional Therapy of this policy and Exhibit 430-2, AHCCCS Certificate of Medical Necessity for Commercial Oral Nutritional Supplements).

26. Provide education and assists with referrals of eligible members to Head Start to ensure eligible members receive appropriate EPSDT services to optimize child health and development.

27. Coordinate with behavioral health services agencies and providers to ensure continuity of care for members who are receiving or are eligible to receive behavioral health services.

F. CONTRACTOR REQUIREMENTS FOR THE EPSDT ANNUAL PLAN

Each Contractor must have a written EPSDT Annual Plan that addresses minimum Contractor requirements as specified in the prior section (Contract Requirements for Providing EPSDT Services – numbers one through 27 and Contractor Requirements for Oral Health Care – numbers one through four), as well as the objectives of the Contractor’s program that are focused on achieving AHCCCS requirements. It must also incorporate monitoring and evaluation activities for these minimum requirements (see Exhibit 400-2B, EPDST Annual Plan Checklist). The EPSDT Annual Plan must be submitted no later than December 15th to the AHCCCS Division of Health Care Management/Clinical Quality Management Unit and is subject to approval (see Exhibit 400-1, Maternal and Child Health Reporting Requirements). The written EPSDT Annual Plan must contain, at a minimum, the following:

1. EPSDT Narrative Plan – A written description of all planned activities to address the Contractor’s minimum requirements for EPSDT services, as specified in the prior section (Contractor Requirements for Providing EPSDT Services - Numbers 1 through 27), including, but not limited to, informing providers and members that EPSDT is a comprehensive child health program of prevention,
treatment, correction, and improvement (amelioration) of physical and behavioral/mental health problems for AHCCCS members under the age of 21. The narrative description must also include Contractor activities to identify member needs, coordination of care, and follow-up activities to ensure appropriate treatment is received in a timely manner.

2. EPSDT Work Plan Evaluation – An evaluation of the previous year’s Work Plan to determine the effectiveness of strategies, interventions, and activities used toward meeting stated objectives.

3. EPSDT Work Plan that includes:
   a. Specific measurable objectives. These objectives must be based on AHCCCS established Minimum Performance Standards. In cases where AHCCCS Minimum Performance Standards have been met, other generally accepted benchmarks that continue the Contractor’s improvement efforts will be used (e.g., National Committee on Quality Assurance, Healthy People 2020 standards). The Contractor may also develop their own specific measurable goals and objectives aimed at enhancing the EPSDT program when Minimum Performance Standards have been met. Objectives must include a focus toward blood lead testing and follow-up for abnormal blood lead test levels identified, childhood obesity, care coordination efforts, and member utilization.
   b. Strategies and specific measurable interventions to accomplish objectives (e.g., member outreach, provider education and provider compliance with mandatory components of the EPSDT program).
   c. Targeted implementation and completion dates of work plan activities.
   d. Assigned local staff position(s) responsible and accountable for meeting each established goal and objective.
   e. Identification and implementation of new interventions, continuation of or modification to existing interventions, based on analysis of the previous year’s Work Plan Evaluation.

4. Relevant policies and procedures, referenced in the EPSDT Annual Plan, submitted as separate attachments.

G. Fee-For-Service/EPSDT Provider Requirements

This section discusses the procedural requirements for FFS EPSDT service providers. FFS providers must:
1. Provide EPSDT services in accordance with Section 42 USC 1396d(a) and (r), 1396a (a) (43), 42 C.F.R. 441.50 et seq. and AHCCCS rules and policies.

2. Provide and document EPSDT screening services in accordance with the AHCCCS EPSDT and Dental Periodicity Schedules.

3. Refer members for follow up, diagnosis and treatment, ensuring that treatment is initiated within 60 days of screening services.

4. If appropriate, document in the medical record the member’s or legal guardian’s decision not to utilize EPSDT services or receive immunizations.

5. Document a health database assessment on each EPSDT participant. The database must be interpreted by a physician or licensed health professional who is under the supervision of a physician, and

6. Provide health counseling/education at initial and follow up visits.

H. CLAIM FORMS

Claims for EPSDT services must be submitted on a CMS (formerly HCFA) 1500 form. Providers must bill for preventative EPSDT services using the preventative service, office or other outpatient services and preventive medicine CPT codes (99381 – 99385, 99391 – 99395) with an EP modifier. EPSDT visits are paid at a global rate for the services specified in this Chapter. With the exception of those items listed above as separately reimbursable services, no additional reimbursement is allowed. Providers must use an EP modifier to designate all services related to the EPSDT well child check-ups, including routine vision and hearing screenings.
EXHIBIT 430-1

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
EPSDT PERIODICITY SCHEDULE
| PROCEDURE/AGE                      | New born | 3-5 days | By 1 mo | 2 mo | 4 mo | 6 mo | 9 mo | 12 mo | 15 mo | 18 mo | 24 mo | 3 yr | 4 yr | 5 yr | 6 yr | 7 yr | 8 yr | 9 yr | 10 yr | 11 yr | 12 yr | 13 yr | 14 yr | 15 yr | 16 yr | 17 yr | 18 yr | 19 yr | 20 yr |
|-----------------------------------|----------|----------|---------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|
| History Initial/Interval         | X        | X        | X       | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    |
| Length/Height & Weight           | X        | X        | X       | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    |
| Weight for Length                | X        | X        | X       | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    |
| Head Circumference               | X        | X        | X       | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    |
| Body Mass Index (BMI)            |          |          |          |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |
| Blood Pressure – PCP should assess the need for BP measurement for children birth to 24 months | +        | +        | +        | +    | +    | +    | +    | +    | +    | +    | +    | +    | +    | +    | +    | +    | +    | +    | +    | +    | +    | +    | +    | +    | +    | +    | +    | +    | +    | +    |
| Nutritional Assessment           | X        | X        | X       | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    | X    |

**Vision/Hearing/Speech**

**SEE SEPARATE SCHEDULE**

**Developmental Surveillance**

**Developmental Screening**

**Psychosocial/Behavioral Assessment (Social-Emotional Health)**

**Alcohol and Drug Use Assessment**

**Physical Examination**

**Newborn Metabolic Screening**

**Immunizations**

**Tuberculin Test**

**Hemotocrit/Hemoglobin**

**Lead Screening/Testing**

**Verbal Lead Screen**

**Blood Lead Testing**

**Lead Screening/Testing**

**Verbal Lead Screen**

**Blood Lead Testing**

**Dyslipidemia Screening**

**Dyslipidemia Testing**

**STI Screening**

**Cervical Dysplasia Screening**

**Oral Health Screening by PCP**

**Topical Fluoride Varnish**

**Dental Referral**

**Anticipatory Guidance**

---

**NOTICE**

**OUTSIDE HIGH RISK ZIP CODE**

**WITHIN HIGH RISK ZIP CODE**

**ONE TIME TESTING BETWEEN 18 AND 20 YEARS OF AGE**

**SEE CENTERS FOR DISEASE CONTROL AND PREVENTION WEBSITE**

**MORE INFORMATION AVAILABLE AT**

**Arizona Health Care Cost Containment System (AHCCCS) Website**

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

*** See Separate Schedules within AMPM Chapter 400 for Vision, Hearing/Speech, and Immunizations

1 Utilization of one AHCCCS approved developmental screening tools (ASQ and PEDS Tool) for members at 9, 18, and 24 months of age. The MCHAT may be used for members 16-30 months of age to assess the risk of autism spectrum disorders in place of the ASQ or PEDS Tool when medically indicated.

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

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

4 Fluoride varnish is limited in a primary care provider’s office to once every six months, during an EPSDT visit for children who have reached six months of age with at least one tooth erupted, with recurrent applications up to two years of age.

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

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

Key:

\( x \) = to be completed

\( + \) = to be performed for members at risk when indicated

\( \leftarrow x \) = the range during which a service may be provided, with the \( x \) indicating the preferred age

\( * \) = Members not previously screened who fall within this range (36 to 72 months of age) must have a blood lead test performed

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

NOTE: The American Association of Pediatric Dentistry recommends that dental visits begin by age one (1). Referrals should be encouraged by one (1) year of age. Parents of young children may self-refer to a dentist within the Contractor’s network at any time.

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

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

Ocular photoscreening with interpretation and report, bilateral is covered for children ages three to five as part of the EPSDT visit due to challenges with a child’s ability to cooperate with traditional vision screening techniques. Ocular photoscreening is limited to a lifetime coverage limit of one.

Revised: 04/01/15, 04/01/2014, 4/1/2007, 8/1/2005

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM**

**VISION PERIODICITY SCHEDULE**

| PROCEDURE/AGE | New born | 3-5 days | 2 mo | 4 mo | 6 mo | 9 mo | 12 mo | 15 mo | 18 mo | 24 mo | 3 yr | 4 yr | 5 yr | 6 yr | 7 yr | 8 yr | 9 yr | 10 yr | 11 yr | 12 yr | 13 yr | 14 yr | 15 yr | 16 yr | 17 yr | 18 yr | 19 yr | 20 yr |
|---------------|----------|----------|------|------|------|------|-------|-------|-------|-------|------|------|------|------|------|------|------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| Vision +      | S        | S        | S    | S    | S    | S    | S     | S     | S     | S     | O*   | O    | O    | O    | S    | O    | S    | S    | S    | S    | S    | S    | S    | S    | S    |

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

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

Revised: 04/01/15, 04/01/2014, 4/1/2007, 8/1/2005

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM**

**HEARING/SPEECH SCHEDULE**

| PROCEDURE/AGE | New born | 3-5 days | 2 Wks | By 1mo | 6 Wks | 2 mo | 4 mo | 6 mo | 9 mo | 12 mo | 15 mo | 18 mo | 24 mo | 3 yr | 4 yr | 5 yr | 6 yr | 7 yr | 8 yr | 9 yr | 10 yr | 11 yr | 12 yr | 13 yr | 14 yr | 15 yr | 16 yr | 17 yr | 18 yr | 19 yr | 20 yr |
|---------------|----------|----------|-------|--------|-------|------|------|------|------|-------|-------|-------|-------|------|------|------|------|------|------|------|------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| Hearing/Speech + | O**      | S        | O**   | S      | S      | S    | S    | S    | S    | S     | S     | S     | O     | O    | O    | O    | O    | O    | O    | O    | O    | O    | O    | O    | O    | O    | O    | S    | S    | S    | S    |
EXHIBIT 430-2

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
CERTIFICATE OF MEDICAL NECESSITY FOR COMMERCIAL ORAL NUTRITIONAL
SUPPLEMENTS
(EPSDT AGED MEMBERS - INITIAL OR ONGOING REQUESTS)
**EXHIBIT 430-2**

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM**

**CERTIFICATE OF MEDICAL NECESSITY FOR COMMERCIAL ORAL NUTRITIONAL SUPPLEMENTS (EPSDT AGED MEMBERS - INITIAL OR ONGOING REQUESTS)**

<table>
<thead>
<tr>
<th>MEMBER INFORMATION</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Member’s AHCCCS ID Number:</td>
<td>Contracted Health Plan:</td>
</tr>
<tr>
<td>Last Name:</td>
<td>First Name:</td>
</tr>
<tr>
<td>Members’ Address:</td>
<td></td>
</tr>
</tbody>
</table>

Assessment performed by:  
AHCCCS Provider ID:  
Provider Specialty:  
Telephone Number:  
Assessment Date:  

<table>
<thead>
<tr>
<th>TYPE OF REQUEST</th>
<th>Initial</th>
<th>Ongoing</th>
<th>PREFERRED SUPPLEMENT</th>
<th>Type:</th>
<th>Substitution Permissible:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Nutrition Feeding</td>
<td>Weaning from Tube Feeding</td>
<td>Oral Feeding – Sole Source</td>
<td>Oral Feeding – Supplemental</td>
<td>Emergency Supplemental Nutrition</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**ASSESSMENT FINDINGS:** Indicate which of the following criteria have been met to support that oral supplemental nutritional feedings are medically necessary. (Supporting documentation dated no earlier than 3 months prior to the date of this request must be submitted with the Certificate of Medical Necessity to support each of the criteria selected below.)

<table>
<thead>
<tr>
<th>Member Meets the Criteria in the Left Column OR Meets at Least Two Criteria in the Right Column</th>
<th>Use the space below, to indicate which two or more criteria have been met:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Member has been diagnosed with a chronic disease or condition, is below the recommended BMI percentile (or weight-for-length percentile for members less than two years of age) for the diagnosis per evidence-based guidance as issued by the American Academy of Pediatrics, and there are no alternatives for adequate nutrition.</td>
<td>□ Member is at or below the 10th percentile for weight-for-length/BMI, on the appropriate growth chart for their age and gender, for 3 months or more.</td>
</tr>
<tr>
<td>□ Member has already demonstrated a medically significant decline in weight within the 3 month period prior to the assessment.</td>
<td>□ Member has reached a plateau in growth and/or nutritional status for more than 6 months, or more than 3 months if member is an infant less than 1 year of age.</td>
</tr>
<tr>
<td>□ Member is able to consume/eat no more than 25% of nutritional requirements from age-appropriate food sources.</td>
<td>□ 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 430.</td>
</tr>
</tbody>
</table>

**Additionally, Both of the Following Requirements Must be Met**

- The member has been evaluated and treated for medical conditions that may cause problems with growth (such as feeding problems, behavioral conditions or psychosocial problems, endocrine or gastrointestinal problems, etc.), AND
- 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 430.**

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 supplemental use. This must include the member’s tolerance to formula, recent hospitalizations, current height/weight percentiles, and BMI percentile for members two years of age or older. 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

Revised: 10/01/15, 04/01/07  
Effective: 01/01/2000
EXHIBIT 430-3

PROCEDURES FOR THE COORDINATION OF SERVICES UNDER EARLY PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT, AND EARLY INTERVENTION
EXHIBIT 430-3

PROCEDURES FOR THE COORDINATION OF SERVICES UNDER EARLY PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT, AND EARLY INTERVENTION

REVISION DATES: 07/01/15, 04/01/15

INITIAL EFFECTIVE DATE: 02/01/2011

Applicability:

The procedure described below applies to Contractors (Health Plans) contracted with the Arizona Health Care Cost Containment System (AHCCCS) for the implementation of Early Periodic Screening, Diagnostic and Treatment (EPSDT) services, such as physical therapy, occupational therapy, speech/language therapy and care coordination under Sec. 1905. [42 U.S.C. 1396d]; EPSDT for enrolled members birth through 20 years of age.

The Procedure for the Coordination of Services under EPSDT and Early Intervention was collaboratively developed and implemented in May, 2005 jointly by AHCCCS and the Arizona Early Intervention Program (AzEIP) to ensure the coordination and provision of EPSDT and early intervention services.

Background:

Medicaid’s Early Periodic Screening, Diagnostic and Treatment (EPSDT) is a comprehensive child health program of prevention and treatment developed to ensure the availability and accessibility of health care resources, as well as to assist Medicaid recipients in effectively utilizing these resources. Under EPSDT, Medicaid reimburses for services to treat or ameliorate physical and behavioral health disorders, a defects, or a conditions identified in an EPSDT screening. Limitations and exclusions, other than the requirement for medical necessity, do not apply to EPSDT services. These services should be authorized and provided through the AHCCCS Health Plan. The AHCCCS Health Plan should coordinate with AzEIP and notify the AzEIP service coordinator when services are approved by the AHCCCS Health Plan.

NOTE: State and Federal guidelines do not prohibit the provision of EPSDT services to a child in their home or other settings, if “recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level.”

AHCCCS cannot require Contractors to provide services in the natural environment, but encourages Contractors to do so whenever possible.

This procedure states AzEIP must ensure that enrolled members begin services within 45 days of the completed Individual Family Service Plan (per IDEA Part C). Although federal regulations for Medicaid specify reasonable standards of practice in terms of timeliness for provision of EPSDT services, 441.56(e) sets forth a “general” outer limit of six months from the request for screening services.

Under IDEA Part C, AzEIP must ensure enrolled members begin services within 45 days of the completed IFSP.
PROCEDURES FOR THE COORDINATION OF SERVICES UNDER EARLY PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT, AND EARLY INTERVENTION

Introduction: AHCCCS and AzEIP jointly developed this process to ensure the coordination and provision of EPSDT and early intervention services. This process describes procedures taken by (A) the child’s Primary Care Provider, and (B) AzEIP, when concerns about a child’s development are initially identified.

PCP Initiated Service Requests

A. When concerns about a child’s development are initially identified by the child’s Primary Care Provider (PCP), the PCP will request an evaluation and, if medically necessary, approval of services from the AHCCCS Health Plan.

1. Screening/Identification: During the EPSDT visit the Primary Care Provider will determine the child’s developmental status through discussion with the parents/caregiver and developmental screening. If the PCP identifies potential developmental delays, the PCP requests an evaluation and possibly service authorization from the AHCCCS Health Plan. The PCP must submit the clinical information to support the request for evaluation and any services. In addition, the PCP must consider related screening and evaluation needs when exploring if a child has a developmental delay. For example, if the PCP and parents have concerns about a child’s communication, steps should be taken to confirm that the child’s hearing is within normal limits in addition to evaluating a child’s speech and language.

2. Evaluation/Services: The AHCCCS Health Plan may pend approval for services until the evaluation has been completed by the provider and may deny services if the PCP determines there is no medical need for services based on the results of the evaluation. The AHCCCS Health Plan must follow all prior authorization requirements including sending a Notice of Action (NOA) letter to the requesting provider and the member’s guardian/parent when services are denied, suspended, or reduced.

   a. Requests for services from Primary Care Provider, licensed providers or the AzEIP service coordinator based on the Individual Family Service Plan (IFSP) must be reviewed for medical necessity prior to authorization and reimbursement.

   b. If services are approved based on the determination of medical necessity, the AHCCCS Health Plan will authorize the services and notify the PCP (or requesting provider, if other than the PCP) that (a) the services are approved and (b) identify the provider that has been authorized, the frequency, the duration, the service begin and end dates.

      i. AHCCCS Health Plans are encouraged to contract with AHCCCS registered AzEIP providers to expand the network of providers available to serve children with potential or identified developmental delays. AHCCCS registered AzEIP providers are also encouraged to contract with the AHCCCS Health Plan(s) to provide services.

      ii. AHCCCS Health Plans are encouraged, but not required, to contract with AzEIP providers if service utilization indicates that the Health Plan has sufficient network capacity to timely meet the medically necessary needs of the members.

      iii. If services have already been initiated by an AHCCCS registered AzEIP provider not contracted with the AHCCCS Health Plan, the AHCCCS Health Plan must authorize the
AHCCCS registered AzEIP provider to continue providing services deemed medically necessary to maintain continuity of care.

iv. AzEIP providers may only be reimbursed (a) if they are AHCCCS registered and (b) for the categories of services for which they are registered and that were provided. Billing must be completed in accordance with AHCCCS guidelines.

c. If services are denied, the Contractor will follow all prior authorization requirements including sending a Notice of Action (NOA) letter to the requesting provider and the member’s guardian/parent.

d. Referral to AzEIP: After the completion of the evaluation, the provider who conducted the evaluation will submit an Evaluation Report to the PCP (requesting provider if other than the PCP) and the AHCCCS Health Plan Prior Authorization department for authorization of medically necessary services.

i. If the evaluation indicates that the child scored two standard deviations below the mean, which generally translates to AzEIP’s eligibility criteria of 50 percent developmental delay, the child will continue to receive all medically necessary EPSDT covered services through the AHCCCS Health plan. The MCH coordinator will refer the child to AzEIP for non-medically necessary services that are not covered by Medicaid but are covered under IDEA Part C.

ii. If the evaluation report indicates that the child does not have a 50 percent developmental delay, the MCH Coordinator will continue to coordinate medically necessary care and services for the child.

The AHCCCS Health Plan will not delay or postpone the initiation of medically necessary EPSDT services while waiting for the AzEIP eligibility or the IFSP process.

3. AHCCCS Health Plans and AzEIP will continue to coordinate services for Medicaid children who are eligible for and enrolled in both AzEIP and Medicaid. The MCH Coordinator or designee assists the parent/caregiver in scheduling the EPSDT covered services, as necessary or as requested. The EPSDT services will be provided by the AHCCCS Health Plan’s contracted provider (or AzEIP service provider reimbursed by the AHCCCS Health Plan) until the services are determined by the PCP and provider to no longer be medically necessary.

AzEIP Initiated Service Requests

B. When concerns about a Medicaid enrolled child’s development are initially identified by AzEIP:

1. If an EPSDT eligible child is referred to AzEIP, AzEIP will screen and, if needed, conduct evaluation to determine the child’s eligibility for AzEIP. AzEIP will obtain parental consent to request and release records to/from the AHCCCS Health Plan and the child’s PCP.

2. If the child is determined to be AzEIP eligible, AzEIP will develop an IFSP that will identify (1) the child’s present level of development, (2) child outcomes, and (3) the services that are needed to support the
**EXHIBIT 430-3**

**PROCEDURES FOR THE COORDINATION OF SERVICES UNDER EARLY PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT, AND EARLY INTERVENTION**

family and child in reaching the IFSP outcomes, and (4) the planned start date for each early intervention service(s) identified on the IFSP. IFSP services that are EPSDT covered will identify the child’s AHCCCS Health Plan as the payer.

3. The AzEIP service coordinator will send (fax or e-mail) the AzEIP AHCCCS Member Service Request form (Exhibit 430-4) and copies of the evaluations/developmental summaries completed during the IFSP process to the AHCCCS Health Plan MCH Coordinator or designee within two business days of completing the IFSP.

4. The AHCCCS Health Plan MCH Coordinator or designee ensures the service request is entered into the Contractor’s prior authorization system within one business day of receipt of the request.

5. The AHCCCS Health Plan MCH Coordinator or designee sends (faxes/e-mails) the AzEIP AHCCCS Member Service Request form and accompanying documentation to the member’s PCP within two business days.

6. The PCP will review all AzEIP documentation and determine which services are medically necessary based on review of the documentation.

7. The PCP shall take no longer than ten business days from the date that the MCH Coordinator faxes the documentation to the PCP to determine which services are medically necessary and return the signed AzEIP AHCCCS Member Service Request form (Exhibit 430-4) to the MCH Coordinator.

8. The PCP will determine:

   a. The requested services are medically necessary:

      i. Within two business days the AHCCCS Health Plan MCH Coordinator or designee will send the completed AzEIP AHCCCS Member Service Request form (Exhibit 430-4) to the AzEIP service coordinator and PCP advising them that: (a) the services are approved and (b) identify the provider that has been authorized, the frequency, the duration, the service begin and the service end dates.

      ii. AHCCCS Health Plans are encouraged to contract with AHCCCS registered AzEIP providers to expand the network of providers available to serve children with potential or identified developmental delays. AHCCCS registered AzEIP providers are also encouraged to contract with the AHCCCS Health Plan(s) to provide services.

      iii. AHCCCS Health Plans are encouraged, but not required to contract with AzEIP providers if service utilization indicates that the Health Plan has sufficient network capacity to timely meet the medically necessary needs of the members.

      iv. The AHCCCS Health Plan will authorize the services with a contracted provider whenever possible. However, if services have already been requested for or initiated by an AHCCCS registered AzEIP provider not contracted with the AHCCCS Health Plan, the AHCCCS
EXHIBIT 430-3

PROCEDURES FOR THE COORDINATION OF SERVICES UNDER EARLY PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT, AND EARLY INTERVENTION

Health Plan must authorize the AHCCCS registered AzEIP provider to continue providing services deemed medically necessary to maintain continuity of care.

NOTE: For those members two years nine months of age or older who have not initiated services, the Contractor may choose to assigned the member to a contracted provider within the health plans provider network to maintain continuity of care as the member ages out of the AzEIP program.

v. AzEIP providers may only be reimbursed (a) if they are AHCCCS registered and (b) for the categories of services for which they are registered and that were provided. Billing must be completed in accordance with AHCCCS guidelines.

b. The requested services are not medically necessary:

i. The AHCCCS MCH Coordinator or designee will notify the AzEIP service coordinator within two business days of receipt of the PCP’s determination and that services are denied.

ii. The AHCCCS Health Plan must send a Notice of Action (NOA) to the PCP, the member’s guardian/parent and the AzEIP service coordinator notifying them that the service is denied.

iii. The AzEIP AHCCCS Member Service Request form (Exhibit 430-4) must also be returned to the AzEIP service coordinator indicating the services were determined not medically necessary.

c. An examination by the PCP is needed to determine medical necessity:

i. The AHCCCS Health Plan must send a Notice of Action letter to the PCP, the AzEIP service coordinator, the member’s guardian/parent, and the AHCCCS MCH coordinator or designee denying the service pending examination by the PCP.

ii. AzEIP AHCCCS Member Service Request form (Exhibit 430-4) must also be returned to the AzEIP service coordinator indicating the PCP wishes to examine the member and services are denied pending examination by the PCP.

iii. AHCCCS MCH coordinator must assist the member’s guardian/parent in making an appointment with the PCP and follow up with the PCP to ensure all medically necessary services identified on the AzEIP AHCCCS Member Service Request form (Exhibit 430-4) are considered for medical necessity.

iv. After the member is examined by the PCP and a determination is made, steps 8.a. through 8.b. should be followed.
EXHIBIT 430-3

PROCEDURES FOR THE COORDINATION OF SERVICES UNDER EARLY PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT, AND EARLY INTERVENTION

9. The AzEIP service coordinator must amend the IFSP to reflect the appropriate payer.

10. The MCH coordinator or designee assists the member’s guardian/parent in scheduling the EPSDT covered services, as necessary or as requested. The EPSDT services will be provided until the services are determined by the PCP and service provider to no longer be medically necessary.

11. When services are determined by the PCP and service provider to be no longer medically necessary, the AzEIP service coordinator shall implement the process for amending the IFSP which may include (a) non-medically necessary services covered by AzEIP, and (b) changes made to IFSP outcomes and IFSP services, including payer, setting, etc.

12. The AzEIP service coordinator, family and other IFSP team members will review the IFSP at least every six months, or sooner, if requested by any team member. If services are changed (deleted or added) during an annual IFSP or IFSP review, the AzEIP service coordinator will notify the MCH Coordinator or designee and PCP within two business days of the IFSP review. If a service is added, the AzEIP service coordinator’s notification to the MCH Coordinator will initiate the process for determining medical necessity and authorizing the service as outlined above.
EXHIBIT 430-4

ARIZONA EARLY INTERVENTION PROGRAM (AzEIP)
AHCCCS MEMBER SERVICE REQUEST
Arizona Department of Economic Security  
Arizona Early Intervention Program (AzEIP) 

AzEIP AHCCCS Member Service Request

Date

AzEIP SERVICE COORDINATOR’S NAME  
PHONE NO.  
FAX NO.  
EMAIL

AzEIP TBEIS CONTRACTOR  
PHONE NO.  
FAX NO.  
EMAIL

TYPE:  

- Initial IFSP  
- Six Month Review  
- Annual IFSP  
- Other/Addendum

DATE:

Child’s Information

Child’s Name  
AHCCCS ID No.  
Date of Birth  
Expected Month/Year of Transition From AzEIP

Parents/Guardians’ Name(s)  
PREFERRED LANGUAGE  
AHCCCS Health Plan  
Primary Care Physician

Mailing Address (No., Street, City, State, ZIP)  
Home Phone No.  
Work Phone No.  
Cell/Message Phone No.

See Attached: AzEIP Developmental Evaluation Report and results of the most recent evaluations and assessments.

Expected outcomes:

Dear Primary Care Physician: The child identified above is eligible for AzEIP and the AzEIP Individualized Family Service Plan (IFSP) Team is recommending the EPSDT services identified below. Please review the documentation, indicate whether each requested service is medically necessary by checking “yes” in shaded box next to each service and return to the health plan MCH coordinator who will coordinate prior authorization for the services you deem medically necessary. If you feel the services are not medically necessary, or the child should not receive these services at this time, please explain below:

Primary Care Physician’s Signature  
Date

To be completed by the AzEIP Service Coordinator:

<table>
<thead>
<tr>
<th>Requested Services/CPT Code</th>
<th>Requested Provider and Phone No.</th>
<th>Planned Start Date</th>
<th>Frequency</th>
<th>Duration</th>
<th>Medically necessary service</th>
<th>Approved by PCP</th>
<th>Approved by AHCCCS Contractor</th>
<th>NOA Sent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

If services are not medically necessary, or if the PCP wants to examine the member to determine medical necessity, the AHCCCS Contractor will deny the services and send a Notice of Action (NOA) letter to the member’s parents/guardians and the AzEIP Service Coordinator.

To be completed by the AHCCCS Contractor:

The AHCCCS Contractor must document what is approved: provider, frequency, duration and service begin date and service end date.

- If the Service Provider is unknown, the AHCCCS Contractor will identify a Service Provider below for:  
  - PT  
  - OT  
  - SLP

- If the requested Service Provider is not approved by the Contractor, the AHCCCS Contractor will identify an approved provider below.

<table>
<thead>
<tr>
<th>Approved Provider</th>
<th>Provider Phone No.</th>
<th>Approved Service(s)</th>
<th>Begin Date</th>
<th>End Date</th>
<th>Frequency</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

See reverse for EOE/ADA/LEP/GINA disclosures
### Contacts

<table>
<thead>
<tr>
<th>Health Plan:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>MCH Coordinator:</td>
<td></td>
</tr>
<tr>
<td>Phone No.:</td>
<td></td>
</tr>
<tr>
<td>Fax No.:</td>
<td></td>
</tr>
</tbody>
</table>

| AzEIP Coordinator: |  |
| Phone No.: |  |
| Fax No.: |  |

| Primary Care Physician: |  |
| Phone No.: |  |
| Fax No.: |  |

| Service Provider: |  |
| Phone No.: |  |
| Fax No.: |  |

### Additional Information

Equal Opportunity Employer/Program • Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Title II of the Genetic Information Nondiscrimination Act (GINA) of 2008, the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service or activity. For example, this means if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy, contact your local office; TTY/TDD Services: 7-1-1. • Free language assistance for DES services is available upon request.
As part of the physical examination, the physician, physician’s assistant or nurse practitioner must perform an oral health screening. A screening is intended to identify gross dental or oral lesions, but is not a thorough clinical examination and does not involve making a clinical diagnosis resulting in a treatment plan. Depending on the results of the oral health screening, referral to a dentist must be made as outlined in the Contract:

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>RECOMMENDATION FOR NEXT DENTAL VISIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMERGENT</td>
<td>Within 24 hours of request</td>
</tr>
<tr>
<td>URGENT</td>
<td>Within three days of request</td>
</tr>
<tr>
<td>ROUTINE</td>
<td>Within 45 days of request</td>
</tr>
</tbody>
</table>

An oral health screening must be part of an EPSDT screening conducted by a PCP. However, it does not substitute for examination through direct referral to a dentist. PCPs must refer EPSDT members for appropriate services based on needs identified through the screening process and for routine dental care based on the AHCCCS EPSDT Periodicity Schedule. Evidence of this referral must be documented on the EPSDT Tracking Form and in the member’s medical record.

PCPs who have completed the AHCCCS required training, may be reimbursed for fluoride varnish applications completed at the EPSDT visits for members who are at least six months of age, with at least one tooth eruption. Additional applications occurring every six months during an EPSDT visit, up until member’s second birthday, may be reimbursed according to AHCCCS-approved fee schedules. Application of fluoride varnish by the PCP, does not take the place of an oral health visit.
AHCCCS recommended training for fluoride varnish application is located at [http://www.smilesforlifeoralhealth.org/buildcontent.aspx?tut=584&pagekey=64563&cbrecipient=0](http://www.smilesforlifeoralhealth.org/buildcontent.aspx?tut=584&pagekey=64563&cbrecipient=0). Please refer to Training Module 6 that covers caries risk assessment, fluoride varnish and counseling. Upon completion of the required training, providers should submit a copy of their certificate to each of the contacted health plans in which they participate, as this is required prior to issuing payment for PCP applied fluoride varnish. This certificate may be used in the credentialing process to verify completion of training necessary for reimbursement.

Additional training resources may be found on the Arizona Department of Health Services website [http://www.azdhs.gov/clinicians/training-opportunities/developmental/index.php](http://www.azdhs.gov/clinicians/training-opportunities/developmental/index.php).

**DENTAL HOME**

The American Academy of Pediatric Dentistry (AAPD) defines the dental home as “the ongoing relationship between the dentist and the member, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way” that must include:

1. Comprehensive oral health care including acute care and preventive services in accordance with AHCCCS Dental Periodicity Schedule.
2. Comprehensive assessment for oral diseases and conditions.
3. Individualized preventive dental health program based upon a caries-risk assessment and a periodontal disease risk assessment.
4. Anticipatory guidance about growth and development issues (ie, teething, digit or pacifier habits).
5. Plan for acute dental trauma.
6. Information about proper care of the child’s teeth and gingivae. This would include the prevention, diagnosis, and treatment of disease of the supporting and surrounding tissues and the maintenance of health, function, and esthetics of those structures and tissues.
7. Dietary counseling.
8. Referrals to dental specialists when care cannot directly be provided within the dental home.

Members must be assigned to a dental home by one year of age and seen by a dentist for routine preventative care according to the AHCCCS Dental Periodicity Schedule (Exhibit
MEMBER HEALTH CARE (EPSDT MEMBERS)

A. COVERED SERVICES

EPSDT covers the following dental services:

1. Emergency dental services including:
   a. Treatment for pain, infection, swelling and/or injury
   b. Extraction of symptomatic (including pain), infected and non-restorable primary and permanent teeth, as well as retained primary teeth (extractions are limited to teeth which are symptomatic), and
   c. General anesthesia, conscious sedation or anxiolysis (minimal sedation, members respond normally to verbal commands) when local anesthesia is contraindicated or when management of the member requires it. (See Policy 430, Section C, Item No. 9 regarding conscious sedation.)

2. Preventive dental services provided as specified in the AHCCCS Dental Periodicity Schedule (Exhibit 431-1), including but not limited to:
   a. Diagnostic services including comprehensive and periodic examinations. All Contractors must allow two oral examinations and two oral prophylaxis and fluoride treatments per member per year (i.e., one every six months) for members 12 months through 20 years of age.
   b. Radiology services screening for diagnosis of dental abnormalities and/or pathology, including panoramic or full-mouth x-rays, supplemental bitewing x-rays, and occlusal or periapical films, as medically necessary and following the recommendations by the American Academy of Pediatric Dentistry.

   NOTE: Panorex films will be covered as recommended by the American Academy of Pediatric Dentistry, up to three times maximum per provider for children between the ages of three to 20. Further panorex films needed above this limit must be deemed
CHAPTER 400
MEDICAL POLICY FOR MATERNAL AND CHILD HEALTH

POLICY 431
ORAL HEALTH CARE (EPSDT AGE MEMBERS)

medically necessary through the Contractor’s Prior Authorization (PA) process.

c. Preventive services which include:

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

ii. Application of topical fluorides. The use of a prophylaxis paste containing fluoride or fluoride mouth rinses do not meet the AHCCCS standard for fluoride treatment.

iii. Dental sealants for first and second molars are covered every three years up to 15 years of age, with a two-time maximum benefit. Additional applications must be deemed medically necessary and require PA through the Contractor.

iv. Space maintainers when posterior primary teeth are lost and when deemed medically necessary through the Contractor’s PA process.

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

a. Periodontal procedures, scaling/root planing, curettage, gingivectomy, and osseous surgery.

b. Crowns:

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

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

c. Endodontic services including pulp therapy for permanent and primary teeth, except third molars (unless a third molar is functioning in place of a missing molar).
d. Restoration of carious permanent and primary teeth with accepted dental materials other than cast or porcelain restorations, unless the member is 18 through 20 years of age and has had endodontic treatment.

e. Restorations of anterior teeth for children under the age of five, when medically necessary. Children, five years and over with primary anterior tooth decay should be considered for extraction, if presenting with pain or severely broken down tooth structure, or be considered for observation until the point of exfoliation as determined by the dental provider.

f. Removable dental prosthetics, including complete dentures and removable partial dentures.

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

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

i. Congenital craniofacial or dentofacial malformations requiring reconstructive surgical correction in addition to orthodontic services

ii. Trauma requiring surgical treatment in addition to orthodontic services, or

iii. Skeletal discrepancy involving maxillary and/or mandibular structures.

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

B. PROVIDER REQUIREMENTS

Informed Consent

Informed consent is a process by which the dental provider advises the member/member’s parent or legal guardian of the diagnosis, proposed treatment and alternate treatment methods with associated risks and benefits of each, as well as the associated risks and benefits of not receiving treatment.
Informed consents for oral health treatment include:

1. A written consent for examination and/or any preventative treatment measure, which does not include an irreversible procedure, as mentioned below. This consent is completed at the time of initial examination and is updated at each subsequent six month follow-up appointment.

2. A separate written consent for any irreversible, invasive procedure, including but not limited to dental fillings, pulpotomy, etc. In addition, a written treatment plan must be reviewed and signed by both parties, as described below, with the member’s parent or legal guardian receiving a copy of the complete treatment plan.

All providers must complete the appropriate informed consents and treatment plans for AHCCCS members as listed above, in order to provide quality and consistent care, in a manner that protects and is easily understood by the member and/or the member’s parent or legal guardian. Consents and treatment plans must be in writing and signed/dated by both the provider and the member, or the member’s parent or legal guardian, if the member is under 18 years of age or is 18 years of age or older and considered an incapacitated adult (as defined in A.R.S. § 14-5101). Completed consents and treatment plans must be maintained in the members’ chart and are subject to audit.

C. CONTRACTOR REQUIREMENTS

Contractors must:

1. Conduct annual outreach efforts to members receiving oral health care through school-based or mobile unit providers (whether in or out of network), ensuring members are aware of their dental home provider and contact information, as well as understand the availability of ongoing-access to care through the dental home provider, when school-based or mobile unit providers are not accessible.

2. Contractors must conduct written member educational outreach related to dental home, importance of oral health care, dental decay prevention measures, recommended dental periodicity schedule, and other Contractor selected topics at a minimum of once every 12 months. These topics may be addressed separately or combined into one written outreach material; however, each topic must be covered during the 12-month period (Refer to Exhibit 400-3, AHCCCS Maternal Child Health/EPSDT Member Outreach).

3. Educate providers in the importance of offering continuously accessible, coordinated, family-centered care.
4. Develop processes to:

   a. Ensure members are enrolled into a dental home by one year of age to allow for an ongoing relationship providing comprehensive oral health care. This process should allow members the choice of dental providers from within the Contractor’s provider network and provide members instructions on how to select or change a dental home provider. Member’s not selecting a dental home provider will be automatically assigned a provider by the Contractor.

   b. Connect all EPSDT age members to a dental home before one year of age or upon assignment to the Contractor, informing members of selected or assigned dental home provider contact information and recommended dental visit schedule.

   c. Monitor member participation with the dental home and provide outreach to members who have not completed visits as specified in the AHCCCS Dental Periodicity Schedule (Exhibit 431-1).

   d. Develop, implement, and maintain a procedure to notify all members/responsible parties of visits required by the AHCCCS EPSDT and Dental Periodicity Schedules (Exhibits 430-1 and 431-1). Processes other than mailings must be pre-approved by AHCCCS Clinical Quality Management. This procedure must include notification to members or responsible parties regarding due dates of biannual (once every six months) dental visits. If a dental visit has not taken place, a second notice must be sent.

   e. Monitor provider engagement, related to scheduling and follow-up of missed appointments, to ensure care consistent with the recommended AHCCCS Dental Periodicity Schedule (Exhibit 431-1) for assigned EPSDT members.

   f. Improve oral health utilization by ten percent by the year 2015, which addresses the objectives, monitoring and evaluation activities of their program.

5. Develop and implement processes to reduce no-show appointment rates for Dental services.

6. Provide targeted outreach to those members who did not show for appointments.
NOTE: Contractors must encourage all providers to schedule the next Dental screening at the current office visit, particularly for children 24 months of age and younger.

7. Require the use of the AHCCCS Dental Periodicity Schedules (Exhibit 431-1) by all contracted providers. The AHCCCS Dental Periodicity Schedule gives providers necessary information regarding timeframes in which age-related required screenings and services must be rendered by providers.

D. CONTRACTOR REQUIREMENTS FOR THE DENTAL ANNUAL PLAN

Each Contractor must have a written Dental Annual Plan that addresses minimum Contractor requirements as specified in the prior section, as well as the objectives of the Contractor’s program that are focused on achieving AHCCCS requirements. It must also incorporate monitoring and evaluation activities for these minimum requirements (see Exhibit 400-2C, Dental Annual Plan Checklist). The Dental Annual Plan must be submitted no later than December 15th to the AHCCCS Division of Health Care Management/Clinical Quality Management Unit and is subject to approval (see Exhibit 400-1, Maternal and Child Health Reporting Requirements). The written Dental Annual Plan must contain, at a minimum, the following:

1. Dental Narrative Plan – A written narrative description of all planned activities to address the Contractor’s minimum requirements for Dental services, as specified in the prior section. The narrative description must also include Contractor activities to identify member needs and coordination of care, as well as follow-up activities to ensure appropriate treatment is received in a timely manner.

2. Dental Work Plan Evaluation – An evaluation of the previous year’s Work Plan to determine the effectiveness of strategies, interventions, and activities used toward meeting stated objectives.

3. Dental Work Plan that includes:
   a. Specific measurable objectives. These objectives must be based on AHCCCS established Minimum Performance Standards. In cases where AHCCCS Minimum Performance Standards have been met, other generally accepted benchmarks that continue the Contractor’s improvement efforts will be used (e.g., National Committee on Quality Assurance, Healthy People 2020 standards). The Contractor may also develop their own specific measurable goals and objectives aimed at enhancing the Dental program when Minimum Performance Standards have been met.
   b. Strategies and specific measurable interventions to accomplish objectives (e.g., member outreach, provider education and provider compliance with mandatory components of the Dental program).
c. Targeted implementation and completion dates of work plan activities.

d. Assigned local staff position(s) responsible and accountable for meeting each established goal and objective.

e. Identification and implementation of new interventions, continuation of or modification to existing interventions, based on analysis of the previous year’s Work Plan Evaluation.

4. Relevant policies and procedures, referenced in the Dental Annual Plan, submitted as separate attachments.

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

Refer to Chapter 300, Policy 320-A, Affiliated Practice Dental Hygienist Policy, regarding services for members 18 years of age or younger provided by dental hygienists with an affiliated practice agreement.
EXHIBIT 431-1

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
DENTAL PERIODICITY SCHEDULE
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
DENTAL PERIODICITY SCHEDULE

RECOMMENDATIONS FOR PREVENTIVE PEDIATRIC ORAL HEALTH CARE *

These recommendations are designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations may require modification for children with special health care needs.

<table>
<thead>
<tr>
<th>AGE</th>
<th>12-24 months</th>
<th>2-6 years</th>
<th>6-12 years</th>
<th>12 years and older</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical oral examination including but not limited to the following:1</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>- Assess oral growth and development</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>- Caries-risk Assessment</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>- Assessment for need for fluoride supplementation</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>- Anticipatory Guidance/Counseling</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>- Oral hygiene counseling</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>- Dietary counseling</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>- Injury prevention counseling</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>- Counseling for nonnutritive habits</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>- Substance abuse counseling</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>- Counseling for intraoral/perioral piercing</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>- Assessment for pit and fissure sealants</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Radiographic Assessment</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Prophylaxis and topical fluoride</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

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

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

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

* Adaptation from the American Academy of Pediatric Dentistry Schedule
This Policy provides information about the health care services available under the Federal Children’s Health Insurance Program (Title XXI), known as the Arizona KidsCare Program. The KidsCare Program is administered by AHCCCS and provides health care coverage statewide to eligible children under age 19. Covered services are provided through AHCCCS Contractors. In addition, AHCCCS enters into Intergovernmental Agreements with Indian Health Services and 638 Tribal Facilities for services to be provided to American Indian members who select these programs for primary care.

A. COVERED SERVICES

The KidsCare Program offers comprehensive medical, behavioral health, preventive and treatment services, pursuant to Arizona Revised Statutes Title 36, Chapter 29, Article 4. All covered services must be medically necessary and provided by a primary care provider or other AHCCCS registered providers who meet qualifications as described in Chapter 600, Provider Qualifications and Provider Requirements of this Manual.

KidsCare services must be provided according to community standards and standards set forth for members enrolled under Title XIX for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. Service descriptions and limitations included in Chapter 300, Medical Policy for AHCCCS Covered Services and Chapter 400, Medical Policy for Maternal and Child Health of this Manual will also apply for the KidsCare Program.

Some services provided to KidsCare members will require Prior Authorization (PA), either from the Contractor with whom the member is enrolled, or from the AHCCCS Division of Fee-For-Service Management (DFSM) for members who are receiving services on a Fee-For-Service basis. Specific Contractor PA requirements are not identified in this manual. To obtain details regarding these PA requirements for specific services, please contact the appropriate Contractor.

Refer to Chapter 800, Policy 810, Utilization Management Overview for procedures/methodologies to request PA and requirements related to concurrent review.
Refer to Arizona Administrative Code, Title 9, Chapter 34 (9 A.A.C. 34) for notice of action requirements if a service requiring PA is denied, reduced, suspended or terminated by either a Contractor or AHCCCS.

B. **EXCLUDED SERVICES UNDER THE KIDS CARE PROGRAM**

The following services are excluded:

1. Licensed midwife services for prenatal care and home births, in accordance with A.A.C. R9-31-205.

2. Services provided under the Medicaid School Based Claiming Program (Title XXI is not eligible for Medicaid School Based Claiming).

3. Persons residing in an Institution for Mental Disease at the time of initial eligibility determination or subsequent redetermination are not eligible for KidsCare.

Refer to Chapter 800, Policy 810, Utilization Management Overview for procedures/methodologies to request PA and requirements related to concurrent review.

C. **CARE COORDINATION RESPONSIBILITIES**

Contractors must follow policies set forth in Chapter 500 of this Manual.

D. **MONITORING AND ASSESSING THE QUALITY OF CARE RECEIVED BY KIDS CARE MEMBERS**

Contractors must comply with all Quality Management and Performance Improvement requirements specified in Chapter 900 of this manual. In addition, Contractors must comply with care management and utilization management requirements specified in Chapter 1000. Contractors are encouraged to include in their EPSDT Annual Plan and quarterly progress reports, activities that will increase utilization of services and/or acknowledge that EPSDT activities and objectives apply to both Title XIX members and those covered under Title XXI.

Contractors are encouraged to implement PA, care coordination and utilization management processes for the KidsCare Program services whenever appropriate.

E. **SERVICE DELIVERY REQUIREMENTS FOR INDIAN HEALTH SERVICE (IHS) AND 638 TRIBAL FACILITIES**

For their primary health care provider, KidsCare members who are American Indians may elect to enroll with an AHCCCS Contractor or the American Indian health Program. Behavioral health services not provided by IHS or a 638 Tribal Facility may
be provided by a Regional Behavioral Health Authority (RBHA) or a Tribal RBHA (TRBHA).

When an American Indian member is enrolled with the CRS Contractor (based on the choice that they make regarding where to receive their acute and behavioral health services, regardless of whether the member selects the fully integrated or CRS only option), the contractor, T/RBHA, or the FFS program must ensure that all covered behavioral health services are available to CRS enrolled American Indians, whether they live on or off reservation. The Contractor is not responsible for payment of behavioral health services provided to CRS enrolled American Indians by an IHS or 638 Provider, even if the member is enrolled with the Contractor.

The Contractor shall work in collaboration with the tribes to ensure that appropriate, accessible and culturally competent behavioral health services are available. The Contractor may enter into or maintain an agreement for behavioral health services with interested tribes who want to be a subcontractor such as a TRBHA or other culturally competent tribal providers.

If the American Indian Health Program is selected, the member must obtain services specified in this Chapter from IHS or the 638 Tribal Facility whenever possible. Covered services not available through IHS or the 638 Tribal Facility may be provided by AHCCCS Fee-For-Service (FFS) providers and reimbursed through AHCCCS. A non-IHS provider or facility rendering AHCCCS covered services must obtain PA from the AHCCCS/DFSM/UM/CM Unit for services specified in Policy 820 of this Manual when scheduling an appointment or admission for the FFS member (PA is not required for emergency transportation or medical, dental or behavioral health services provided on an emergency basis). The benefit and coverage conditions for each service are addressed in Chapter 300 and Chapter 400 of this Manual.

IHS and 638 Tribal Facilities must ensure that providers who render services under the KidsCare Program are registered with AHCCCS. Each member should be assigned to an IHS or 638 Tribal Facility provider who is responsible for providing, coordinating, and/or supervising medical services rendered to assigned members. This includes maintaining continuity of care and maintaining a complete individual medical record for each assigned member that is in compliance with requirements of Chapter 900, Policy 940, Medical Records and Communication of Clinical Information of this Manual. IHS and 638 Tribal Facilities are also responsible for providing necessary referrals for specialty care.
CHAPTER 400
MEDICAL POLICY FOR MATERNAL AND CHILD HEALTH

POLICY 450
RESERVED

450 RESERVED