



410 MATERNITY CARE SERVICES

REVISION DATES: 09/08/16, 10/01/15, 10/01/14, 03/01/14, 10/01/13, 10/01/11, 09/01/11, 02/01/11, 10/01/09, 10/01/08, 04/01/07, 08/01/05, 04/01/04, 02/14/03, 10/01/01, 08/07/01, 02/01/01, 06/27/00, 10/01/97

INITIAL
EFFECTIVE DATE: 01/01/1997

DESCRIPTION

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

AMOUNT, DURATION AND SCOPE

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

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

A. MATERNITY CARE SERVICE DEFINITIONS

1. Certified Nurse Midwife (CNM) is certified by the American College of Nursing Midwives (ACNM) on the basis of a national certification examination and licensed to practice in Arizona by the State Board of Nursing. CNMs practice independent management of care for pregnant women and newborns, providing antepartum, intrapartum, postpartum, gynecological, and newborn care, within a health care system that provides for medical consultation, collaborative management, or referral.



2. High-risk pregnancy refers to a pregnancy in which the mother, fetus, or newborn is, or is anticipated to be, at increased risk for morbidity or mortality before or after delivery. High-risk is determined through the use of the Medical Insurance Company of Arizona (MICA) or American Congress of Obstetricians and Gynecologists (ACOG) standardized medical risk assessment tools.
3. Licensed Midwife means an individual licensed by the Arizona Department of Health Services to provide maternity care pursuant to Arizona Revised Statutes (A.R.S.) Title 36, Chapter 6, Article 7 and Arizona Administrative Code Title 9, Chapter 16 (This provider type does not include certified nurse midwives licensed by the Board of Nursing as a nurse practitioner in midwifery or physician assistants licensed by the Arizona Medical Board).
4. Maternity care includes identification of pregnancy, prenatal care, labor/delivery services, and postpartum care.
5. Maternity care coordination consists of the following maternity care related activities: determining the member's medical or social needs through a risk assessment evaluation; developing a plan of care designed to address those needs; coordinating referrals of the member to appropriate service providers and community resources; monitoring referrals to ensure the services are received; and revising the plan of care, as appropriate.
6. Practitioner refers to certified nurse practitioners in midwifery, physician's assistants and other nurse practitioners. Physician's assistants and nurse practitioners are defined in A.R.S. Title 32, Chapters 25 and 15 respectively.
7. Postpartum care is the health care provided for a period of up to 60 days post-delivery. Family planning services are included, if provided by a physician or practitioner, as addressed in Policy 420 of this Chapter.
8. Preconception counseling services, as part of a well woman visit, are provided when medically necessary. This counseling focuses on the early detection and management of risk factors before pregnancy, and includes efforts to influence behaviors that can affect a fetus (even before conception is confirmed), as well as regular health care. The purpose of preconception counseling is to ensure that a woman is healthy prior to pregnancy. Preconception counseling does not include genetic testing.
9. Prenatal care is the health care provided during pregnancy and is composed of three major components:
 - a. Early and continuous risk assessment,
 - b. Health education and promotion, and
 - c. Medical monitoring, intervention, and follow-up.



B. CONTRACTOR REQUIREMENTS FOR PROVIDING MATERNITY CARE SERVICES

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

1. Employ sufficient numbers of appropriately qualified local personnel in order to meet the requirements of the maternity care program for eligible enrolled members and achieve contractual compliance.
2. Provide written member educational outreach related to risks associated with elective inductions and cesarean sections prior to 39 weeks gestation, healthy pregnancy measures (addressing nutrition, sexually transmitted infections, substance abuse and other risky behaviors), dangers of lead exposure to mother and baby during pregnancy, postpartum depression, importance of timely prenatal and postpartum care, and other Contractor selected topics at a minimum of once every 12 months. These topics may be addressed separately or combined into one written outreach material; however, each topic must be covered during the twelve month period. Contractors may utilize multiple different venues to meet these requirements.
3. Conduct outreach and education activities to identify currently enrolled pregnant members, and enter them into prenatal care as soon as possible. The program must include protocols for service providers to notify the Contractor promptly when members have tested positive for pregnancy. In addition, Contractors must have an ongoing process to monitor and evaluate the effectiveness of outreach activities for all pregnant members. If activities prove to be ineffective, the Contractor must implement different activities.
4. Participate in community and quality initiatives within the communities served by the Contractor.
5. Implement written protocols to inform pregnant women and maternity care providers of voluntary prenatal HIV testing and the availability of counseling, if the test is positive.
 - a. Each Contractor must include information to encourage pregnant women to be tested and provide instructions on where testing is available at least annually in the member newsletter, new member welcome packet, maternity packet, provider instructions, and the member handbook.
 - b. Semiannually, each Contractor must report to AHCCCS the number of pregnant women who have been identified as HIV positive. The AHCCCS Semiannual Report of Number of Pregnant Women Who Are HIV Positive (AMPM Exhibit 410-1) is due no later than 30 days after the end of the second and fourth quarters of the federal fiscal year (contract year).



6. Designation of a maternity care provider for each enrolled pregnant woman for the duration of her pregnancy and postpartum care. Such designations must be consistent with AHCCCS Acute Care and Long Term Care contract requirements, allowing freedom of choice, while not compromising the continuity of care. Members who transition to a new Contractor or become enrolled during their third trimester must be allowed to complete maternity care with their current AHCCCS registered provider, regardless of contractual status, to ensure continuity of care.
7. Provision of information, regarding the opportunity to change Contractors to ensure continuity of prenatal care, to newly-assigned pregnant members and those currently under the care of a non-network provider.
8. Written new member assessment procedures for the provider that include identifying risk factors through the use of a comprehensive assessment tool covering psychosocial, nutritional, medical and educational factors (available from the American Congress of Obstetricians and Gynecologists [ACOG] or the Mutual Insurance Company of Arizona [MICA]).
9. Mandatory availability of maternity care coordination services for enrolled pregnant women, who are determined to be medically or socially at-risk/high-risk by the maternity care provider or the Contractor. This includes identified difficulties with navigating the health care system, evident by missed visits, transportation difficulties, or other perceived barriers.
10. Demonstration of an established process for assuring:
 - a. Network physicians, practitioners, and licensed midwives adhere to the highest standards of care, including the use of a standardized medical risk assessment tool for initial and ongoing risk assessments, and appropriate consults/referrals for increased-risk or high-risk pregnancies using ACOG or MICA criteria.
 - b. Maternity care providers educate members about healthy behaviors during pregnancy, including the importance of proper nutrition; dangers of lead exposure to mother and child; tobacco cessation; avoidance of alcohol and other harmful substances, including illegal drugs; screening for sexually transmitted infections; the physiology of pregnancy; the process of labor and delivery; breast-feeding; other infant care information; and postpartum follow-up.
 - c. Members are referred for support services to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), as well as other community-based resources to support healthy pregnancy outcomes. In the event where a member loses eligibility, the member must be notified where they may obtain low-cost or no-cost maternity services.
 - d. Maternity care providers maintain a complete medical record, documenting all aspects of maternity care.



- e. High-risk pregnant members have been referred to and are receiving appropriate care from a qualified physician, and
 - f. Postpartum services are provided to members within 60 days of delivery.
11. Mandatory provision of initial prenatal care appointments within the established timeframes. The established timeframes are as follows:
 - a. First trimester -- within 14 days of a request for an appointment
 - b. Second trimester -- within seven days of a request for an appointment
 - c. Third trimester -- within three days of a request for an appointment, or
 - d. High-risk pregnancy care must be initiated within three days of identification to the member's Contractor or maternity care provider, or immediately, if an emergency exists.
 12. Primary verification of pregnant members, to ensure that the above mentioned timeframes are met, and to effectively monitor members are seen in accordance with those timeframes.
 13. Monitoring and evaluation of infants born with low/very low birth weight, and implementation of interventions to decrease the incidence of infants born with low/very low birth weight.
 14. Monitoring and evaluation of cesarean section and elective induction rates prior to 39 weeks gestation, as well as implementation of interventions to decrease occurrence.
 15. Identification of postpartum depression and referral of members to the appropriate health care providers.

NOTE: Contractors may refer to AMPM, Exhibit F, *Tool Kit for the Management of Adult Postpartum Depression*, which is intended to assist the provider in assessing the postpartum needs of women regarding depression and decisions regarding health care services provided by the PCP or subsequent referral to the Regional Behavioral Health Authority (RBHA) if clinically indicated.
 16. Process for monitoring provider compliance for perinatal/postpartum depression screenings being conducted at least once during the pregnancy and then repeated at the postpartum visit, with appropriate counseling and referrals made, if a positive screening is obtained.
 17. Return visits in accordance with ACOG standards. A process, with primary verification, must be in place to monitor these appointments and ensure timeliness. Contractors must include the first and last prenatal care dates of service and the number of obstetrical visits that the member had with the provider on claim forms to AHCCCS regardless of the payment methodology.



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

18. Timely provision of medically necessary transportation services, as described in AMPM Policy 310-BB, *Transportation*.
19. Postpartum activities must be monitored and evaluated, and interventions to improve the utilization rate implemented, where needs are identified.
20. Participation of Contractors in reviews of the maternity care services program conducted by AHCCCS as requested, including provider visits and audits.

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

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

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



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

D. MATERNITY CARE PROVIDER REQUIREMENTS

1. Physicians and practitioners must follow the American Congress of Obstetricians and Gynecologists standards of care, including the use of a standardized medical risk assessment tool and ongoing risk assessment.
2. Licensed midwives, if included in the Contractor's provider network, adhere to the requirements contained within AHCCCS policy, procedures, and contracts.
3. All maternity care providers will ensure that:
 - a. High-risk members have been referred to a qualified provider and are receiving appropriate care.
 - b. Members are educated about health behaviors during pregnancy, including the importance of proper nutrition; dangers of lead exposure to mother and child; tobacco cessation; avoidance of alcohol and other harmful substances, including illegal drugs; screening for sexually transmitted infections; the physiology of pregnancy; the process of labor and delivery; breastfeeding; other infant care information; and postpartum follow-up.
 - c. Perinatal/Postpartum depression screenings are conducted at least once during the pregnancy and then repeated at the postpartum visit with appropriate counseling and referrals made, if a positive screening is obtained. Postpartum depression screening is considered part of the global service and is not a separately reimbursable service.



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

- d. Member medical records are appropriately maintained and document all aspects of the maternity care provided.
- e. Members must be referred for support services to the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), as well as other community-based resources, in order to support healthy pregnancy outcomes.
- f. Members must be notified that in the event they lose eligibility for services, they may contact the Arizona Department of Health Services Hotline for referrals to low-cost or no-cost services.
- g. The first and last prenatal care dates of service, as well as the number of obstetrical visits that the member had with the provider, are recorded on all claim forms submitted to the Contractor regardless of the payment methodology used.
- h. Postpartum services must be provided to members within 60 days of delivery utilizing a separate “zero-dollar” claim for the postpartum visit.

E. ADDITIONAL COVERED RELATED SERVICES

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

1. Circumcision of newborn male infants, is a covered service when it is determined to be medically necessary
2. Extended stays for normal newborns related to status of mother’s stay
3. Home uterine monitoring technology
4. Labor and delivery services provided in freestanding birthing centers
5. Labor and delivery services provided in a home setting
6. Licensed Midwife services
7. Supplemental stillbirth payment
8. Pregnancy termination (including Mifepristone [Mifeprex or RU-486])



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

DESCRIPTION

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

AMOUNT, DURATION AND SCOPE

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

2. **EXTENDED STAYS FOR NORMAL NEWBORNS RELATED TO STATUS OF MOTHER'S STAY**

DESCRIPTION

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

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

CYE 2014 Limitations

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

AMOUNT, DURATION AND SCOPE

The mother of the newborn may be discharged prior to the minimum 48/96 hour stay if agreed upon by the mother in consultation with the physician or practitioner. In addition, if the mother's stay is to extend beyond 48/96 hours, an extended stay for the newborn should be granted if the mother's condition allows for mother-infant interaction and the child is not a ward of the State or is not to be adopted.



Prior authorization is required for extended stays for newborn infants for the Fee-For-Service population.

3. HOME UTERINE MONITORING TECHNOLOGY

DESCRIPTION

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

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

- a. Multiple gestation, particularly triplets or quadruplets,
- b. Previous obstetrical history of one or more births before 35 weeks gestation, or
- c. Hospitalization for premature labor before 35 weeks gestation with a documented change in the cervix, controlled by tocolysis and ready to be discharged for bed rest at home.

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

4. LABOR AND DELIVERY SERVICES PROVIDED IN FREESTANDING BIRTHING CENTERS

DESCRIPTION

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

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

AMOUNT, DURATION AND SCOPE

- a. Labor and delivery services rendered through freestanding birthing centers must be provided by a physician, (i.e., the member's primary care provider or an obstetrician with hospital admitting privileges) or by a registered nurse who is



accredited/certified by the American College of Nurse Midwives and has hospital admitting privileges for labor and delivery services.

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

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

5. LABOR AND DELIVERY SERVICES PROVIDED IN THE HOME SETTING

DESCRIPTION

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

AMOUNT, DURATION AND SCOPE

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

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

A risk assessment must be conducted when a new presenting complication or concern arises to ensure appropriate care and referral to a qualified provider, if necessary.



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

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

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

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

6. LICENSED MIDWIFE SERVICES

DESCRIPTION

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

AMOUNT DURATION AND SCOPE

Licensed midwife services may be provided only to members for whom an uncomplicated prenatal course and a low-risk labor and delivery can be anticipated. The age of the member must be included as a consideration in the risk status evaluation. Refer to the AHCCCS Maternity Care Risk Screening Guidelines



(AMPM Exhibit 410-2) for more detailed explanation of what AHCCCS does not consider as low-risk deliveries, nor appropriate for planned home-births or births in freestanding birthing centers.

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

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

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

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

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



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

7. **SUPPLEMENTAL STILLBIRTH PAYMENT**

DESCRIPTION

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

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

- a. Attained a weight of at least 600 grams, or
- b. Attained a gestational age of at least 24 weeks, as verified by Provider's obstetrical prenatal records (History & Physical) including an Estimated Date of Confinement (EDC). An ultrasound report may also be used to verify EDC, when completed prior to 20 weeks gestation. A Ballard Assessment, done at delivery by nursing and/or physician staff to determine physical maturity of the infant, confirming a gestational age of at least 24 weeks may also be used.

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

AHCCCS
Division of Health Care Management
Clinical Quality Management Unit/MCH Manager
701 E. Jefferson, MD 6700
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 AHCCCS Clinical Quality Management Unit. Exemptions will be considered on a case-by-case basis.

**8. PREGNANCY TERMINATION
(INCLUDING MIFEPRISTONE [MIFEPREX OR RU-486])**

DESCRIPTION

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

- a. The pregnant member suffers from a physical disorder, physical injury, or physical illness including a life-endangering physical condition caused by, or arising from, the pregnancy itself that would, as certified by a physician, place the member in danger of death, unless the pregnancy is terminated.
- b. The pregnancy is a result of incest.
- c. The pregnancy is a result of rape.
- d. The pregnancy termination is medically necessary according to the medical judgment of a licensed physician, who attests that continuation of the pregnancy could reasonably be expected to pose a serious physical or behavioral health problem for the pregnant member by:
 - i. Creating a serious physical or behavioral health problem for the pregnant member,
 - ii. Seriously impairing a bodily function of the pregnant member,
 - iii. Causing dysfunction of a bodily organ or part of the pregnant member,
 - iv. Exacerbating a health problem of the pregnant member, or
 - v. Preventing the pregnant member from obtaining treatment for a health problem.

Conditions, Limitations and Exclusions

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

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

Additional Required Documentation

- a. A written informed consent must be obtained by the provider and kept in the member's chart for all pregnancy terminations. If the pregnant member is



younger than 18 years of age, or is 18 years of age or older and considered an incapacitated adult (as defined in A.R.S. § 14-5101), a dated signature of the pregnant member's parent or legal guardian indicating approval of the pregnancy termination procedure is required.

- b. When the pregnancy is the result of rape or incest, documentation must be obtained that the incident was reported to the proper authorities, including the name of the agency to which it was reported, the report number (if available), and the date the report was filed. This documentation requirement must be waived if the treating physician certifies that, in his or her professional opinion, the member was unable, for physical or psychological reasons, to comply with the requirement.

Additional Considerations Related to Use of Mifepristone

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

- a. Mifepristone can be administered through 49 days of pregnancy.
- b. If the duration of pregnancy is unknown or if ectopic pregnancy is suspected, ultrasonography should be used for confirmation.
- c. Any Intrauterine Device (“IUD”) should be removed before treatment with Mifepristone begins.
- d. 400 mg of Misoprostol must be given two days after taking Mifepristone unless a complete abortion has already been confirmed.
- e. Pregnancy termination by surgery is recommended in cases when Mifepristone and Misoprostol fail to induce termination of the pregnancy.

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

- a. Duration of pregnancy in days,
- b. The date IUD was removed if the member had one,
- c. The date Mifepristone was given,
- d. The date Misoprostol was given, and
- e. Documentation that pregnancy termination occurred.

NOTE: Contractors must submit a standardized AHCCCS Monthly Pregnancy Termination Report (Exhibit 410-6) to AHCCCS/Division of Health Care Management Clinical Quality Management Unit, which documents the number of pregnancy terminations performed during the month (including pregnancy terminations resulting from the use of



Mifepristone). If no pregnancy terminations were performed during the month, the monthly report must still be submitted to attest to that information.

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

- a. A copy of the completed AHCCCS Certificate of Necessity for Pregnancy Termination form, which has been signed by the Contractor's Medical Director,
- b. A copy of the completed AHCCCS Verification of Diagnosis by Contractor for Pregnancy Termination Request (Exhibit 410-5) confirming requirements for pregnancy termination have been met,
- c. A copy of the official incident report, in the case of rape or incest,
- d. A copy of documentation confirming pregnancy termination occurred, and
- e. A copy of the clinical information supporting the justification/necessity for pregnancy termination.

(See AMPM Exhibit 410-6, *AHCCCS Monthly Pregnancy Termination Report* for the reporting form and Exhibit 400-1, *Maternal and Child Health Reporting Requirements* for submission timeframes.)

Prior Authorization (PA)

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

In cases of medical emergencies, the provider must submit all documentation of medical necessity to the Contractor, or AHCCCS/Division of FFS Management CMSU 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 AMPM Chapter 500 of this Manual for AHCCCS policy on the transfer of a neonate between acute care centers.

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

Refer to AMPM Chapter 900 of this Manual for quality management for all covered services.