16 Women and Children's Services

EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) PROGRAM

Program Description

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

A well child visit is synonymous with an EPSDT visit and includes all screenings and services described in the AHCCCS EPSDT Chapter 400, Policy 430, as well as referenced in the EPSDT & Dental Periodicity Schedule (Exhibit 3.2).

Amount, Duration and Scope

The Medicaid Act defines EPSDT services to include screening services, vision services, dental services, hearing services and "*such other necessary health care, diagnostic services, treatment and other measures described in Federal Law Subsection 42 USC 1396d (a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the (AHCCCS) State Plan."* This means that EPSDT covered services include services that correct or ameliorate physical and mental defects, conditions, and illnesses discovered by the screening process when those services fall within one of the 28 optional and mandatory categories of "Medical Assistance" as defined in the Medicaid Act. Services covered under EPSDT include all 29 categories of services in the Federal Law even when they are not listed as covered services in the AHCCCS State Plan, AHCCCS statutes, rules, or policies as long as the services are medically necessary and

cost effective.

EPSDT includes, but is not limited to, coverage of:

- Inpatient and outpatient hospital services
- Laboratory and x-ray services
- Physician services, nurse practitioner services
- Medications
- Dental services
- Therapy services
- Behavioral health services
- Medical supplies
- Prosthetic devices
- Eyeglasses
- Transportation
- Family planning services

EPSDT also includes diagnostic, screening, preventive and rehabilitative services. However, EPSDT services do not include services that are experimental, that are solely for cosmetic purposes, or that are not cost effective when compared to other interventions or treatments.

EPSDT screening services are provided in compliance with the periodicity requirements of Title 42 of the Code of Federal Regulations (42 CFR 441.58). Providers must ensure members receive required health screenings in compliance with the AHCCCS EPSDT Periodicity Schedule and the AHCCCS Dental Periodicity Schedule. The AHCCCS Periodicity Schedules for EPSDT are intended to meet reasonable and prevailing standards of medical and dental practice and specify screening services at each stage of the child's life (see Exhibit 3.2). The service intervals represent minimum requirements, and any services determined by a primary care provider to be medically necessary must be provided, regardless of the interval. EPSDT focuses on the continuum of care by assessing health needs, providing preventive screening, initiating needed referrals, and completing recommended medical treatment and appropriate follow-up.

EPSDT Definitions

1. Early means in the case of a child already enrolled with Health Choice Arizona as early as possible in the child's life, or in other cases, as soon after the member's eligibility for AHCCCS services has been established.
2. Periodic means at intervals established by AHCCCS Administration for screening to assure that a condition, illness, or injury is not incipient or present.
3. Screening means regularly scheduled examinations and evaluations of the general physical and behavioral health, growth, development, and nutritional status of infants, children and youth, and the identification of those in need of more definitive evaluation. For the purpose of the AHCCCS EPSDT program, screening and diagnosis are not synonymous.
4. Diagnosis means the determination of the nature or cause of a condition, illness, or injury through the combined use of health history, physical, developmental and psychological examination, laboratory tests, and X-rays, when appropriate.

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

Screening Requirements

Comprehensive periodic screenings must be performed by a provider according to the time frames identified in the AHCCCS EPSDT (Early and Periodic Screening, Diagnostic and Treatment) Periodicity Schedule, the AHCCCS Dental Periodicity Schedule Inter-periodic screenings should be performed as appropriate for each member. Providers must utilize AHCCCS approved standard developmental screening tools and complete training in the use of the tools. Health Choice Arizona will monitor providers and implement interventions for non-compliance. Providers must ensure that the newborn screening tests are conducted, including initial and second screening, in accordance with 9 A.A.C. 13, Article 2.

The AHCCCS EPSDT Periodicity Schedule is based on recommendations by the Arizona Medical Association and is closely aligned with guidelines of the American Academy of Pediatrics. The service intervals represent minimum requirements, and any services determined by a PCP to be medically necessary must be provided, regardless of the interval. EPSDT screenings must include the following:

1. A comprehensive health and developmental history, including growth and development screening (42 CFR 441.56(B)(1) which includes physical, nutritional and behavioral health assessments. Refer to the Centers for Disease Control and Prevention Website at http://www.cdc.gov/growthcharts/ for Body Mass Index Charts, or contact your Provider Services Representative for copies of the charts.

2. Nutritional Assessment provided by PCP - Nutritional assessments are conducted to assist EPSDT members whose health status may improve with nutritional intervention. Payment for the assessment of nutritional status provided by the member's PCP is part of the EPSDT screening specified in the AHCCCS EPSDT Periodicity Schedule (Exhibit 3.2), and on an inter-periodic basis as determined necessary by the member's PCP. Payment for nutritional assessments are included in the EPSDT visit and are not a separately billable service.

3. Behavioral Health Screening and Services provided by a PCP - AHCCCS covers behavioral health services for members eligible for EPSDT. EPSDT behavioral health services include the services listed in Federal Law 42 USC 1396d(a) necessary to correct or ameliorate mental illnesses and conditions discovered by the screening services, whether or not the services are covered under the (AHCCCS) State Plan. PCPs may treat Attention Deficit Hyperactivity Disorder (ADHD), depression and anxiety. All other behavioral health conditions must be referred to the Regional Behavioral Health Authority (RBHA).

4. Developmental Screening Tools used by a PCP - AHCCCS approved developmental screening tools should be utilized for developmental screening by all participating

PCPs who care for EPSDT-age members. PCPs must be trained in the use and scoring of the developmental screening tools, as indicated by the American Academy of Pediatrics. The developmental screening should be completed for EPSDT members from birth through three years of age during the 9 month, 18 month and 24 month EPSDT visits. A copy of the screening tool must be kept in the medical record. Use of AHCCCS approved developmental screening tools may be billed separately using CPT-4 code 96110 (Developmental screening, with interpretation and report, per standardized instrumentation) for the 9 month, 18 month and 24 month visit when the developmental screening tool is used. A developmental screening CPT code (with EP modifier) must be listed in addition to the preventive medicine CPT codes. Other CPT-4 codes, such as 96111 – Developmental Testing (includes assessment of motor, language, social, adaptive) are not considered screening tools and are not separately billable. To receive the developmental screening tool payment, the modifier EP must be added to the 96110. For claims to be eligible for payment of code 96110; the provider must have satisfied the training requirements, the claim must be a 9, 18, or 24-month EPSDT visit, and an AHCCCS approved developmental screening tool must have been completed. AHCCCS approved developmental screening tools include:

a. The Parent's Evaluation of Developmental Status (PEDS) tool which may be obtained from http://www.pedstest.com/default.aspx or https://pedstestonline.com/

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

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

5. A comprehensive unclothed physical examination.

6. Appropriate immunizations according to age and health history (administration of the immunizations may be billed in addition to the EPSDT visit using the CPT-4 code appropriate for the immunization with an SL modifier). Combination vaccines are paid as one vaccine. Providers must be registered as Vaccines for Children (VFC) providers and VFC vaccines must be used.

7. Laboratory tests including blood lead screening assessment and blood lead testing appropriate to age and risk, anemia testing and diagnostic testing for sickle cell trait (if a child has not been previously tested with sickle cell preparation or a hemoglobin solubility test). EPSDT covers blood lead screening. All children are considered at risk and must be screened for lead poisoning. All children must receive a screening blood lead test at 12 months and 24 months of age. Children between 36 and 72 months of age must receive a screening blood lead test if they have not been previously screened for lead poisoning.

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

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

10. Appropriate vision, hearing, and speech testing and diagnosis, as well as treatments for defects in vision and hearing, including provision of eyeglasses and hearing aids. Appropriate medically necessary therapies, including speech therapy, are also covered under EPSDT.

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

    a. Confirmed or suspected as having TB
    b. In jail or prison during the last five years
    c. Living in a household with an HIV-infected person or the child is infected with HIV
    d. Traveling/emigrating from, or having significant contact with persons indigenous to, endemic countries

EPSDT Service Standards

EPSDT services must be provided according to community standards of practice and the AHCCCS EPSDT and Dental Periodicity Schedules. The AHCCCS EPSDT Tracking Forms, revision date April 1, 2014, must be used to document services provided and compliance with AHCCCS standards. The EPSDT Tracking Forms must be signed by the clinician who performs the screening.

Offices using electronic medical records please note: the EPSDT portion must adhere to and contain all of the components found within the AHCCCS EPSDT Tracking Forms. A copy of the electronic medical record must be sent to Health Choice Arizona in lieu of the current AHCCCS EPSDT Tracking Form.

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

Immunizations - EPSDT covers all child and adolescent immunizations as specified in the AHCCCS Recommended Childhood Immunization Schedules. All appropriate immunizations must be provided to establish, and maintain, up-to-date immunization status for each EPSDT member. See Exhibit 3.1.1 through 3.1.5 for all Child and Adult Immunization schedules.

1. **Vaccine for Children (VFC) Program:**

Health Choice Arizona, in accordance with AHCCCS and federal requirements, provides immunization services for EPSDT eligible children and young adults under the age of 19. All PCPs treating members under the age of 19 must enroll every year with the Vaccine

for Children (VFC) Program through Arizona Department of Health Services (ADHS) in order to deliver EPSDT immunizations. Through the VFC Program, the federal government purchases and makes available to the states, free of charge, vaccines for children under age nineteen (19) who are eligible, Native American or Alaskan Native, not insured and some underinsured. Health Choice Arizona provides an administration fee for each VFC antigen administered to a Health Choice Arizona member. Health Choice Arizona cannot utilize AHCCCS funding to reimburse VFC vaccines for members younger than 19 years of age.

The PCP will need to contact their State/Territory VFC Program Coordinator at (602) 364-3630 to request an enrollment package for the VFC program. Additional information regarding enrollment can be found at Arizona Department of Health Services website (Arizona Immunization Program-VFC): http://azdhs.gov/index.php. Once the enrollment package is received the PCP:

- Completes the Arizona Provider Enrollment Form and returns it as soon as possible
- Prepares the office and staff for a site visit to go over the administrative requirements of the program and to ensure proper storage and handling of vaccines when received
- Screens and maintains eligibility records for VFC eligible children
- Provides vaccine at no charge to VFC eligible children
- Adheres to other reporting requirements as outlined by the state of Arizona

PCPs should use every opportunity to assess the immunization status of assigned members and provide necessary immunizations. Providers shall notify members of overdue immunizations and/or encourage visits for EPSDT services including immunizations.

AHCCCS will cover the human papilloma virus (HPV) vaccine for female and male EPSDT members age 11 through 20 years and members age 9 and 10 years of age if the member is deemed to be in a high risk situation.

Arizona State Immunization Information Systems (ASIIS)

Arizona State Law requires the reporting of all immunizations given to children under the age of 20. Immunizations must be reported at least monthly to ADHS. Reported immunizations are held in a central database known as ASIIS (Arizona State Immunization Information System), which can be accessed by providers to obtain complete accurate immunization records. Software is available from ADHS to assist providers in meeting this reporting requirement. EPSDT Providers must document immunizations into the ASIIS database.

To learn more about ASIIS, please refer to their web site at www.azdhs.gov/phs/asiis/

In accordance with A.R.S. Title 36, Section 135, each provider must document all immunizations administered to EPSDT members in ASIIS, as well as update and maintain a complete immunization record in the member's medical record. Health Choice Arizona

strongly encourages the use of the Arizona Department of Health Services (ADHS) Immunization Administration Record (Form 111) which is available at the address listed below:

Arizona Department of Health Services
Arizona Immunization Program Office
150 North 18th Avenue, Suite 120
Phoenix, AZ 85007
(602) 364-3630

Health Choice Arizona follows the "Standards for Pediatric Immunization Practices", as published by the U.S. Department of Health & Human Services. These guidelines state:

- Providers should question the parent or guardian about contraindications before immunizing a child and inform them in specific terms about the risks and benefits of the immunizations their child is to receive
- The "Vaccine Information Pamphlets" should be provided and reviewed with parents or guardians. (Alternative vaccine information materials that meet all the requirements of the law can be used). Providers must ensure that information materials are current and available in appropriate languages
- Providers are required by statute to record **what vaccine was given, the date the vaccine was given (month, day, and year) the name of the manufacture, the lot number, and the signature and title of the person who gave the vaccine.** This should be documented on an "Immunization Administration Record", along with the signature of the person who receives the vaccine or the person authorized to make the request. This serves as informed consent for the immunizations received
- Providers are required by statute to report all immunizations given to the Arizona State Immunization Registry

- **Eye Examinations and Prescriptive Lenses** - EPSDT covers eye examinations as appropriate to age according to the AHCCCS EPSDT Periodicity Schedule and as medically necessary using standardized visual tools. Prescriptive lenses are provided to correct or ameliorate defects, physical illness and conditions discovered by EPSDT screenings, subject to medical necessity.

- **Blood Lead Screening**
  EPSDT Covers blood lead screening. All children are considered at risk and must be screened for lead poisoning. All children must receive a screening blood lead test at 12 months and 24 months of age. Blood lead screening, is a federally mandated test. Children between 36 and 72 months (6 years) of age must receive a screening blood lead test if they have not been previously screened for lead poisoning. A verbal blood lead screening risk assessment must be competed at each EPSDT Visit for children 6 through 72 months of age (up to 6 years of age) to assist in determining risk. If at risk, a blood lead test must be performed.

LEAD RISK ASSESSMENT QUESTIONNAIRE:

- Does your child live in or regularly visit an old house built before 1960? Does the house have peeling or chipping paint?
- Does your child live in a house built before 1960 with recent ongoing or planned renovation or remodeling?
- Have any of your children or their playmates had lead poisoning?
- Does your child frequently come in contact with an adult who works with lead? Examples are construction, welding, pottery or other trades practiced in your community.
- Does your child live near a lead smelter, battery recycling plant, or other industry likely to release lead?
- Do you give your child any home or folk remedy, which may contain lead?
- Does your child live near a heavily traveled major highway where soil and dust may be contaminated with lead?
- Does your home's plumbing have lead pipes or copper with lead solder joints?
- Do you cook or serve your food in imported pottery from Mexico? Jarros or Casuelas?
- Do you have Surma make-up products in your home, which were purchased outside of the United States?

Ask any additional questions that may be specific to a situation, which may exist in a particular community.

Results of Blood Lead Test

If the result of the blood test is greater than or equal to 5 ug/dL, a venous blood sample must be obtained to confirm the results. Providers must report all lead poisoning with lead levels greater than or equal to 5 ug/dL to the Arizona Department of Health Services at (602) 364-3118. (A.A.C. R9-4-302).

Patients with tests resulting in lead levels 5-19 micrograms per deciliter must be re-tested in three months. Lead levels measuring 20-44 ug/dl also need to be re-tested one month to 1 week. Patients with lead levels measuring 45-59 ug/dl should have the blood levels re-tested in 48 hours. Any lead levels 60-69 should be re-tested in 24 hours. Blood lead levels over 70 ug/dl are considered a medical emergency and should be re-tested immediately. The patient will need a full medical work-up and treatment immediately.

All elevated blood lead levels are tracked at Health Choice Arizona. These levels are monitored on a monthly basis when Health Choice Arizona receives the most recent results from LabCorp. Health Choice Arizona is in contact with members with elevated blood lead levels. The families are encouraged to seek re-testing at the appropriate times.

Arizona Department of Health Services provides family education and environmental investigations, sometimes in cooperation with county health departments, in accordance with the CDC 2012 guidelines, as follows:

Blood lead levels of >5 µg/dL and <20 µg/dL
• Counseling by phone
• Educational materials by mail
• Referrals to other resources
• Certified letters if the family cannot be contacted by phone

Blood-lead levels of >20 µg/dL or two consecutive tests >15 µg/dL three months apart

1. Environmental investigation, including in-home interview and environmental sampling to identify lead sources.
   • Specific intervention and prevention advice
   • Referrals to other resources

2. **Organ and Tissue Transplantation Services** – Note: Please refer to the AHCCCS Medical Policy Manual, Chapter 300, Policy 310-DD with Attachment A for further discussion of AHCCCS-covered transplantations.

3. **Tuberculosis Screening** - EPSDT covers TB screening. Providers must ensure timely reading of the TB skin test for members who received TB testing and treatment if medically necessary.

4. **Nutritional Assessment and Nutritional Therapy**

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

   To initiate the referral for a nutritional assessment, the PCP must use the Health Choice Arizona prior authorization form.
   If a Health Choice Arizona member has a congenital metabolic disorder (such as Phenylketonuria, Homocystinuria, Maple Syrup Urine Disease or Galactosemia), certain conditions, limitations and exclusions apply per the AHCCCS Medical Policy Manual, Chapter 300, Policy 320, Medical Foods.

   Nutritional Therapy: Health Choice Arizona covers nutritional therapy for EPSDT-eligible members on an enteral, parenteral or oral basis when determined medically necessary to provide either complete daily dietary requirements, or to supplement a member's daily nutritional and caloric intake.

   a. Commercial Oral Supplemental Nutritional Feedings: Provides nourishment and increases caloric intake as a supplement to the member's intake of other age appropriate foods, or as the sole source of nutrition for the member.

Nourishment is taken orally and is generally provided through commercial nutritional supplements available without prescription.

1) PA is required for commercial oral nutritional supplements unless the member is also currently receiving nutrition through enteral or parenteral feedings. PA is not required for the first 30 days if the member requires commercial oral nutritional supplements on a temporary basis due to an emergent condition.

2) Medical necessity for commercial oral nutritional supplements must be determined on an individual basis by the member's PCP or attending physician, using at least the criteria specified in this policy. An example of a nutritional supplement is an amino acid-based formula used by a member for eosinophilic gastrointestinal disorder. The PCP or attending physician must use the AHCCCS approved form, "Certificate of Medical Necessity for Commercial Oral Nutritional Supplements" (Exhibit 16-8) to obtain PA.

3) The Certificate of Medical Necessity for Commercial Oral Nutritional Supplements must document that the PCP or attending physician has provided nutritional counseling as a part of the EPSDT services provided to the member. The documentation must specify alternatives that were tried in an effort to boost caloric intake and/or change food consistencies before considering commercially available nutritional supplements for oral feedings, or to supplement feedings.

b. The Certificate of Medical Necessity for Commercial Oral Nutritional Supplements must indicate which criteria were met when assessing the medical necessity of providing commercial oral nutritional supplements. At least two of the following criteria must be met:

1) The member is at or below the 10th percentile on the appropriate growth chart for their age and gender for three months or more

2) The member has reached a plateau in growth and/or nutritional status for more than six months (prepubescent)

3) The member has already demonstrated a medically significant decline in weight within the past three months (prior to the assessment)

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

5) Absorption problems as evidenced by emesis, diarrhea, dehydration, and/or weight loss and intolerance to milk or formula products has been ruled out

6) The member requires nutritional supplements on a temporary basis due to an emergent condition; i.e. post-hospitalization (PA is not required for the first 30 days)

7) The member is at high risk for regression due to chronic disease or condition and there are no alternatives for adequate nutrition

In the event that a member is transitioning from Health Choice Arizona to another AHCCCS health plan, the Enrollment Transition Coordinator will notify the new health plan of the member's special needs. However, the member's new health plan will be responsible for obtaining the required AHCCCS Certificate of Medical Necessity for Commercial Oral Nutritional Supplements and any additional information needed for prior authorization.

Oral Health Services -

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

Emergent – Within 24 hours of request
Urgent – Within 3 days of request
Routine – Within 45 days of request

An oral health screening must be part of an EPSDT screening conducted by a PCP, however, it does not substitute for examination through direct referral to a dentist. PCPs are expected to refer EPSDT members for appropriate services based on needs identified through the screening process and for routine dental care based on the AHCCCS Dental Periodicity Schedule see Exhibit 431-1 of the AHCCCS AMPM Policy. Evidence of this referral must be documented on the EPSDT form.

NOTE: Although the AHCCCS Dental Periodicity Schedule identifies when routine referrals begin, PCPs may refer EPSDT members for a dental assessment at an earlier age if their oral health screening reveals potential carious lesions or other conditions requiring assessment and/or treatment by a dental professional. In addition to PCP referrals, EPSDT members are allowed self-referral to a dentist who is included in the Contractor's provider network.

8. **Cochlear Implantation -** Cochlear implantation provides an awareness and identification of sounds and facilitates communication for persons who have profound, sensorineural hearing loss (nerve deafness). Deafness may be prelingual/perilingual or postlingual. Health Choice Arizona covers medically necessary services for cochlear implantation for EPSDT members only. Cochlear implantation is limited to one (1) functioning implant per member. Health Choice Arizona will not cover cochlear implantation in instances where individuals have one functioning cochlear implant.

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

   a. A diagnosis of bilateral profound sensorineural deafness (using age-appropriate standard testing), with little or no benefit from a hearing (or

vibrotactile) aid, as established by audiologic and medical evaluation

b. Presence of an accessible cochlear lumen structurally suited to implantation, with no lesions in the auditory nerve and acoustic areas of the central nervous system, as demonstrated by CT scan or other appropriate radiologic evaluation
c. No known contraindications to surgery
d. Demonstrated age appropriate cognitive ability to use auditory clues
e. The device must be used in accordance with the FDA approved labeling

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

(a) Complete auditory testing and evaluation by an Otolaryngologist, Speech Language Pathologist or Audiologist
(b) Pre-surgery inpatient/outpatient evaluation by a board certified Otolaryngologist
(c) Diagnostic procedures and studies, including CT scan or other appropriate radiologic evaluation, for determining candidacy suitability
(d) Pre-operative psychosocial assessment/evaluation by Psychologist or Licensed Counselor
(e) Prosthetic device for implantation (must be non-experimental/noninvestigational and be FDA approved and used according to labeling instructions)
(f) Surgical implantation and related services
(g) Post-surgical rehabilitation, education, counseling and training
(h) Equipment maintenance, repair and replacement of the internal/external components or both if not operating effectively and is cost effective

Examples include but are not limited to: the device is no longer functional or the used component compromises the member's safety. Documentation which establishes the need to replace components not operating effectively must be provided at the time prior authorization is sought

(i) Cochlear implantation requires PA from the Health Choice Arizona Medical Director
(j) Osseointegrated implants (bone anchored hearing aid [BAHA]).

Health Choice Arizona coverage of medically necessary services for osseointegrated implantation is limited to EPSDT members. Osseointegrated implants are devices implanted in the skull that replace the function of the middle ear and provide mechanical energy to the cochlea via a mechanical transducer. These devices are indicated only when hearing aids are medically inappropriate or cannot be utilized due to congenital malformation, chronic disease, severe sensorineural hearing loss or surgery. Osseointegrated implantation requires PA from the Health Choice Arizona Medical Director.

9. Conscious Sedation – Health Choice Arizona covers conscious sedation for members receiving EPSDT services. Conscious sedation provides a state of consciousness that allows the member to tolerate an unpleasant procedure while continuously maintaining

adequate cardiovascular and respiratory function, as well as the ability to respond purposely to verbal command and/or tactile stimulation.

Coverage is limited to the following procedures:

a. Bone marrow biopsy with needle or trocar
b. Bone marrow aspiration
c. Intravenous chemotherapy administration, push technique
d. Chemotherapy administration into central nervous system by spinal puncture
e. Diagnostic lumbar spinal puncture
f. Therapeutic spinal puncture for drainage of cerebrospinal fluid

10. Behavioral Health Services – Health Choice Arizona covers behavioral health services for members eligible for EPSDT services described in Chapter 300, Policy 310, and the Behavioral Health Services Guide. EPSDT behavioral health services include the services listed in Federal Law 42 USC 1396d(a) necessary to correct or ameliorate mental illnesses and conditions discovered by the screening services whether or not the services are covered under the AHCCCS State Plan. Please refer to the AHCCCS clinical guidelines (Appendix E of the AMPM) for the diagnosis of attention deficit disorder/attention deficit hyperactivity disorder, depression and/or anxiety disorders. The AHCCCS clinical guidelines include assessment tools and algorithms. The clinical guidelines are to be used by the PCPs as an aid in treatment decisions.

As adopted by AHCCCS, Health Choice Arizona has integrated 12 Principles to maintain the integrity of the best practices and approaches to providing behavioral health services for children (EPSDT age members).

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

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

3. Collaboration with Others: When children have multi-agency, multi-system involvement, a joint assessment is developed and a jointly established behavioral health services plan is collaboratively implemented. Client centered teams plan and deliver services. Each child's team includes the child, parents, any foster parent, and any individual important in the child's life who is invited to participate by the child or parents. The team also includes all other persons needed to develop an effective plan, including as appropriate, the child's teacher, the child's Child Protective Service and/or Division of Developmental Disabilities case worker, and the child's probation officer. The team develops a common assessment of the child's and family's strengths and needs, develops an Individualized Service Plan

and monitors the implementation of the plan and makes adjustments in the plan if it is not succeeding.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. The member is over three years and under twenty-one years old
b. The member is incontinent due to a documented disability that causes incontinence of bowel and/or bladder
c. The PCP or attending physician has issued a prescription ordering the incontinence briefs
d. Incontinence briefs do not exceed 240 briefs per month unless the prescribing physician presents evidence of medical necessity for more than 240 briefs per month for a member diagnosed with chronic diarrhea or spastic bladder
e. The member obtains incontinence briefs from providers in Health Choice Arizona's

network

f. Prior authorization must be obtained from Health Choice Arizona. Health Choice Arizona may require a new prior authorization to be issued no more frequently than every twelve months. Prior authorization for a renewal of an existing prescription may be provided by the physician through telephone contact with the member rather than an in-person physician visit

16. Medically Necessary Therapies – Health Choice Arizona covers medically necessary therapies including physical therapy, occupational therapy and speech therapy necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services. Therapies are covered under both an inpatient and outpatient basis when medically necessary.

EPSDT Visits

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

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

2. The "sick visit" is documented on a separate note

3. History, Exam, and Medical Decision Making components of the separate "sick visit" already performed during the course of an EPSDT visit are not to be considered when determining the level of the additional service (CPT Code 99201-99215)
4. The current status (not history) of the abnormality or preexisting condition is the basis of determining medical necessity.

Modifier 25 must be added to the Office/Outpatient code to indicate that a significant, separately identifiable evaluation and management service was provided by the same physician on the same day as the preventive medicine service.

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

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

For additional information or for staff training on the EPSDT Program, providers may call the Health Choice Arizona EPSDT Supervisor at (480) 760-4662 or (800) 322-8670 extension 4662, and ask for the EPSDT Supervisor

EPSDT Notification

The Member Handbook, which is found on our website or can be requested to be mailed, includes a section that explains the benefits of the EPSDT program. Health Choice

Arizona mails a notice to the parent/guardian of each EPSDT eligible member, informing them when an EPSDT exam is due with instructions to contact their PCP/PCO (Primary Care Organization) to schedule an appointment. The PCP/PCO is responsible for the following:

- Informing Health Choice Arizona of EPSDT eligible members who fail to make or keep EPSDT visits by faxing or emailing this information to the EPSDT Coordinator at:

  Fax (480) 760-4716
  EPSDT_CHEC@iasishealthcare.com

- Completing standard EPSDT Tracking Forms, during every EPSDT visit
- Placing copies of the EPSDT Tracking Forms and developmental screening tool, as appropriate, signed by the provider, in the member's medical record
  Fax or email a copy of the completed EPSDT Tracking Form and developmental screening tool, as appropriate, to the Health Choice Arizona EPSDT Coordinator (Fax) (480) 760-4716 or email EPSDT_CHEC@iasishealthcare.com
  - The tracking forms should be forwarded on a daily or weekly basis to ensure timely processing.
- Please do not submit EPSDT Tracking Forms or developmental screening tool copies to AHCCCS Administration
- EPSDT Tracking Forms are available from your Provider Services Representative, faxing the EPSDT Tracking Form Order to Health Choice Arizona (Provider Manual Exhibit 3.7) to (480) 784-2933, or by downloading them from the AHCCCS web site at http://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/AppendixB.pdf

- Please use the following codes to ensure proper reporting for well-child visits:

Age	New Patient	Established
Under 1 year	99381	99391
1-4 years	99382	99392
5-11 years	99383	99393
12-17 years	99384	99394
18-20 years	99385	99395

Well adult exams, also known as physical exams or well-care visits. The benefit applies to members ages 21 and over. ICD10 Diagnosis codes and CPT codes that may be billed are listed in the table below.

ICD10-CM DIAGNOSIS CODES
Z01.411 – Z01.419 Routine gynecological examination
Z00.00 – Z00.01 Routine general medical examination without abnormal findings
Z00.8 Encounter general medical examination
CPT CODES
NEW PATIENT SERVICE

99385	Initial comprehensive preventive medicine evaluation and management; new patient; 18-39 years
99386	Initial comprehensive preventive medicine evaluation and management; new patient; 40-64 years
99387	Initial comprehensive preventive medicine evaluation and management ; new patient: 65 and older
ESTABLISHED PATIENT SERVICE	
99395	Periodic comprehensive preventive medicine reevaluation; established patient : 18-39
99396	Periodic comprehensive preventive medicine reevaluation; established patient; 40-64
99397	Periodic comprehensive preventive medicine reevaluation; established patient; 65 and older

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- PCP/PCOs must report all services performed by submitting a CMS 1500 or an electronic 837P
- PCP/PCOs are encouraged to use their monthly member roster to identify and outreach to assigned members who are due for an EPSDT visit
- Refer to the EPSDT Periodicity Schedule (Exhibit 3.2) for the required age appropriate services for children under the age of 21
- Appropriate referral to Children's Rehabilitative Services (CRS) when a CRS eligible condition is diagnosed including assistance with the submission of an application with the appropriate medical documentation
- Refer members to WIC and Head Start as appropriate
- Refer members to AzEIP services as appropriate
- Initiate and coordinate referrals to behavioral health providers as necessary

CHILDREN'S REHABILITATIVE SERVICES

The Children's Rehabilitative Services (CRS) Program is administered by the Arizona Health Care Cost Containment System (AHCCCS). The mission of CRS is:

"To provide medical treatment, rehabilitation, and related support services to medically and financially qualified individuals who have certain medical, disabling or potentially disabling conditions which have the potential for functional improvement".

Health Choice Arizona providers are responsible for referring children with CRS eligible conditions to the CRS program. Effective October 1, 2013 referrals should now be made to AHCCCS CRS Enrollment Department.

Referrals must be accompanied by:

- A completed CRS application (Exhibit 16.1-English.16.2 Spanish and also located on the website under Forms).
- A copy of the medical record to include:

- Pertinent hospital medical records and summaries of suspected CRS condition
- Laboratory results
- Medical imaging studies

Early referral is encouraged by the CRS Program to assure the most successful results.

If the supporting documentation is not included with the application, AHCCCS will send the referral source as well as the parent and PCP a letter asking for additional information to be sent as soon as possible. If no additional information is received by AHCCCS within ninety (90) days they will cancel the application.

General Eligibility

• Be an Arizona resident under 21 years of age
• Have one or more of the conditions listed in ARS R9-22-1303

Medical Eligibility

Conditions accepted for care include, but are not limited to the following examples:

- Deformities present at birth or acquired, such as club feet, dislocated hip, cleft palate, mal-united fractures, scoliosis, spina bifida, and congenital GU and GI anomalies
- Many muscle and nerve disorders
- Epilepsy (only when not well managed or controlled in spite of medication within therapeutic range)
- Heart conditions due to congenital malformation
- Certain eye and ear conditions may be eligible
- Cystic fibrosis
- Burn scars which are causing functional limitations
- PKU and other related metabolic disorders
- Sickle cell anemia
- Neuroflbromatosis
- Hydrocephalus
- Rheumatoid Arthritis
- Rehabilitative Care three months after traumatic injury

For a complete list of covered as well as excluded conditions please refer to AHCCCS Medical Policy Manual, Chapter 300, Exhibit 330-1.

If additional information or assistance is required, please contact Health Choice Arizona CRS Specialist at (480) 760-4589.

You may also visit the ADHS Office for Children with Special Healthcare Needs (OCSHCN) website: http://www.azdhs.gov/prevention/womens-childrens-health/ocshcn/index.php or visit the AHCCCS website.

ARIZONA EARLY INTERVENTION PROGRAM (AZEIP)

AzEIP is a statewide system of supports and services for families of children, birth to three, with disabilities or developmental delays.

AHCCCS and AzEIP jointly developed processes to ensure the coordination and provision of EPSDT and early intervention services. This process describes the procedure when concerns about a child's development are initially identified by (A) the child's parent who can contact AzEIP or (B) the child's PCP.

When concerns about a child's Development are initially identified by the child's PCP:

- During the EPSDT/Well Child visit, the PCP will determine the child's developmental status through discussion with the parent/caregiver and developmental screening
- If the PCP identifies potential developmental delays, the PCP may request an evaluation and possible service authorization from Health Choice Arizona
- PCP must submit the clinical information supporting the request for evaluation and service authorization by Health Choice Arizona
- PCP should consider related screening and evaluation needs when exploring if a child has a developmental delay e.g., if the PCP and parents have concerns about a child's communication, steps should be taken to confirm that the child's hearing is within normal limits in addition to evaluating a child's speech and language
- If services are approved, Health Choice Arizona will authorize the services and notify the PCP that the services are approved and will identify the provider that has been authorized to provide services

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

1. AzEIP will screen and, if needed, conduct evaluation to determine the child's eligibility for AzEIP.
2. If the child is determined to be AzEIP eligible, AzEIP will develop an Individualized Family Service Plan (IFSP) that will identify:
    a) The child's present level of development
    b) Child outcomes
    c) The services that are needed to support the family and child in reaching the IFSP outcomes
    d) Planned start date for each early intervention service(s) identified on the IFSP
3. The AzEIP Service Coordinator will send via fax or email the "AzEIP Member Service Request form" and copies of the evaluation/developmental summaries completed during the IFSP process to Health Choice Arizona within **2 business**

days of completing the IFSP.

4. Health Choice Arizona will enter the AzEIP Member Service request into the prior authorization system within **1 business day** of receipt of the request.
5. Health Choice Arizona will forward the documentation to the PCP within **2 business days.**
6. PCP is required to review all AzEIP documentation and determine which services are medically necessary based on review of the documentation. If the PCP needs to see the child before determining the child's need for services, the appointment will be scheduled as a routine appointment.
7. Within **5 business days** from the date Health Choice Arizona forwards the documentation to the PCP, PCP will determine which services are medically necessary by indicating on the AzEIP Referral Form and signing the form. The PCP will send the form back to Health Choice Arizona along with script (s), and medical records that support the medical necessity for services.
8. Within **2 business days** Health Choice Arizona will notify the PCP and AzEIP Service Coordinator of the authorization determination and service provider, if applicable.

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

9. The AHCCCS Health Plan must send a Notice of Action letter to the PCP, the AzEIP service coordinator, the member's guardian/ parent, and the AHCCCS MCH coordinator or designee denying the service pending examination by the PCP.
10. AzEIP AHCCCS Member Service Request form (Exhibit 430-4) must also be returned to the AzEIP service coordinator indicating the PCP wishes to examine the member and services are denied pending examination by the PCP.
11. AHCCCS MCH coordinator must assist the member's guardian/ parent in making an appointment with the PCP and follow up with the PCP to ensure all medically necessary services identified on the AzEIP AHCCCS Member Service Request form (Exhibit 430-4) are considered for medical necessity.
12. After the member is examined by the PCP and a determination is made, steps 1 through 8 should be followed.

When concerns about a child's development are initially identified by the PCP:

Health Choice Arizona encourages providers to refer children 0-3 years of age with developmental disabilities to AzEIP. AzEIP will recommend medically necessary services through Health Choice Arizona. Health Choice Arizona will act as the liaison between the Provider, AzEIP and the servicing agency to coordinate medically necessary services for the member.

To initiate the referral process contact AzEIP directly at (602) 635-9799, toll free at (888) 592-0140, or via the AzEIP website at http://www.azdes.gov/azeip.

Please note that Health Choice Arizona will provide all medically necessary services regardless of the child's AzEIP enrollment status. Therefore, please do not delay requesting therapy evaluation and/or therapy sessions.

For assistance with issues related to child health, the EPSDT program, and developmental screening, you may call the EPSDT Supervisor at (480) 760-4662, or toll free at (800) 322-8670 extension 4662

TRANSPORTATION

Members are eligible to receive medically necessary transportation when there is no other means of transportation available (i.e., family, friends, community services or public transit.) Medically necessary transportation must meet one of the following criteria:

- Visits to PCP, dentists, specialists, specialty clinics
- Visits to sites for diagnostic testing
- Pharmacy stops (Please inform the transportation service that the member requires an RX stop.)

It is the responsibility of the member to call Health Choice Arizona Member Services at (800) 322-8670 to arrange medically necessary transportation.

Family Planning Services

Health Choice Arizona members who voluntarily choose to delay or prevent pregnancy are eligible for family planning services. These services are at no cost to members. PCOs are required to inform the member of family planning options during the member's last trimester and postpartum visits. PCOs are required to submit a claim for all family planning services. When submitting claim encounters for Health Choice Arizona members with "Family Planning Services only" providers are expected to use the FP modifier.

Health Choice Arizona Primary Care Physicians (PCPs) and Primary Care Obstetricians (PCOs) must record annually in the member's medical records that each male and female member of reproductive age (12 through 55years of age) has been notified verbally or in writing of the availability of family planning services. Notification of members who are 17 years of age or younger must be given through the member's parent or guardian.

Covered family planning services include:

Natural Family Planning Education

Medications:

- Birth Control Pills
- Depo Provera injections
- Transdermal (Ortho Evra®)
- Copper (Paraguard®)
- Contraceptive intrauterine device (Progestacert®)
- Vaginal Ring (Nuvaring®)
- Long Acting Reversible Contraceptives (LARC)
- Emergency Contraception (Plan B®)

Supplies:

- Cervical Cap
- Condoms, foams, suppositories, creams and gels (male and female)
- Diaphragm
- OTC supplies require a script in order to be covered

Surgical Procedures

- Implanon® (subdermal implantable rod)
- Tubal Ligation
- Hysteroscopic tubal sterilization (such as the Essure Micro-Insert).
- Male vasectomies

Note member must meet certain criteria for sterilization: See "Sterilization" section

Other Covered Services:

Medical and laboratory examinations for sterilization if criteria for sterilization are met.

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- Family planning counseling

NON-COVERED FAMILY PLANNING SERVICES

- Pregnancy termination and/or pregnancy termination counseling
- Non-medically necessary hysterectomies
- Infertility
- Reversal of voluntary sterilization

There is no co-payment for family planning services and supplies.

FAMILY PLANNING SERVICES FOR MEMBERS WHO LOSE AHCCCS ELIGIBILITY

In the event members lose AHCCCS eligibility, PCPs/PCOs are encouraged to help inform and direct such members to available community resources where they may receive low or no-cost service. The following resources are available to members that are not covered under the AHCCCS program.

For statewide assistance

- ADHS Hotline (800) 833-4642
- Arizona Family Health Partnership
  - In Maricopa County (602) 258-5777
  - Outside Maricopa County (888) 272-5652
- Planned Parenthood (800) 230-7526

Apache County	Apache County Health Department (928) 333-2415
Coconino County	Coconino County Health Department (928) 679-7222
Gila County	Gila County Health Department (928) 425-3189
Maricopa County	Arizona Family Planning Council (602) 258-5777 Planned Parenthood (602) 265-2227
Mohave County	Kingman Area (928) 753-0714 extension 4176 Bullhead City (928) 758-0703 extension 2030 Lake Havasu (928) 453-0703 extension 3026
Navajo County	Navajo County Health Department (928) 524-4750
Pima County	Pima County Health Department (520) 243-2880 Planned Parenthood of Southern Arizona (800) 230-7526
Pinal County	Pinal County Health Department (866) 960-0633

Health Choice Arizona recognizes that providers may not always be aware of the resources available to members. We encourage your staff to contact us for assistance or have the Members contact our Member Service Department for assistance.

WELL WOMAN PREVENTATIVE SERVICES

Well-woman preventative care services are intended for the identification of risk factors for disease, medical/mental health problems, and promotion of healthy lifestyle habits to reduce or prevent risk factors for various disease processes. The well-woman preventative care visit should include at a minimum the following:

- A well exam that assess the member's overall health
- Clinical breast exam
- Pelvic Exam (as necessary, according to current recommendations and best practice standards)
- Review and administration of immunizations, screenings and testing as appropriate for age and risk factors

The following preventative health risk assessment and screenings are a covered service:

- Hypertension screening
- Cholesterol screening
- Routine mammography annually after age 40 and at any age if considered medically necessary
- Pap smears
- Colon cancer screening
- Sexually transmitted disease screenings
- Tuberculosis screening
- Human Immunodeficiency Virus (HIV) screening

- Immunizations
- Prostate screening
- Physical examinations

Screening and counseling is included as part of the well-woman preventative care visit and is focused on maintaining a healthy lifestyle and reducing harmful risks. The following is addressed during the well-woman preventative care appointment, at a minimum:

- Proper nutrition
- Physical activity
- Elevated BMI related to obesity
- Tobacco/substance use, abuse and/or dependency
- Depression screening
- Interpersonal and domestic violence screening
- Sexually transmitted infections
- Human Immunodeficiency Virus (HIV)
- Family planning counseling
- Preconception counseling includes:
    - Reproductive history and sexual practices
    - Healthy weight, nutritional supplements and folic acid intake
    - Physical exercise
    - Oral health care
    - Chronic disease management
    - Emotional wellness
    - Tobacco/substance use, including prescription drug use
    - Recommended intervals between pregnancies

If during a well-woman preventative care visit it is necessary to refer a member to a specialist the provider will initiate all referrals when the need for further evaluation, diagnosis and/or treatment is identified.

AHCCCS covers the Human Papilloma Virus (HPV) vaccine for female's members 11 to 26 years of age. AHCCCS also covers other immunizations for adults such as:

- Diphtheria-tetanus
- Influenza
- Pneumococcus
- Rubella
- Measles
- Hepatitis B
- Pertussis, as recommended by the CDC or ACIP
- Zoster vaccine, for members 60 years or older

Health Choice monitors provider compliance with providing well-woman preventative care services through a medical record audit conducted by a delegated vendor. The vendor audits random provider charts to ensure well-woman preventative care services are being performed according to Health Choice policy and AHCCCS regulations. All audit results are provided to the Quality Management Department and presented at Quality Committee at a minimum annually. Providers who fall to

pass the audit will receive a corrective action plan, which will be monitored by the Quality Management Committee. All audit results are part of Health Choice's provider case file.

STERILIZATION

Members 21 years and older can request to have a sterilization procedure if the following criteria are met:

- Member must be 21 years or older
- Member must have completed a Federal Consent Form (see Exhibit 16-3) 30 days prior to the procedure. The member must be 21 years or older when the consent is signed
- Voluntary consent was obtained without coercion (Exhibit 16.3)
- The procedure is done within 180 days from the date the consent was obtained
- Mental competency of the member has been determined
- Sterilization requires prior authorization. The physician must submit a signed and dated copy of the Federal Consent Form when requesting prior authorization
- Members may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since they gave informed consent for sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery

Health Choice Arizona enforces utilization of voluntary sterilization consent forms consistent with AHCCCS regulations. Any eligible member requesting sterilization must sign the approved Federal Consent Form (included as an attachment to this chapter) with a witness present and be offered factual information including:

- Consent form requirements
- Answers to questions regarding the specific procedure to be performed
- Notification that withdrawal of consent can occur at any time prior to surgery without affecting future care and/or loss of federally funded program benefits
- Explanation of available alternative methods
- Descriptions of the discomforts and risks that may accompany or follow the procedure. This should include an explanation of the possible effects of the anesthetic to be used
- Advantages and disadvantages that may be expected as a result of the sterilization
- Notification that sterilization cannot be performed for at least 30 days once the consent is signed
- All information should be presented to the member in a manner that is suitable to ensure that the information in the consent form is effectively communicated. Consideration of the member's English proficiency, reading skills, cultural or ethnic background, as well as the member's visual or auditory abilities must be taken into account when obtaining consent for sterilization

Bilateral Tubal Ligation (at time of delivery)

- Member must be 21 years or older

- Member must complete a Federal Consent Form (see Exhibit 16.3) and meet sterilization guidelines. The member must be 21 years or older when the consent is signed
- OB/GYN must submit a signed and dated copy of the Federal Consent Form when requesting prior-authorization
- The procedure will be done immediately after delivery
- The performance of the BTL with delivery should not extend the normal hospitalization beyond the established 48-hours for normal vaginal delivery or 96-hours for C-Section

Sterilization consents cannot be obtained when a member:

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

OBSTETRICAL SERVICES

Health Choice Arizona emphasizes the critical importance of prenatal health care. The Maternal Child Health Unit at Health Choice Arizona assists obstetrical members by facilitating access to community services and programs for pregnant women. Health Choice Arizona obstetrical providers must adhere to the American College of Obstetrics and Gynecology (ACOG) standards of care that include referrals to community resources, patient education, and maintenance of the medical record. Health Choice Arizona has staff available to assist you with any needs you may have.

Member's Choice of PCO

A Health Choice Arizona member who is known to be pregnant will choose a Health Choice Arizona Primary Care Obstetrician provider (PCO). The PCO serves as the member's Primary Care Provider throughout the course of pregnancy and six (6) weeks postpartum after a vaginal delivery, providing at least one (1) postpartum follow up visit, or eight (8) weeks postpartum following a Cesarean section, providing at least two (2) postpartum follow up visits. Health Choice Arizona encourages the PCO to see members 21-60 days post-delivery. Services as a PCP include: routine illnesses, referrals to specialists not necessarily related to pregnancy and requests for specialty medications.

Member's choice of a PCO is based on the following, but not limited to:

- Referral by the Member's PCP (must be to a contracted OB) no authorization is required
- Geographic location of the member and provider
- Availability/limitation of the PCO
- Assessment of medical risk

Primary Care Obstetrician Responsibility (PCO)

The PCO must notify Health Choice Arizona of each pregnant woman at the beginning of her prenatal care (initial visit) by faxing a completed Maternal Health Risk Assessment

for Total OB Authorization form. This Risk Assessment form is a critical component of coordinated care between Health Choice Arizona and the Obstetrician or Maternal Fetal Medicine provider and MUST be completed and submitted promptly after the member's first visit. A copy of the member's ACOG notes may be submitted in lieu of the clinical documentation requested on the Maternal Risk Assessment form as long as all of the requested information is included in the notes. The Maternal Risk Assessment should be faxed to Health Choice Arizona at (480) 760-4762. Upon receipt of the Maternal Risk Assessment, the Maternal Child Health Department will issue a Total OB Prior Authorization number to the PCO. The PCO will use this number for all professional services related to the pregnancy. See Exhibit 3.6.12 for a copy of the Maternal Health Request for Total OB Authorization form.

Health Choice Arizona as a Secondary Insurance Plan

No Prior Authorization is required when Health Choice Arizona is secondary, Except for:

- Inpatient services
- Maternal Risk Assessment form should be submitted for notification of pregnancy

Education for Pregnant Women

During your patients' pregnancy, be sure to document any and all education done by you and your staff. Important topics to discuss with your patients include proper nutrition, breast feeding, smoking cessation, physiology of pregnancy, labor and delivery process, warning signs, drug and alcohol avoidance, postpartum depression and family planning options.

OB ultrasound:

Your Total OB package authorization number can be used to bill for the two (2) routine OB ultrasounds included with the TOB. Your office does not need to obtain authorization numbers from eviCore for those two (2) OB ultrasounds. CPT codes that can be used as routine OB ultrasounds are 76801/76802, 76805/76810, 76813/76814, 76815, 76816, and 76817.

Please note that any additional OB ultrasounds require authorization by eviCore. If you have a pregnant member who presents with symptoms indicating an urgent or emergent need for an ultrasound, you may proceed with the ultrasound.

Remember, you will need to contact eviCore within three (3) business days for an authorization of the ultrasound.

eviCore contact information:

Phone number (888) 693-3211
Fax number: (888) 693-3210
Provider Portal: https://www.evicore.com/pages/providerlogin.aspx

eviCore Clinical Guidelines are available at:

http://www.evicore.com/resources/Pages/Providers.aspx

Prior Authorization and Referrals

It is the responsibility of the PCO to obtain prior authorization for services not related to the pregnancy, (i.e. if you have to refer the member out), and for services related to pregnancy but not included in the TOB authorization (e.g. MFM consults). In the event that a PCO feels the member needs to be referred to a Maternal Fetal Medicine Doctor, it is the responsibility of the PCO to contact the Maternal Fetal Medicine Doctor's office, discuss the member's condition and set up the initial appointment.

All prior authorization requests must include a copy of the member's up-to-date medical record. (Standard ACOG OB reporting forms are the preferred documentation.)

Please refer to Chapter 6 of the Provider Manual for detailed information on prior authorizations and referrals.

Women, Infants and Children

PCOs are required to educate all Health Choice Arizona pregnant members on the WIC Program as well as other appropriate community based resources geared toward healthy pregnancy outcomes. For information regarding available services in your area, please call (800) 252-5942.

Transfer of Care

If a member chooses to transfer care to another PCO, a new Maternal Risk Assessment Form needs to be completed and faxed to (480) 760-4762. A new authorization will then be issued to the new physician. Dependent upon the number of visits performed, the new PCO may receive either fee-for-service for number of visits plus the charge for the delivery or the total OB package. It is the responsibility of the transferring physician to send the medical record in a timely manner to the new physician per your contract guidelines.

In the rare event that a PCO feels the member's care needs to be transferred to a Maternal Fetal Medicine specialist, the PCO must obtain an authorization prior to transferring care. The Maternal Fetal Medicine doctor's office would be required to fill out a Maternal Risk Assessment Form and fax it to (480) 760-4762 after assuming care of the member.

Prenatal Appointments

PCOs must make it possible for Health Choice Arizona members to obtain initial prenatal care based on the standards listed in *Chapter 3: Provider Responsibility.* Providers are encouraged to use an appointment system that monitors missed appointments. Health Choice Arizona monitors appointment availability through various means. Providers who do not meet the AHCCCS standard may have a cap placed on their membership or a reduction in assigned members.

Health Choice Arizona members must be able to schedule an appointment within the

following time frames.

- First Trimester: Within 14 days of request
- Second Trimester: Within 7 days of request
- Third Trimester: Within 3 days of request
- High Risk Pregnancy: Within 3 days of identification of high-risk status or immediately if an emergency exists

Perinatal Depression Screening

PCOs must conduct a perinatal depression screening at a minimum once during the member's pregnancy. If it is determined the member needs a referral to behavioral health services the PCO can initiate the referral, the member can self-refer and/or the PCO can contact Health Choice member services for assistance. Please refer to Chapter 18: Behavioral Health Services for further guidance on the referral process. PCOs at any time during the pregnancy can make a referral to the Maternal Child Health Case Management Department for outreach and support services. If a member has a significant behavioral health concern impacting the pregnancy the OB CM will work collaboratively with a behavioral health CM to ensure the member receives all needed services to have a healthy pregnancy and baby.

EPSDT Services for OB Members

At the initial OB visit, the PCO will perform a risk assessment on all pregnant members prior to obtaining a total OB authorization number, and perform an Early and Periodic Screening Diagnostic and Treatment (EPSDT) exam for members under the age of 21. The EPSDT program is governed by federal and state regulations to provide the following EPSDT services for ages 0 through 20 years of age.

EPSDT includes, but is not limited to, coverage of:

- Inpatient and outpatient hospital services
- Laboratory and x-ray services
- Physician services, nurse practitioner services
- Medications
- Dental services
- Therapy services
- Behavioral health services
- Medical supplies
- Prosthetic devices
- Eyeglasses
- Transportation
- Family planning services

Laboratory Services for OB Members

Laboratory services for pregnant members must be referred to a Health Choice Arizona

contracted laboratory. Please refer to the Provider Directory for the contracted laboratory in your area. **Laboratory requisitions must include all appropriate diagnostic codes and all required 4th and 5th digits.**

HIV Testing for OB Members

ACOG recommends that every pregnant woman, regardless of risk, be tested for HIV as a routine part of prenatal care. Pretest and post-test counseling should be provided to all members. Documentation in the medical record of member refusal is required.

Reporting Non-Compliant OB High Risk Members

PCOs are encouraged to notify Health Choice Arizona Maternal Child Health Department at (800) 828-7514 if an OB member:

- Has a positive drug screen or a history of substance abuse
- Does not set up an initial appointment within a 4 week period
- Fails to appear for two or more prenatal visits and doesn't attempt to reschedule, or reschedules and does not show up for the rescheduled visit
- Is diabetic and is consistently complacent regarding dietary control and/or insulin usage
- Does not adhere to the prescribed regimen of bed rest
- Has preterm labor and does not take tocolytics as prescribed or does not adhere to home monitoring schedules
- Uses/abuses tobacco and/or alcohol or other substances
- Frequently visits the emergency room/urgent care or maternity outpatient setting with complaints about acute pain and frequently requests prescriptions for controlled analgesics and/or mood altering drugs
- Is at risk for domestic violence
- Shows a lack of resources which could influence well-being

PCOs are also encouraged to contact OB Case Management regarding any member identified as "High-Risk". Health Choice Arizona follows ACOG guidelines when determining "High-Risk" for OB Members.

The following conditions should be identified as "high risk":

- Previous pre-term delivery at or before 37 weeks gestation and/or delivery of an infant weighing less than 2500 grams.
- Multiple gestation pregnancy (twins or more).
- Teen pregnancies (17 years of age or younger)
- Women with complex psychological, emotional, education or physical support needs
- Non-adherent behaviors
- Current preterm labor, PIH or diabetes requiring insulin and/or nutritional education
- Premature or preterm rupture of membranes
- Homeless
- Reoccurring sexually transmitted diseases
- Substance abuse

- Domestic violence

Health Choice Arizona is contracted with home health agencies that can provide many services for the obstetrical patient. The following services can be provided with prior authorization:

- Gestational Diabetes Case Management
- Management of Preterm Labor
- Nutritional therapy
- Hyperemesis Management
- Hypertensive Disorders in Pregnancy

For more information on home care services, please contact the MCH Department.

Storkline

The Health Choice Arizona Storkline was developed as a direct line allowing members and providers access to the Health Choice Arizona Maternal Child Health Unit. Members can call and notify staff of their newly diagnosed pregnancy. Providers can call to report non-compliant or at-risk members, or to ask questions about the Maternal Child Health benefits. The Health Choice Arizona Storkline is answered Monday – Friday 7:00AM to 4:00PM. After hours, the number has a recording, which prompts the caller to leave information. The number to call is (800) 828-7514.

Reporting Births

Hospitals are required to report the birth and health status of all newborns to Health Choice Arizona Maternal Child Health Department within 12 hours of a child's birth. Health Choice Arizona Newborn Notification forms (see Exhibit 16.4) should be faxed to **(480) 760-4867.** Health Choice Arizona, in turn, reports all births to AHCCCS.

Genetic Consult and Testing

Genetic Counseling requires authorization. PCP/PCOs must submit documentation to support medical necessity when requesting prior-authorization. A specialist in Perinatal Medicine may be authorized to identify a fetus at risk for medical conditions that would require a planned delivery at a high-risk facility.
Genetic testing is only covered when the results of such testing are necessary to differentiate between treatment options. Genetic testing is not covered to determine specific diagnoses or syndromes when such diagnoses would not definitively alter the medical treatments of the member. Genetic testing is not covered to determine the likelihood of associated medical conditions occurring in the future. Genetic testing is not a covered service for purposes of determining current or future family planning.

Infertility

Treatment for infertility is not an AHCCCS or Health Choice Arizona covered service.

Pregnancy Terminations (Including Mifepristone)

Health Choice Arizona, based on AHCCCS rules and regulations, covers pregnancy termination if one of the following conditions is present:

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

Prior authorization is required for all pregnancy terminations. (See exception for medical emergencies).

The attending physician must acknowledge that a pregnancy termination has been determined medically necessary by submitting the Certificate of Medical Necessity for Pregnancy Termination in addition to the Prior Authorization request form and clinical information that supports the medical necessity for the procedure. The Certificate of Medical Necessity form is available by calling the Health Choice Arizona Maternal and Child Health Manager at (480) 760-4536. The Health Choice Arizona Chief Medical Officer will review all requests for pregnancy terminations.

Cases of Incest, Rape or Incapacitated Adult

If the pregnancy is a result of rape or incest, the following additional documentation must be included with the Certificate of Medical Necessity for Pregnancy Termination form:

- Documentation that the incident was reported to the proper authorities, including the name of the agency to which it was reported, the report number if available, and the date the report was filed. This documentation requirement must be waived if the treating physician certifies that, in his or her professional opinion, the member was unable, for physical or psychological reasons, to comply with the requirement
- A copy of the complete police report
- A written consent must be obtained from the member for all pregnancy terminations. If the member is under 18 years of age, or is 18 years of age or older and considered an incapacitated adult, a dated signature of the member's parent or legal guardian is required

Medical Emergencies

In medical emergencies, the provider must submit all documentation to Health Choice Arizona within two working days of the date on which the termination procedure was performed.

Additional Considerations Related to Use of Mifepristone

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

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

Additional Required Documentation

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

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

3. When Mifepristone is administered, the following documentation is also required:
    a. Duration of pregnancy in days
    b. The date IUD was removed if the member had one
    c. The date Mifepristone was given
    d. The date Misoprostol was given
    e. Documentation that pregnancy termination occurred

Billing and Reimbursement

Claims should not be submitted until after the delivery of the newborn or the care is transferred to another provider. Each provider should submit all prenatal services, ancillary services, and delivery of the newborn on a CMS 1500 form using the OB authorization number. Health Choice Arizona will reimburse the physician via the

contractual agreement. Review your Health Choice Arizona Subcontractor Agreement for the required minimum number of prenatal visits in order to receive the Total Global OB Package fee if applicable. The global fee reimbursement is paid to the members assigned PCO for all professional services listed in the "The Total OB Reimbursement". Reimbursements for carve-out service are listed separately on the CMS 1500. The authorization number should be listed on all claims submitted for reimbursement.

Financial reimbursement to any physician covering for the PCO is a decision between the two physicians involved. Health Choice Arizona is not responsible for payment to other than the members assigned PCO. Arrangements should be made in advanced with your covering providers.

Medical Record Review

Health Choice conducts medical record reviews systematically on all contracted Obstetricians/Gynecologists to ensure compliance with Health Choice requirements and contractual agreement. Health Choice utilizes an AHCCCS approved vendor to conduct all medical record reviews. Providers will receive a letter outlining their audit results. All audit results will be shared with the Quality Management Committee.