

CHAPTER 400

MEDICAL POLICY FOR MATERNAL AND CHILD HEALTH

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CHAPTER 400

MEDICAL POLICY FOR MATERNAL AND CHILD HEALTH

DRAFT Implementation 10/01/2013



400 CHAPTER OVERVIEW

REVISION DATES: 02/01/2011, 10/01/09, 10/01/08, 04/01/07, 08/01/05, 04/01/04, 10/01/01,
10/01/97

INITIAL

EFFECTIVE DATE: 10/01/1994

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, EPSDT and KidsCare services. Contractors must participate in community initiatives and/or quality initiatives within the communities they serve.

Contractors must attend maternal and child health related meetings when requested by AHCCCS Administration.

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 complete discussion of care coordination and requirements.

Refer to [Chapter 600](#) for a complete discussion of provider and network requirements.

Refer to [Appendix I](#), Body Mass Index Charts, for a group of weight charts for both children and adults.

REFERENCES

1. Title 42, Code of Federal Regulations (42 C.F.R.) Part 441, Subpart B [EPSDT]
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. Social Security Act, Section 1905(R)
6. 42 USC 1396d(r) [EPSDT]
7. 42 USC 1396 a(a)(43)
8. 42 USC 1396d(a) [Mandatory and Optional Medicaid Services]
9. Social Security Act, Title V, Parts 1 and 4 [Maternal and Child Health]
10. Arizona Revised Statutes (A.R.S.) 36-2907 [Covered Health and Medical Services]
11. A.R.S. Title 36, Chapter 2, Article 3 [Children's Rehabilitative Services]
12. A.R.S. Title 36, Chapter 29, Article 4 [KidsCare]
13. Arizona Administrative Code (A.A.C.) Title 9, Chapter 22, Article 2 [EPSDT]
14. A.A.C., Title 9, Chapter 31 [KidsCare]
15. A.A.C., Title 9, Chapter 13, Article 2 [Newborn Infant Screening]
16. A.R.S. Title 36, Chapter 6, Article 5 [Maternal and Child Health]
17. AHCCCS Acute Care Contract, Section D
18. AHCCCS ALTCS Contract, Section D
19. AHCCCS CMDP Contract, Section D

20. AHCCCS CRS Contract, Section D
21. AHCCCS Contractor Operations Manual (ACOM), <http://www.azahcccs.gov>
22. Arizona Hospitals' Universal Newborn Hearing Screening, 2001 Guidelines, <http://www.azdhs.gov/phs/owch>
23. Joint Committee on Infant Hearing Statement 2007 Position Statement, http://www.cdc.gov/ncbddd/ehdi/documents/JCIH_2007.pdf
24. Centers for Medicare and Medicaid Services (CMS), Guide to Children's Dental Care in Medicaid, <http://www.cms.hhs.gov/medicaidearlyperiodicscrn/downloads/epsdtdentalguide.pdf>
25. Centers for Disease Control and Prevention (CDC), Immunization Schedules, <http://www.cdc.gov/vaccines/recs/schedules/default.htm>

DRAFT Implementation 10/01/2013

EXHIBIT 400-1

**MATERNAL AND CHILD HEALTH REPORTING REQUIREMENTS
(DUE TO AHCCCS/DHCM)**

DRAFT Implementation 10/01/2013

EXHIBIT 400-1

**MATERNAL AND CHILD HEALTH REPORTING REQUIREMENTS
(DUE TO AHCCCS/DHCM) ***

REPORT	DUE DATE*	REPORTS DIRECTED TO:
MONTHLY PREGNANCY TERMINATION REPORT [INCLUDING USE OF MIFEPRISTONE (MIFEPREX OR RU-486)] (EXHIBIT 410-2)	Monthly no later than 30 days following the end of the month.	Division Of Health Care Management - Clinical Quality Management Unit (DHCM/CQM)
MATERNITY CARE ANNUAL PLAN	Annually, by December 15.	DHCM/CQM
SEMIANNUAL REPORT OF NUMBER OF PREGNANT WOMEN WHO ARE HIV/AIDS POSITIVE (EXHIBIT 410-4)	Semiannually, no later than 30 days after the end of the 2 nd and 4 th quarters of each contract year. (April 30 and October 30)	DHCM/CQM
EPSDT ANNUAL PLAN	Annually, by December 15.	DHCM/CQM
EPSDT IMPROVEMENT AND ADULT QUARTERLY MONITORING REPORT.	Quarterly, within 15 days of the end of each quarter (see Appendix A for report template and instructions). As noted on Appendix A, effective 10/1/09, shaded areas are not in effect.	DHCM/CQM
ADDITIONAL REPORTING (AS NEEDED)		
STILLBIRTH SUPPLEMENT REQUEST (EXHIBIT 410-5)	Within six months of delivery date	DHCM/CQM

Revised: 10/2009, 10/2008, 4/2004, 2/2001

* An extension of time to complete a report may be requested by contacting the Administrator of the Clinical Quality Management Unit in DHCM.

EXHIBIT 400-2

MATERNITY PLAN/EPSDT/DENTAL PLAN CHECKLIST

DRAFT Implementation 10/01/2013

Exhibit 400-2
MATERNITY PLAN/EPSDT/DENTAL PLAN CHECKLIST
CONTRACTOR

BBA ¹ SECTION AND AMPM ² SECTION	CHAPTER 400 MATERNAL AND CHILD HEALTH	PLAN PAGE # ³	YES	NO	EXPLANATION OF “NO” ANSWER
MATERNITY PROGRAM EVALUATION					
AMPM: 410-C	1. An evaluation and assessment that documents the effectiveness of Maternal Program strategies, interventions and activities directed at achieving good birth outcomes. The report must be completed annually (report on the last year).				
MATERNITY PROGRAM WORK PLAN					
AMPM: 410-C	2. A work plan that formally documents the Maternal Program objectives, strategies and activities directed at achieving good birth outcomes.				
BBA: 438.240 (c)-# 1 AMPM: 410-C	3. Specific measurable objectives. These objectives may be based on AHCCCS established minimum performance standards.				
AMPM: 410-C	4. In cases where AHCCCS minimum performance standards have been met, other generally accepted benchmarks may be used (e.g., National Committee on Quality Assurance, Healthy People 2010 standards). The Contractors may also develop their own specific measurable goals and objectives aimed at enhancing the maternity program.				
AMPM: 410-C	5. Strategies and activities to accomplish objectives.				
AMPM: 410-C	6. Targeted implementation and completion dates of work plan activities.				
AMPM: 410-C	7. A listing of staff positions responsible and accountable for meeting established goals and objectives.				

DRAFT - Public Comment Period 10/01/2014

Exhibit 400-2
MATERNITY PLAN/EPSDT/DENTAL PLAN CHECKLIST
CONTRACTOR

BBA ¹ SECTION AND AMPM ² SECTION	CHAPTER 400 MATERNAL AND CHILD HEALTH	PLAN PAGE # ³	YES	NO	EXPLANATION OF “NO” ANSWER
	MATERNITY AND FAMILY PLANNING PROGRAM NARRATIVE DESCRIPTION / POLICY & PROCEDURES				
AMPM: 410-C	8. A narrative description of services such as outreach, education, and family planning services provided when appropriate based on the member’s current eligibility and enrollment, including participation in community and/or quality initiatives within the communities served by the Contractor. Include in the narrative a description of the process to inform Contractor OB/GYN providers of AHCCCS requirements.				
AMPM: 410-A	9. Description of activities that ensure prenatal care, labor/delivery and postpartum care services are provided by licensed midwives within their scope of practice.				
AMPM: 410-A	10. 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 College of Obstetrics and Gynecology (ACOG) Standards for Obstetric and Gynecologic Services.				
AMPM: 410-B	11. Appropriately qualified personnel in sufficient numbers to carry out the components of the maternity care program for eligible enrolled members to achieve compliance.				
AMPM: 410-B	12. Process to conduct outreach activities to identify currently enrolled pregnant women and enter them into prenatal care as soon as possible.				

¹BBA = Balanced Budget Act of 1997

²AMPM = AHCCCS Medical Policy Manual

³Plan Page # = Page Number in Contractor’s MCH/EPSDT Plan

Exhibit 400-2
MATERNITY PLAN/EPSDT/DENTAL PLAN CHECKLIST
CONTRACTOR

BBA ¹ SECTION AND AMPM ² SECTION	CHAPTER 400 MATERNAL AND CHILD HEALTH	PLAN PAGE # ³	YES	NO	EXPLANATION OF “NO” ANSWER
AMPM: 410-B	13. Process by which service providers notify the Contractor of case finding activities and when members have tested positive for pregnancy.				
AMPM: 410-B	14. 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.				
AMPM: 410-B	15. Process to ensure designation of a maternity care provider for each enrolled pregnant women for the duration of her pregnancy and postpartum care.				
AMPM: 410-B	16. Process to inform newly assigned pregnant members and those currently in care with a provider in another network, or allowing the opportunity to change Contractors to ensure continuity of prenatal care.				
AMPM: 410-B	17. 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.				
AMPM: 410-B	18. Description of activities to assure network providers adhere to AHCCCS requirements defined in Policy 410-B – 9. a through h (Including prenatal care, return visits and postpartum visits).				
AMPM: 410-B	19. Process to document written intake procedures for the provider, which include identifying risk factors through the use of a comprehensive tool that covers psychosocial, nutritional, medical and educational factors (i.e. ACOG, MICA).				

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²AMPM = AHCCCS Medical Policy Manual

³Plan Page # = Page Number in Contractor’s MCH/EPSDT Plan

Exhibit 400-2
MATERNITY PLAN/EPSDT/DENTAL PLAN CHECKLIST
CONTRACTOR

BBA ¹ SECTION AND AMPM ² SECTION	CHAPTER 400 MATERNAL AND CHILD HEALTH	PLAN PAGE # ³	YES	NO	EXPLANATION OF “NO” ANSWER
AMPM: 410-B	20. Process to educate network physicians and practitioners about the Baby Arizona Program and the process for becoming a Baby Arizona provider. (Acute Plan only)				
AMPM: 410-B	21. 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 Dept. of Health Services Hotline for a referral to a low or no-cost service/agency.				
AMPM: 410-B	22. Process that ensures that all providers maintain complete medical records documenting all aspects of maternity care.				
AMPM: 410-B	23. Description of activities to ensure mandatory provision of initial prenatal care appointments within established timeframes.				
AMPM: 410-B	24. Establishment of a specific objective for postpartum visit utilization rate provided to members within 60 days of delivery.				
AMPM: 410-B	25. Process to monitor and evaluate postpartum activities and interventions to increase postpartum utilization.				
AMPM: 410-B	26. Process to monitor C-section rate.				
AMPM: 410-B	27. Process to monitor and evaluate low birth weight/very low birth weight and implement interventions to decrease LBW/VLBW.				
AMPM: 410-B	28. Process to identify postpartum depression and refer members to the appropriate health care providers.				
AMPM: 410-B	29. Process to ensure that all enrolled pregnant women receive transportation services as needed and as described in Chapter 300, Policy 310-BB.				

¹BBA = Balanced Budget Act of 1997

²AMPM = AHCCCS Medical Policy Manual

³Plan Page # = Page Number in Contractor’s MCH/EPSDT Plan

Exhibit 400-2
MATERNITY PLAN/EPSDT/DENTAL PLAN CHECKLIST
CONTRACTOR

BBA ¹ SECTION AND AMPM ² SECTION	CHAPTER 400 MATERNAL AND CHILD HEALTH	PLAN PAGE # ³	YES	NO	EXPLANATION OF “NO” ANSWER
AMPM: 420-A	30. 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.				
AMPM: 420-A	31. Process to assist providers with referrals to an agency which provides treatment at no/low cost to those who have a sexually transmitted disease and are enrolled in SOBRA Family Planning Extension Program. (Acute Plan only)				
AMPM: 420-A-2	32. Process in place to inform SOBRA members who lose eligibility for medical services (enrolled in the SOBRA Family Planning Extension Program) of no/low cost primary care services. The Notification must include the need for redetermination for eligibility at 12 months. (Acute Plan only)				
AMPM: 420-A-2	33. Process to assist providers in establishing procedures for referral of members enrolled in SOBRA Family Planning Extension Program with a medical need to primary care services at no/low cost. (Acute Plan only)				
AMPM: 420-A	34. Develop and implement a process for monitoring whether referrals for low/no cost primary care services were made. (Acute Plan only)				
AMPM: 420	35. Process to assist providers in establishing procedures for referral of those members who lose AHCCCS eligibility to low/no cost agencies for family planning services. (Acute Plan only)				
AMPM: 410-C	36. Contractors must attach all relevant policies and procedures, i.e. medically necessary pregnancy termination (including administration of RU 486), family planning, maternity care etc.				

¹BBA = Balanced Budget Act of 1997

²AMPM = AHCCCS Medical Policy Manual

³Plan Page # = Page Number in Contractor’s MCH/EPSDT Plan

Exhibit 400-2
MATERNITY PLAN/EPSTD/DENTAL PLAN CHECKLIST
CONTRACTOR

13

BBA ¹ SECTION AND AMPM ² SECTION	CHAPTER 400 MATERNAL AND CHILD HEALTH	PLAN PAGE # ³	YES	NO	EXPLANATION OF “NO” ANSWER
	EPSTD/DENTAL PROGRAM				
	EPSTD/DENTAL PROGRAM EVALUATION				
AMPM: 430-E	37. An evaluation and assessment that documents the effectiveness of EPSTD/Dental Program strategies, interventions, and activities directed at achieving healthy outcomes, at least annually (report on the last year).				
	EPSTD/DENTAL PROGRAM WORK PLAN				
AMPM: 430-E	38. A work plan that formally documents the EPSTD/Dental Program objectives, strategies and activities and demonstrate how these activities will improve the quality of services, the continuum of care, and health care outcomes (including PEDS and Childhood Obesity Program according to AHCCCS policy).				
BBA: 438.240 (c)-# 1 AMPM: 430-E	39. Specific measurable objectives. These objectives may be based on AHCCCS established minimum performance standards.				
AMPM: 430-E	40. In cases where AHCCCS minimum performance standards have been met, other generally accepted benchmarks may be used (e.g., National Committee on Quality Assurance, Healthy People 2010 standards). The Contractors may also develop their own specific measurable goals and objectives aimed at enhancing the EPSTD/Dental program.				
AMPM: 430-E	41. Strategies and activities to accomplish objectives.				

¹BBA = Balanced Budget Act of 1997

²AMPM = AHCCCS Medical Policy Manual

³Plan Page # = Page Number in Contractor’s MCH/EPSTD Plan

Exhibit 400-2
MATERNITY PLAN/EPSTD/DENTAL PLAN CHECKLIST
CONTRACTOR

BBA ¹ SECTION AND AMPM ² SECTION	CHAPTER 400 MATERNAL AND CHILD HEALTH	PLAN PAGE # ³	YES	NO	EXPLANATION OF “NO” ANSWER
AMPM: 430-E	42. Targeted implementation and completion dates of work plan activities.				
AMPM: 430-E	43. A listing of staff positions responsible and accountable for meeting established goals and objectives for EPSTD activities.				
EPSTD/DENTAL PROGRAM NARRATIVE DESCRIPTION POLICY & PROCEDURES					
AMPM: 430-E	44. A narrative written EPSTD plan, including dental, which addresses how the objectives will improve the quality of services, the continuum of care, and health care outcomes (including PEDS and Childhood Obesity Program according to AHCCCS policy).				
AMPM: 430-D	45. Process for completion and submission of EPSTD Improvement & Adult Monitoring Quarterly Report, using report template (refer to Appendix A) to AHCCCS Administration.				
AMPM: 430-D	46. Description of activities that inform all participating PCPs that EPSTD is a comprehensive child health program of prevention, treatment, correction, and improvement (amelioration) of physical and mental health problems for AHCCCS members under the age of 21 as described in 42 USC 1396d (a) and (r), including new updates as they become available.				
AMPM: 430-D	47. A description of activities that inform members that an EPSTD visit is synonymous with a well child visit and identifies all EPSTD Screenings and services in detail, as well as how to access the services.				

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²AMPM = AHCCCS Medical Policy Manual

³Plan Page # = Page Number in Contractor’s MCH/EPSTD Plan

Exhibit 400-2
MATERNITY PLAN/EPSTD/DENTAL PLAN CHECKLIST
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BBA ¹ SECTION AND AMPM ² SECTION	CHAPTER 400 MATERNAL AND CHILD HEALTH	PLAN PAGE # ³	YES	NO	EXPLANATION OF “NO” ANSWER
AMPM: 430-D	48. Description of activities used to identify the needs of EPSTD aged members, coordinate their care; conduct adequate follow-up and ensure members receive timely and appropriate treatment.				
AMPM: 430-D	49. Description of activities that ensure notification of all members/caretakers of EPSTD/Dental visits required by the AHCCCS EPSTD and Dental Periodicity Schedules. Second notices must be sent if visit is not completed. Additional notices may be necessary to ensure required schedule is met.				
AMPM: 430-D	50. Process to reduce no-show appointment rates for EPSTD services and a description of outreach activities targeted to those members who did not attend scheduled appointments.				
AMPM: 430-D	51. Process for distributing and requiring use of the AHCCCS EPSTD and Dental Periodicity Schedules and AHCCCS approved, standardized EPSTD Tracking Forms by all contracted providers.				
AMPM: 430-D	52. Process for monitoring that providers use the EPSTD tracking forms at every EPSTD visit and that age appropriate screening and services are conducted during each EPSTD visit in accordance with the AHCCCS EPSTD and Dental Periodicity Schedules.				
AMPM: 430-D	53. Process to inform PCPs when a NICU–discharged member is assigned to their panel.				
AMPM: 430-D	54. Process for coordination of care and services by appropriate state agencies for EPSTD eligible members (CRS, AzeIP, WIC, VFC, ASIIS, Head Start).				

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²AMPM = AHCCCS Medical Policy Manual

³Plan Page # = Page Number in Contractor’s MCH/EPSTD Plan

Exhibit 400-2
MATERNITY PLAN/EPSTD/DENTAL PLAN CHECKLIST
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BBA ¹ SECTION AND AMPM ² SECTION	CHAPTER 400 MATERNAL AND CHILD HEALTH	PLAN PAGE # ³	YES	NO	EXPLANATION OF “NO” ANSWER
AMPM: 430-D	55. Process to transition members who are aging out of Children’s Rehabilitative Services (CRS).				
AMPM: 430-D	56. Process for providing necessary supplemental nutrition to eligible members of EPSTD age.				
AMPM: 430-D	57. Process to assist members in navigating the healthcare system to ensure that members receive appropriate support services, as well as inform members of any other community-based resources that support good health outcomes.				
AMPM: 430-D	58. 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 EPSTD covered services because there is not a contracted provider available; or the Contractor wishes to preserve continuity of care for services already initiated by a non-contracted AHCCCS registered AzEIP provider. (Acute Plan only)				
AMPM: 430-D	59. Educate providers to comply with the AHCCCS/AzEIP Procedures for the coordination of services under early periodic screening diagnostic and treatment and early intervention (Exhibit 430-4) when the need for medically necessary services are identified for members birth to 3 years of age and ensure 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.				

¹BBA = Balanced Budget Act of 1997

²AMPM = AHCCCS Medical Policy Manual

³Plan Page # = Page Number in Contractor’s MCH/EPSTD Plan

Exhibit 400-2
MATERNITY PLAN/EPSDT/DENTAL PLAN CHECKLIST
CONTRACTOR

BBA¹ SECTION AND AMPM² SECTION	CHAPTER 400 MATERNAL AND CHILD HEALTH	PLAN PAGE #³	YES	NO	EXPLANATION OF “NO” ANSWER
AMPM: 430-E	60. Contractor must include relevant and current revisions of policies and procedures related to this section, i.e. EPSDT, Dental, PEDS, AzEIP, Childhood Obesity, supplemental nutrition and coordination of care and services with the appropriate state agencies.				

DRAFT Implementation 10/01/2008

¹BBA = Balanced Budget Act of 1997

²AMPM = AHCCCS Medical Policy Manual

³Plan Page # = Page Number in Contractor’s MCH/EPSDT Plan



410 MATERNITY CARE SERVICES

REVISION DATES: XX/XX/XX, 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 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, education, 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 College of Obstetricians and Gynecologists (ACOG) standards for obstetric and gynecologic services. Prenatal care, labor/delivery and postpartum care services may be provided by licensed midwives within their scope of practice. According to ACOG guidelines, cesarean section deliveries must be medically necessary. Inductions and cesarean section deliveries prior to 39 weeks are not recommended in the ACOG guidelines.

A. MATERNITY CARE SERVICE DEFINITIONS

1. High-risk pregnancy is 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 College of Obstetricians and Gynecologists (ACOG) standardized medical risk assessment tool.
2. 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).
3. Maternity care includes medically necessary preconception counseling, identification of pregnancy, prenatal care, labor and delivery services and postpartum care.
 4. Maternity care coordination consists of the following maternity care related activities: determining the member's medical or medical/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; monitoring to ensure the services are received and revising the plan of care as appropriate.
 5. 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.
 6. Postpartum care is the health care provided for a period of up to 60 days post delivery. Family planning services, as addressed in Policy 420 of this Chapter, are included if provided by a physician or practitioner.
 7. Preconception 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.
 8. Prenatal care is the health care provided during pregnancy and is composed of three major components:
 - a. Early and continuous risk assessment
 - b. Health 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 good birth outcomes. The minimum requirements of the maternity care program are:



1. Employ sufficient numbers of appropriately qualified local personnel in order to carry out the components of the maternity care program for eligible enrolled members in order to achieve contractual compliance.
2. Conduct outreach activities to identify currently enrolled pregnant women 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.
3. Participate in community and/or quality initiatives within the communities served by the Contractor.
4. Written protocols 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.
 - a. Each Contractor must include information in the member newsletter, maternity packets, provider instructions, and/or the member handbook at least annually to encourage pregnant women to be tested and provide instructions on where testing is available.
 - b. Semiannually, each Contractor must report to AHCCCS the number of pregnant women who have been identified as HIV positive. This report (Exhibit 410-4) is due no later than 30 days after the end of the second and fourth quarters of the contract year.
5. 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.
6. Provision of 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.
7. 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 College of Obstetricians and Gynecologists [ACOG] or the Mutual Insurance Company of Arizona [MICA]).



8. Mandatory availability of maternity care coordination services for enrolled pregnant women who are determined to be medically/socially at risk or high risk by the maternity care provider or the Contractor.
9. Demonstration of an established mechanism for assuring that:
 - a. Network physicians and practitioners adhere to the ACOG standards of care including the use of a standardized medical risk assessment tool and ongoing risk assessment.
 - b. Network physicians and practitioners are educated about the Baby Arizona Program and the process for becoming a Baby Arizona provider. For additional information, please call the Arizona Department of Health Services Hotline at 1-800-833-4642 or visit the Baby Arizona website at www.babyarizona.gov.
 - c. Licensed midwives, if included in the Contractor's provider network, adhere to standards of care specified within their scope of practice and use the AHCCCS standardized risk assessment form (Exhibit 410-3) in accordance with requirements specified in the Licensed Midwife Services section of this policy.
 - d. Maternity care providers educate members about healthy behaviors during pregnancy, including the importance of proper nutrition; smoking cessation; avoidance of alcohol and other harmful substances, including illegal drugs; screening for sexually transmitted diseases; the physiology of pregnancy; the process of labor and delivery; breast-feeding; other infant care information; and postpartum follow-up.
 - e. 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. Members must be notified that in the event they lose eligibility, they may contact the Arizona Department of Health Services Hotline for referrals to low or no-cost services.
 - f. Maternity care providers maintain a complete medical record documenting all aspects of maternity care.
 - g. High-risk pregnant members have been referred to, and are receiving appropriate care from, a qualified physician, and
 - h. Postpartum services are provided to members within 60 days of delivery.



10. 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.
11. A process to monitor and evaluate infants born with low/very low birth weight, and implement interventions to decrease the incidence of infants born with low/very low birth weight.
12. Mandatory process for primary verification of pregnant members to ensure that the above mentioned timeframes are met, and to effectively monitor that members are seen in accordance with those timeframes.
13. Mandatory provision of return visits in accordance with ACOG standards. A process, with primary verification, must be in place to monitor these appointments to ensure timeliness.
14. Timely provision of medically necessary transportation services as described in [Chapter 300, Policy 310](#).
15. The establishment of a specific objective for postpartum visit utilization rate. Postpartum activities must be monitored and evaluated, and interventions to improve the utilization rate must be implemented.
16. Participation of Contractors in all reviews of the maternity care services program conducted by the AHCCCS Administration, including provider visits and chart audits.



C. CONTRACTOR REQUIREMENTS FOR THE WRITTEN MATERNITY CARE PLAN AND FAMILY PLANNING SERVICES PLAN

Each Contractor must have a written maternity care plan that addresses minimum Contractor requirements as specified in the prior policy (numbers 1 through 15) as well as the objectives of the Contractor's program. It must also incorporate monitoring and evaluation activities for these minimum requirements (see Exhibit 400-2). The Maternity Care and Family Planning Services plan must be submitted annually to the AHCCCS Division of Health Care Management/Clinical Quality Management Unit and may be subject to approval (see Exhibit 400-1). The written maternity care plan must contain, at a minimum, the following:

1. A narrative description of all planned activities to address the Contractor's minimum requirements for maternity care services, including participation in community and/or quality initiatives within the communities served by the Contractor.
2. Contractors may attach relevant policies and procedures to this section.
3. A work plan containing:
 - a. Specific measurable objectives. These objectives may be based on AHCCCS established minimum performance standards or other generally accepted benchmarks. In cases where AHCCCS minimum performance standards have been met, other generally accepted benchmarks may be used (e.g., National Committee on Quality Assurance, Healthy People 2010 standards). The Contractors may also develop their own specific measurable goals and objectives aimed at enhancing the maternity program.
 - b. Strategies and activities to accomplish objectives (e.g., member outreach, provider education and provider compliance with mandatory components of the maternity care services program)
 - c. Targeted implementation and completion dates of work plan activities
 - d. Assessment of work plan monitoring activities and evaluation of outcomes, and
 - e. A listing of local staff positions responsible and accountable for meeting established goals and objectives.



D. FEE-FOR-SERVICE (FFS) MATERNITY CARE PROVIDER REQUIREMENTS

1. Physicians and practitioners must follow the American College of Obstetricians and Gynecologists standards of care, including the use of a standardized medical risk assessment tool and ongoing risk assessment.
2. Licensed midwives must provide services within their scope of practice and use the AHCCCS standardized risk assessment form (Exhibit 410-3) in accordance with requirements specified in the Licensed Midwife Services section of this policy.
3. All maternity care providers will ensure that:
 - a. High-risk members have been referred to a qualified physician and are receiving appropriate care.
 - b. Members are educated about health behaviors during pregnancy, including the importance of proper nutrition; smoking cessation; avoidance of alcohol and other harmful substances, including illegal drugs; screening for sexually transmitted diseases; the physiology of pregnancy; the process of labor and delivery; breastfeeding; other infant care information; and postpartum follow-up.
 - c. Member medical records are appropriately maintained and document all aspects of the maternity care provided, and
 - d. Members will 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. 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 or no cost services.
4. Postpartum services will be provided to members within 60 days of delivery.



E. COVERED RELATED SERVICES WITH SPECIAL POLICIES

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, which is not a covered service unless it is determined to be medically necessary
2. Extended stays for normal newborns
3. Home uterine monitoring
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

Description

Effective October 1, 2002, under Arizona Revised Statutes Title 36-2907(b), 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. INPATIENT HOSPITAL STAYS

Description

For members **under** the age of 21 years, AHCCCS will cover 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.

For members age 21 years and older, AHCCCS will cover 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 to the extent that the stay does not exceed the 25 day inpatient limit specified in Policy 310-K, Hospital Inpatient Services. Prior authorization is not required for hospitalizations that do not exceed 48 hours of inpatient hospital care for a normal vaginal delivery or do not exceed 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. If the mother's stay in the hospital exceeds the 25 day inpatient limit, the newborn may be granted an extended stay and is not subject to the 25 day inpatient limit.

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 and 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 College 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.

5. LABOR AND DELIVERY SERVICES PROVIDED IN THE HOME

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 pregnant 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.

Risk status must be determined by:

- a. The attending physician, physician assistant or certified nurse midwife using the standardized assessment tools for high-risk pregnancies from the Mutual Insurance Company of Arizona or the American College of Obstetricians and Gynecologists; or
- b. The licensed midwife using the AHCCCS standardized risk assessment form (Exhibit 410-3) in accordance with requirements specified in the Licensed Midwife Services section of this policy.

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 mandatory newborn screening for metabolic disorders, and referring the member and infant to a physician for a mandatory hearing screening and follow-up care of any assessed problematic conditions, as well as second mandatory specimen testing for metabolic disorders and second newborn hearing screening test. Licensed midwives refer to Exhibit 410-3, Sections III and IV. In addition, the provider must notify the mother's contractor or the AHCCCS newborn reporting line for infants born to fee-for-service mothers, of the birth. Notification must be given no later than three days after the birth in order to properly enroll the newborn with AHCCCS.

6. LICENSED MIDWIFE SERVICES

Description

AHCCCS covers maternity care and coordination provided by licensed midwives, within their scope of practice, for fee-for-service (FFS) members or enrolled members if licensed midwives are included in the Contractor 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. Risk status must initially be determined at the time of the first visit and each trimester thereafter by either:

- a. The member's attending physician or practitioner using the standardized assessment criteria and protocols for high-risk pregnancies from the American College of Obstetrics and Gynecology or Mutual Insurance Company of Arizona, or
- b. The licensed midwife using the AHCCCS standardized assessment form and evaluation criteria included in Exhibit 410-3 of this Chapter.

Before providing licensed midwife services, documentation certifying 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) Prior Authorization (PA) Unit for FFS members. In addition, a disclosure 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 services. The AHCCCS DFSM PA 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 with the assessment form, Exhibit 410-3, 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 mandatory newborn screening for metabolic disorders, and referring the member and infant to a physician for a mandatory hearing screening and follow-up care of any assessed problematic conditions, as well as second mandatory specimen testing for metabolic disorders and second newborn hearing screening test (licensed midwives refer to Exhibit 410-3, Sections III and IV).

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

7. SUPPLEMENTAL DELIVERY 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 child is stillborn. Stillbirth refers to those infants, either pre-term or term, delivered in the third trimester of a documented pregnancy, who were born dead. In order for Contractors to be



eligible to receive this payment for a delivery of a stillborn child, the following criteria must be met:

1. 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 a physician's prenatal records and/or history and physical with estimated date of normal delivery, or
 - c. Attained a documented gestational age of at least 24 weeks at time of delivery by use of the Ballard system of evaluation for age assessment. Testing for gestational age can be performed by either nursing or physician staff in attendance at the time of delivery of the stillborn child.
2. For stillbirths meeting one of the above medical criteria, Contractors must submit medical documentation with the "Request for Stillbirth Supplement" form (Exhibit 410-5) to:

AHCCCS
Division of Health Care Management
Clinical Quality Management Unit/MCH Manager
701 E. Jefferson, MD 6500
Phoenix, AZ 85034

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 Clinical Quality Management Unit at AHCCCS. Exemptions will be considered on a case-by-case basis.



8. PREGNANCY TERMINATION (INCLUDING MIFEPRISTONE)

Description

AHCCCS covers pregnancy termination if one of the following conditions 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 rape or incest.
- c. 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 mental health problem for the pregnant member by:
 - i. Creating a serious physical or mental 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 has been determined medically necessary by submitting the Certificate of Necessity for Pregnancy Termination (see Exhibit 410-1) and clinical information that supports the medical necessity for the procedure.

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 or more of the above criteria have been met.

Additional Considerations Related to Use of Mifepristone

Mifepristone (also known as Mifeprex or RU-486) is not a postcoital emergency oral contraceptive. The administration of Mifepristone for the purposes of inducing



intrauterine pregnancy termination is covered by AHCCCS when all of the AHCCCS required conditions are 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.

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.
- c. When Mifepristone is administered, the following documentation is also required:
 - i. Duration of pregnancy in days
 - ii. The date IUD was removed if the member had one
 - iii. The date Mifepristone was given
 - iv. The date Misoprostol was given
 - v. Documentation that pregnancy termination occurred.

NOTE: Contractors must submit a standardized monthly Pregnancy Termination report (Exhibit 410-2) to AHCCCS/Division of Health Care Management 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 Certificate of Necessity for Pregnancy Termination which has been signed by the Contractor Medical Director or designee in addition to the form completed by the Contractor that verifies the diagnosis/condition that confirms that the medical necessity criteria have been met.
- b. A copy of the official incident report in the case of rape or incest, and
- c. A copy of documentation confirming pregnancy termination occurred.
- d. A copy of the clinical information that supports the medical necessity for the procedure.

(See Exhibit 410-2 for the reporting form and Exhibit 400-1 for submission timeframes.)

Prior Authorization (PA)

Except in cases of medical emergencies, the provider must obtain PA for all covered pregnancy terminations from the Contractor Medical Director, or his/her designee. PA for FFS pregnant members must be obtained from the AHCCCS Chief Medical Officer or designee. A completed Certificate of Necessity for Pregnancy Termination must be submitted with the request for PA along with the lab, radiology, consultation or other testing results that supports the medical necessity for the procedure. The Contractor Medical Director or AHCCCS Chief Medical Officer or designee will review the request and the Certificate, and expeditiously authorize the procedure if the documentation establishes the termination of pregnancy to be a medically necessary covered service.

In cases of medical emergencies, the provider must submit all documentation of medical necessity to the Contractor, or AHCCCS/Division of Fee-for-Service Management Prior Authorization 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.

DRAFT Implementation 10/01/2013

EXHIBIT 410-1

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
CERTIFICATE OF NECESSITY FOR PREGNANCY TERMINATION**

DRAFT Implementation 10/01/2013

EXHIBIT 410-1
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
CERTIFICATE OF NECESSITY FOR PREGNANCY TERMINATION

JUSTIFICATION FOR PREGNANCY TERMINATION (CHECK ONE AND PROVIDE ADDITIONAL RATIONALE):

<input type="checkbox"/> LIFE OF MOTHER ENDANGERED 	Member Name: _____ <div style="text-align: center; font-size: small;">Last First Middle</div> Member Address: _____ Date of Birth: _____ Member AHCCCS ID #: _____ Health Plan: _____
<input type="checkbox"/> RAPE Reported to authorities, pursuant to A.R.S. Section 13-3620 or A.R.S. Section 46-454 Yes _____ No _____ If yes, to what Agency? _____ Report #: _____ Date filed: _____ <input type="checkbox"/> Police report attached.	Facility: _____ Date of Service: _____ Procedure Code(s): _____
<input type="checkbox"/> INCEST Reported to authorities, pursuant to A.R.S. Section 13-3620 or A.R.S. Section 46-454 Yes _____ No _____ If yes, to what Agency? _____ Report #: _____ Date filed: _____ <input type="checkbox"/> Police report attached.	<p><u>COMPLETE ONLY WITH THE USE OF MIFEPRISTONE (MIFEPREX OR RU-486)</u></p> Duration of Pregnancy: _____ Days (in days) Date IUD Removed: _____ (if applicable) Date Mifepristone Given: _____ Date Misoprostol Given: _____ <input type="checkbox"/> Documentation of Confirmed Termination is Attached
<input type="checkbox"/> MEDICALLY NECESSARY 	

Physician's Printed Name: _____ Physician's Phone: _____ Fax: _____

Physician Signature: _____ Date: _____

Prior Authorization Number: _____ Date: _____

Denial Reason: _____ Date: _____

Contractor Medical Director/AHCCCS Chief Medical Officer Signature: _____

Verification of Diagnosis by Contractor

This page must be submitted by the Contractor with the Certificate of Necessity for Pregnancy Termination along with the clinical information as specified below for each member included in the 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

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 and request the following:

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

Name of Provider contacted: _____

Contact Information:

Telephone Number: _____

Address: _____

Facility/Practice Name: _____

An authorization decision must be made after contact is made with the provider that determined that the member had the qualifying diagnosis/condition.

EXHIBIT 410-2

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
MONTHLY PREGNANCY TERMINATION REPORT**

DRAFT Implementation 10/01/2013

EXHIBIT 410-2

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
MONTHLY PREGNANCY TERMINATION REPORT**

Contractor Name: _____

Reporting Period: _____
Month Year

Name of Individual completing form: _____
Name Title

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:

*REASON:	**AGE:	AHCCCS MEMBER ID	RATE CODE	PROCEDURE CODE	DATE OF SERVICE	AMOUNT PAID
1.						
2.						
3.						
4.						

Choose one of the following codes:

***Reasons for Termination**

- A. Life of Mother Endangered
- B. Result of Incest
- C. Result of Rape
- D. Medically Necessary

****Age/Condition**

- (a) Under 18 years of age
- (b) Incapacitated, over 18 years of age
- (c) 18 years of age and older

Attach to this report for each approved pregnancy termination:

- A copy of the AHCCCS Certificate of Necessity; and
- A copy of the official incident report when rape or incest is involved.

Mark the envelope **confidential** and send the completed information to the following address:

Arizona Health Care Cost Containment System
Division of Health Care Management
Clinical Quality Management Unit
701 East Jefferson, MD 6700
Phoenix, AZ 85034

DO NOT FAX

**ANY REQUIRED INFORMATION THAT IS NOT AVAILABLE AT THE TIME OF THIS REPORT
MAY BE INCLUDED IN THE NEXT MONTH'S REPORT.**

EXHIBIT 410-3

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
RISK ASSESSMENT TOOL SPECIFIC TO THE PROVISION OF
LOW RISK MATERNITY/DELIVERY CARE SERVICES BY LICENSED MIDWIVES
(PRIOR AUTHORIZATION FORM)**

DRAFT Implementation 10/01/2013

EXHIBIT 410-3

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
RISK ASSESSMENT TOOL SPECIFIC TO THE PROVISION OF
LOW RISK MATERNITY/DELIVERY CARE SERVICES BY LICENSED MIDWIVES
(PRIOR AUTHORIZATION FORM)**

Revised: 8/1/2005

DATE: _____	MIDWIFE NAME: _____	PROVIDER # _____
STREET ADDRESS: _____		CITY: _____
RECIPIENT NAME: _____		AHCCCS ID: _____
COUNTY: _____	STATE: _____	ZIP: _____
TELEPHONE: _____		

A Score of 3 (specific to each condition not accumulative) requires immediate transfer to a physician, and scores of 2 require consultation with a physician, (See A.A.C. R9-16-108 to R9-16-110). AHCCCS specific requirements in addition to Rule are identified by an asterisk (*). The requirement for continued prior authorization approval is dependent upon three submissions of this form at set intervals - Initial visit, between 32-36 weeks gestation, and immediate postpartum.

I. INITIAL SCREEN (Presentation)

SCORE (Circle)

A. Socio-Demographic Factors:

- | | | | |
|---|----|-----------------------------------------------------|-----|
| * | 1. | No assistance at home. | 2 |
| * | 2. | Recipient residence over 1 hour for midwife travel. | 1.5 |
| | 3. | Chronological age: | |
| | a. | Nulliparous over 40 years of age | 2 |
| * | b. | Multiparous over 45 years of age | 2 |
| | c. | Younger than 16 years of age. | 2 |

B. Maternal Medical History:

- | | | | |
|----|----------------------|----------------------------------------------------------------------------------|-----|
| 1. | Cardiovascular: | | |
| | a. | Chronic hypertension | 3 |
| | b. | Heart disease: | 3 |
| | | i. Valve replacement or other serious condition. | |
| | | ii. Mitral valve prolapse | 2-3 |
| | c. | Congenital heart defects | 3 |
| | d. | Pulmonary embolus | 3 |
| 2. | Urinary System: | | |
| | a. | Renal disease moderate to severe including nephritis or chronic renal disease. | 3 |
| * | b. | One episode of pyelonephritis prior to this pregnancy. | 2 |
| 3. | Psycho-Neurological: | | |
| | a. | History of severe psychiatric illness in the 6 month period prior to pregnancy. | 3 |
| * | b. | Previous psychotic episode diagnosed by psychiatric evaluation. | 2 |
| * | c. | Current mental health problem requiring treatment or management with medication. | 2 |
| | d. | Epilepsy or seizures. | 2 |

EXHIBIT 410-3
RISK ASSESSMENT TOOL
Page 2

		<u>SCORE (Circle)</u>
	* e. Current required use of anticonvulsant drugs	2
	f. Drug addiction (heroin, barbiturates, ETOH, cocaine, crack), current use of drugs, or therapy for drug abuse.	3
	* g. Cigarette smoking:	
	(1) < one pack/day.	1
	(2) > one pack/day.	1.5
	* h. Severe recurring migraines necessitating medication	2
4.	Endocrine:	
	a. Diabetes mellitus	3
	* b. Thyroid disease:	
	(1) History of thyroid surgery.	2
	(2) Enlarged thyroid with symptoms of thyroid disease and/or abnormal laboratory tests.	2
	(3) Current use of thyroid stimulating medications.	2
	(4) Current use of thyroid suppressing medications.	2
5.	Respiratory:	
	a. Active tuberculosis	3
	* b. Asthma and/or chronic bronchitis within the last 5 years.	1
6.	Other Systems:	
	a. Bleeding disorder and/or hemolytic disease.	3
	* b. Previous breast surgery for malignancy.	2-3
	* c. Other serious medical problems _____.	2-3
7.	H _x of severe postpartum bleeding, of unknown cause, which required transfusion.	3
8.	Active syphilis.	3
9.	Active hepatitis or active gonorrhea until treated and recovered, following which midwife care may resume.	3
10.	Primary genital herpes simplex infection in first trimester.	3
* 11.	Refusal of RH blood work or treatment.	2
C. Maternal Obstetrical History:		
* 1.	EDC < 12 months from date of previous delivery.	1.5
2.	Previous Rh sensitization.	3
3.	Parity greater than five	2
4.	Use of fertility drugs to achieve this pregnancy.	2-3
* 5.	3 or more spontaneous abortions (12-28 weeks)	2
6.	Previous uterine surgery including cesarean section.	3
* 7.	Previous ectopic pregnancy	2
* 8.	Previous cone biopsy.	2
* 9.	Previous abruptio placentae.	2
* 10.	Previous <u>placenta previa</u> or significant 3rd trimester bleeding.	2-3
* 11.	Severe hypertensive disorder during previous pregnancy (eclampsia).	3
* 12.	History of prolonged labor:	
	a. First labor: stage I > 24 hours, stage II > 3 hours, and/or stage III > 1 hour.	1
	b. Subsequent labors: stage I > 18 hours, stage II > 2 hours.	1
D. History Related to Previous Infants:		
1.	Stillbirth	2
* 2.	Birth weight (< 2500 grams or > 4500 grams).	1
* 3.	Major congenital malformations.	1
* 4.	Genetic metabolic disorder (genetic counseling).	1-2

EXHIBIT 410-3
RISK ASSESSMENT TOOL
Page 3

SCORE (Circle)

E. Maternal Physical Findings

1.	Length of gestation at registration;	
*a.	< 26 weeks.	0
*b.	26-30 weeks (labs normal and dates consistent).	1
*c.	30-32 weeks (labs normal and dates consistent).	1
*d.	> 32 weeks.	2
*e.	Gestational age > 34 weeks with no prenatal care	3
* 2.	Weight for height outside normal range (see attached sheet).	0-2
* 3.	Clinical evidence of uterine malformations or adnexal mass	2

DISPOSITION:

Initial Screen: (Circle)

Eligible

Not Eligible Because: _____

Referred to: _____

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**EXHIBIT 410-3
RISK ASSESSMENT TOOL**

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II. ANTEPARTUM REFERRAL/TRANSFER AND CONSULTATION FACTORS

SCORE (Circle)

A. Medical Complications:

1.	Rh disease with positive titers.	3
2.	A blood pressure of 140/90 or an increase of 30mm Hg systolic or 15mm Hg diastolic over client's lowest baseline blood pressure for two consecutive readings taken at least six hours apart.	3
3.	Hematocrit/Hemoglobin:	
a.	A persistent hemoglobin < 10gm/dl or a hematocrit < 30% during the third trimester.	3
* b.	Hematocrit < 32% or hemoglobin < 10.5 gm/dl at 37 weeks.	2
4.	A pelvis that will not safely allow a baby to pass through during labor.	3
5.	Severe, persistent headaches, with visual disturbances, stomach pains, or swelling of the face and hands.	2
6.	Greater than 1 + sugar, ketones, or protein in the urine on two consecutive visits.	2
7.	Excessive vomiting or continued vomiting after 20 weeks gestation.	2
8.	A fever of 100.4° Fahrenheit or 38° Centigrade twice at 24 hours apart.	2
9.	Persistent shortness of breath requiring more than 24 breaths per minute, or breathing which is difficult or painful.	2
10.	Testing positive for HIV.	2
11.	Deep vein thrombophlebitis or pulmonary embolism.	3

B. Obstetric Complications:

1.	Prematurity or labor beginning before 36 weeks gestation.	3
2.	Multiple gestation in the current pregnancy.	3
3.	Gestation beyond 42 weeks.	3
4.	Presence of ruptured membranes without onset of labor within 24 hours.	3
5.	Abnormal fetal heart rate of below 120 beats per minute or above 160 beats per minute.	3
6.	Failure to auscultate fetal heart tones by 22 weeks gestational age.	2
7.	Measurements for fetal growth are not within 2cm of gestational age.	2
8.	Failure to gain 12 pounds by 30 weeks gestation or gaining more than 8 pounds in any two week period during pregnancy.	2
9.	An abnormal presentation after 36 weeks.	2
10.	Effacement or dilation of the cervix, greater than a fingertip, accompanied by contractions, prior to 36 weeks gestation.	2
11.	Symptoms of decreased fetal movement.	2

C. Environmental Factors:

* 1.	Lack of electricity	1-2
* 2.	Lack of available water source.	1-2
* 3.	Consistent non-attendance at prenatal visits.	2-3
* 4.	Lack of available support person in the home for first 3 post partum days.	3
5.	An unsafe location for delivery.	3

DISPOSITION:

Initial Screen: (Circle): Eligibility Continued
Not Eligible Because: _____

Referral to: _____

III. LABOR/POSTPARTUM REFERRAL/TRANSFER AND CONSULTATION FACTORS

SCORE (Circle)

A MATERNAL FACTORS:

1.	Active genital herpes at the onset of labor.	3
2.	A pelvis that will not safely allow a baby to pass through during labor.	3
3.	A severe psychiatric illness evident during assessment of recipient's preparation for birth.	3
4.	Presence of ruptured membranes without onset of labor within 24 hours.	3
5.	A post partum hemorrhage of greater than 500cc in the current pregnancy.	3
6.	A fever of 100.4° Fahrenheit or 38° Centigrade twice at 24 hours apart.	2
7.	Second degree or greater lacerations of the birth canal.	2
8.	Failure of the uterus to return to normal size in the current postpartum period.	2
9.	Persistent shortness of breath requiring more than 24 breaths per minute, or breathing which is difficult or painful.	2
10.	Lack of progress in labor:	
	* a. First stage: Lack of steady progress in dilation and descent after 24 hours in multiparas and 18 hours in multiparas.	2
	* b. Second stage: > 2 hours without progress in descent.	2
	* c. Third stage: > 1 hour	2
* 11.	Marked cervical edema.	2
* 12.	Intrapartum blood loss > 500cc	2
* 13.	Evidence of infectious process.	2
* 14.	Development of other severe medical/surgical problems and/or condition requiring more than 12 hours of postpartum observation.	2
* 15.	Non-bleeding placenta retained more than 40 minutes	3

B. FETAL FACTORS:

1.	Abnormal fetal heart rate of below 120 beats per minute or above 160 beats per minute.	3
2.	Presence of thick meconium, blood-stained amniotic fluid or abnormal fetal heart tones.	3
3.	An unengaged head at seven centimeters dilation in active labor.	2
* 4.	Presence of light/moderate meconium staining.	2
* 5.	Estimated fetal weight < 2500 gm or > 4500 gm.	2
* 6.	Umbilical cord prolapse.	3

DISPOSITION:

Initial Screen: (Circle) Eligibility Continued
Not Eligible Because: _____

Referred to: _____

Exhibit 410-3
RISK ASSESSMENT TOOL
Page 6

IV. INFANT REFERRAL/TRANSFER AND CONSULTATION FACTORS

	<u>SCORE</u>
(Circle)	
1. Birth weight less than 2000 grams.	3
2. Pale blue or gray color after ten minutes.	3
3. Excessive edema.	3
4. Major congenital anomalies.	3
5. Respiratory distress.	3
6. Weight less than 2500 grams or 5 lbs., 8 oz.	2
7. Congenital anomalies.	2
8. An Apgar score less than seven at five minutes.	2
9. Persistent breathing at a rate of more than 60 breaths per minute.	2
10. An irregular Heartbeat.	2
11. Persistent poor muscle tone.	2
12. Less than 36 weeks gestation or greater than 42 weeks gestation by gestation exam.	2
13. Yellow colored skin within 48 hours.	2
14. Abnormal crying.	2
15. Meconium staining of the skin.	2
16. Lethargy, irritability, or poor feeding.	2
17. Excessively pink coloring over entire body.	2
18. Failure to urinate or pass meconium in the first 24 hours of life.	2
19. A hip examination which results in a clicking or incorrect angle.	2
20. Skin rashes not commonly seen in the newborn.	2
21. Temperature persistently above 99.0° or below 97.6° Fahrenheit.	2
* 22. Signs of Pre or Post-maturity.	1-2
* 23. Persistent Hypothermia (< 97° rectal after 2 hours of life).	2
* 24. Exaggerated Tremors	2
* 25. Any condition requiring > 12 hours of post-delivery observation.	2

BIRTH OUTCOME

Delivery Date: _____ EDC: _____ Time: _____ Infant Sex: _____ Weight: _____

Apgar Score: (Circle) 1 minute 5 minute (Circle) Breast Bottle Feed

Infant Prophylactic Procedures: Yes No (if no indicate if waivers are signed)

Infant Transfer Date and Time if Sick: _____ Newborn Screening Done: (Circle) Yes No

Postpartum:

Vital Signs Stable _____ Voiding _____ Foods/Fluids _____ Lab Work if Rh Negative _____ Laceration _____ (Degree) _____

Fundus _____

Mother

Referral Date: _____ Physician Name: _____ Outcome: _____

Transported: Yes No Hospital _____

Infant

Referral Date: _____ Physician Name: _____ Outcome: _____

Transported: Yes No Hospital: _____

Social Service: WIC: _____ Family Planning: _____ Domestic Violence: _____ Other: _____

EXHIBIT 410-4

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
SEMIANNUAL REPORT OF NUMBER OF PREGNANT WOMEN
WHO ARE HIV/AIDS POSITIVE**

DRAFT Implementation 10/01/2013

EXHIBIT 410-4



ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
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 contract year (due by April 30 and October 30).

Contractor Name: _____

Reporting Period: ___ October 1 through March 30
 ___ 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).

Mark the envelope confidential and send the completed information to the following address:

Arizona Health Care Cost Containment System
Division of Health Care Management
Clinical Quality Management Unit
701 East Jefferson, Mail Drop 6700
Phoenix, AZ 85034

PLEASE DO NOT FAX

EXHIBIT 410-5

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
REQUEST FOR STILLBIRTH SUPPLEMENT**

DRAFT Implementation 10/01/2013

EXHIBIT 410-5

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
REQUEST FOR STILLBIRTH SUPPLEMENT**

CONTRACTOR: _____

Infant Name: _____ Date of Delivery: _____

Place of Delivery: _____

Mother's Name: _____ Mother's
AHCCCS ID #: _____

Mother's Date of Birth: _____

Mother's Address: _____

Cause of Stillbirth (if known): _____

Application must be accompanied by one or more of the following forms:

- a. Neonatal I or similar hospital document, or
- b. Physician obstetrical prenatal records (history and physical) identifying EDC, or
- c. Ballard assessment (physical maturity rating) done at delivery or shortly thereafter by nursing and/or physician staff.

Send to: AHCCCS Administration
Division of Health Care Management/CQM
Maternal & Child Health Manager
701 E. Jefferson, MD 6700
Phoenix, AZ 85034

**THE FOLLOWING IS TO BE COMPLETED BY THE AHCCCS DIVISION OF
HEALTH CARE MANAGEMENT STAFF:**

Request Approved: _____

Request Denied: _____

Explanation: _____

Authorized Signature

Date



420 FAMILY PLANNING

REVISION DATES: XX/XX/XX, 02/01/11, 10/01/09, 11/01/08, 10/01/08, 04/01/07, 08/01/05,
04/01/04, 10/01/01, 02/01/99

INITIAL

EFFECTIVE DATE: 10/01/1994

Description

Family planning services are covered when provided by physicians or practitioners to members who voluntarily choose to delay or prevent pregnancy. Family planning and Sixth Omnibus Budget Reconciliation Act (SOBRA) Family Planning Extension Program (demonstration) 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 are receiving services through Fee-For-Service (FFS), may elect to receive family planning services in addition to other covered services.

Female members whose SOBRA postpartum eligibility has expired (Arizona Revised Statutes § 36-2907.04) and are enrolled with a Contractor, or are receiving services on a FFS basis, are eligible for the SOBRA Family Planning Extension Program for up to 24 months with redetermination of eligibility, including income, at 12 months. SOBRA family planning extension services include only those services related to family planning and complications of family planning services; other services are not covered.

Members who are enrolled with a Contractor at the time SOBRA eligibility expires will remain with their Contractor. Member may remain with their assigned maternity provider or exercise their option to select another provider from the Contractor's provider network for SOBRA family planning extension services. Members receiving services on a FFS basis may elect to remain with their attending FFS physician, or select a new FFS provider or a new Contractor for SOBRA family planning extension services.

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



CHAPTER 400
MEDICAL POLICY FOR MATERNAL AND CHILD HEALTH

POLICY 420
FAMILY PLANNING

1. Contraceptive counseling, medication, and/or supplies, including, but not limited to: oral and injectable contraceptives, subcutaneous 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. Postcoital emergency oral contraception within 72 hours after unprotected sexual intercourse (RU 486 is not postcoital emergency oral contraception).

Coverage for the following family planning services varies based upon eligibility status as indicated in the matrix below.

SERVICES	AHCCCS ACUTE CARE, ALTCS AND FFS MEMBERS	FEMALE MEMBERS * RECEIVING FAMILY PLANNING EXTENSION SERVICES
PREGNANCY SCREENING	Covered service	Covered only when completed prior to provision of long-term contraceptives.
PHARMACEUTICALS	Covered service when associated with medical conditions related to family planning or other medical conditions.	Covered service only when associated with medical conditions related to family planning.
SCREENING AND TREATMENT FOR SEXUALLY TRANSMITTED DISEASES (STDs)	Both screening and treatment for STDs are covered services.	Screening services for STDs are covered but treatment services are not provided through AHCCCS - a referral is made to an agency, which provides low or no cost STD treatment services.
STERILIZATION	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).	Services (including hysteroscopic tubal sterilizations effective 7-1-08) are covered for female members when the requirements specified in this policy for sterilization are met.
PREGNANCY TERMINATION AND HYSTERECTOMY	Covered as specified in this Policy [including Mifepristone (Mifeprex or RU 486)].	Not covered [including Mifepristone (Mifeprex or RU 486)].

* SOBRA family planning extension services are available only to female members who have lost SOBRA eligibility for medical services; men are not eligible for these services.



LIMITATIONS

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

1. Infertility services including diagnostic testing, treatment services or reversal of surgically induced infertility
2. Pregnancy termination counseling, or
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. 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 on 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 inform SOBRA members who lose eligibility for medical services (enrolled in the SOBRA Family Planning Extension Program) of no/low cost primary care services.

Must also have policies and procedures in place to inform providers of no/low cost primary care services available to these members.



3. 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.
4. Have family planning services that are:
 - a. Provided in a manner free from coercion or mental pressure
 - b. Available and easily accessible to members
 - c. Provided in a manner which assures continuity and confidentiality
 - d. Provided by, or under the direction of, a qualified physician or practitioner, and
 - e. Documented in the medical record. In addition, documentation must be recorded that each member of reproductive age was notified verbally or in writing of the availability of family planning.
5. Provide translation/interpretation of information related to family planning in accordance with requirements of the AHCCCS Division of Healthcare Management “Cultural Competency” policy, available from the AHCCCS Contractor Operations Manual (available online at www.azahcccs.gov).
6. Incorporate medical audits for family planning services within quality management activities to determine conformity with acceptable medical standards.
7. Establish quality/utilization management indicators to effectively measure/monitor the utilization of family planning services.
8. Have written practice guidelines that detail specific procedures for the provision of long-term contraceptives. These guidelines shall be written in accordance with acceptable medical standards.
9. Prior to insertion of subcutaneous implantable contraceptives, the family planning provider must provide proper counseling to the eligible member to minimize the likelihood of a request for early removal. Counseling information is to include a statement to the member indicating if the implant is removed within two years of insertion, the member may not be an appropriate candidate for reinsertion for at least one year after removal, and



10. In addition, Acute Care Contractors, as a part of the provision of SOBRA family planning extension services, must:
 - a. Assist providers in establishing procedures for referral of members, who are screened and determined to have sexually transmitted disease, to an agency which provides low/no cost treatment for members receiving SOBRA family planning extension services.
 - b. Assist providers in establishing procedures for referral of those members who lose AHCCCS eligibility to low/no cost agencies for family planning services.
 - c. Assist providers in establishing procedures for referral of those members with medical needs to an agency that provides low/no cost primary care services.
 - d. Develop a process for monitoring whether referrals for low/no cost primary care services were made.

B. PROTOCOL FOR MEMBER NOTIFICATION OF FAMILY PLANNING AND SOBRA FAMILY PLANNING EXTENSION 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. Acute Care Contractors are also responsible for the provision of SOBRA family planning extension services and information regarding these services. Contractors are responsible for reporting sterilization of SOBRA members, which will result in either ineligibility for or termination of AHCCCS family planning extension services for those members.

The AHCCCS Administration will notify all SOBRA members if their eligibility for full health care coverage is reduced to SOBRA family planning extension services only, and/or when members have lost eligibility for SOBRA family planning extension services. In addition, AHCCCS Administration will provide information about AHCCCS covered family planning services and SOBRA family planning extension services to members who receive services on a fee-for-service basis.

Member notification of these covered services must meet the following minimum requirements:

1. Notification shall be in accordance with A.R.S. § 36-2904L.
2. The requirement for 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 Administration 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 Contractor members who enroll after November 1, notification will 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. Acute Care Contractors must also provide such information to members regarding SOBRA family planning extension services.
 5. Notification to SOBRA Family Planning Extension Services members must include the need for redetermination for eligibility at 12 months.
 6. Notification must be written at a reading level appropriate for the membership.
 7. Notification must be presented in a second language in accordance with the requirements of the AHCCCS Division Of Health Care Management “Cultural Competency” policy, available in the AHCCCS Contractor Operations Manual (available at www.azahcccs.gov).
 8. Contractors must implement procedures to ensure that primary care providers (PCP) verbally notify members during office visits of the availability of family planning services at least annually.
 9. Acute Care Contractors’ maternity care providers must also provide information regarding SOBRA family planning extension services to assigned SOBRA members during their postpartum visit(s).
 10. Contractors must report to AHCCCS Division of Member Services (DMS) any member who receives a sterilization procedure during SOBRA eligibility. Reporting information must include the member’s name, AHCCCS identification number, date of birth, and date of sterilization. The Contractor must either:
 - a. Inform the AHCCCS DMS Newborn Reporting Unit at (602) 417-7400 or 1-800-228-6411 of the sterilization at the same time as the report of the newborn member (for sterilizations performed at the time of delivery of a child), or
 - b. Timely inform the AHCCCS DMS Verification Unit at (602) 417-7000 of sterilization of SOBRA members performed at any time during the 24-month coverage of family planning extension services.



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 obtained confirming that the member is sterile. After the confirmatory test the member is considered sterile. Contractors should not report sterilization of SOBRA members who received a hysteroscopic tubal sterilization until minimally 3 months post procedure and receipt of confirmatory hysterosalpingogram.

C. 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 and SOBRA family planning extension services
3. Comply with AHCCCS Division of Fee-for-Service Management Prior Authorization (PA) requirements for prescriptions and/or related family planning supplies, and
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 FFS provider.

D. STERILIZATION

The following AHCCCS requirements regarding member consent for covered sterilization services apply to Contractors and Fee-For-Service (FFS) providers. Reporting requirements for sterilization of SOBRA members only apply to Contractors (see the above policy entitled "Protocol for Member Notification of Family Planning and SOBRA Family Planning Extension Services and Contractor Reporting Requirements").

Sterilization of a member can occur when:

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



2. Mental competency is determined
3. Voluntary consent was obtained without coercion
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, or
5. 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 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 consent form member must first have been offered factual information including:

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
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.

DRAFT Implementation 10/01/2013

EXHIBIT 420-1

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
STERILIZATION CONSENT FORM**

DRAFT Implementation 10/01/2013

EXHIBIT 420-1

CONSENT FORM

42 C.F.R., Pt. 441, Subpart F, Appendix 10-01-02 Edition

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 (doctor or clinic). 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 A.F.D.C. or Medicaid that I am not 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 a. 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 thirty 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 Month Day Year

I, hereby consent of my

own free will to be sterilized by (doctor)

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 that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

Signature Date Month Day Year

You are requested to supply the following information, but it is not required: Race and ethnicity designation (please check)

- American Indian or Black (not of Hispanic origin)
Alaska Native Hispanic
Asian or Pacific Islander White (not of Hispanic origin)

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 Date

STATEMENT OF PERSON OBTAINING CONSENT

Before (name of individual) signed the consent form, 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 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

Facility

Address

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon on

Name: individual to be sterilized Date: sterilization 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 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 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 paragraphs: 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 thirty 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 Date



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

REVISION DATES: XX/XX/XX, 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, 10/01/01, 10/01/99

INITIAL EFFECTIVE DATE: 10/01/1994

Description

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

A well child visit is synonymous with an EPSDT visit and includes all screenings and services described in the AHCCCS EPSDT visit and includes all screenings and services described in the AHCCCS EPSDT and Dental Periodicity Schedules throughout this Chapter.

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



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 28 optional and mandatory categories of “Medical Assistance” as defined in the Medicaid Act. Services covered under EPSDT include all 28 categories of services in the Federal Law even when they are not listed as covered services in the AHCCCS State Plan, AHCCCS statutes, rules, or policies as long as the services are medically necessary and cost effective.

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

EPSDT screening services are provided in compliance with the periodicity requirements of Title 42 of the Code of Federal Regulations (42 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 Schedules for EPSDT are intended to meet reasonable and prevailing standards of medical and dental practice and specifies screening services at each stage of the child's life (see Exhibits 430-1 and 430-1A). The service intervals represent minimum requirements, and any services determined by a primary care provider to be medically necessary must be provided, regardless of the interval. The requirements and reporting forms for an EPSDT screening service are described in this Policy. EPSDT focuses on continuum of care by: assessing health needs, providing preventive screening, initiating needed referrals, and completing recommended medical treatment and appropriate follow-up.



A. EPSDT DEFINITIONS

1. Early means in the case of a child already enrolled with an AHCCCS Contractor as early as possible in the child's life, or in other cases, as soon after the member's eligibility for AHCCCS services has been established.
2. Periodic means at intervals established by AHCCCS Administration for screening to assure that a condition, illness, or injury is not incipient or present.
3. Screening means regularly scheduled examinations and evaluations of the general physical and behavioral health, growth, development, and nutritional status of infants, children and youth, and the identification of those in need of more definitive evaluation. For the purpose of the AHCCCS EPSDT program, screening and diagnosis are not synonymous.
4. Diagnostic means the determination of the nature or cause of a condition, illness, or injury through the combined use of health history, physical, developmental and psychological examination, laboratory tests, and X-rays, when appropriate.
5. Treatment means any of the 28 mandatory or optional services described in Federal Law 42 USC 1396d(a), even if the service is not covered under the AHCCCS State Plan, when necessary to correct or ameliorate defects and physical and mental illnesses and conditions detected by screening or diagnostic procedures.

B. SCREENING REQUIREMENTS

Comprehensive periodic screenings must be performed by a clinician according to the time frames identified in the AHCCCS EPSDT (Early and Periodic Screening, Diagnostic and Treatment) Periodicity Schedule, the AHCCCS Dental Periodicity Schedule and inter-periodic screenings as appropriate for each member. Contractors must implement processes to ensure age appropriate screening and care coordination when member needs are identified. The Contractor will encourage providers to utilize AHCCCS approved standard developmental screening tools and complete training in the use of the tools. The Contractor must monitor providers and implement interventions for non-compliance. Contractors must ensure that the newborn screening tests are conducted, including initial and second screening, in accordance with 9 A.A.C. 13, Article 2.



The AHCCCS EPSDT Periodicity Schedule is based on recommendations by the Arizona Medical Association and is closely aligned with guidelines of the American Academy of Pediatrics. EPSDT screenings must include the following:

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

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

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

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

2. A comprehensive unclothed physical examination
3. Appropriate immunizations according to age and health history.
4. Laboratory tests (including blood lead screening assessment and blood lead testing appropriate to age and risk, anemia testing and diagnostic testing for sickle cell trait if a child has not been previously tested with sickle cell preparation or a hemoglobin solubility test).
5. Health education
6. Appropriate oral health screening, intended to identify oral pathology, including tooth decay and/or oral lesions, conducted by a physician, physician's assistant or nurse practitioner.
7. Appropriate vision, hearing, and speech testing and diagnosis, as well as treatments for defects in vision and hearing, including provision of eyeglasses and hearing aids. Appropriate medically necessary therapies, including speech therapy, are also covered under EPSDT.



Contractors must ensure that:

- a. Each hospital or birthing center screens all newborns using a physiological hearing screening method as early as clinically possible prior to initial discharge
 - b. Each hospital or birthing center provides outpatient re-screening for babies who were missed or are referred from the initial screen. Outpatient screening must be scheduled at the time of the initial discharge and completed between two and six weeks of age.
 - c. When there is an indication that a newborn or infant may have a hearing loss or congenital disorder, the family is referred to a medical home for appropriate assessment, and
 - d. All infants with confirmed hearing loss receive services before turning six months of age.
8. Tuberculin skin testing as appropriate to age and risk. Children at increased risk of Tuberculosis (TB) include those who have contact with persons:
- a. Confirmed or suspected as having TB
 - b. In jail or prison during the last five years
 - c. Living in a household with an HIV-infected person or the child is infected with HIV, and
 - d. Traveling/emigrating from, or having significant contact with persons indigenous to, endemic countries.

C. EPSDT SERVICE STANDARDS

EPSDT services must be provided according to community standards of practice and the AHCCCS EPSDT and Dental Periodicity Schedules. The AHCCCS EPSDT Tracking Forms must be used to document services provided and compliance with AHCCCS standards (see [Appendix B](#)). The tracking forms must be signed by the clinician who performs the screening.



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

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

AHCCCS will cover the human papilloma virus (HPV) vaccine for female and male EPSDT members age 11 through 20 years and members age 9 and 10 years of age if the member is deemed to be in a high risk situation. Providers must coordinate with the Arizona Department of Health Services Vaccines for Children (VFC) program in the delivery of immunization services. Immunizations must be provided according to the Advisory Committee on Immunization Practices Recommended Schedule included in Exhibit 430-2. Contractors must ensure providers enroll and re-enroll annually with the VFC program in accordance with AHCCCS Contract requirements. The Contractor shall not utilize AHCCCS funding to purchase VFC vaccines for members younger than 19 years of age.

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

2. **Eye Examinations and Prescriptive Lenses** - EPSDT covers eye examinations as appropriate to age according to the AHCCCS EPSDT Periodicity Schedule and as medically necessary using standardized visual tools. Prescriptive lenses are provided to correct or ameliorate defects, physical illness and conditions discovered by EPSDT screenings, subject to medical necessity.
3. **Blood Lead Screening** - EPSDT covers blood lead screening. All children are considered at risk and must be screened for lead poisoning. All children must receive a screening blood lead test at 12 months and 24 months of age. Children between 36 and 72 months of age must receive a screening blood lead test if they have not been previously screened for lead poisoning. A blood lead test result equal to or greater than 10 micrograms of lead per deciliter of whole blood obtained by capillary specimen or fingerstick must be confirmed using a venous blood sample. A verbal blood lead screening risk assessment must be completed at each EPSDT visit for children six through 72 months of age (up to 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 the Arizona Department of Health Services (A.A.C. R9-4-302).

Contractors must implement protocols for:

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

Refer to [Chapter 500](#) for more information related to transitioning members.

4. **Organ and Tissue Transplantation Services** - Refer to [Chapter 300](#) (Policy 310-DD with Attachment A) in this Manual for a discussion of AHCCCS-covered transplantations.
5. **Tuberculosis Screening** - EPSDT covers TB screening. Contractors must implement protocols for care and coordination of members who received TB testing to ensure timely reading of the TB skin test and treatment if medically necessary.
6. **Nutritional Assessment and Nutritional Therapy**

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

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

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

- WIC-eligible infant formulas



- Medical foods
- Parenteral feedings
- Enteral feedings

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

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

- a. Enteral nutritional therapy: Provides liquid nourishment directly to the digestive tract of a member who cannot ingest an appropriate amount of calories to maintain an acceptable nutritional status. Enteral nutrition is commonly provided by Jejunostomy tube (J-tube), Gastrostomy Tube (G-tube) or Nasogastric (N/G) tube. Refer to the specific AHCCCS Contractor for managed care members, and the AHCCCS PA Unit for Fee-for-Service members regarding PA requirements.
- b. Parenteral nutritional therapy: Provides nourishment through the venous system to members with severe pathology of the alimentary tract, which does not allow absorption of sufficient nutrients to maintain weight and strength. Refer to the specific AHCCCS Contractor for managed care members, and the AHCCCS Prior Authorization Unit for Fee-for-Service members regarding PA requirements.
- c. Commercial Oral Supplemental Nutritional Feedings: Provides nourishment and increases caloric intake as a supplement to the member's intake of other age appropriate foods, or as the sole source of nutrition for the member. Nourishment is taken orally and is generally provided through commercial nutritional supplements available without prescription.
 - i. PA is required from the member's Managed Care Contractor or Tribal Case Manager or the AHCCCS PA Unit for Fee-for-Service members for commercial oral nutritional supplements unless the member is also currently receiving nutrition through enteral or parenteral feedings. PA is not required for the first



30 days if the member requires commercial oral nutritional supplements on a temporary basis due to an emergent condition.

- ii. Medical necessity for commercial oral nutritional supplements must be determined on an individual basis by the member's PCP or attending physician, using at least the criteria specified in this policy. An example of a nutritional supplement is an amino acid-based formula used by a member for eosinophilic gastrointestinal disorder. The PCP or attending physician must use the AHCCCS approved form, "Certificate of Medical Necessity for Commercial Oral Nutritional Supplements" (Exhibit 430-3) to obtain PA from the Contractor.
- iii. The Certificate of Medical Necessity for Commercial Oral Nutritional Supplements must document that the PCP or attending physician has provided nutritional counseling as a part of the EPSDT services provided to the member. The documentation must specify alternatives that were tried in an effort to boost caloric intake and/or change food consistencies before considering commercially available nutritional supplements for oral feedings, or to supplement feedings.
- d. The Certificate of Medical Necessity for Commercial Oral Nutritional Supplements must indicate which criteria were met when assessing the medical necessity of providing commercial oral nutritional supplements. At least two of the following criteria must be met:
 - i. The member is at or below the 10th percentile on the appropriate growth chart for their age and gender for three months or more
 - ii. The member has reached a plateau in growth and/or nutritional status for more than six months (prepubescent)
 - iii. The member has already demonstrated a medically significant decline in weight within the past three months (prior to the assessment)
 - iv. The member is able to consume/eat no more than 25% of his/her nutritional requirements from age-appropriate food sources
 - v. Absorption problems as evidenced by emesis, diarrhea, dehydration, and/or weight loss and intolerance to milk or formula products has been ruled out
 - vi. The member requires nutritional supplements on a temporary basis due to an emergent condition; i.e. post-hospitalization (PA is not required for the first 30 days), or
 - vii. The member is at high risk for regression due to chronic disease or condition and there are no alternatives for adequate nutrition.

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

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



- b. Encouragement and assistance to the caregiver in weaning the member from the necessity for supplemental nutritional feedings, and
- c. Education and training, if the member's parent or guardian elects to prepare the member's food, regarding proper sanitation and temperatures to avoid contamination of foods that are blended or specially prepared for the member.

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

Refer to [Chapter 500](#), Policy 520, for more information related to transitioning members.

- 7. **Oral Health Services** - As part of the physical examination, the physician, physician's assistant or nurse practitioner must perform an oral health screening. A screening is intended to identify gross dental or oral lesions, but is not a thorough clinical examination and does not involve making a clinical diagnosis resulting in a treatment plan. Depending on the results of the oral health screening, referral to a dentist must be made as outlined in the Acute Care contract:

CATEGORY	RECOMMENDATION FOR NEXT DENTAL VISIT
EMERGENT	Within 24 hours of request
URGENT	Within three days of request
ROUTINE	Within 45 days of request

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

NOTE: Although the AHCCCS Dental Periodicity Schedule identifies when routine referrals begin, PCPs may refer EPSDT members for a dental assessment at an earlier age if their oral health screening reveals potential carious lesions or other conditions requiring assessment and/or treatment by a dental professional. In addition to PCP



referrals, EPSDT members are allowed self-referral to a dentist who is included in the Contractor's provider network.

EPSDT covers the following dental services:

- a. Emergency dental services including:
 - i. Treatment for pain, infection, swelling and/or injury
 - ii. 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
 - iii. General anesthesia, conscious sedation or anxiolysis (minimal sedation, patients respond normally to verbal commands) when local anesthesia is contraindicated or when management of the patient requires it. (See #9 of this section regarding conscious sedation policy)
- b. Preventive dental services provided as specified in the AHCCCS Dental Periodicity Schedule (Exhibit 430-1A), including, but not limited to:
 - i. 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
 - ii. Radiology services which are screening in nature for diagnosis of dental abnormalities and/or pathology, including panoramic or full-mouth x-rays, supplemental bitewing x-rays, and occlusal or periapical films as needed, and
 - iii. Preventive services which include:
 - (a) Oral prophylaxis performed by a dentist or dental hygienist which includes self-care oral hygiene instructions to member, if able, or to the parent/legal guardian
 - (b) Application of topical fluorides. Use of a prophylaxis paste containing fluoride and fluoride mouth rinses do not meet the AHCCCS standard for fluoride treatment (fluoride treatment in the PCP office is not a covered service)
 - (c) For members under age sixteen, dental sealants on all non-carious permanent first and second molars, and
 - (d) Space maintainers when posterior primary teeth are lost permanently.



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- c. All therapeutic dental services will be covered when they are considered medically necessary and cost effective but may be subject to PA by the Contractor, or AHCCCS Division of Fee-for-Service Management for FFS members. These services include but are not limited to:
- i. Periodontal procedures, scaling/root planing, curettage, gingivectomy, and osseous surgery
 - ii. Crowns:
 - (a) When appropriate, stainless steel crowns may be used for both primary and permanent posterior teeth; composite, prefabricated stainless steel crowns with a resin window or crowns with esthetic coatings should be used for anterior primary teeth, or
 - (b) Precious or cast semi-precious crowns may be used on functional permanent endodontically treated teeth, except third molars, for members who are 18 through 20 years old.
 - iii. 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)
 - iv. 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
 - v. Removable dental prosthetics, including complete dentures and removable partial dentures, and
 - vi. 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:

- a. Congenital craniofacial or dentofacial malformations requiring reconstructive surgical correction in addition to orthodontic services
- b. Trauma requiring surgical treatment in addition to orthodontic services, or
- c. Skeletal discrepancy involving maxillary and/or mandibular structures.



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

Refer to [Chapter 800](#) for information related to FFS dental services and prior authorization requirements.

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

8. Cochlear 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 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



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- (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 will be considered on a case by case basis and require medical review and prior authorization by the Contractor Medical Director for enrolled members or by the AHCCCS Chief Medical Officer or designee for FFS members.

10. Behavioral Health Services – AHCCCS covers behavioral health services for members eligible for EPSDT services as described in [Chapter 300](#), Policy 310, and the [Behavioral Health Services Guide](#). EPSDT behavioral health services include the services listed in Federal Law 42 USC 1396d(a) necessary to correct or ameliorate mental illnesses and conditions discovered by the screening services whether or not the services are covered under the AHCCCS State Plan.

There are two appendices, [Appendix E](#) for children and adolescents and [Appendix F](#) for adults. For the diagnosis of attention deficit disorder/attention deficit hyperactivity disorder, depression (including postnatal depression), and/or anxiety disorders, there are clinical guidelines that include assessment tools and algorithms. The clinical guidelines are to be used by the PCPs as an aid in treatment decisions.

11. Religious Non-Medical Health Care Institution Services – AHCCCS covers religious non-medical health care institution services for members eligible for EPSDT services as described in [Chapter 300](#), Policy 310.

12. Case Management Services – AHCCCS covers case management services for both physical and behavioral health care as appropriate for members eligible for EPSDT services. In EPSDT, case management involves identifying the health needs of a child, ensuring necessary referrals are made, maintaining health history, and initiating further evaluation/diagnosis and treatment when necessary.

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



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

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

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

Prior authorization will be permitted to ascertain that:

- i. The member is over age three and under twenty-one
- 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 and physical and mental illnesses and conditions discovered by the screening services. Therapies are covered under both an inpatient and outpatient basis when medically necessary.

D. CONTRACTOR REQUIREMENTS FOR PROVIDING EPSDT SERVICES

This section provides the procedural requirements for Contractors.

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

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

Contractors must:

1. Employ sufficient numbers of appropriately qualified local personnel in order to meet the health care needs of members and fulfill Federal and State EPSDT requirements as well as to achieve contractual compliance.
2. Inform all participating Primary Care Providers (PCPs) about EPSDT requirements.

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

3. Develop processes to:
 - a. Ensure PCPs providing care to children are trained to use the PEDS tool. The PCP will obtain additional reimbursement for use of the PEDS tool during EPSDT visits for NICU-discharged EPSDT members only when there is proof of PEDS tool training.
 - b. Assist families with NICU-discharged children in the selection of PEDS trained providers. AHCCCS Contractors may verify PEDS training with online resources.



- c. Notify PCPs when a NICU-discharged member is assigned to their panel.
 - d. Ensure appropriate reimbursement of claims is submitted for use of the PEDS tool.
 - e. Monitor providers for compliance with training and use of the PEDS tool.
 - f. Implement specific interventions to improve provider compliance of PEDS training and use.
4. Develop, implement, and maintain a program to inform members about EPSDT services within 30 days of enrollment with the Contractor. This information must include:
- a. The benefits of preventive health care
 - b. Information that an EPSDT visit is a well child visit
 - c. A complete description of the services available as described in this section
 - d. Information on how to obtain these services and assistance with scheduling appointments
 - e. A statement that there is no co-payment or other charge for EPSDT screening and resultant services, and
 - f. A statement that assistance with medically necessary transportation and scheduling appointments is available to obtain EPSDT services.
 - g. Outreach requirements for Contractors are included in ACOM Policy 404.
5. Provide EPSDT information, defined in #4 above, in a second language, in addition to English, in accordance with the requirements of the AHCCCS Division of Health Care Management (DHCM) “Cultural Competency” policy available in the AHCCCS Contractor Operations Manual (available online at www.azahcccs.gov).
6. Develop and implement processes to assist members and their families regarding community health resources, including but not limited to WIC, AZEIP, and behavioral health.



7. Participate in community and/or quality initiatives to promote and support best local practices and quality care within the communities served by the Contractor.
8. Attend EPSDT related meetings when requested by AHCCCS Administration.
9. Coordinate with other entities when Contractor determines a member has third party coverage.
10. Develop, implement, and maintain a procedure for ensuring timeliness of re-screening and treatment for all conditions identified as a result of examination, screening, and diagnosis. Treatment, if required, must occur on a timely basis and generally no longer than six months beyond the request for screening services (refer to contractor requirements in this chapter).
11. Develop and implement a process for monitoring that providers use the most current EPSDT Tracking Forms at every EPSDT visit (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) and that all age appropriate screening and services are conducted during each EPSDT visit.
12. Develop, implement and maintain a procedure to notify all members/caretakers prior to visits required by the AHCCCS EPSDT and Dental Periodicity Schedules. This procedure must include:
 - a. Notification of members or responsible parties regarding due dates of each periodic screen. If a periodic screening visit has not taken place, a second written notice must be sent.
 - b. Notification of members or responsible parties regarding due date of an annual dental visit. If a dental visit has not taken place, a second notice must be sent.
13. Develop and implement processes to reduce no-show appointment rates for EPSDT services, and
14. Provide targeted outreach to those members who did not show for appointments.

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



15. Implement processes to print two part carbonless EPSDT Tracking Forms (a copy for the medical record and a copy for providers to send to the Contractor EPSDT Coordinator).
16. Distribute EPSDT Tracking Forms to contracted providers.
17. Require the use of the AHCCCS EPSDT and Dental Periodicity Schedules and AHCCCS approved, standardized EPSDT Tracking Forms (see [Appendix B](#)) by all contracted providers. The AHCCCS EPSDT and Dental Periodicity Schedules give providers necessary information regarding timeframes in which age-related required screenings and visits must be rendered by providers.

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

- a. Use the EPSDT Tracking Forms (or electronic equivalent) at every EPSDT visit
 - b. Perform all age appropriate screening and services during each EPSDT visit in accordance with the AHCCCS EPSDT and Dental Periodicity Schedules, including, but not limited to, utilizing the PEDS Tool as described in this Chapter.
 - c. Sign EPSDT Tracking Forms and place them in the member's medical record (if an electronic medical record is used an electronic signature must be used).
 - 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 Administration.
 - 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 but do not need to send copies elsewhere (if an electronic medical record is used an electronic signature must be used).
18. Submit to AHCCCS DHCM, within 15 days of the end of each reporting quarter, a detailed progress report that describes the activities of the quarter and the progress made in reaching the established goals of the plan (see Exhibit 400-1). Quarterly reports must include documentation of monitoring and evaluation of EPSDT requirements, and implementation of improvement processes. The quarterly report must include results of Contractor's ongoing monitoring of performance rates in a format that will facilitate comparison of rates in order to identify possible need for interventions to improve or sustain rates. The report must also identify the Contractor's established goals (see Appendix A, EPSDT Improvement and Adult Quarterly



Monitoring Report, for report template and requirements/instructions). As noted on Appendix A, effective 10/01/09, shaded areas are not in effect.

19. Have a written EPSDT plan including oral health, which addresses the objectives, monitoring and evaluation activities of their program.
20. Participate in an annual review of EPSDT requirements conducted by AHCCCS Administration; including, but not limited to, Contractor results of on-site visits to providers and medical record audits.
21. Include language in PCP contracts that requires PCPs to:
 - a. Provide EPSDT services for all assigned members from birth through 20 years of age. Services must be provided in accordance with the AHCCCS EPSDT and Dental Periodicity Schedules, and
 - b. Agree to utilize the standardized AHCCCS EPSDT Tracking Forms 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. 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.
 - f. Refer eligible members to the special supplemental nutrition program for Women, Infants and Children (WIC), for WIC approved formula and support services. Ensure that medically necessary nutritional supplements are covered by the contractor (refer to Exhibit 430-3).
 - g. Coordinate with Head Start programs to ensure eligible members receive appropriate EPSDT services to optimize child health and development.



- h. Coordinate with the Arizona Early Intervention Program (AzEIP) to identify children 0-3 years of age with developmental disabilities for services, including family education and family support needs focusing on each child's natural environment, to optimize child health and development (EPSDT services, as defined in 9 A.A.C. 22, Article 2, must be provided by the Contractors). Contractors must encourage their providers to communicate results of assessments and services provided to AzEIP enrollees within 45 days of the member's AzEIP enrollment.
- i. Educate providers to comply with the AHCCCS/AzEIP Procedures for the Coordination of Services Under Early Periodic Screening Diagnostic and Treatment and Early Intervention (Exhibit 430-5) when the need for medically necessary services are identified for members birth to three years of age.
- j. Ensure 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.
- k. AHCCCS Contractors must reimburse all AHCCCS registered Arizona Early Intervention Program (AzEIP) providers whether or not they are contracted with the AHCCCS Contractor. The individual family service plan services must be reviewed for medical necessity prior to reimbursement, and
- l. Coordinate with behavioral health services agencies and providers to ensure continuity of care for members who are receiving or are eligible to receive behavioral health services.

E. CONTRACTOR REQUIREMENTS FOR THE WRITTEN EPSDT PLAN

The written EPSDT plan must contain the following:

1. A narrative description of all planned activities, including, but not limited to, informing providers and members that EPSDT is a comprehensive child health program of prevention, treatment, correction, and improvement (amelioration) of physical and mental health problems for AHCCCS members under the age of 21. The narrative description must also include Contractor activities to identify member needs, coordinate care and follow-up activities to ensure appropriate treatment is received in a timely manner. Contractors must attach relevant policies and procedures to this section.



2. An evaluation and assessment that documents the effectiveness of EPSDT/dental program strategies, interventions, and activities directed at achieving healthy outcomes, at least annually (report on the last year).
3. A work plan that formally documents the EPSDT/Dental program objectives, strategies and activities and demonstrates how these activities will improve the quality of services, the continuum of care, and health care outcomes (including Childhood Obesity Program according to AHCCCS policy) containing:
 - a. Specific measurable objectives. These objectives may be based on AHCCCS established minimum performance standards or other generally accepted benchmarks. In cases where AHCCCS minimum performance standards have been met, other generally accepted benchmarks may be used (e.g., National Committee on Quality Assurance, Healthy People 2010 standards). The Contractors may also develop their own specific measurable goals and objectives aimed at enhancing the EPSDT program.
 - b. Strategies and activities to accomplish objectives (e.g., member outreach, provider education and provider compliance with mandatory components of the EPSDT program)
 - c. Targeted implementation and completion dates of work plan activities
 - d. Monitoring of work plan activities and evaluation of outcomes
 - e. Evaluation of outcome of activities
 - f. Identification and implementation of new interventions, or modifications to improve existing interventions, to reach goals, and
 - g. Contractor assigned resources for EPSDT activities, including local staff designated to specific EPSDT responsibilities.
3. The plan must be submitted annually to AHCCCS/Division of Health Care Management as per the contract and is subject to approval (see Exhibit 400-1).

F. FEE-FOR-SERVICE/EPSDT PROVIDER REQUIREMENTS

This section discusses the procedural requirements for FFS EPSDT service providers. FFS providers must:



CHAPTER 400
MEDICAL POLICY FOR MATERNAL AND CHILD HEALTH

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

1. Provide EPSDT services in accordance with Section 42 USC 1396d(a) and (r), 1396 a (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.

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EXHIBIT 430-1

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
EPSDT PERIODICITY SCHEDULE**

DRAFT Implementation 10/01/2013

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

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

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

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

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

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

EXHIBIT 430-1 (con't)

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
VISION PERIODICITY SCHEDULE

Procedure	MONTHS OF AGE											YEARS OF AGE														
	New born	2 - 4 Days	by 1 mo	2	4	6	9	12	15	18	24	3*	4	5	6	8	10	11	12	13	14	15	16	17	18	19 through 20 years of age
Vision +	S	S	S	S	S	S	S	S	S	S	S	O	O	O	O	O	O	S	O	S	S	O	S	S	O	S

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

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

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

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
HEARING AND SPEECH PERIODICITY SCHEDULE

Procedure	MONTHS OF AGE													YEARS OF AGE														
	New born	2 - 4 days	2 weeks	By 1 mo	6 weeks	2	4	6	9	12	15	18	24	3	4	5	6	8	10	11	12	13	14	15	16	17	18	Through 20 years of age
Hearing/ Speech+	O**	S	O**			S	S	S	S	S	S	S	S	S	O	O	O	O	O	S	O	S	S	O	S	S	O	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: 4/1/2007, 8/1/2005

EXHIBIT 430-1A

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

DRAFT Implementation 10/01/2013

EXHIBIT 430-1A

AHCCCS DENTAL PERIODICITY SCHEDULE

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

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

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

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

* Adaptation from the American Academy of Pediatric Dentistry Schedule

Initial Effective Date: 10/01/08

EXHIBIT 430-2

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

DRAFT Implementation 10/01/2013

FIGURE 1: Recommended immunization schedule for persons aged 0 through 6 years—United States, 2012 (for those who fall behind or start late, see the catch-up schedule [Figure 3])

Vaccine ▼	Age ►	Birth	1 month	2 months	4 months	6 months	9 months	12 months	15 months	18 months	19–23 months	2–3 years	4–6 years	
Hepatitis B ¹	Hep B	HepB	HepB			HepB		HepB						Range of recommended ages for all children
Rotavirus ²			RV	RV	RV ²									
Diphtheria, tetanus, pertussis ³			DTaP	DTaP	DTaP		see footnote ¹	DTaP					DTaP	
<i>Haemophilus influenzae</i> type b ⁴			Hib	Hib	Hib ⁴			Hib						Range of recommended ages for certain high-risk groups
Pneumococcal ⁵			PCV	PCV	PCV			PCV				PPSV		
Inactivated poliovirus ⁶			IPV	IPV				IPV					IPV	
Influenza ⁷								Influenza (Yearly)						
Measles, mumps, rubella ⁸								MMR		see footnote ⁹			MMR	Range of recommended ages for all children and certain high-risk groups
Varicella ⁹								Varicella		see footnote ⁹			Varicella	
Hepatitis A ¹⁰								Dose 1 ¹⁰				HepA Series		
Meningococcal ¹¹								MCV4 — see footnote ¹¹						

This schedule includes recommendations in effect as of December 23, 2011. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Vaccination providers should consult the relevant Advisory Committee on Immunization Practices (ACIP) statement for detailed recommendations, available online at <http://www.cdc.gov/vaccines/pubs/acip-list.htm>. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (<http://www.vaers.hhs.gov>) or by telephone (800-822-7967).

- Hepatitis B (HepB) vaccine.** (Minimum age: birth)
 - At birth:**
 - Administer monovalent HepB vaccine to all newborns before hospital discharge.
 - For infants born to hepatitis B surface antigen (HBsAg)-positive mothers, administer HepB vaccine and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth. These infants should be tested for HBsAg and antibody to HBsAg (anti-HBs) 1 to 2 months after receiving the last dose of the series.
 - If mother's HBsAg status is unknown, within 12 hours of birth administer HepB vaccine for infants weighing $\geq 2,000$ grams, and HepB vaccine plus HBIG for infants weighing $< 2,000$ grams. Determine mother's HBsAg status as soon as possible and, if she is HBsAg-positive, administer HBIG for infants weighing $\geq 2,000$ grams (no later than age 1 week).
 - Doses after the birth dose:**
 - The second dose should be administered at age 1 to 2 months. Monovalent HepB vaccine should be used for doses administered before age 6 weeks.
 - Administration of a total of 4 doses of HepB vaccine is permissible when a combination vaccine containing HepB is administered after the birth dose.
 - Infants who did not receive a birth dose should receive 3 doses of a HepB-containing vaccine starting as soon as feasible (Figure 3).
 - The minimum interval between dose 1 and dose 2 is 4 weeks, and between dose 2 and 3 is 8 weeks. The final (third or fourth) dose in the HepB vaccine series should be administered no earlier than age 24 weeks and at least 16 weeks after the first dose.
- Rotavirus (RV) vaccines.** (Minimum age: 6 weeks for both RV-1 [Rotarix] and RV-5 [Rota Teq])
 - The maximum age for the first dose in the series is 14 weeks, 6 days; and 8 months, 0 days for the final dose in the series. Vaccination should not be initiated for infants aged 15 weeks, 0 days or older.
 - If RV-1 (Rotarix) is administered at ages 2 and 4 months, a dose at 6 months is not indicated.
- Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine.** (Minimum age: 6 weeks)
 - The fourth dose may be administered as early as age 12 months, provided at least 6 months have elapsed since the third dose.
- Haemophilus influenzae* type b (Hib) conjugate vaccine.** (Minimum age: 6 weeks)
 - If PRP-OMP (PedvaxHib or Comvax [HepB-Hib]) is administered at ages 2 and 4 months, a dose at age 6 months is not indicated.
 - Hiberix should only be used for the booster (final) dose in children aged 12 months through 4 years.
- Pneumococcal vaccines.** (Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPSV])
 - Administer 1 dose of PCV to all healthy children aged 24 through 59 months who are not completely vaccinated for their age.
 - For children who have received an age-appropriate series of 7-valent PCV (PCV7), a single supplemental dose of 13-valent PCV (PCV13) is recommended for:
 - All children aged 14 through 59 months
 - Children aged 60 through 71 months with underlying medical conditions.
 - Administer PPSV at least 8 weeks after last dose of PCV to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant. See *MMWR* 2010;59(No. RR-11), available at <http://www.cdc.gov/mmwr/pdf/rr/rr5911.pdf>.
- Inactivated poliovirus vaccine (IPV).** (Minimum age: 6 weeks)
 - If 4 or more doses are administered before age 4 years, an additional dose should be administered at age 4 through 6 years.
 - The final dose in the series should be administered on or after the fourth birthday and at least 6 months after the previous dose.
- Influenza vaccines.** (Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 2 years for live, attenuated influenza vaccine [LAIV])
 - For most healthy children aged 2 years and older, either LAIV or TIV may be used. However, LAIV should not be administered to some children, including 1) children with asthma, 2) children 2 through 4 years who had wheezing in the past 12 months, or 3) children who have any other underlying medical conditions that predispose them to influenza complications. For all other contraindications to use of LAIV, see *MMWR* 2010;59(No. RR-8), available at <http://www.cdc.gov/mmwr/pdf/rr/rr5908.pdf>.
 - For children aged 6 months through 8 years:
 - For the 2011–12 season, administer 2 doses (separated by at least 4 weeks) to those who did not receive at least 1 dose of the 2010–11 vaccine. Those who received at least 1 dose of the 2010–11 vaccine require 1 dose for the 2011–12 season.
 - For the 2012–13 season, follow dosing guidelines in the 2012 ACIP influenza vaccine recommendations.
- Measles, mumps, and rubella (MMR) vaccine.** (Minimum age: 12 months)
 - The second dose may be administered before age 4 years, provided at least 4 weeks have elapsed since the first dose.
 - Administer MMR vaccine to infants aged 6 through 11 months who are traveling internationally. These children should be revaccinated with 2 doses of MMR vaccine, the first at ages 12 through 15 months and at least 4 weeks after the previous dose, and the second at ages 4 through 6 years.
- Varicella (VAR) vaccine.** (Minimum age: 12 months)
 - The second dose may be administered before age 4 years, provided at least 3 months have elapsed since the first dose.
 - For children aged 12 months through 12 years, the recommended minimum interval between doses is 3 months. However, if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.
- Hepatitis A (HepA) vaccine.** (Minimum age: 12 months)
 - Administer the second (final) dose 6 to 18 months after the first.
 - Unvaccinated children 24 months and older at high risk should be vaccinated. See *MMWR* 2006;55(No. RR-7), available at <http://www.cdc.gov/mmwr/pdf/rr/rr5507.pdf>.
 - A 2-dose HepA vaccine series is recommended for anyone aged 24 months and older, previously unvaccinated, for whom immunity against hepatitis A virus infection is desired.
- Meningococcal conjugate vaccines, quadrivalent (MCV4).** (Minimum age: 9 months for Menactra [MCV4-D], 2 years for Menveo [MCV4-CRM])
 - For children aged 9 through 23 months 1) with persistent complement component deficiency; 2) who are residents of or travelers to countries with hyperendemic or epidemic disease; or 3) who are present during outbreaks caused by a vaccine serogroup, administer 2 primary doses of MCV4-D, ideally at ages 9 months and 12 months or at least 8 weeks apart.
 - For children aged 24 months and older with 1) persistent complement component deficiency who have not been previously vaccinated; or 2) anatomic/functional asplenia, administer 2 primary doses of either MCV4 at least 8 weeks apart.
 - For children with anatomic/functional asplenia, if MCV4-D (Menactra) is used, administer at a minimum age of 2 years and at least 4 weeks after completion of all PCV doses.
 - See *MMWR* 2011;60:72–6, available at <http://www.cdc.gov/mmwr/pdf/wk/mm6003.pdf>, and Vaccines for Children Program resolution No. 6/11-1, available at <http://www.cdc.gov/vaccines/programs/vfc/downloads/resolutions/06-11mening-mcv.pdf>, and *MMWR* 2011;60:1391–2, available at <http://www.cdc.gov/mmwr/pdf/wk/mm6040.pdf>, for further guidance, including revaccination guidelines.

FIGURE 2: Recommended immunization schedule for persons aged 7 through 18 years—United States, 2012 (for those who fall behind or start late, see the schedule below and the catch-up schedule [Figure 3])

Vaccine ▼	Age ►	7–10 years	11–12 years	13–18 years	
Tetanus, diphtheria, pertussis ¹		1 dose (if indicated)	1 dose	1 dose (if indicated)	Range of recommended ages for all children
Human papillomavirus ²		see footnote ²	3 doses	Complete 3-dose series	
Meningococcal ³		See footnote ³	Dose 1	Booster at 16 years old	Range of recommended ages for catch-up immunization
Influenza ⁴		Influenza (yearly)			
Pneumococcal ⁵		See footnote ⁵			Range of recommended ages for certain high-risk groups
Hepatitis A ⁶		Complete 2-dose series			
Hepatitis B ⁷		Complete 3-dose series			
Inactivated poliovirus ⁸		Complete 3-dose series			
Measles, mumps, rubella ⁹		Complete 2-dose series			
Varicella ¹⁰		Complete 2-dose series			

This schedule includes recommendations in effect as of December 23, 2011. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Vaccination providers should consult the relevant Advisory Committee on Immunization Practices (ACIP) statement for detailed recommendations, available online at <http://www.cdc.gov/vaccines/pubs/acip-list.htm>. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (<http://www.vaers.hhs.gov>) or by telephone (800-822-7967).

- Tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine.** (Minimum age: 10 years for Boostrix and 11 years for Adacel)
 - Persons aged 11 through 18 years who have not received Tdap vaccine should receive a dose followed by tetanus and diphtheria toxoids (Td) booster doses every 10 years thereafter.
 - Tdap vaccine should be substituted for a single dose of Td in the catch-up series for children aged 7 through 10 years. Refer to the catch-up schedule if additional doses of tetanus and diphtheria toxoid-containing vaccine are needed.
 - Tdap vaccine can be administered regardless of the interval since the last tetanus and diphtheria toxoid-containing vaccine.
- Human papillomavirus (HPV) vaccines (HPV4 [Gardasil] and HPV2 [Cervarix]).** (Minimum age: 9 years)
 - Either HPV4 or HPV2 is recommended in a 3-dose series for females aged 11 or 12 years. HPV4 is recommended in a 3-dose series for males aged 11 or 12 years.
 - The vaccine series can be started beginning at age 9 years.
 - Administer the second dose 1 to 2 months after the first dose and the third dose 6 months after the first dose (at least 24 weeks after the first dose).
 - See *MMWR* 2010;59:626–32, available at <http://www.cdc.gov/mmwr/pdf/wk/mm5920.pdf>.
- Meningococcal conjugate vaccines, quadrivalent (MCV4).**
 - Administer MCV4 at age 11 through 12 years with a booster dose at age 16 years.
 - Administer MCV4 at age 13 through 18 years if patient is not previously vaccinated.
 - If the first dose is administered at age 13 through 15 years, a booster dose should be administered at age 16 through 18 years with a minimum interval of at least 8 weeks after the preceding dose.
 - If the first dose is administered at age 16 years or older, a booster dose is not needed.
 - Administer 2 primary doses at least 8 weeks apart to previously unvaccinated persons with persistent complement component deficiency or anatomic/functional asplenia, and 1 dose every 5 years thereafter.
 - Adolescents aged 11 through 18 years with human immunodeficiency virus (HIV) infection should receive a 2-dose primary series of MCV4, at least 8 weeks apart.
 - See *MMWR* 2011;60:72–76, available at <http://www.cdc.gov/mmwr/pdf/wk/mm6003.pdf>, and Vaccines for Children Program resolution No. 6/11-1, available at <http://www.cdc.gov/vaccines/programs/vfc/downloads/resolutions/06-11mening-mcv.pdf>, for further guidelines.
- Influenza vaccines (trivalent inactivated influenza vaccine [TIV] and live, attenuated influenza vaccine [LAIV]).**
 - For most healthy, nonpregnant persons, either LAIV or TIV may be used, except LAIV should not be used for some persons, including those with asthma or any other underlying medical conditions that predispose them to influenza complications. For all other contraindications to use of LAIV, see *MMWR* 2010;59(No. RR-8), available at <http://www.cdc.gov/mmwr/pdf/rr/rr5908.pdf>.
 - Administer 1 dose to persons aged 9 years and older.
 - For children aged 6 months through 8 years:
 - For the 2011–12 season, administer 2 doses (separated by at least 4 weeks) to those who did not receive at least 1 dose of the 2010–11 vaccine. Those who received at least 1 dose of the 2010–11 vaccine require 1 dose for the 2011–12 season.
 - For the 2012–13 season, follow dosing guidelines in the 2012 ACIP influenza vaccine recommendations.
- Pneumococcal vaccines (pneumococcal conjugate vaccine [PCV] and pneumococcal polysaccharide vaccine [PPSV]).**
 - A single dose of PCV may be administered to children aged 6 through 18 years who have anatomic/functional asplenia, HIV infection or other immunocompromising condition, cochlear implant, or cerebral spinal fluid leak. See *MMWR* 2010;59(No. RR-11), available at <http://www.cdc.gov/mmwr/pdf/rr/rr5911.pdf>.
 - Administer PPSV at least 8 weeks after the last dose of PCV to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant. A single revaccination should be administered after 5 years to children with anatomic/functional asplenia or an immunocompromising condition.
- Hepatitis A (HepA) vaccine.**
 - HepA vaccine is recommended for children older than 23 months who live in areas where vaccination programs target older children, who are at increased risk for infection, or for whom immunity against hepatitis A virus infection is desired. See *MMWR* 2006;55(No. RR-7), available at <http://www.cdc.gov/mmwr/pdf/rr/rr5507.pdf>.
 - Administer 2 doses at least 6 months apart to unvaccinated persons.
- Hepatitis B (HepB) vaccine.**
 - Administer the 3-dose series to those not previously vaccinated.
 - For those with incomplete vaccination, follow the catch-up recommendations (Figure 3).
 - A 2-dose series (doses separated by at least 4 months) of adult formulation Recombivax HB is licensed for use in children aged 11 through 15 years.
- Inactivated poliovirus vaccine (IPV).**
 - The final dose in the series should be administered at least 6 months after the previous dose.
 - If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.
 - IPV is not routinely recommended for U.S. residents aged 18 years or older.
- Measles, mumps, and rubella (MMR) vaccine.**
 - The minimum interval between the 2 doses of MMR vaccine is 4 weeks.
- Varicella (VAR) vaccine.**
 - For persons without evidence of immunity (see *MMWR* 2007;56[No. RR-4], available at <http://www.cdc.gov/mmwr/pdf/rr/rr5604.pdf>), administer 2 doses if not previously vaccinated or the second dose if only 1 dose has been administered.
 - For persons aged 7 through 12 years, the recommended minimum interval between doses is 3 months. However, if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.
 - For persons aged 13 years and older, the minimum interval between doses is 4 weeks.

FIGURE 3. Catch-up immunization schedule for persons aged 4 months through 18 years who start late or who are more than 1 month behind—United States • 2012
 The figure below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age. **Always use this table in conjunction with the accompanying childhood and adolescent immunization schedules (Figures 1 and 2) and their respective footnotes.**

Persons aged 4 months through 6 years					
Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to dose 2	Dose 2 to dose 3	Dose 3 to dose 4	Dose 4 to dose 5
Hepatitis B	Birth	4 weeks	8 weeks and at least 16 weeks after first dose; minimum age for the final dose is 24 weeks		
Rotavirus ¹	6 weeks	4 weeks	4 weeks ¹		
Diphtheria, tetanus, pertussis ²	6 weeks	4 weeks	4 weeks	6 months	6 months ²
<i>Haemophilus influenzae</i> type b ³	6 weeks	4 weeks if first dose administered at younger than age 12 months 8 weeks (as final dose) if first dose administered at age 12–14 months No further doses needed if first dose administered at age 15 months or older	4 weeks ³ if current age is younger than 12 months 8 weeks (as final dose) ³ if current age is 12 months or older and first dose administered at younger than age 12 months and second dose administered at younger than 15 months No further doses needed if previous dose administered at age 15 months or older	8 weeks (as final dose) This dose only necessary for children aged 12 months through 59 months who received 3 doses before age 12 months	
Pneumococcal ⁴	6 weeks	4 weeks if first dose administered at younger than age 12 months 8 weeks (as final dose for healthy children) if first dose administered at age 12 months or older or current age 24 through 59 months No further doses needed for healthy children if first dose administered at age 24 months or older	4 weeks if current age is younger than 12 months 8 weeks (as final dose for healthy children) if current age is 12 months or older No further doses needed for healthy children if previous dose administered at age 24 months or older	8 weeks (as final dose) This dose only necessary for children aged 12 months through 59 months who received 3 doses before age 12 months or for children at high risk who received 3 doses at any age	
Inactivated poliovirus ⁵	6 weeks	4 weeks	4 weeks	6 months ⁵ minimum age 4 years for final dose	
Meningococcal ⁶	9 months	8 weeks ⁶			
Measles, mumps, rubella ⁷	12 months	4 weeks			
Varicella ⁸	12 months	3 months			
Hepatitis A	12 months	6 months			
Persons aged 7 through 18 years					
Tetanus, diphtheria/ tetanus, diphtheria, pertussis ⁹	7 years ⁹	4 weeks	4 weeks if first dose administered at younger than age 12 months 6 months if first dose administered at 12 months or older	6 months if first dose administered at younger than age 12 months	
Human papillomavirus ¹⁰	9 years		Routine dosing intervals are recommended ¹⁰		
Hepatitis A	12 months	6 months			
Hepatitis B	Birth	4 weeks	8 weeks (and at least 16 weeks after first dose)		
Inactivated poliovirus ⁵	6 weeks	4 weeks	4 weeks ⁵	6 months ⁵	
Meningococcal ⁶	9 months	8 weeks ⁶			
Measles, mumps, rubella ⁷	12 months	4 weeks			
Varicella ⁸	12 months	3 months if person is younger than age 13 years 4 weeks if person is aged 13 years or older			

- Rotavirus (RV) vaccines (RV-1 [Rotarix] and RV-5 [Rota Teq]).**
 - The maximum age for the first dose in the series is 14 weeks, 6 days; and 8 months, 0 days for the final dose in the series. Vaccination should not be initiated for infants aged 15 weeks, 0 days or older.
 - If RV-1 was administered for the first and second doses, a third dose is not indicated.
- Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine.**
 - The fifth dose is not necessary if the fourth dose was administered at age 4 years or older.
- Haemophilus influenzae* type b (Hib) conjugate vaccine.**
 - Hib vaccine should be considered for unvaccinated persons aged 5 years or older who have sickle cell disease, leukemia, human immunodeficiency virus (HIV) infection, or anatomic/functional asplenia.
 - If the first 2 doses were PRP-OMP (Pedvax-HIB or Comvax) and were administered at age 11 months or younger, the third (and final) dose should be administered at age 12 through 15 months and at least 8 weeks after the second dose.
 - If the first dose was administered at age 7 through 11 months, administer the second dose at least 4 weeks later and a final dose at age 12 through 15 months.
- Pneumococcal vaccines.** (Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPSV])
 - For children aged 24 through 71 months with underlying medical conditions, administer 1 dose of PCV if 3 doses of PCV were received previously, or administer 2 doses of PCV at least 8 weeks apart if fewer than 3 doses of PCV were received previously.
 - A single dose of PCV may be administered to certain children aged 6 through 18 years with underlying medical conditions. See age-specific schedules for details.
 - Administer PPSV to children aged 2 years or older with certain underlying medical conditions. See *MMWR* 2010:59(No. RR-11), available at <http://www.cdc.gov/mmwr/pdf/rr/rr5911.pdf>.
- Inactivated poliovirus vaccine (IPV).**
 - A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose.
 - In the first 6 months of life, minimum age and minimum intervals are only recommended if the person is at risk for imminent exposure to circulating poliovirus (i.e., travel to a polio-endemic region or during an outbreak).
 - IPV is not routinely recommended for U.S. residents aged 18 years or older.
- Meningococcal conjugate vaccines, quadrivalent (MCV4).** (Minimum age: 9 months for Menactra [MCV4-D]; 2 years for Menveo [MCV4-CRM])
 - See Figure 1 ("Recommended immunization schedule for persons aged 0 through 6 years") and Figure 2 ("Recommended immunization schedule for persons aged 7 through 18 years") for further guidance.
- Measles, mumps, and rubella (MMR) vaccine.**
 - Administer the second dose routinely at age 4 through 6 years.
- Varicella (VAR) vaccine.**
 - Administer the second dose routinely at age 4 through 6 years. If the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.
- Tetanus and diphtheria toxoids (Td) and tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccines.**
 - For children aged 7 through 10 years who are not fully immunized with the childhood DTaP vaccine series, Tdap vaccine should be substituted for a single dose of Td vaccine in the catch-up series; if additional doses are needed, use Td vaccine. For these children, an adolescent Tdap vaccine dose should not be given.
 - An inadvertent dose of DTaP vaccine administered to children aged 7 through 10 years can count as part of the catch-up series. This dose can count as the adolescent Tdap dose, or the child can later receive a Tdap booster dose at age 11–12 years.
- Human papillomavirus (HPV) vaccines (HPV4 [Gardasil] and HPV2 [Cervarix]).**
 - Administer the vaccine series to females (either HPV2 or HPV4) and males (HPV4) at age 13 through 18 years if patient is not previously vaccinated.
 - Use recommended routine dosing intervals for vaccine series catch-up; see Figure 2 ("Recommended immunization schedule for persons aged 7 through 18 years").

Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (<http://www.vaers.hhs.gov>) or by telephone (800-822-7967). Suspected cases of vaccine-preventable diseases should be reported to the state or local health department. Additional information, including precautions and contraindications for vaccination, is available from CDC online (<http://www.cdc.gov/vaccines>) or by telephone (800-CDC-INFO [800-232-4636]).

EXHIBIT 430-3

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

DRAFT Implementation 10/01/2013

EXHIBIT 430-3

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

SUBMITTED BY:

Provider Name: _____

Provider AHCCCS ID Number: _____ Telephone: _____

MEMBER INFORMATION

Member's Name: _____ Date of Birth: _____
Last First Initial

Member's AHCCCS ID Number: _____ Enrollment: _____
(Contractor)

Member's Address: _____

ASSESSMENT FOR COMMERCIAL ORAL NUTRITIONAL SUPPLEMENTS

Assessment performed by: _____

AHCCCS Provider ID: _____ Telephone Number: _____

Date of Assessment: _____

ASSESSMENT FINDINGS: (If necessary, add attachments to provide the most complete information)

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

a. The member is at or below the 10th percentile on the appropriate growth chart for their age and gender for three months or more.	
b. The member has reached a plateau in growth and/or nutritional status for more than 6 months (prepubescent).	
c. The member has already demonstrated a medically significant decline in weight within the past 3 months (prior to the assessment).	
d. The member is able to consume/eat no more than 25% of his/her nutritional requirements from normal food sources.	
e. Absorption problems are evidenced by emesis, diarrhea, dehydration, weight loss, and intolerance to milk or formula products has been ruled out.	
f. The member requires oral supplemental nutritional feedings on a temporary basis due to an emergent condition; i.e. post-hospitalization (No PA for first 30 days).	
g. The member is at risk for regression due to chronic disease or condition.	

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

ORAL SUPPLEMENTAL NUTRITIONAL FEEDING RECOMMENDATIONS

TYPE OF NUTRITIONAL FEEDING

SOURCE OF NUTRITION

WEANING FROM TUBE FEEDING	
ORAL FEEDING - SOLE SOURCE (PA REQUIRED)	
ORAL FEEDING - SUPPLEMENTAL (PA REQUIRED)	
EMERGENCY SUPPLEMENTAL NUTRITION (NO PA REQUIRED FOR FIRST 30 DAYS)	

ADDITIONAL COMMENTS:

NUTRITIONAL ASSESSMENT PROVIDER DATE

MEMBER'S PCP/ATTENDING PHYSICIAN DATE

DRAFT Implementation 10/01/2013

EXHIBIT 430-4

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

EXHIBIT 430-4

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

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 jointly 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, Diagnosis 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 defect, or a condition 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 IFSP (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 6 months from the request for screening services.

¹BBA = Balanced Budget Act of 1997

²AMPM = AHCCCS Medical Policy Manual

³Plan Page # = Page Number in Contractor's MCH/EPSDT Plan

Under IDEA Part C, AzEIP must ensure enrolled members begin services within 45 days of the completed IFSP.

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

When concerns about a child's development are *initially* identified by the child's Primary Care Physician (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 Physician (PCP) 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. 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.*
 - a. Requests for services from primary care physicians, 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, the AHCCCS Health Plan will authorize the services with a provider contracted with the AHCCCS Health Plan, whenever possible, and notify the PCP (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 the service end dates.
 - i. If services have already been initiated by an AHCCCS registered AzEIP provider not contracted with the AHCCCS Health Plan, the AHCCCS Health Plan may authorize the AHCCCS registered AzEIP provider to continue providing services to maintain continuity of care.
 - ii. If the AHCCCS Health Plan does not have the appropriate contracted provider within a reasonable distance from the member's home, or the member must be placed on a wait list, the AHCCCS Health Plan may reimburse an AHCCCS registered non-contracted AzEIP provider to provide timely services. Payment for non-contracted providers is limited to (or, shall not exceed) the AHCCCS fee schedule rate.
 - iii. AHCCCS Health Plan's 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 the AHCCCS Health Plan(s) to provide services.

- iv. 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.
 - 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.
- 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.

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 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 “EPSDT service request form ” 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 **1 business day** of receipt of the request.
5. The AHCCCS Health Plan MCH Coordinator or designee sends (faxes/e-mails) the EPSDT service request form and accompanying documentation to the member’s PCP within 2 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 EPSDT service request form to the MCH Coordinator.
8. The PCP will determine:
 - a. The requested services are medically necessary:
 - i. Within 2 business days the AHCCCS Health Plan MCH Coordinator or designee will send the completed EPSDT service request form 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. The AHCCCS Health Plan will authorize the services with a contracted provider whenever possible.
 - iii. If services have already been initiated by an AHCCCS registered AzEIP provider not contracted with the AHCCCS Health Plan, the AHCCCS Health Plan may authorize the AHCCCS registered AzEIP provider to continue providing services to maintain continuity of care.
 - iv. If the AHCCCS Health Plan does not have the appropriate contracted provider within a reasonable distance from the member’s home, or the member must be placed on a wait list, the AHCCCS Health Plan may reimburse an AHCCCS registered non-contracted AzEIP provider to provide timely services. Payment for non-contracted providers is limited to (or, shall not exceed) the AHCCCS fee schedule rate.
 - v. 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.
 - vi. 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.
 - vii. 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 EPSDT service request form 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. The EPSDT service request form 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. The 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 EPSDT service request form are considered for medical necessity
 - iv. After the member is examined by the PCP and a determination is made, steps B.8.a. through B.8.b. should be followed.
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 by the AHCCCS Health Plan's contracted provider (or AHCCCS registered AzEIP service provider reimbursed by the AHCCCS Health Plan) 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, (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 of the MCH Coordinator will initiate the process for determining medical necessity and authorizing the service as outlined above.

EXHIBIT 430-5

**THE ARIZONA EARLY INTERVENTION PROGRAM (AZEIP)
REQUEST FOR EARLY PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT
(EPSDT) SERVICES**

DRAFT Implementation 10/01/2013

EXHIBIT 430-5

**THE ARIZONA EARLY INTERVENTION PROGRAM (AZEIP)
REQUEST FOR EARLY PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES**

DATE: _____ AZEIP SERVICE COORDINATOR: _____ PHONE #: _____

INITIAL IFSP SIX MONTH IFSP ANNUAL IFSP OTHER

Child's name:	AHCCCS ID Number:	Date of birth:	Expected month/year of transition from AzEIP:
Parents'/guardians' names:	AHCCCS Health Plan:	Primary Care Physician:	
Mailing address:	Home phone number:	Work phone number:	Message/cell phone/pager

THE CHILD IS ENROLLED IN THE FOLLOWING PROGRAMS: check all that apply

DES/AzeIP DES/DDD Children's Rehabilitative Services (CRS) Behavioral Health Women, Infants & Children (WIC)

BASIS FOR AZEIP ELIGIBILITY:

SEE ATTACHED: AZEIP DEVELOPMENTAL EVALUATION REPORT OR RESULTS OF THE MOST RECENT EVALUATIONS AND ASSESSMENTS

EXPECTED OUTCOME(S):

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 the 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.

Comments:

PHYSICIAN'S SIGNATURE _____

DATE _____

TO BE COMPLETED BY THE AZEIP SERVICE COORDINATOR					COMPLETED BY PCP	COMPLETED BY AHCCCS CONTRACTOR	
REQUESTED SERVICES	REQUESTED PROVIDER & PHONE #	START DATE	FREQUENCY	DURATION	PCP MEDICALLY NECESSARY SERVICE	AHCCCS CONTRACTOR	NOA SENT
					yes <input type="checkbox"/> no <input type="checkbox"/>	approve <input type="checkbox"/> deny <input type="checkbox"/>	yes <input type="checkbox"/> no <input type="checkbox"/>
					yes <input type="checkbox"/> no <input type="checkbox"/>	approve <input type="checkbox"/> deny <input type="checkbox"/>	yes <input type="checkbox"/> no <input type="checkbox"/>
					yes <input type="checkbox"/> no <input type="checkbox"/>	approve <input type="checkbox"/> deny <input type="checkbox"/>	yes <input type="checkbox"/> no <input type="checkbox"/>

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 GUARDIAN/PARENT AND THE AZEIP SERVICE COORDINATOR.

TO BE COMPLETED BY THE AHCCCS CONTRACTOR
<input type="checkbox"/> If the service provider is unknown, the AHCCCS Contractor will identify a service provider below for <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> SLP <input type="checkbox"/> If the requested service provider is not approved by the Contractor, the AHCCCS Contractor will identify an approved provider below

THE AHCCCS CONTRACTOR MUST DOCUMENT WHAT IS APPROVED: PROVIDER, FREQUENCY, DURATION AND SERVICE BEGIN DATE AND SERVICE END DATE						
APPROVED PROVIDER	PROVIDER PHONE #	APPROVED SERVICES	BEGIN DATE	END DATE	FREQUENCY	DURATION

CONTACTS

HEALTH PLAN:

MCH COORDINATOR:

PHONE NO.:

FAX NO.:

AZEIP SERVICE COORDINATOR:

PHONE NO.:

FAX NO.:

PRIMARY CARE PHYSICIAN:

PHONE NO.:

FAX NO.:

SERVICE PROVIDER:

PHONE NO.:

FAX NO.:



440 KIDSCARE SERVICES

REVISION DATES: XX/XX/XX, 10/01/08, 04/01/07, 08/01/05, 05/01/04, 04/01/04, 10/01/01

REVIEW DATE: 02/01/2011

INITIAL

EFFECTIVE DATE: 02/01/1999

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 Service 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, preventive and treatment services, and a full array of behavioral health care 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](#) 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, Diagnosis and Treatment services. Service descriptions and limitations included in [Chapter 300](#) and [Chapter 400](#) 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 AHCCCS Division of Fee-For-Service Management (DFSM) for members who are receiving services on a fee-for-service basis.

Refer to [Chapter 800](#), Policy 810, 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 Administration.



B. EXCLUDED SERVICES UNDER THE KIDSCARE PROGRAM

The following services are excluded:

- a. Licensed lay midwife services for prenatal care and home births, in accordance with A.A.C. R9-31-205.
- b. Services provided under the Medicaid School Based Claiming Program (Title XXI is not eligible for Medicaid School Based Claiming).
- c. 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, 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 KIDSCARE 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 utilization management requirements included in [Chapter 1000](#). Acute care Contractors are encouraged to include in their annual Early and Periodic Screening, Diagnosis and Treatment (EPSDT) plans and quarterly progress reports activities that will increase utilization of services by KidsCare members and/or acknowledge that EPSDT activities and objectives apply to both Title XIX members and those covered under Title XXI.

Contractors for Acute Care are encouraged to implement Prior Authorization (PA) and utilization management for the KidsCare Program services whenever appropriate. 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.



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, IHS, or a 638 Tribal Facility. 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).

If IHS or a 638 Facility 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 Administration. A non-IHS provider or facility rendering AHCCCS covered services must obtain PA from the AHCCCS/DFSM/PA 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, of this Manual. IHS and 638 Tribal Facilities are also responsible for providing necessary referrals for specialty care.

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