320 SERVICES WITH SPECIAL CIRCUMSTANCES

320-A AFFILIATED PRACTICE DENTAL HYGIENIST POLICY

REVISION DATE: 10/01/09

INITIAL

EFFECTIVE DATE: 04/01/2007

DESCRIPTION

AHCCCS covers oral health care services as described in Chapter 400, Policy 430, EPSDT services. As allowed by State law, A.R.S. §32-1281 and §32-1289, and described in this policy, dental hygienists with an affiliated practice agreement, may provide dental hygiene services to AHCCCS members 18 years of age and younger.

AMOUNT, DURATION AND SCOPE

AHCCCS covers dental hygiene services provided by Arizona licensed dental hygienists subject to the terms of the written affiliated practice agreement entered into between a dentist and a dental hygienist.

Each affiliated dental hygienist, when practicing under an affiliated practice relationship may perform only those duties specified within the terms of the affiliated practice relationship and they must maintain an appropriate level of contact, communication and consultation with the affiliated practice dentist.

In addition to the requirements specified in A.R.S. §32-1281 and §32-1289, AHCCCS requires the following:

1. Both the dental hygienist and the dentist in the affiliated practice relationship must be registered AHCCCS providers.

2. The affiliated practice dental hygienist must maintain individual medical records of AHCCCS members in accordance with the Arizona State Dental Practice Act. At a minimum this must include member identification, parent/guardian identification, signed authorization (parental consent) for services, member medical history and documentation of services rendered.

3. The affiliated practice dental hygienist must register with AHCCCS and bill for services under his or her individual AHCCCS provider identification number/NPI number.
4. The affiliated practice dental hygienist will only be reimbursed for providing services in accordance with State regulations, AHCCCS policy and provider agreement, and their affiliated practice agreement.

5. AHCCCS reimbursement for dental radiographs is restricted to providers who are qualified to perform both the exposure and the interpretation of dental radiographs.
320-B AHCCCS MEMBER PARTICIPATION IN EXPERIMENTAL TREATMENT

REVISION DATES: 07/01/12, 03/01/09, 06/01/07, 07/01/04, 10/01/01

INITIAL

EFFECTIVE DATE: 10/01/1994

DESCRIPTION

AHCCCS members who are enrolled with a Contractor, or are receiving services on a Fee-For-Service (FFS) basis, may participate in experimental treatment, but AHCCCS will not reimburse for the experimental treatment.

AMOUNT, DURATION AND SCOPE

If the experimental treatment provided to an AHCCCS member requires laboratory tests, imaging services, inpatient services, or other medical services that would not otherwise be required for non-experimental treatments provided to the member, AHCCCS will not cover the additional services. Coverage of care associated with complications resulting from the experimental treatment will be considered on an individual basis. Participation in experimental treatment will not result in the loss of the member's other benefits.

The member's primary care provider must not have any financial interest in the experimental treatment and cannot accept a finder's fee for referral of a member to participate in the experiment.

Any individual expected to assess the appropriateness of services for the member cannot have a financial interest in conducting the experimental treatment, or its outcome.

Participation in a U.S. Food and Drug Administration Phase I or Phase II clinical trial must be approved by the member's Contractor, or by the AHCCCS Chief Medical Officer. If a Contractor approves participation of one or more members in an experimental trial, it must provide notice to AHCCCS/Division of Health Care Management (DHCM), Medical Management Unit, which includes assurance that the member's rights are protected. FFS member participation will be evaluated for approval by the AHCCCS Medical Director. The basis for approval will include:

1. Verification that full financial liability for the experimental treatment is taken by the researcher or the sponsor, and documentation indicates that the costs associated with the experimental treatment and direct complications will not be charged to, or paid by, AHCCCS
2. The experimental treatment regimen is well designed, and adequate protection of the member's welfare is assured. The trial provides adequate participant information, assures participant consent, and

3. AHCCCS Contractor employees or network providers cannot receive fees, finder's fees or other payment for referring members.
320-C  **BREAST AND CERVICAL CANCER TREATMENT PROGRAM**

**REVISION DATES:** 09/01/2011, 6/01/07, 07/01/04

**INITIAL EFFECTIVE DATE:** 01/01/2002

**Description**

Effective January 1, 2002, the Breast and Cervical Cancer Treatment Program (BCCTP) was added as a new eligibility category under AHCCCS. The Native American Breast and Cervical Cancer Treatment technical amendment that was signed into law on January 15, 2002, made it possible for American Indian women to qualify for the BCCTP coverage group even if they are eligible for health services from the Indian Health Service (IHS) or a 638 Tribal Facility.

Requirements for the program specify that a woman must be screened and diagnosed as needing treatment for breast and/or cervical cancer. Any of the following Arizona programs of the National Breast and Cervical Cancer Early Detection Program funded by the Centers for Disease Control and Prevention (CDC) can provide such services:

1. The Well Woman Health Check Program (WWHP), administered by the Arizona Department of Health Services (ADHS),
2. The Hopi Women's Health Program, and

**Amount, Duration and Scope**

A woman who is eligible for AHCCCS under the BCCTP receives the full range of AHCCCS covered services pursuant to Arizona Administrative Code Title 9, Chapter 22, Article 20. A woman who is eligible under this program will be enrolled with a Contractor of her choice. If she does not choose one, she will be automatically assigned to one.

**TREATMENT SERVICES AND ELIGIBILITY**

Breast Cancer - Eligibility for the breast cancer program shall conclude 12 months after the last provider visit for specific treatment of the cancer, or at the end of hormonal therapy for breast cancer, whichever is later.
Treatment includes any of the following:

1. Surgical removal of the breast cancer
2. Chemotherapy
3. Radiation therapy, or
4. A treatment that, as determined by the AHCCCS Medical Director or designee, is considered the standard of care as supported by a peer-reviewed study published in a medical journal.

Pre-cancerous cervical lesion(s) - Eligibility for the program for a pre-cancerous cervical lesion, including moderate or severe cervical dysplasia or carcinoma in situ, shall conclude four months after the last provider visit for specific treatment for the pre-cancerous lesion(s).

Treatment includes any of the following:

1. Conization
2. Loop Electrosurgical Excision Procedure
3. Cryotherapy, or
4. A treatment that, as determined by the AHCCCS Medical Director or designee, is considered the standard of care as supported by a peer-reviewed study published in a medical journal.

Cervical Cancer – Eligibility for the program for cervical cancer shall conclude 12 months after the last provider visit for specific treatment of the cancer.

Treatment includes any of the following:

1. Surgery
2. Chemotherapy
3. Radiation therapy, or
4. A treatment that, as determined by the AHCCCS Medical Director or designee, is considered the standard of care as supported by a peer-reviewed study published in a medical journal.
Metastasized Cancer - A woman’s eligibility and treatment under this program will continue if a metastasized cancer is found in another part of the woman’s body and the metastasized cancer is a known or presumed complication of the breast or cervical cancer.

Re-occurrence of the Cancer - A woman will have eligibility re-established, after eligibility under this program ends, if:

The woman is screened under the WWHP program or one of the American Indian programs, and

1. Additional breast or cervical cancer is found, or

2. There is re-occurrence of pre-cancerous lesion(s).

EXCLUSIONS

Males are precluded from receiving screening and diagnostic services under the National Breast and Cervical Cancer Early Detection Program and thus are ineligible under this program.

RESPONSIBILITIES

The National Breast and Cervical Cancer Early Detection Program and staff shall:

1. Direct any woman whose screening shows a diagnosis of breast cancer, cervical cancer or pre-cancerous cervical lesion(s) to apply to AHCCCS for treatment. However, AHCCCS eligibility cannot be determined until a positive diagnosis is confirmed.

2. Assist the woman with a Title XIX application

A woman may apply for eligibility by completing an application for AHCCCS health insurance provided by National Breast and Cervical Cancer Early Detection Program staff. The National Breast and Cervical Cancer Early Detection Program mails or faxes the application directly to AHCCCS after receiving a positive diagnosis. A complete application contains all the information requested, including documentation verifying alien status if born outside the United States.
3. Provide AHCCCS with the diagnosis and date of diagnosis.

**Responsibilities for Reporting**

Background: This program is unique, in that continued eligibility is primarily determined by active treatment, and in that this program involves not only AHCCCS, but also ADHS and the CDC. The requirements for this program have created the need for special reporting by Contractors or the American Indian programs as follows:

1. AHCCCS Division of Member Services (DMS) must be notified when active treatment has ended.

2. ADHS must be notified of:
   a. Date the treatment began
   b. Tumor size
   c. Tumor stage, and
   d. Date treatment ended.

**The Process for Reporting Clinical Information and Status of Treatment**

1. AHCCCS Division of Member Services (DMS) will send forms to the appropriate Contractor that identify which women in the program require updated treatment information. The Contractor will complete the form and send it back to DMS.

2. For fee-for-service members, including American Indian program members, DMS will send forms to AHCCCS Division of Fee-For-Service Management/Prior Authorization Unit (DFSM/PA) or the IHS/638 BCCTP clinic. DFSM/PA or the IHS/638 BCCTP clinic will complete the form and return it to DMS.

3. DMS will acquire the information they need from the forms and then send the forms on to ADHS.

**REFERENCES**

- Breast and Cervical Cancer Prevention and Treatment Act
- Arizona Administrative Code
- Arizona Department of Health Services Well Woman Health Check Program
- National Breast and Cervical Cancer Early Detection Program
CHAPTER 300
MEDICAL POLICY FOR AHCCCS COVERED SERVICES

POLICY 320
SERVICES WITH SPECIAL CIRCUMSTANCES

320-D RESERVED
320-E HEALTH AND BEHAVIOR INTERVENTION

DESCRIPTION

Health and behavioral assessment procedures (CPT codes 96150-96155) are used to identify and treat the psychological, behavioral, emotional, cognitive and social factors important to the prevention, treatment and management of physical health problems. The focus of the assessment is not on mental health, but on the stresses, expectations, lifestyle and perceptions that are associated with the underlying medical condition. Codes 96150 - 96155 describe services offered to members who present with primary physical illnesses, diagnosis or symptoms and may benefit from assessments and interventions that focus on the biopsychosocial factors related to the member's health. These services do not represent preventative medicine counseling and risk factor reduction interventions. Therefore, evaluation and management services codes (including preventative medicine, individual counseling codes 99401-99404 and preventative medicine, group counseling codes 99411-99412) should not be reported on the same day.

AMOUNT, DURATION AND SCOPE

AHCCCS covers medically necessary health and behavioral assessment procedures (CPT codes 96150-96155). The focus of the assessment/interventions is not on mental health but the biopsychosocial factors important to physical health problems and treatment. The focus of the intervention is to improve the member's health and well-being utilizing cognitive, behavioral, social, and/or psychophysiological procedures designed to ameliorate specific disease-related problems.

Individuals requiring the service(s) described above must not be referred to the Integrated Regional Behavioral Health Authorities (Integrated RBHAs) or Regional Behavioral Health Authorities (RBHAs).

CODES

96150- Health and behavior assessment (e.g. health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment.
96151 - Re-assessment
96152 - Health and behavior intervention, each 15 minutes, face-to-face; individual
96153 - Group (two or more patients)
96154 - Family (with the patient present)
96155 - Family (without the patient present)
The following professionals are approved by AHCCCS to provide health and behavioral assessments/interventions:

1. Psychologist
2. Licensed clinical social worker
3. Licensed marriage and family therapist
4. Licensed professional counselor, and
5. Psychiatric nurse practitioner

Health and behavior intervention services may be performed in the following places of service:

1. Federally Qualified Health Clinic (FQHC)
2. Rural Health Clinic
3. Provider Office
4. The member’s home
5. Indian Health Service (IHS) Freestanding Facility
6. IHS Provider Based Facility
7. Tribal 638 Freestanding Facility, and
8. Tribal 638 Provider Based Facility.
9. Integrated Behavioral Health Residential Facility

**Limitations**

1. Services are limited to 48 units annually (unit is equal to 15 minutes).

   Members with mental health treatment needs exceeding the scope or duration of services described (which are medical codes for behavioral health interventions) should be appropriately referred for behavioral health services that will require the specific use of behavioral health codes.

2. Services are limited to the providers and settings listed above.
CHAPTER 300  
MEDICAL POLICY FOR AHCCCS COVERED SERVICES  
POLICY 320  
SERVICES WITH SPECIAL CIRCUMSTANCES  

320-F HIV/AIDS TREATMENT SERVICES  

REVISION DATES: 06/01/07, 03/01/05, 07/01/04, 09/01/03, 10/01/01, 04/06/98  

REVIEW DATE: 09/01/2011  

INITIAL EFFECTIVE DATE: 02/02/1997  

DESCRIPTION  

AHCCCS-covered medically necessary treatment services, rendered by qualified providers, are available for the treatment of members who have been diagnosed with HIV/AIDS. Members who are diagnosed with HIV/AIDS are also listed as members with special health care needs. AMPM Chapter 500 describes the requirements for special health care needs members. AHCCCS requires Contractors to follow the Centers for Disease Control and Prevention (CDC) guidelines for the treatment of HIV/AIDS. It is the responsibility of each Contractor to distribute these guidelines, and all updates, to HIV/AIDS treatment professionals included in their network.  

As appropriate, AHCCCS shall review new technological advances in HIV/AIDS treatment, including recommended pharmacological regimens.  

This review shall include the AHCCCS Chief Medical Officer, the AHCCCS Medical Director, Contractor Medical Directors and physician experts in the treatment of HIV/AIDS.  

The review may include, but is not limited to, information regarding:  

1. Established treatment and pharmaceutical regimens  
2. Changes in technology and treatment protocols, and  

CONTRACTOR MONITORING  

Contractors must develop policies and protocols that document care coordination services provided to members with HIV/AIDS. This includes monitoring of member
medical care in order to ensure that medical services, medication regimens and necessary support services (i.e., transportation) are provided within specified timelines, as defined in contractual arrangements with AHCCCS, and that these services are utilized appropriately. Support services may be coordinated with existing community resources.

In addition, Contractors must ensure that the care for members diagnosed with HIV/AIDS, who are receiving services specified by and in accordance with the guidelines set by AHCCCS, is well coordinated and managed in collaboration with the member's treating physician.

If a conflict regarding treatment or denial of treatment arises between the member's treating physician and the Contractor Medical Director, the issue may be referred to the AHCCCS Medical Director or designee. However, this does not preclude the member’s right to file an appeal.

**HIV/AIDS Treatment Professionals**

AHCCCS will compile, update and make available to Contractors, upon request, a listing of qualified HIV/AIDS treatment professionals (physicians, nurse practitioners and/or physician assistants). The listing will be based on information submitted by the Contractors as specified in contractor reporting requirements.

A qualified HIV/AIDS treatment professional, for the purpose of this policy, is defined as a physician or practitioner who:

1. Is recognized in the community as having a special interest, knowledge and experience in the treatment of HIV/AIDS,

2. Agrees to adhere to CDC treatment guidelines for HIV/AIDS,

3. Agrees to provide primary care services and/or specialty care to AHCCCS members with HIV/AIDS,

4. Demonstrates ongoing professional development by clinically managing at least five patients with HIV/AIDS during the last year, and

5. Meets one of the criteria below:
   a. Current Board Certification or Recertification in Infectious Diseases, or
   b. Annual completion of at least ten hours of HIV/AIDS-related Continuing Medical Education (CME), which meet the CME requirements under A.A.C. R4-16-101.
LIMITATIONS

A physician or practitioner not meeting the criteria to be a qualified HIV/AIDS treatment professional who wishes to provide primary care services to a member with HIV/AIDS must send documentation to the Contractor demonstrating that s/he has established a consultative relationship with a physician who meets the criteria for a qualified HIV/AIDS treatment professional as identified in this policy.

This documentation should be maintained in the Contractor's credentialing file. These practitioners may treat members with HIV/AIDS under the following circumstances:

- In geographic areas where the incidence of members with HIV/AIDS is low, and/or where there are no available AHCCCS-registered network HIV/AIDS treatment professionals meeting this criteria, or

- When a member with HIV/AIDS chooses a provider who does not meet the criteria.

CONTRACTOR NETWORK

Contractors must include in their individual provider networks sufficient numbers of qualified HIV/AIDS treatment professionals (physicians, nurse practitioners and/or physician assistants). Contractors must also have policies and procedures to assure that provider requirements and standards specified in the AMPM are met. Each Contractor provider network of HIV/AIDS treatment professionals is subject to review and approval by AHCCCS, Division of Health Care Management (DHCM). Contractors must submit, annually by December 15, a list of HIV/AIDS treatment providers to AHCCCS/ DHCM/Medical Management Unit (MM) which includes:

1. Name and location of all qualified HIV/AIDS treatment professionals treating members with HIV/AIDS, and

2. For each Primary Care Provider (PCP) treating members with HIV/AIDS who is not a qualified HIV/AIDS treatment specialist, the name and location of the consulting HIV/AIDS treatment professional.

Contractors must also notify AHCCCS/DHCM/CQM of any material change to the HIV/AIDS provider network during the year.
Contractor policies must reflect that members with HIV/AIDS have freedom of choice to select an HIV/AIDS provider from the Contractor network. If the member selects a PCP in the Contractor network who is not a provider designated by the Contractor as a qualified HIV/AIDS disease treatment professional, the member must be informed that only those designated providers are authorized to render treatment regimens such as antiretroviral therapies. The selected PCP must consult with a qualified HIV/AIDS provider and follow the recommendations of the consultant in order for the treatment regimen (such as protease inhibitors) to be a covered service.
AHCCCS covers LVRS, or reduction pneumoplasty, for persons with severe emphysema when performed at a facility approved by Medicare to perform this surgery and in accordance with all of the established Medicare guidelines. AHCCCS follows the Medicare National Coverage Decision as published on 11/17/05. In the event Medicare’s policy is revised, AHCCCS may reevaluate and/or revise our policy accordingly.

The member’s treating physician is responsible for providing appropriate documentation, establishing medical necessity, and verification of compliance with Medicare and AHCCCS guidelines. The documentation must be sent to the Contractor Medical Director or, to the AHCCCS Medical Director for fee-for-service members, when requesting authorization.

When possible, such surgeries, and the required pre- and post-operative therapies, will be performed at facilities approved by Medicare for LVRS reimbursement within the State of Arizona. However, AHCCCS may cover this procedure at out-of-state facilities if needed. All facilities must meet Medicare LVRS facility requirements as well as AHCCCS Provider Registration requirements.

If medically necessary, AHCCCS may pay for an adult caregiver to accompany members when out-of-state-travel is required. Transportation, lodging and board may be covered as appropriate.

**Medicare Criteria**

The Centers for Medicare and Medicaid Services (CMS) has issued a National Coverage Decision (NCD) for lung volume reduction surgery (reduction pneumoplasty) specifying covered and non-covered criteria. As stated above, AHCCCS will follow Medicare established guidelines for this procedure according to the NCD effective 11/17/2005. NCD for lung volume reduction surgery (reduction pneumoplasty) is included as Exhibit 320-1.
320-H  METABOLIC MEDICAL FOODS

DESCRIPTION OF BENEFIT

Inherited metabolic disorders are rare genetic conditions in which normal metabolic function is inhibited by a deficiency in a crucial enzyme. To avoid toxic effects, treatment of the associated metabolic disorder depends on dietary restriction of foods containing the substances that cannot be metabolized by the affected member. Foods that restrict the offending amino acid(s) for disorders of amino acid metabolism are not generally available from the grocery store or health food store. Modified foods that are available in the grocery store or health food store are not covered by this policy. Treatment of inherited metabolic disorders is accomplished by use of specialized diets employing metabolic formula or medical foods.

AHCCCS covers metabolic formulas and medical foods, within the limitations specified in this policy, for member’s diagnosed with one of the following inherited metabolic conditions:

1. Phenylketonuria
2. Homocystinuria
3. Maple Syrup Urine Disease
4. Galactosemia (requires soy formula)
5. Beta Keto-Thiolase Deficiency
6. Citrullinemia
7. Glutaric Acidemia Type I
8. 3 Methylcrotonyl CoA Carboxylase Deficiency
9. Isovaleric Acidemia
10. Methylmalonic Acidemia
11. Propionic Acidemia
12. Arginosuccinic Acidemia

13. Tyrosinemia Type I

14. HMG CoA Lyase Deficiency

15. Cobalamin A, B, C Deficiencies

DEFINITIONS

1. Medical foods means metabolic formula or modified low protein foods that are produced or manufactured specifically for persons with a qualifying metabolic disorder and that are not generally used by persons in the absence of a qualifying metabolic disorder.

2. Metabolic nutritionist means an AHCCCS registered provider who is a registered dietitian specializing in nutritional assessment and treatment of metabolic conditions.

CONDITIONS, LIMITATIONS AND EXCLUSIONS

1. Contractors are responsible for:
   a. Initial and follow-up consultations by a genetics physician and/or a metabolic nutritionist,
   b. Lab tests and other services related to the provision of medical foods for enrolled members diagnosed with an inherited metabolic disorder listed below,
   c. Metabolic formula and modified medical foods for members who have been diagnosed with one of the inherited metabolic disorders listed in this policy.

2. Metabolic formula and modified low protein foods must be:
   a. Processed or formulated to be deficient in the nutrient(s) specific to the member's metabolic condition.
   b. Meet the member's distinctive nutritional requirements that are established through medical evaluations conducted by the member's PCP, attending physician or appropriate specialist, and/or the metabolic nutritionist for the specific dietary management of the member's metabolic condition.
   c. Determined to be essential to sustain the member's optimal growth within nationally recognized height/weight or BMI (body mass index), health and metabolic homeostasis.
   d. Obtained only under physician order, and
   e. Supervised by the member’s PCP, attending physician or appropriate specialist for the medical and nutritional management of a member who has other specific nutritional requirements as established by medical evaluation.
3. Modified low protein foods must be formulated to contain less than one gram of protein per unit or serving. For purposes of this policy, modified low protein foods do not include foods that are naturally low in protein.

4. Soy formula is covered only for members receiving Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services and KidsCare members diagnosed with galactosemia and only until they are able to eat solid lactose-free foods.

5. Foods purchased through grocery or health food stores are not covered.
320-I  TELEHEALTH AND TELEMEDICINE

**REVISION DATES:** 10/01/15, 04/01/12, 12/01/06, 10/01/06, 05/01/06, 07/01/04, 10/01/01

**INITIAL EFFECTIVE DATE:** 01/01/2001

**DESCRIPTION**

AHCCCS covers medically necessary consultative and/or treatment telemedicine services for all eligible members within the limitations described in this policy when provided by an appropriate AHCCCS registered provider.

**DEFINITIONS**

1. **Asynchronous or "Store and Forward"** is the transfer of data from one site to another through the use of a camera or similar device that records (stores) an image that is sent (forwarded) via telecommunication to another site for consultation. Asynchronous or "store and forward" applications would not be considered telemedicine but may be utilized to deliver services.

2. **Consulting Provider** means any AHCCCS registered provider who is not located at the originating site who provides an expert opinion to assist in the diagnosis or treatment of a member.

3. **Distant or Hub site** is the site at which the physician or other licensed practitioner delivering the service is located at the time the service is provided via telecommunications system.

4. **Originating or Spoke site** is the location of the Medicaid patient at the time the service being furnished via a telecommunications system occurs. Telepresenters may be needed to facilitate the delivery of this service.

5. **Telecommunications Technology**, which includes store and forward, means the transfer of medical data from one site to another through the use of a camera, electronic data collection system such as an Electrocardiogram (ECG), or other similar device, that records (stores) an image which is then sent (forwarded) via telecommunication to another site for consultation. Services delivered using telecommunications technology, but **not** requiring the member to be present during their implementation, are **not** considered telemedicine. For information about coverage of these services, see Section B of the policy.

6. **Teledentistry** refers to the acquisition and transmission of all necessary subjective and objective diagnostic data through interactive audio, video or data
communications by an AHCCCS registered dental provider to a distant dentist for triage, dental treatment planning, and referral.

a. Teledentistry includes the provision of preventive and other approved therapeutic services by the AHCCCS registered Affiliated Practice Dental Hygienist, who provides dental hygiene services under an affiliated practice relationship with a dentist.

b. Teledentistry does not replace the dental examination by the dentist; limited, periodic, and comprehensive examinations cannot be billed through the use of teledentistry alone.

7. **Telehealth (or Telemonitoring)** is the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance.

a. Telehealth includes such technologies as telephones, facsimile machines, electronic mail systems, and remote patient monitoring devices, which are used to collect and transmit patient data for monitoring and interpretation. While they do not meet the Medicaid definition of telemedicine they are often considered under the broad umbrella of telehealth services. Even though such technologies are not considered "telemedicine," they may nevertheless be covered and reimbursed as part of a Medicaid coverable service, such as laboratory service, x-ray service or physician services (under section 1905(a) of the Social Security Act).

8. **Telemedicine** means the practice of health care delivery, diagnosis, consultation and treatment and the transfer of medical data between the originating and distant sites through real-time interactive audio, video or data communications that occur in the physical presence of the member.

9. **Telepresenter** means a designated individual who is familiar with the member's case and has been asked to present the member's case at the time of telehealth service delivery if the member's originating site provider is not present. The telepresenter must be familiar, but not necessarily medically expert, with the member's medical condition in order to present the case accurately.

A. **USE OF TELEMEDICINE**

For the services listed below, AHCCCS covers any medically necessary services provided via telemedicine. Services must be real-time visits otherwise reimbursed by AHCCCS.

The following medical services are covered:

1. Cardiology
2. Dermatology
3. Endocrinology

4. Hematology/oncology

5. Infectious diseases

6. Neurology

7. Obstetrics/gynecology

8. Oncology/radiation

9. Ophthalmology

10. Orthopedics

11. Pain clinic

12. Pathology

13. Pediatrics and pediatric subspecialties

14. Radiology

15. Rheumatology

16. Surgery follow-up and consultations

17. Behavioral Health

18. Diagnostic consultation and evaluation
   a. Psychotropic medication adjustment and monitoring
   b. Individual and family counseling
   c. Case management

B. USE OF TELECOMMUNICATIONS

Services delivered using telecommunications are generally not covered by AHCCCS as a telemedicine service. The exceptions to this are described below:

1. A provider in the role of telepresenter may be providing a separately billable service under their scope of practice such as performing an ECG or an x-ray. In this case, that separately billable service would be covered, but the specific act of telepresenting would not be covered.
2. A consulting provider at the distant site may offer a service that does not require real time interaction with the member. Reimbursement for this type of consultation is limited to dermatology, radiology, ophthalmology, and pathology and is subject to review by AHCCCS Medical Management.

3. In the special circumstance of the onset of acute stroke symptoms within three hours of presentation, AHCCCS recognizes the critical need for a neurology consultation in rural areas to aid in the determination of suitability for thrombolytic administration. Therefore, when a member presents within three hours of onset of stroke symptoms, AHCCCS will reimburse the consulting neurologist if the consult is placed for assistance in determining appropriateness of thrombolytic therapy even when the patients’ condition is such that real-time video interaction cannot be achieved due to an effort to expedite care.

C. USE OF TELEDENTISTRY SERVICES

AHCCCS covers teledentistry for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) aged members when provided by an AHCCCS registered dental provider. Refer to AMPM Policy 431 for more information on Oral Health Care for EPSDT aged members including covered dental services.

CONDITIONS, LIMITATIONS AND EXCLUSIONS

1. Both the referring and consulting providers must be registered with AHCCCS.

2. A consulting service delivered via telemedicine by other than an Arizona licensed provider must be provided to a specific member by an AHCCCS registered provider licensed to practice in the state or jurisdiction from which the consultation is provided or, if employed by an Indian Health Services (IHS), Tribal or Urban Indian health program, be appropriately licensed based on IHS and 638 Tribal facility requirements.

3. At the time of service delivery via real time telemedicine, the member's health care provider may designate a trained telepresenter to present the case to the consulting provider if the member's primary care provider or attending physician, or other medical professional who is familiar with the member's medical condition, is not present. The telepresenter must be familiar with the member's medical condition in order to present the case accurately. Medical questions may be submitted to the referring provider when necessary but no payment is made for such questions.

4. Nonemergency transportation to and from the telemedicine originating site to receive a medically necessary consultation or treatment service is covered.
D. ADDITIONAL INFORMATION

Refer to AMPM Policy 310 of this Chapter and to the AHCCCS Behavioral Health Services Guide for complete information regarding covered behavioral health services for Title XIX and Title XXI members.

AHCCCS Division of Fee-for-Service Management does not require Prior Authorization (PA) for medically necessary telemedicine services performed by Fee-For-Service (FFS) providers. Refer to AMPM Chapter 800 for complete information regarding PA requirements. Refer to the AHCCCS FFS Provider Billing Manual, the IHS/Tribal Provider Billing Manual and the AHCCCS Telehealth Training Manual for complete information regarding billing procedures. These manuals are available on the AHCCCS Web site at www.azahcccs.gov.
320-J  HIGH FREQUENCY CHEST WALL OSCILLATION (HFCWO) THERAPY

REVISION DATE: 10/01/10, 06/01/07

INITIAL EFFECTIVE DATE: 10/01/2004

High Frequency Chest Wall Oscillation therapy (HFCWO) is a form of chest physiotherapy that promotes airway clearance for retained pulmonary secretions. This form of therapy has been shown to be equally as effective as other forms of such therapy, such as postural drainage and clapping (CPT), flutter valve or blow glove, etc., in helping an individual with clearing secretions from the lungs. A HFCWO percussive vest will not replace a percussor, caregiver and/or self-administration of chest physiotherapy unless it is demonstrated that these forms of therapy are no longer effective. HFCWO therapy percussive vest are not covered for members who are age 21 and older.

HFCWO percussive vest requires prior authorization. All cases will be reviewed on a case-by-case basis. Requests for prior authorization must be accompanied by specific documentation in the individual’s personal medical record that supports the medical necessity for HFCWO percussive vest. Criteria for medical necessity include, but are not limited to, all of the following:

1. Diagnosis of cystic fibrosis,

2. Documentation of excessive sputum production combined with the member’s inability to clear the sputum without assistance,

3. Copy of chest x-ray report and pulmonary function tests showing findings consistent with moderate or severe Chronic Obstructive Pulmonary Disease (COPD),

4. Prescription signed by a M.D. or D.O. with a specialty in pulmonary disease, indicating the need for at least daily (or more frequent) chest physiotherapy,

5. Age two years or older or 20 inch chest size, whichever comes first,

6. Specific documentation of failure of other, more cost-effective, methods of chest physiotherapy, or airway clearance, including CPT and flutter valve,

7. Specific documentation supporting why HFCWO therapy for the member is superior to other more cost-effective therapy methods, including at least one of the following:
   a. Promotes independent self-care for the individual
b. Allows independent living or university or college attendance for the individual,
c. Provides health stabilization in single adults or emancipated individuals without able partners to assist with CPT, or
d. Severe end-stage lung disease requiring complex or frequent chest physiotherapy.

8. Evidence that the member can use the percussive vest effectively, including continuing compliance with all forms of prescribed therapy and treatment and member and family acceptance of HFCWO therapy, and

9. Coordination between the provider office or clinic and AHCCCS or other payer source, such as ADHS/CRS or AHCCCS Contractor, prior to implementation of HFCWO therapy for long-term use.

**DISCONTINUATION CRITERIA FOR HFCWO**

Discontinuation criteria for the HFCWO percussive vest include, but are not limited to, the following:

1. Member and/or prescribing physician request

2. Member treatment compliance at a rate of less than 50% usage as prescribed in the medical treatment plan, to be checked at two and six months of usage.
320-K  TOBACCO CESSION PRODUCT POLICY

REVISION DATES:  03/01/12, 06/01/09

INITIAL
EFFECTIVE DATE:  10/01/2008

DESCRIPTION

AHCCCS covers tobacco cessation products, which include Nicotine Replacement Therapy (NRT) and tobacco use medications, for members who wish to stop using tobacco. AHCCCS encourages members to enroll in a tobacco cessation program offered by the Arizona Department of Health Services (ADHS).

Coverage is limited to Title XIX members (Acute Care, Arizona Long Term Care System [ALTCS] and Medicare Cost sharing members).

AMOUNT, DURATION AND SCOPE

The following criteria apply to AHCCCS members choosing to receive a tobacco cessation product.

1. Members 18 years and older are encouraged to enroll in a tobacco cessation program through ADHS. To enroll in an ADHS cessation program the member must call 1-800-556-6222.

2. Members must contact their Primary Care Provider (PCP) for a prescription for a tobacco cessation product. The PCP will identify an appropriate tobacco cessation product. In order to be covered by AHCCCS, all tobacco use medications require a prescription. This includes all tobacco cessation products, including those that are available over-the-counter.

3. The maximum supply a member may receive of a tobacco cessation product is a 12 week supply in a six month time period. The six month period begins on the date the pharmacy fills the first tobacco cessation product.

4. The prior authorization protocol described in AMPM Exhibit 320-K-1 must be followed by all contractors.
320-L  NEUROPSYCHOLOGICAL TESTING

REVISION DATES:  03/01/14, 02/01/14, 10/01/13, 03/01/12

INITIAL EFFECTIVE DATE:  10/01/2009

DESCRIPTION

AHCCCS covers medically necessary neuropsychological evaluation services within certain limits for all members, with the exception of the Federal Emergency Services (FES) population (Refer to AMPM Chapter 1100 for FES coverage). It may be covered due to a medical condition or a behavioral health condition dependent on the member presentation. The purpose of this policy is to clarify under what circumstances, whether due to a medical condition or a behavioral health condition, neuropsychological evaluation is reimbursable and by whom.

Neuropsychological testing is specialized psychological testing. Neuropsychological testing seeks to establish presence or absence of organic brain dysfunction or damage and to make inferences concerning brain function. Neuropsychological testing can be an important tool in determining localization of brain dysfunction or damage, or in determining effects of toxic substances, medical conditions or traumatic injury on brain function, or in evaluating progress in individuals undergoing treatment or rehabilitation from a brain insult.

By contrast, psychological testing, in general, (excluding neuropsychological testing) may measure mental functioning such as intelligence, achievement, ability, thought process, perception and personality. Psychological testing is performed in a variety of settings, including schools and employment agencies, and is performed in behavioral health settings when questions arise concerning the individual's psychiatric diagnosis or impact of an individual's intelligence, thought, perception, or personality on behavioral health care.

Neuropsychological evaluation is considered medically necessary when a member has exhibited a change in cognitive function, mental status, memory or behavior due to a confirmed brain disorder, or when a differential diagnosis includes brain dysfunction (damage, disease or trauma). Members referred to a neuropsychologist for assessment may be classified into one of three groups:

1. Members who have known brain damage. Examples include but are not limited to cerebrovascular disorders, head injury, hydrocephalus, Alzheimer's disease, Parkinson's disease, Multiple Sclerosis, Huntington's chorea, tumors, seizures, and infections.
2. Members who have a recognized risk factor for brain damage and who demonstrate a change in behavior that might be the result of disease or injury to the brain. Examples include but are not limited to: systemic illnesses, endocrinopathies, metabolic and electrolyte disturbances, diseases of the kidney, liver, and pancreas, nutritional deficiencies, toxins, including substance abuse (particularly alcohol), conditions producing decreased blood supply to the brain (e.g. trauma, vascular disorders, cardiac disease, pulmonary disease, anemia, carbon monoxide exposure, and complications of anesthesia or surgery).

3. Members in which brain disease or trauma is suspected but no specific etiology or risk factor has been identified. Examples include but are not limited to: members with observed and well-documented changes in behavior or mental deterioration; lack of identifiable risk factors for brain injury; and other potential medical illnesses have been excluded.

Additionally, the results of neuropsychological evaluation must be expected to resolve questions about the member’s condition necessary to contribute to a diagnostic or functional determination that will contribute to a change in the treatment plan anticipated to improve the member’s condition.

**Reimbursement**

The condition of the member determines whether the test is for medical or behavioral health purposes. Tests performed for medical reasons are the responsibility of the medical Contractors. Tests performed for behavioral health reasons are the responsibility of the behavioral health Contractors. Arizona Long Term Care System (ALTCS) Contractors are fiscally responsible for both medical and behavioral health conditions.

If the neuropsychological evaluation is requested for medical conditions as described in Section A, Medical Condition and Neuropsychological Evaluation, the reimbursement is the responsibility of the following entities:

1. Acute Care Contractors
2. ALTCS Contractors
3. AHCCCS Administration for Fee-For-Service (FFS) members (Tribal ALTCS, American Indian Health Plan (AIHP) and other FFS members, with the exception of Federal Emergency Services [FES] members)
If the neuropsychological evaluation is requested for behavioral health conditions as described in Section B, Behavioral Health Condition and Neuropsychological Evaluation, the reimbursement is the responsibility of the following entities:

1. Integrated Regional Behavioral Health Authorities (Integrated RBHAs) or Regional Behavioral Health Authorities (RBHAs) including Tribal/RBHA (TRBHA).

2. ALTCS Contractors

3. AHCCCS Administration for Tribal ALTCS members or AIHP members treated in an Indian Health Services [IHS] or 638 facility

Once prior authorization approval is given for neuropsychological evaluation, the results of those tests cannot be used to retroactively deny reimbursement for the tests.

AMOUNT, DURATION AND SCOPE

A. MEDICAL CONDITION AND NEUROPSYCHOLOGICAL EVALUATION

1. Conditions for Coverage/Reimbursement

   Neuropsychological evaluation is a covered medical service and reimbursable by Acute Care and ALTCS Contractors as well as the AHCCCS Administration for FFS members if both:
   a. The evaluation is necessary to assess the extent of dysfunction and determine an effective medical treatment plan and outcome goals or the evaluation is necessary to effect an expected change in the current medical treatment plan and outcome goals; and
   b. The evaluation is expected to provide additional information regarding the nature and severity of functional problems involving higher mental functions that may be the result of organic brain damage (damage, disease or trauma). Conditions associated with organic brain dysfunction affecting higher mental function include, but are not limited to the following:
      i. Traumatic Brain Injury/Head Injury
      ii. Cerebral Vascular Disorders/Stroke
      iii. Hydrocephalus
      iv. Epilepsy
      v. Brain Tumors (Primary or Metastatic; Malignant or Benign)
      vi. Cerebral Anoxia or Hypoxia
vii. Exposure to toxic chemicals, substances or treatments that are known to cause toxic effects on the brain (acute or chronic) such as lead poisoning, intrathecal methotrexate, cranial irradiation

viii. Exposure to infectious diseases that affect brain functions or cause brain damage (e.g., Herpes Encephalitis, Human Immunodeficiency Virus [HIV])

ix. Chronic and progressive toxic/metabolic encephalopathic states resulting from systemic medical illnesses or conditions

x. Neurological conditions resulting in chronic deteriorating course of illness affecting brain functions and behavior, including Multiple Sclerosis, Parkinson’s disease, Alzheimer’s Disease, Huntington’s Chorea, Acquired Immune Deficiency Syndrome (AIDS), and others.

xi. Prenatal, perinatal, or infant exposure to alcohol or drugs of abuse.

Refer to section C of this policy for limitations

B. BEHAVIORAL HEALTH CONDITION AND NEUROPSYCHOLOGICAL EVALUATION

1. Conditions for Coverage/Reimbursement

Neuropsychological evaluation is a covered behavioral health service and reimbursable by the Integrated RBHA/RBHA/TRBHA, ALTCS Contractor or the AHCCCS Administration for Tribal ALTCS or AIHP members treated in an IHS OR 638 facility if both:

   a. Possible organic brain damage or dysfunction is suspected of contributing to the member’s behavioral health disorder (e.g., Mood Disorder, depression with psychosis secondary to traumatic brain injury; Mood Disorder due to Cerebrovascular Accident (CVA) with Major Depressive-Like episode; Inhalant-Induced Persisting Dementia) and

   b. A behavioral health treatment decision rests on the clarification of the possible organic brain damage or dysfunction or other results of the neuropsychological testing.

Refer to section C of this Policy for limitations.

C. LIMITATIONS

1. A neuropsychological evaluation is not a covered service by either the medical or behavioral health Contractors when:
   a. The objective of evaluation is educational planning. The school district is responsible for the cost of evaluation to evaluate conditions such as learning disabilities.
   b. The individual has permanent, persistent, and static organic brain dysfunction, and it is unlikely that evaluation results would provide new
information that would be utilized to alter the course of treatment or
treatment planning.

The current condition of the member may render evaluation results invalid due
to such conditions as:

i. Present substance use/abuse or withdrawal

ii. Medication regimen that may affect evaluation performance or

d. The primary purpose of evaluation is not related to a treatment plan

2. Neuropsychological evaluation is not a covered service under the medical condition
category when a member has behavioral health disorders that are primarily
attributable to organic brain damage that results in higher-level mental organic brain
dysfunction. Examples include Mood Disorder, depression with psychosis secondary
to traumatic brain injury; Mood Disorder due to Cerebrovascular Accident (CVA)
with Major Depressive-Like episode; Inhalant-Induced Persisting Dementia. The
service is not reimbursable by Acute Care Contractors. However, ALTCS Contractors
or the AHCCCS Administration for FFS members as noted in B (1) may be
financially responsible if it is determined that the neuropsychological service is
medically necessary and covered under behavioral health.

NOTE: If the basis of the referral for the neuropsychological evaluation is to obtain
treatment recommendations for use of psychotropic medications for these
conditions, a direct referral to the Integrated RBHA/RBHA/TRBHA for psychiatric
consultation should be made for Acute Care members. Tribal ALTCS members
and ALTCS members should be referred to a behavioral health specialist within
their system/network. Reimbursement is the responsibility of the Integrated
RBHA/RBHA/TRBHA, AHCCCS Administration or ALTCS Contractor as
appropriate.

3. Neuropsychological evaluation is not a covered service under the behavioral
health condition category when

a. Organic brain damage or dysfunction is not suspected of contributing to the
member's behavioral health disorder, or

b. Behavioral health treatment is not expected to change due to results of
neuropsychological testing.

D. REQUEST FOR PRIOR AUTHORIZATION OF NEUROPSYCHOLOGICAL EVALUATION

The requesting provider (AHCCCS Contractor provider or Integrated RBHA/RBHA/
TRBHA Provider) must submit a request for prior authorization for a
neuropsychological evaluation in writing to the appropriate entity (AHCCCS Acute Care
Health Plan, Integrated RBHA/RBHA/TRBHA, ALTCS Program Contractor AHCCCS
Administration for FFS members) that will include, at a minimum, the following
information:

1. The specific reasons why the evaluation is being requested. The specific diagnostic
or treatment-related question(s) to be answered by the evaluation must be included or the request will be returned to the requesting physician/clinician for completion.

2. The complete list of current diagnoses and medications.

3. The most recent complete history and physical examination and pertinent findings, including laboratory tests and diagnostic procedures that may be relevant to the evaluation request.

4. Results of any consultations from sub-specialists in neurology or psychiatry/behavioral health, if available.

5. Results of any prior psychological evaluation that may be available.

6. The specific areas of concern for evaluation that could improve the proposed course of treatment or treatment planning.

7. The desired or expected outcome of treatment identified by the referring practitioner/provider, which may result from the evaluation. Address how this evaluation could benefit or improve the overall treatment approach for the member.

Refer to the following policies for adjunct information related to this Policy:

AMPM Policy 310-B, Behavioral Health Services.


ACOM Policy 409, Intra-Agency Care Coordination.

ACOM Policy 414, Content of Notices of Action for Service Authorization.
320-M  MEDICAL MARIJUANA

INITIAL

EFFECTIVE DATE: 08/01/2011

DESCRIPTION

Under 42 CFR §440.120 marijuana does not qualify as a federally reimbursable medication.

AHCCCS does not currently cover and has never covered medical marijuana as a medical or pharmacy benefit. AHCCCS will not provide reimbursement for an office visit or any other services that are primarily for the purpose of determining if a member would benefit from medical marijuana.

AHCCCS covers medically necessary federally reimbursable medications prescribed by physician, physician's assistant, nurse practitioner, dentist or other AHCCCS approved practitioner and dispensed by a licensed AHCCCS registered pharmacy, as defined in 9 A.A.C. 22, Article 2.

AHCCCS recognizes that registered providers operating within the scope of their license may recommend the use of medical marijuana although it is not a covered benefit.

REFERENCES

- 9 A.A.C. 22, Article 2
- 42 CFR §440.120
- Title 21 United States Code 812
320-N HEPATITIS C (HCV) PRIOR AUTHORIZATION REQUIREMENTS FOR DIRECT ACTING ANTIVIRAL MEDICATION TREATMENT FOR AHCCCS MEMBERS AGE 18 YEARS AND OLDER

REVISION DATE: 10/01/16, 03/15/15, 08/01/14

INITIAL EFFECTIVE DATE: 07/17/2014

Description

This Policy delineates AHCCCS prior authorization requirements for Title XIX and XXI members eighteen years and older for coverage of direct acting antiviral medications for treatment of Hepatitis C virus (HCV). These medications include, but are not limited to, Epclusa, Harvoni, Zepatier, Technivie, Viekira, and their successors. All such medications require prior authorization from AHCCCS for FFS members or its Contractors, as applicable.

Amount, Duration and Scope

In order to obtain prior authorization approval of HCV direct acting antiviral medications, members must meet all of the following requirements:

1. Are age ≥18 years,

2. Have a diagnosis of HCV which has been confirmed by detectable serum HCV RNA by quantitative assay completed within the past 90 days from the date of the prior authorization request,

3. Are prescribed HCV medications by, or in consultation with, a gastroenterologist, hepatologist, or infectious disease physician, and

4. Have a diagnosis of liver fibrosis/cirrhosis as further described in 4a-4b and meet all other requirements specified for the applicable Metavir score. The Metavir score must be established through testing which is completed no earlier than 90 days from the date of the prior authorization request. Contractors may require additional testing to confirm the values identified below.

   a. Fibrosis F2 score or greater. The diagnosis of liver fibrosis/cirrhosis of Metavir stage F2 or greater must be evidenced by biopsy, Fibroscan, elastography, Fibrosure/FibroTest-Actitest level, or APRI as described in Table 1,
Table 1

<table>
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<tr>
<th>METAVIR SCORE</th>
<th>BIOPSY</th>
<th>FIBROSCAN</th>
<th>ELASTOGRAPHY (ARFI/PSWE)</th>
<th>FIBROSURE/ FIBROSURE-ACTITEST</th>
<th>APRI</th>
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<tr>
<td>F3</td>
<td>F3</td>
<td>9.6 – 12.4 kPa</td>
<td>2.01 – 2.33 m/s</td>
<td>0.58 – 0.74</td>
<td>1.5 – 1.9</td>
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<tr>
<td>F2</td>
<td>F2</td>
<td>7.1 – 9.5 kPa</td>
<td>1.38 – 2.0 m/s</td>
<td>0.49 – 0.57</td>
<td>0.9 – 1.4</td>
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<td>F1/0</td>
<td>&lt; 7.0 kPa</td>
<td>&lt; 1.37 m/s</td>
<td>&lt; 0.48</td>
<td>&lt; 0.9</td>
</tr>
</tbody>
</table>

b. Members who have one of the conditions in (i)-(v) below, regardless of fibrosis level:
   i. Member is recently post liver transplantation,
   ii. Member is diagnosed with Stage I-III Hepatocellular Carcinoma meeting Milan Criteria,
   iii. Member is diagnosed with Type 2 or Type 3 essential mixed cryoglobulinemia with end organ manifestations,
   iv. Member is diagnosed with HCV induced renal disease (e.g. nephrotic syndrome, membranoproliferative glomerulonephritis (MPGN), or
   v. Member is diagnosed with leukocytoclastic vasculitis.

As a prerequisite to requesting direct acting antiviral medications for treatment of Hepatitis C, members must have received at least one Hepatitis A and at least one Hepatitis B vaccine prior to requesting treatment unless the member demonstrates laboratory evidence of immunity.

If a member has a substance use disorder in the past 12 months from the request date for treatment, the member must be in remission for the past three months from the request date for treatment and must be engaged in a substance use disorder treatment program at the time of the prior authorization request and over the course of treatment if the HCV medications are approved.

A. TREATMENT MONITORING REQUIREMENTS

1. Members prescribed HCV treatment must participate in a treatment adherence program.

2. At a minimum, providers are responsible for completing HCV viral load laboratory testing at weeks 4 and 12, for members approved for 12 week HCV regimens.

3. At a minimum, providers are responsible for completing HCV viral load laboratory testing at weeks 4 and 24 for members approved for 24 week HCV regimens.

4. Providers are required to monitor hemoglobin levels periodically when a member is prescribed ribavirin.
B. LIMITATIONS

Direct Acting Antiviral HCV treatment coverage is not provided for the following:

1. Monotherapy of:
   a. Daclatasvir (Daklinza),
   b. Simeprevir (Olysio),
   c. Sofosbuvir (Sovaldi).

2. Sofosbuvir for greater than 24 weeks of therapy.

3. Direct Acting Antiviral Dosages greater than the FDA approved maximum dosage.

4. Ombitasvir, Paritaprevir and Ritonavir (Technivie) or Ombitasvir, Paritaprevir and Ritonavir; Dasabuvir tablets (Viekira Pak) shall not be approved for members whose Child Pugh score is B or C.

5. Grazoprevir/elbasvir (Zepatier) if the NS5A polymorphism testing has not been completed and submitted with the prior authorization request.

6. Members when there is documented non-adherence to prior HCV medications, HCV medical treatment, or failure to complete HCV disease evaluation appointments and laboratory and imaging procedures.

7. Members declining to participate in a treatment adherence program.

8. Members declining to participate in a substance abuse disorder treatment program.

9. Members whose comorbidities are such that their life expectancy is one year or less.

10. Members currently using a potent P-gp inducer drug (St. John’s wart, rifampin, carbamazepine, ritonavir, tipranavir, etc.)

11. Greater than one course of therapy per lifetime.

12. Lost or stolen medication absent of good cause.

13. Fraudulent use of HCV medications.

C. REQUIRED DOCUMENTATION FOR SUBMISSION OF HCV PRIOR AUTHORIZATION REQUESTS

In order for a prior authorization request for HCV medications to be considered, the following minimum information must be submitted for the member:
1. Evidence of liver fibrosis as referenced in I.4a-4b.

2. HCV treatment history and responses.

3. Evidence of Hepatitis A & B vaccinations or laboratory evidence of immunity.


5. Laboratory results for all of the following:

   HCV screen, genotype and current baseline viral load, total bilirubin, albumin, INR, CrCl or GFR, LFTs, CBC and drug/alcohol screen completed within the past 90 days.

REFERENCES

1. A new scoring system for prediction of fibrosis in chronic hepatitis C; Simona Bota, Roxana Sirli, Ioan Sporea, Mircea Focsa, Alina Popescu, Mirela Danila, Mihnea Strain, Madalina Sendroiu, Alexandra Deleanu, and Isabel Dan; July 1, 2011.

2. Cryoglobulinaemia and Hepatitis C Virus; Clodoveo Ferri, Marco Sebastiani, David Saadoun and Patrice Cacoub; March 9, 2012.


6. Treatment Considerations from the Department of Veterans Affairs National Hepatitis C Resource Center Program and the Office of Public Health; March 2014.

7. The Comparative Clinical Effectiveness and Value of Simeprevir and Sofosbuvir in the Treatment of Chronic Hepatitis C Infection; California Technology Assessment Forum; March 2014.

8. Sofosbuvir for the Treatment of Hepatitis C and Evaluation of the 2014 American Association for the Study of Liver Diseases Treatment Guideline; Oregon Health & Science University Center for Evidence-based Policy; May 2014.


10. Harvoni<sup>TM</sup> (package insert); Foster City, CA: Gilead Sciences, Inc. October 2014.


20. Drug Facts and Comparisons on-line (www.drugfacts.com); Wolters Kluwer Health; St Louis, MO Updated daily.
320-O RESERVED
320-P  RESERVED
CHAPTER 300
MEDICAL POLICY FOR AHCCCS COVERED SERVICES

POLICY 320
SERVICES WITH SPECIAL CIRCUMSTANCES

320-Q RESERVED
BACKGROUND

Contractors and Tribal Regional Behavioral Health Authorities (TRBHA), the Arizona State Hospital (AzSH) and subcontracted providers must identify and report to the AHCCCS Office of Human Rights (OHR) persons determined to have a Serious Mental Illness (SMI) who meet the criteria for Special Assistance. If the person’s Special Assistance needs appear to be met by an involved family member, friend, designated representative or guardian, the Contractor, TRBHA or behavioral health provider must still submit a notification to the OHR. Contractors, TRBHAs, AzSH, subcontracted providers and the Behavioral Health Office of Grievances and Appeals (BHOGA) must ensure that the person designated to provide Special Assistance is involved at key stages.

AMOUNT, DURATION AND SCOPE

The purpose of this policy is to establish uniform guidelines for:

1. Identifying persons determined to have a Serious Mental Illness (SMI) who are in need of Special Assistance,

2. Ensuring that persons in need of Special Assistance have their Special Assistance needs met, and

3. Maintaining and disseminating required reports on persons in need of Special Assistance.

As applicable, RBHAs must ensure that all subcontracted providers adhere to the requirements of this Policy.

A. GENERAL REQUIREMENTS

1. Criteria to deem a person to be in need of Special Assistance are as follows:
   a. A person determined to have a Serious Mental Illness (SMI) is in need of Special Assistance if he/she is also unable to do any of the following:
      i. Communicate preferences for services,
      ii. Participate effectively in Individual Service Planning (ISP) or Inpatient Treatment Discharge Planning (ITDP),
      iii. Participate effectively in the appeal, grievance or investigation processes, and
iv. The person’s limitations described in i–iii above must also be due to any of the following:
   (a) Cognitive ability/intellectual capacity (i.e. cognitive impairment, borderline intellectual functioning, or diminished intellectual capacity),
   (b) Language barrier (an inability to communicate, other than a need for an interpreter/translator), and/or
   (c) Medical condition (including, but not limited to traumatic brain injury, dementia, or severe psychiatric symptoms).

A person who is subject to general guardianship has been found to be incapacitated under A.R.S. § 14-5304, and therefore automatically satisfies the criteria for Special Assistance.

b. For a person determined to have a SMI, the existence of any of the following circumstances should prompt the Contractor, TRBHA, AzSH, or subcontracted provider to more closely review whether the person is in need of Special Assistance:
   i. Developmental disability involving cognitive ability,
   ii. Residence in a 24 hour setting,
   iii. Limited guardianship, or the Contractor, TRBHA or subcontracted provider is recommending and/or pursuing the establishment of a limited guardianship, or
   iv. Existence of a serious medical condition, that affects his/her intellectual and/or cognitive functioning (such as, dementia or traumatic brain injury).

2. The following may deem a person to be in need of Special Assistance:
   a. A qualified clinician providing treatment for the person,
   b. A case manager of a Contractor, TRBHA or subcontracted provider,
   c. A clinical team of a Contractor, TRBHA or subcontracted provider,
   d. A Contractor or TRBHA,
   e. A program director of a subcontracted provider (including AzSH),
   f. The Deputy Director of AHCCCS or designee, or
   g. A hearing officer assigned to an appeal involving a person determined to have a SMI.

3. When to Screen for Special Assistance: Contractors, TRBHAs, AzSH and subcontracted providers must on an ongoing basis screen whether persons determined to have a SMI are in need of Special Assistance in accordance with the criteria set out in Section A of this Policy. Minimally, this must occur at the following stages:
   a. Assessment and annual updates,
   b. Development of or update to the Individual Service Plan (ISP),
   c. Upon admission to a psychiatric inpatient facility,
   d. Development of or update to an Inpatient Treatment and Discharge Plan (ITDP),
   e. Initiation of the grievance or investigation processes,
   f. Filing of an appeal, and
   g. Existence of a condition which may be a basis for a grievance, investigation or an appeal.
4. Documentation  
   a. Contractors, TRBHAs, AzSH and subcontracted providers shall document in the clinical record each time a staff member screens a person for Special Assistance, indicating the factors reviewed and the conclusion. If the conclusion is that the person is in need of Special Assistance, they shall notify the OHR using AMPM Exhibit 320-6, *Notification of Person In Need of Special Assistance* in accordance with the procedures below.  
   b. Before submitting AMPM Exhibit 320-6, Contractors, TRBHAs and their subcontracted providers shall check if the person is already identified as in need of Special Assistance. A notation of Special Assistance designation and a completed AMPM Exhibit 320-6 should already exist in the clinical record. However, if it is unclear, subcontracted providers must review Contractor or TRBHA data or contact the Contractor or TRBHA to inquire about current status. Contractors and TRBHAs are required to maintain a database on persons in need of Special Assistance and share data with providers on a regular basis (at a minimum quarterly).

B. **Notification Requirements to the Office of Human Rights**

1. If a person is not correctly identified as Special Assistance, Contractors, TRBHAs, AzSH and subcontracted providers must submit Part A of AMPM Exhibit 320-6 to the OHR within five working days of identifying a person in need of Special Assistance. If the person has a Special Assistance need requiring immediate assistance, the notification form must be submitted immediately with a notation indicating the urgency. Contractors, TRBHAs, AzSH and subcontracted providers should inform the person of the notification and explain the benefits of having another person involved who can provide Special Assistance, if able.

2. If the person is under a guardianship or one is in process, the documentation of such must also be submitted to OHR. However, if the documentation is not available at the time of submission of the AMPM Exhibit 320-6 notification, the form should be submitted within the required timeframes, followed by submittal of the guardianship documentation.

3. The OHR reviews the notification form to ensure that it contains sufficient information detailing the criteria and responds to the Contractor, TRBHA and subcontracted providers by completing Part B of AMPM Exhibit 320-6 within five working days of receipt of the form. In the event the necessary information is not provided on the form, OHR contacts the staff member submitting the notification for clarification. In the event the notification is urgent, OHR will respond as soon as possible, but generally within one working day of receipt of the notification.

4. The notification process is not complete until OHR completes Part B of the form and sends it back to the Contractor or TRBHA and subcontracted providers. The
Contractors, TRBHAs and subcontracted providers should follow up with OHR if no contact is made or Part B is not received within five working days.

5. OHR designates which agency/person will provide Special Assistance when processing AMPM Exhibit 320-6. When the agency/person providing Special Assistance changes, OHR processes an “updated Part B” to document the change.

6. In the event the person or agency currently identified as providing Special Assistance is no longer actively involved, the Contractor, TRBHA or subcontracted provider must notify DHCAA. If a DHCAA advocate is also assigned, notification to the advocate is sufficient.

C. PERSONS NO LONGER IN NEED OF SPECIAL ASSISTANCE

1. Contractors, TRBHAs, AzSH or subcontracted providers must notify the OHR within 10 days of an event or determination that a person in need of Special Assistance no longer meets criteria by completing Part C of the original notification form (with Parts A & B completed when first identified), noting:
   a. The reason(s) why Special Assistance is no longer required,
   b. The effective date,
   c. The name, title, phone number and e-mail address of the staff person completing the form, and
   d. The date the form is completed.

2. The following are instances that should prompt Contractors, TRBHAs, AzSH or subcontracted providers to submit a Part C:
   a. The original basis for the person meeting Special Assistance criteria is no longer applicable and the person does not otherwise meet criteria,
      i. Contractors, TRBHA, AzSH or subcontracted provider must first discuss the determination with the person or agency providing Special Assistance to obtain any relevant input, and
      ii. This includes when a person is determined to no longer be a person with a SMI (proper notice and appeal rights must be provided and the period to appeal must have expired).
   b. The person passes away.
   c. The person’s episode of care is ended with the Contractor or TRBHA (Non-Title XIX persons with a SMI will also be disenrolled) and the person is not transferred to another Contractor or TRBHA. Contractors, TRBHAs or subcontracted providers must first perform all required re-engagement efforts, which includes contacting the person providing Special Assistance, per AMPM Policy 1040, Engagement, Re-engagement and Closure. Proper notice and appeal rights must be provided and the period to appeal must have expired prior to submission of Part C.
NOTE: Submission of a Part C is not needed when a person transfers to another Contractor or TRBHA, as the Special Assistance designation follows the person.

3. Upon receipt of Part C of the AMPM Exhibit 320-6, OHR-reviews content to confirm accuracy and completeness and returns it to the agency that submitted it, copying any involved Contractors, TRBHAs or subcontracted provider.

D. REQUIREMENT OF CONTRACTORS, TRBHAS, AZSH, SUBCONTRACTED PROVIDERS AND BEHAVIORAL HEALTH OFFICE OF GRIEVANCES AND APPEALS (BHOGA) TO HELP ENSURE THE PROVISION OF SPECIAL ASSISTANCE.

1. Contractors, TRBHAs, AzSH, subcontracted providers and BHOGA must maintain open communication with the person (guardian, family member, friend, OHR advocate, etc.) assigned to meet the person’s Special Assistance needs. Minimally, this involves providing timely notification to the person providing Special Assistance to ensure involvement in the following:
   a. ISP planning and review: Includes any instance when the person makes a decision regarding service options and/or denial/modification/termination of services (service options include not only a specific service but also potential changes to provider, site, -physician and case manager assignment).
   b. ISP development and updates: Must be in accordance with AMPM Policy 320-O, Service Planning, Assessments, and Discharge Planning.
   c. ITDP planning: Includes any time a person is admitted to a psychiatric inpatient facility and involvement throughout the stay and discharge.
   d. Appeal process: Includes circumstances that may warrant the filing of an appeal, so all Notices of Action (NOA) or Notices of Decision (NOD) issued to the person/guardian must also be copied to the person designated to meet Special Assistance needs; and
   e. Investigation or Grievance: Includes when an investigation/grievance is filed and circumstances when initiating a request for an investigation/grievance may be warranted.

2. In the event that such procedures are delayed in order to ensure the participation of the person providing Special Assistance, the Contractors, TRBHAs, AzSH, subcontracted providers and BHOGA must document the reason for the delay in the clinical record, or the investigation, grievance or appeal file. If an emergency service is needed Contractors, TRBHAs, AzSH, and/or subcontracted providers must, ensure that the person receives the needed services in the interim and promptly notify the agency/person providing Special Assistance.

3. Contractors, TRBHAs and subcontracted providers shall timely provide relevant details and a copy of the original AMPM Exhibit 320-6 (both Parts A and B) to the
receiving entity and when applicable, Case Manager, when a person in need of Special Assistance is:
a. Admitted to an inpatient facility,
b. Admitted to a residential treatment setting, or
c. Transferred to a different Contractor, TRBHA, Case Management Provider Site, or Case Manager.

4. Contractors, TRBHAs and subcontracted providers must periodically review whether the person’s needs are being met by the person or agency designated to meet the person’s Special Assistance needs. If a concern arises, they should first address it with the person or agency providing Special Assistance. If the issue is not promptly resolved, they must take further action to address the issue, which may include contacting OHR administration for assistance.

E. BEHAVIORAL HEALTH OFFICE OF GRIEVANCES AND APPEALS (BHOGA) AND RBHA OFFICE OF GRIEVANCE AND APPEALS REPORTING REQUIREMENTS (OGA)

1. Upon receipt of a request for investigation, grievance or an appeal, the Contractor’s or TRBHAs’ OGA and the BHOGA must review whether the person is already identified as in need of Special Assistance.

2. If so, the Contractor, TRBHA or BHOGA must ensure that:
   a. A copy of the request for investigation or grievance is sent to OHR within five days of receipt of the request. The Contractor, TRBHA or BHOGA must also forward a copy of the final grievance/investigation decision to the OHR within five days of issuing the decision.
   b. A copy of an appeal for a person with Special Assistance are sent to OHR.
   c. The results of the Informal Conference (IC) regarding appeals are sent to OHR. The Contractor, TRBHA or BHOGA shall also forward a copy of any subsequent notice of hearing.

F. CONTRACTOR AND TRBHA REPORTING REQUIREMENTS

1. Contractors and TRBHAs must maintain a copy of completed AMPM Exhibit 320-6, Parts A, B and updated if any.

2. Contractors and TRBHAs must maintain a database on persons in need of Special Assistance to ensure compliance with this Policy and the reporting requirements described in this section. This cannot be delegated to Contractor or TRBHA providers.

3. The Contractor and TRBHA must, by the 10th calendar day of each month, provide the OHR with a comprehensive report listing:
a. All persons in need of Special Assistance who are active as of the end of the previous month,
b. Any Part C notifications during the previous month that a person no longer needs Special Assistance.
c. Any persons transferred to the Contractor or TRBHA during the previous month who were Special Assistance in the previous Contractor or TRBHA, and
d. Any person in need of Special Assistance transferred from the Contractor or TRBHA to another Contractor or TRBHA.

4. The monthly reports must contain the following information:
   a. CIS Number
   b. Name
   c. Date of Birth
   d. Guardian (yes or no)
   e. Current address
   f. Current phone number
   g. Type of residence
   h. Whether currently at AzSH & unit name
   i. AzSH Identification Number
   j. Name of Provider
   k. Name/location of Provider site
   l. Name of Case Manager
   m. Name of Clinical Supervisor
   n. GSA (for RBHAs serving more than one)
   o. Title XIX (AHCCCS) enrollment status (yes or no)
   p. Effective Date (date Part B was completed)
   q. Person/relationship or agency meeting Special Assistance needs
   r. Name, address and phone number of person meeting the Special Assistance needs
   s. If applicable, the Date of Discharge from AzSH
   t. If applicable, the Date of the Removal (when Part C of the notification was sent to OHR) or the event and event date that prompted the removal
   u. If applicable, information on any updated Part B (indicating change in person meeting needs), and
   v. If applicable, the Date of the Inter-RBHA transfer including the name of the receiving Contractor or TRBHA.

5. By the 25th day of the month following the end of a quarter, OHR provides Contractors and TRBHAs with a comprehensive report for the previous quarter.

6. The Contractors and TRBHAs in response to OHR’s quarterly report must update the Contractors or TRBHA’s database with data updates contained in the quarterly report for persons assigned to an OHR advocate and submit an updated report to OHR by the 10th day of the next month, as specified in the RBHA Contract, Exhibit-9, Deliverables. The report must identify any changes in client information, for persons not assigned to an OHR Advocate, that occurred during the previous quarter.
Examples include change in Title XIX enrollment, changes in the person’s residence, case management provider or case manager assignment, etc. Contractors, TRBHAs and OHR shall work together to rectify any data discrepancies in a timely manner to ensure that the data maintained is accurate.

7. The OHR, utilizing data it maintains on all persons in need of Special Assistance, must provide a list of persons in each region to each Human Rights Committee (HRC) by the 25th calendar day of each month. The OHR customarily provides a courtesy copy of the report to the corresponding Contractor or TRBHA.

8. By the 10th calendar day of each month, AzSH must provide the OHR with a comprehensive report listing of persons in need of Special Assistance that were receiving services at AzSH during the previous month. OHR provides the final report to the AzSH HRC and a copy to AzSH by the 25th of the month.

9. Contractors must share Special Assistance data with its subcontracted providers that provide case management to persons determined to have a SMI and verify that a process exists at each case management provider to ensure this data is accessible by front-line provider staff (at a minimum quarterly). Contractors must also establish a process with such providers to obtain quarterly updates on persons currently identified as Special Assistance to support the Contractors or TRBHAs quarterly data updates process with the OHR.

G. CONFIDENTIALITY REQUIREMENTS

1. Contractors, TRBHAs, AzSH and subcontracted providers shall grant access to clinical records of persons in need of Special Assistance to the OHR in accordance with federal and state confidentiality laws (see AMPM Policy 550).

2. HRCs and their members shall safeguard the monthly list that contains the names of those persons in need Special Assistance regarding any Protected Health Information (PHI). HRCs must inform AHCCCS annually in writing of how it will maintain the confidentiality of the Special Assistance lists. If HRCs request additional information that contains PHI that is not included in the monthly report, they must do so in accordance with the requirements set out in ACOM Policy 447.

H. OTHER PROCEDURES

1. Contractors, TRBHAs, AzSH and subcontracted providers must maintain a copy of the completed AMPM Exhibit 320-6, (Parts A and B and updated B, if any) in the person’s comprehensive clinical record. In the event a person was identified as no longer needing Special Assistance and a Part C of the notification form was completed, the Contractors, TRBHAs, AzSH, and subcontracted providers must maintain a copy of the form in the comprehensive clinical record.
2. Contractors, TRBHAs, AzSH and subcontracted providers must clearly document in the clinical record (i.e., on the assessment, ISP, ITDP, face sheet) and case management/client tracking system if a person is identified as in need of Special Assistance, the person assigned currently to provide Special Assistance, the relationship, contact information including phone number and mailing address.

3. The HRCs must make regular visits to the residential environments of persons in need of Special Assistance to determine whether the services meet their needs and their satisfaction with the residential environment.

4. Contractors must implement quality management measures to ensure the subcontracted providers implement the requirements of this Policy. Audit tools and procedures must be shared with the AHCCCS/OHR Administration prior to use to ensure they address:
   a. The screening requirements,
   b. The documentation requirements, and
   c. The provisions of Special Assistance requirements.

5. Contractors and TRBHAs must ensure that all applicable TRBHA and provider staff are trained regarding the requirements of Special Assistance. (See AMPM Policy 1060).

REFERENCES

- AMPM Policy 320-O
- AMPM Policy 550
- AMPM Policy 1040
- AMPM Policy 1060
- ACOM Policy 447
- A.R.S. §§ 36-107,
- A.R.S. 36-501,
- A.R.S. 36-504,
- A.R.S. 36-509,
- A.R.S. 36-517.01
- A.R.S. §§ 41-3803,
- A.R.S. 41-3804
- 9 A.A.C 21
- RBHA Contracts
- TRBHA
320-S RESERVED
320-T  NON-DISCRETIONARY FEDERAL GRANTS

INITIAL

EFFECTIVE DATE:  7/01/2016

DESCRIPTION

AHCCCS receives Federal grants to deliver behavioral health services in addition to Federal Medicaid (Title XIX) and the State Children’s Health Insurance Program (Title XXI) funding. The grants are awarded by a Federal agency and made available to AHCCCS. AHCCCS then disburses the funding throughout Arizona for the delivery of covered behavioral health services in accordance with the requirements of the fund source.

Only the Contractors and TRBHAs who receive funding from the grants identified in this Policy are subject to the requirements of this Policy.

This section is intended to present an overview of the major Federal grants that provide AHCCCS and the behavioral health system with funding to deliver services to members who may otherwise not be eligible for covered behavioral health services.

A. Substance Abuse Prevention and Treatment Block Grant (SABG)

The SABG supports primary prevention services and treatment services for members with substance use disorders. It is used to plan, implement and evaluate activities to prevent and treat Substance Use Disorders. Grant funds are also used to provide early intervention services for HIV and tuberculosis disease in high-risk substance users.

1. Eligibility and priority populations

   SABG funds are used to ensure access to treatment and long-term recovery support services for (in order of priority):
   a. Pregnant women/teenagers who use drugs by injection,
   b. Pregnant women/teenagers who use substances,
   c. Other persons who use drugs by injection,
   d. Substance using women and teenagers with dependent children and their families, including females who are attempting to regain custody of their children, and
   e. All other individuals with a substance use disorder, regardless of gender or route of use, (as funding is available).

2. Eligibility Requirements

   a. All members receiving SABG-funded services are required to have a Title XIX/XXI eligibility screening completed and documented in their clinical record at the time of intake and annually.
b. Members can be served through SABG while awaiting a determination of Title XIX/XXI eligibility. However, upon Title XIX/XXI eligibility determination when the retroactive covered dates of Title XIX/XXI eligibility includes dates when Title XIX/XXI covered services were billed to SABG, the Contractor is required to reverse the billing for those services and cover them under their Title XIX/XXI funding.

c. The SABG is specifically allocated to provide services that are not otherwise covered by Title-XIX/XXI funding. This includes substance use services for members who do not qualify for Title XIX/XXI eligibility, as well as the non-Medicaid reimbursable services identified by AHCCCS in the Covered Behavioral Health Services Guide. The SABG is to be used as the payor of last resort.

d. Members must indicate active substance use within the previous 12-months to be eligible for SABG services. This also includes individuals who were incarcerated and reported using while incarcerated. The 12-month standard may be waived for members on medically necessary methadone maintenance upon assessment for continued necessity as well as members incarcerated for longer than 12 months that indicate substance use in the 12 months prior to incarceration.

e. Members shall not be charged a copayment, or any other fee, for substance use treatment services funded by the SABG.

3. Choice of substance use providers
   a. Members receiving substance use treatment services under the SABG have the right to receive services from a provider to whose religious character they do not object.
   b. Behavioral health subcontractors providing substance use services under the SABG must notify members of this right using Exhibit 320-9, Notice to Individuals Receiving Substance Use Services. Providers must document that the member has received notice in their comprehensive clinical record.
   c. If a member objects to the religious character of a behavioral health provider, the provider must refer the member to an alternative provider within seven days, or earlier when clinically indicated, after the date of the objection. Upon making such a referral, providers must notify the Contractor or TRBHA of the referral and ensure that the member makes contact with the alternative provider.
   d. Contractors and TRBHAs must develop and make available policies and procedures that indicate who the providers should contact and how they should notify the Contractor or TRBHA of these referrals.

4. Required services available to members receiving SABG funded services

Behavioral health providers must provide specialized, gender-specific treatment and recovery support services for females who are pregnant or have dependent children and their families in outpatient and residential treatment settings. Services are also provided to mothers who are attempting to regain
custody of their children. Services must treat the family as a unit. As needed, providers must admit both mothers and their dependent children into treatment. The following services are provided or arranged as needed:

a. Referral for primary medical care for pregnant females,

b. Referral for primary pediatric care for children,

c. Gender-specific substance use treatment, and

d. Therapeutic interventions for dependent children.

Contractors and TRBHAs must ensure the following issues do not pose barriers to access to obtaining substance use treatment:

a. Child care,

b. Case management, and

c. Transportation

Contractors and TRBHAs must publicize the availability of gender-based substance use treatment services for females who are pregnant or have dependent children. Publicizing must include at a minimum the posting of fliers at each site notifying the right of pregnant females and females with dependent children to receive substance use treatment services at no cost.

Contractors and TRBHAs must develop and make available to providers specific language with regards to providing the specialty program services for women and children.

SABG funding should be directed to service delivery. The Contractor should utilize other fund sources to provide medications. Medication Assisted Treatments (MAT) identified by AHCCCS as SABG-covered medications are excluded from this restriction.

5. Interim Services for Pregnant Women/Injection Drug Users (Non-Title XIX/XXI only)

The purpose of interim services is to reduce the adverse health effects of substance use, promote the health of the member, and reduce the risk of transmission of disease. Provision of interim services must be documented in the member’s chart as well as reported to AHCCCS through the online Residential Waitlist System. Interim services are required for Non-Title XIX/XXI priority population members who are maintained on an actively managed waitlist. Title XIX/XXI eligible members who also meet a priority population type may not be placed on a waitlist (see ACOM Policy 417, Appointment Availability, Monitoring and Reporting). The minimum required interim services include:

a. Education that covers prevention of and types of behaviors which increase the risk of contracting HIV, Hepatitis C and other sexually transmitted diseases,

b. Education that covers the effects of substance use on fetal development,

c. Risk assessment/screening,
d. Referrals for HIV, Hepatitis C, and tuberculosis screening and services, and

e. Referrals for primary and prenatal medical care.

B. SABG REPORTING REQUIREMENTS

Contractors and TRBHAs must ensure that their providers promptly submit information for Priority Population Members (Pregnant Women, Women with Dependent Children) and Intravenous Drug Users [IVDU]) who are waiting for placement in a Residential Treatment Center, to the online Residential Waitlist System, or in a different format upon written approval from AHCCCS.

1. Title XIX/XXI members may not be added to the waitlist.

2. Priority Population Members must be added to the waitlist if the Contractors, TRBHAs or their providers are not able to place the member in a Residential Treatment Center within the timeframes prescribed in ACOM Policy 417, Appointment Availability, Monitoring and Reporting.

3. For pregnant females the requirement is within 48 hours, for women with dependent children the requirement is within five calendar days, and for all IVDUs the requirement is within 14 calendar days.

4. Non-Title XIX/XXI non priority population members may also be added to the online waitlist if there are no available services.

C. OTHER SABG REQUIREMENTS

1. Contractors and TRBHAs must designate:
   a. A lead substance use treatment coordinator responsible for ensuring Contractor and TRBHA compliance with all SABG requirements,
   b. A women’s treatment coordinator,
   c. An opioid treatment coordinator, and
   d. An HIV early intervention services coordinator.

D. HIV EARLY INTERVENTION SERVICES

Because persons with substance use disorders are considered at high risk for contracting HIV-related illness, the SABG requires HIV intervention services in order to reduce the risk of transmission of this disease.

Contractors and TRBHAs receiving SABG funding, shall develop and make available to providers policies and procedures that describe where and how to access HIV early intervention services.

1. Eligibility for HIV early intervention services
   a. Services are provided exclusively to populations with substance use disorders.
b. HIV services may not be provided to incarcerated populations.

2. Requirements for providers offering HIV early intervention services
   a. HIV early intervention service providers who accept funding under the SABG must provide HIV testing services.
   b. Behavioral health providers must administer HIV testing services in accordance with the Clinical Laboratory Improvement Amendments (CLIA) requirements, which require that any agency that performs HIV testing must register with CMS to obtain CLIA certification. However, agencies may apply for a CLIA Certificate of Waiver which exempts them from regulatory oversight if they meet certain federal statutory requirements. Many of the Rapid HIV tests are waived. For a complete list of waived Rapid HIV tests please see Centers for Disease Control and Prevention (CDC) website. Waived rapid HIV tests can be used at many clinical and non-clinical testing sites, including community and outreach settings. Any agency that is performing waived rapid HIV tests is considered a clinical laboratory.
   c. Any provider planning to perform waived rapid HIV tests must develop a quality assurance plan, designed to ensure any HIV testing will be performed accurately. (See for Centers for Disease Control Quality Assurance Guidelines)
   d. HIV early intervention service providers cannot provide HIV testing until they receive a written HIV test order from a licensed medical doctor, in accordance with A.R.S. § 36-470. HIV rapid testing kits must be obtained from the Arizona Department of Health Services (ADHS) Office of HIV.

3. Reporting requirements for HIV Early Intervention Services
   a. For every occurrence in which an oral swab rapid test provides a reactive result, a confirmatory blood test must be conducted and the blood sample sent to the Arizona State Lab for confirmatory testing. Therefore, each provider who conducts rapid testing must have capacity to collect blood for confirmatory testing whenever rapid testing is conducted.
   b. The number of the confirmatory lab slip will be retained and recorded by the provider. This same number will be used for reporting in the Luther data base. The HIV Early Intervention service provider must establish a Memorandum of Understanding (MOU) with their local County Health Department to define how data and information will be shared.
   c. Providers must use the Luther database to submit HIV testing data after each test administered.

E. CONSIDERATIONS WHEN DELIVERING SERVICES TO SABG POPULATIONS

SABG treatment services must be designed to support the long-term treatment and substance-free recovery needs of eligible members. Specific requirements apply regarding preferential access to services and the timeliness of responding to a member’s identified needs.
Behavioral health providers must also submit specific data elements to identify special populations and record limited clinical information (see AHCCCS Technical Interface Guidelines (TIG) for requirements).

F. **Mental Health Services Block Grant (MHBG)**

The MHBG is allocated from the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide mental health services to adults with Serious Mental Illness (SMI) and children with Serious Emotional Disturbance (SED). Qualifying SED and SMI diagnoses are listed as ICD-10 codes per the SMI and SED Qualifying Diagnoses Table. MHBG funds are only to be used for allowable services identified in the AHCCCS Covered Behavioral Health Services Guide for Non-Title XIX/XXI members with SMI or SED or Non-Title XIX/XXI services for Title XIX/XXI members. Members shall not be charged a copayment, or any other fee, for treatment services funded by the MHBG.

The MHBG must be used:

4. To ensure access to a comprehensive system of care, including employment, housing, case management, rehabilitation, dental, and health services, as well as mental health services and supports,

5. To promote participation by consumer/survivors and their families in planning and implementing services and programs, as well as in evaluating State mental health systems,

6. To ensure access for underserved populations, including people who are homeless, residents of rural areas, and older adults,

7. To promote recovery and community integration for adults with SMI and children with SED,

8. To increase accountability through uniform reporting on access, quality, and outcomes of services.

G. **Restrictions on the Use of SABG & MHBG**

Contractors and TRBHASS shall not expend SABG and MHBG funds on the following activities:

1. To provide inpatient hospital services;

2. To make cash payments to intended recipients of health services;
3. To purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;

4. To satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds (Maintenance of Effort);

5. To provide financial assistance to any entity other than a public or nonprofit private entity;

6. To provide members with hypodermic needles or syringes so that they may use illegal drugs, unless the Surgeon General of the Public Health Service determines that a demonstration needle exchange program would be effective in reducing drug use and the risk that the public will become infected with the etiologic agent for AIDS;

7. To pay the salary of an individual through a grant or other extramural mechanism at a rate in excess of Level I of the Executive Salary Schedule for the award year (see National Institutes of Health (NIH) Grants & Funding Salary Cap Summary);

8. To purchase treatment services in penal or correctional institutions of the State of Arizona;

9. To provide acute care or physical health care services including payments of copays; and

10. To provide flex funds.