SECTION VI: Covered Services

COVERED SERVICES

Services covered by AHCCCS for Care1st members are determined by the AHCCCS Administration. Covered services must be medically necessary. For services that require prior authorization, please reference the Prior Authorization Guidelines.

Below is a reference list of AHCCCS-covered services. Some of these services are limited in scope or duration or available to certain populations only. The list is followed by a more detailed description of selected services that have restrictions or require additional explanation.

1. Doctor visits
2. Visits with a nurse practitioner or physician's assistant
3. Emergency care
4. Emergency transportation
5. Health check-ups including screening and assessments
6. Nutritional evaluations
7. Outpatient hospital care
8. Rehabilitation services in accordance with AHCCCS rules
9. Hospice care for all ages
10. Radiology, medical imaging, lab work and other tests
11. Chiropractic care (for members under age 21 and "QMB" members)
12. Podiatry Care
13. Maternity care
14. Family Planning
15. Well child care (EPSDT care) including immunizations
16. Behavioral health services (see Section VII)
17. Most medically necessary supplies and equipment
18. Prescriptions
19. Home health services
20. Nursing home care (if used instead of hospitalization) up to 90 days per contract year (i.e. October 1st through September 30th)
21. AHCCCS approved organ and tissue transplants and related drugs
22. Dialysis
23. Preventive dental care and treatments for members under age 21
24. Medical and surgical services related to dental (oral) care and certain pre-transplant services and prophylactic extraction of teeth for members over age 21
25. Vision care including eyeglasses for members under age 21

26. Vision care for members age 21 and over following cataract surgery and for emergency eye conditions
27. Hearing evaluations and treatment (hearing aids) for members under age 21
28. Hearing evaluations for members age 21 and over
29. Medically necessary foot care
30. Medically necessary transportation
31. Outpatient Physical Therapy (limited to 15 visits for the purpose of rehabilitation to restore a level of function and 15 visits for the purpose of keeping or getting to a level of function per contract year (10/1-9/30) for adult members 21 years and older)
32. Medically necessary orthotics

CHIROPRACTIC SERVICES

Covered services are available for members under age 21 and "QMB" (Qualified Medicare Beneficiaries). Coverage is limited to manual manipulation of the spine to correct subluxation.

CHILDREN'S REHABILITATIVE SERVICES (CRS)

CRS serves individuals under 21 years of age who has a CRS-covered condition that requires active treatment as established under A.A.C. R9-22-1303.

Anyone can fill out a CRS application form, including, a family member, provider, or health plan representative. To apply for the CRS program, a CRS application needs to be completed and mailed or faxed to the AHCCCS CRS Enrollment Unit, with medical documentation that supports that the applicant has a CRS qualifying condition.

Please submit the application with supporting documentation applicable to the diagnosis to:

AHCCCS/Children's Rehabilitative Services
Attn: CRS Enrollment Unit
801 East Jefferson MD3500
Phoenix, AZ 85034
Or
Fax to 602-252-5286

The AHCCCS CRS Enrollment Unit may also assist an applicant with completing the form. You can contact them at: 602-417-4545 or 1-855-333-7828.

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As a provider if you submit an application on the member's behalf you need to contact the Health Plan through our Care Coordination team by calling 602-778-1800 or 1-866-560-4042 TTY 711 (select option 4 then option 9). Care1st is responsible to notify the member or his/her parent/guardian that an application for CRS designation has been submitted on the member's behalf.

Website for the CRS application:
https://azahcccs.gov/Members/GetCovered/Categories/CRS.html

The definition of active treatment is a current need for treatment or anticipated treatment or evaluation for continuing treatment of the CRS qualifying condition(s) will be needed within the next 18 months from the last date of service for the treatment.

List of qualifying medical conditions is on the AHCCCS website at:
https://www.azahcccs.gov/Members/Downloads/CRS/QualifyingMedicalConditions.pdf

DENTAL

Dates of Service October 1, 2019 and After

Effective October 1, 2019 DentaQuest is administering the dental benefits for Care1st. DentaQuest manages the dental benefits provided to Care1st members on behalf of Care1st.

DentaQuest provides the following functions for Care1st and can be reached at 800.440.3408:

- Prior Authorization
- Claims Adjudication and payment (see section XI for claims information)
- Provider Credentialing
- Provider Customer Service

Dates of Service Prior to October 1, 2019

Advantica will continue to provide customer service for questions regarding prior authorization, and claims payment or covered services for dates of service prior to October 1, 2019.

- Advantica Dental Prior Authorization and Claims: 800.429.0495

Care1st will continue to provide assistance with any contract or credentialing questions prior to October 1, 2019.

- Care1st Network Management: 602.778.1800 (Options 5, 7)

AHCCCS COVERED DENTAL SERVICES

Dental services are covered for all EPSDT members age 20 and younger. This includes medically necessary dental services such as dental screenings, preventive services, therapeutic dental services, medically necessary dentures, and pre-transplantation dental services.

SECTION VI: Covered Services

All EPSDT age members, ages 20 years and younger are assigned to a Dental Home.

What is a Dental Home?
A Dental Home is the ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way, as defined by the American Academy of Pediatric Dentistry.

Member Assignment
Members are assigned to a dental home based on their age and their residence.

A member may change their assigned dental home by calling DentaQuest at 800.440.3408

Periodicity Schedule
Requirements regarding the routine preventative care of AHCCCS members may be found via the AHCCCS Dental Periodicity Schedule (AMPM Policy 431 Attachment A). The schedule is available on our website www.care1staz.com Click on *Care1st > Providers > Practice and Preventive Health Guidelines* and scroll down to the Periodicity Link.

Care1st encourages our EPSDT aged members to schedule checkups with their dentist every 6 months beginning by age one (1).

Beginning October 1, 2017, AHCCCS covers the following dental services for members 21 years and older:

- Emergency dental services up to $1000 per member per contract year (October 1 – September 30). A dental emergency is defined as "an acute disorder of oral health resulting in severe pain and/or infection as a result of pathology or trauma".
- Medical and surgical services related to dental (oral) care for members 21 years and older. Covered dental services must be related to the treatment of a medical condition such as acute pain (excluding TMJ), infection, or fracture of the jaw. Covered dental services include examining the mouth, x-rays, care of fractures of the jaw or mouth, giving anesthesia and pain medications and/or antibiotics.
- Certain pre-transplant services and prophylactic extraction of teeth in preparation for radiation treatment of cancer of the jaw, neck or head is also covered only after a transplant evaluation determines that the member is an appropriate candidate for organ or tissue transplantation.

SECTION VI: Covered Services

DENTAL GUIDELINES

DentaQuest manages the dental benefits provided to Care1st members on behalf of Care1st.

For detailed information, please reference the DentaQuest Office Reference Manual (ORM) on the DentaQuest website at www.dentaquest.com .

If you do not have internet access, you may contact DentaQuest directly at 800.440.3408 and request a hard copy of the ORM.

DENTAL CONSENT

Informed consent is a process by which the dental provider advises the member, member's parent or legal guardian of the diagnosis, proposed treatment and alternate treatment methods with associated risks and benefits of each, as well as the associated risks and benefits of not receiving treatment.

Informed consents for oral health treatment include:

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

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

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

SECTION VI: Covered Services

EMERGENCY SERVICES

DEFINITION
"Emergency Medical Condition" means a medical condition manifesting itself by the sudden onset of symptoms of acute severity, which may include severe pain such that a reasonable person would expect that the absence of immediate medical attention could result in (1) placing the member's health in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part.

EMERGENCY CARE
Care1st members are entitled to access emergency care without prior authorization. However, Care1st requires that when an enrollee is stabilized but requires additional medically-necessary health care services, that providers notify Care1st prior to, or at least during the time of rendering these services. Care1st wishes to assess the appropriateness of care and assure that care is rendered in the proper venue.

LIFE THREATENING OR DISABLING EMERGENCY
Delivery of care for potentially life threatening or disabling emergencies should never be delayed for the purposes of determining eligibility or obtaining prior authorization. These functions should be done either concurrently with the provision of care or as soon after as possible.

BUSINESS HOURS
In an emergency situation, if a member is transported to an emergency department (ED), the ED physician will contact the member's PCP as soon as possible (post stabilization) in order to give him/her the opportunity to direct or participate in the management of care.

MEDICAL SCREENING EXAM
Hospital EDs under Federal and State Laws are mandated to perform a medical screening exam (MSE) on all patients presenting to the ED. Emergency services include additional screening examination and evaluation needed to determine if a psychiatric emergency medical condition exists. Care1st will cover emergency services necessary to screen and stabilize members without prior authorization in cases where a prudent layperson acting reasonably would have believed that an emergency medical condition existed.

AFTER BUSINESS HOURS
After regular Care1st business hours member eligibility is obtained and notification is provided by calling the telephone number on the member ID card, which is the regular Customer Service telephone number. During these hours the number connects to a 24-hour information service, which is available to members as well as to providers. Nurse triage services are available in the event that a member calls for advice relating to a

clinical condition that they are experiencing during, before or after business hours. In these cases the member will be given advice or directed to go to the nearest urgent care facility, ED, or to call 911 depending on the circumstances and the nurse triage protocols.

EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT)

DESCRIPTION

EPSDT is a state-administered, federal program which provides comprehensive health care (as defined in Arizona Administrative Code R9-22-213) through primary prevention, early intervention, diagnosis and medically necessary treatment of physical and behavioral health problems for enrolled AHCCCS members under 21 years of age. EPSDT also provides for all medically necessary services to treat, correct, diminish, or ameliorate physical and behavioral conditions and illnesses, identified in an EPSDT screening. General limitations and exclusions, other than the requirement for medical necessity, do not apply to EPSDT services.

AMOUNT, DURATION AND SCOPE

EPSDT screening services are provided in compliance with the periodicity requirements of Title 42 of the Code of Federal Regulations (42 CFR) Section 441.58. Care1st is required to ensure members receive required health screenings in compliance with the AHCCCS EPSDT periodicity schedule. AHCCCS' EPSDT periodicity schedule is intended to meet reasonable and prevailing standards of medical and dental practice and specifies screening services at each stage of the child's life. The service intervals represent minimum requirements, and any services determined by a primary care provider to be medically necessary should be provided, regardless of the interval.

SCREENING REQUIREMENT

Comprehensive periodic screenings must be conducted according to the time frames identified in the AHCCCS EPSDT Periodicity Schedule, and inter-periodic screenings as appropriate for each member. The AHCCCS EPSDT Periodicity Schedule is based on recommendations by the Arizona Medical Association and is closely aligned with guidelines of the American Academy of Pediatrics. EPSDT visit must include the following:

1. A comprehensive health and developmental history (including physical, nutritional, and behavioral health assessments). For additional information, see Developmental Screening Tools below.
2. Nutritional Screening and Assessment by a PCP
3. Applicable Behavioral Health Screenings and Services provided by a PCP

4. Developmental Screening according to age

5. A comprehensive unclothed physical examination

6.. Appropriate immunizations according to age and health history

7.. Laboratory tests (including blood lead screening assessment and testing, see handbook for requirements, 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)

8.. Health education, counseling, and chronic disease self-management

9. Appropriate oral health screening, intended to identify gross tooth decay or oral lesions, conducted by a physician, physician's assistant, or nurse practitioner

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 therapies including speech therapy are also covered under EPSDT, and

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, and

    d. Traveling/immigrating from or having significant contact with individuals indigenous to endemic countries.

EPSDT SERVICE STANDARDS

EPSDT services must be provided according to community standards of practice and the AHCCCS EPSDT Periodicity Schedule. The EPSDT and Dental periodicity schedules can be found at:
https://www.azahcccs.gov/shared/MedicalPolicyManual/,
Policy 430 Attachment A and Policy 431 Attachment A.

AHCCCS EPSDT tracking forms are used to document services provided in compliance with AHCCCS standards. A copy of the tracking form is submitted to Care1st to the attention of the EPSDT Team. Age-specific EPSDT tracking forms may be ordered by submitting a completed EPSDT Order Form (available on our website under Forms of the Provider drop down menu). Tracking forms may also be downloaded at: https://www.azahcccs.gov/shared/MedicalPolicyManual/, Policy 430 Attachment E
Offices implementing electronic medical records please note: Documentation of the EPSDT visit MUST adhere to and contain all of the components found on the EPSDT tracking form. A copy of the electronic medical record is be submitted to Care1st as a replacement for the current EPSDT Tracking Form that is submitted.

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

1. **Immunizations –** All appropriate immunizations must be provided to bring and maintain each EPSDT member's immunization status up to date. EPSDT covers all child and adolescent immunizations according to the Advisory Committee on Immunization Practices Recommended Schedule. Refer to the CDC website: https://www.cdc.gov/vaccines/schedules/ for current immunization schedules. Providers must participate in the Arizona Department of Health Service (ADHS) Vaccines For Children (VFC) program to ensure the delivery of immunization services, if seeing members under the age of 19. Providers must re-enroll in the VFC Program yearly. Additionally, all immunizations given must be reported to the Arizona State Immunization Information System (ASIIS). VFC can be reached at 602.364.3642. ASIIS can be reached at 877.491.5741.

2. **Eye examinations and prescriptive lenses -** EPSDT covers eye examinations as appropriate to age according to the AHCCCS EPSDT Periodicity Schedule and as medically necessary. 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 for all members at 12 months and 24 months of age and for those members between the ages of 24 and 72 months who have not been previously tested or who missed with the 12 or 24 month test. Lead levels may be measured at other times other than those specified if thought to be medically indicated by the provider, by responses to a lead poisoning verbal risk assessment, or in response to parental concerns. Additional Screening for children under 6 years of age is based on the child's risk as determined by either the member's residential zip code or presence of other known factors. Appropriate follow up shall align with CDC recommendations for actions based on blood lead levels and ADHS recommendations.

3. **Organ and tissue transplantation services -** EPSDT covers medically necessary non-experimental organ and tissue transplants approved for Title XIX reimbursement in accordance with respective transplant policies as noted in Policy 310-DD of the AHCCCS Medical Policy Manual.

4. **Nutritional Assessment and Nutritional Therapy -** Nutritional Assessments are conducted to assist members whose health status may improve with nutrition intervention. AHCCCS covers the assessment of nutritional status provided by the member's primary care provider (PCP) as a part of the EPSDT screenings specified in the Periodicity Schedule and on an inter-periodic basis as determined necessary by the member's PCP. AHCCCS also covers nutritional assessment provided by a registered dietitian when ordered by the member's PCP. AHCCCS covers Nutritional Therapy for EPSDT members on an Enteral Nutrition, TPN Therapy, 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.

   Commercial Oral Supplemental Nutritional Feeding: 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.

   a. PA is required for commercial oral nutritional supplements unless the member is also currently receiving nutrition through enteral nutrition or TPN Therapy. 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.

   b. Medical necessity for commercial oral nutritional supplements must be determined on an individual basis by the member's PCP or specialty provider, using at least the criteria specified inAMPM Policy 430. The PCP or specialty provider must use the AHCCCS approved form, "Certificate of Medical Necessity for Commercial Oral Nutritional Supplements" to obtain PA from Care1st. The "Certificate of Medical Necessity for Commercial Oral Nutritional Supplements" form may be found at https://www.azahcccs.gov/shared/MedicalPolicyManual/, Policy 430, Attachment B.

   c. The Certificate of Medical Necessity for Commercial Oral Nutritional Supplements must document that the PCP or specialty provider has provided nutritional counseling as a part of the health risk assessment and Screening 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.

      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 for weight-for-length or BMI on the appropriate growth chart for their age and gender, as recommended by the CDC, for three months or more,
2. The member has reached a plateau in growth and/or nutritional status for more than six months or more than three months if member is less than one year of age,
3. The member has already demonstrated a medically significant decline in weight within the three month period prior to the assessment and,
4. The member is able to consume/eat no more than 25% of his/her nutritional requirements from age-appropriate food sources

Additionally, both of the following requirements must be met:

1. The member has been evaluated and treated for medical conditions that may cause problems with growth (such as feeding problems, behavioral conditions or psychosocial problems, endocrine or gastrointestinal problems), and
2. The member has had a trail of higher caloric foods, blenderized foods, or commonly available products that may be used as dietary supplements for a period no less than 30 days in duration.

6. **Oral Health Services -** As part of the physical examination, the physician, physician's assistant or nurse practitioner should perform an oral health screening. A screening is intended to identifygross dental or oral lesions (including tooth decay), , and the application of fluoride varnish, 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 should be made according to the following timeframes:

Category	Recommendation	Criteria
Urgent	Within 24 hours	Pain, infection, swelling and/or soft tissue ulceration of approximately two weeks duration or longer.
Early	Within three weeks	Decay without pain, spontaneous bleeding of the gums and/or suspicious white or red tissue areas.
Routine	Next regular checkup	None of the above problems identified.

An oral health screening should 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 periodicity schedule. Evidence of this referral should be documented on the EPSDT form. In addition to PCP referrals, EPSDT members are allowed self-referral to a dentist who is included in the provider network.

Application of fluoride varnish by a PCP during an EPSDT visit is reimbursed separately when:

1. The child is six months of age with at least one tooth erupted
2. Application of the varnish is performed by a physician, physician's assistant or nurse practitioner who has completed the appropriate training (*see **Training** section below for details on how to become certified*);
3. The varnish is billed separately from the EPSDT visit using CDT code 99188.
4. Recurrent applications may occur and be billed every six months up to two years of age

Training
To meet AHCCCS requirements for the enhanced reimbursement of services outlined above, a qualified medical professional must:
1. Complete training/certification for these services, and
2. Submit the proof of training/certification to CAQH. By submitting the proof of training/certification to CAQH, this information is accessible to all AHCCCS health plans with whom you contract.

AHCCCS recommended training for fluoride varnish application is located at http://www.smilesforlifeoralhealth.org. Refer to Training Module 6 that covers caries-risk assessment, fluoride varnish, and counseling.

DEVELOPMENTAL SCREENING TOOLS

AHCCCS approved developmental screening tools should be utilized for developmental screenings 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 during the 9 month, 18 month and 24 month EPSDT visits. A copy of the screening tool must be kept in the medical record.

Additional reimbursement may be received when:

1. One of the AHCCCS approved screening tools (listed below) is completed during a 9, 18 or 24 month EPSDT visit:
    a. Parents' Evaluation of Developmental Status (PEDS)
    b. Modified Checklist for Autism in Toddlers (M-CHAT-R/F)
    c. Ages & Stages Questionnaire (ASQ)

2. PCP is trained in the use and scoring of the developmental screening tools, as indicated by the American Academy of Pediatrics (*see **Training** section below for details on how to become certified*);
3. The screening is billed separately from the EPSDT visit using CPT code 96110 with an EP modifier.

Training
To meet AHCCCS requirements for the enhanced reimbursement of services outlined above, a qualified medical professional must:
1. Complete training/certification for these services, and
2. Submit the proof of training/certification to CAQH. By submitting the proof of training/certification to CAQH, this information is accessible to all AHCCCS health plans with whom you contract.

A list of available training resources may be found in the Arizona Department of health Services website:
www.azdhs.gov/clinicians/training-opportunities/developmental/index.php

FAMILY PLANNING SERVICES

Family planning services for male and female members are covered when provided by physicians or practitioners to members who voluntarily choose to delay or prevent pregnancy. Each year, physicians and other practitioners should discuss and document in the medical record that each member of reproductive age has been notified verbally or in writing of the availability of family planning services. Family planning services include covered medical, surgical, pharmacological and laboratory benefits specified below. Covered services also include the provision of accurate information and counseling to allow members to make informed decisions about the specific family planning methods available.

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

1. Contraceptive counseling, medication, and/or supplies, including, but not limited to: oral and injectable contraceptives, long-acting reversible contraceptives (LARCs), intrauterine devices, diaphragms, condoms, foams and suppositories. Prior to insertion of subcutaneous implantable contraceptives, the family planning provider must provide proper counseling to the eligible member to minimize the likelihood of a request for early removal. Counseling information is to include the statement to the member indicating if the device is removed within two years of insertion, the member may not be an appropriate candidate for reinsertion for at least one year after removal.

2. Associated medical and laboratory examinations including ultrasound studies related to family planning
3. Treatment of complications resulting from contraceptive use, including emergency treatment
4. Natural family planning education or referral to qualified health professionals,
5. Postcoital emergency oral contraception within 72 hours after unprotected sexual intercourse. Note: Mifepristone also know as Mifeprex or RU 486 is not postcoital emergency oral contraception, and
6. Sterilization services are covered for both male and female members when the requirements specified in Policy for sterilization services are met (including hysteroscopic tubal sterilizations).

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

1. Infertility services including diagnostic testing, treatment services or reversal of surgically induced infertility
2. Pregnancy termination counseling, or
3. Pregnancy terminations including the use of Mifepristone (Mifeprex or RU 486) and hysterectomies

Screening and treatment for Sexually Transmitted Infections (STI) are covered for both male and female members.

HOME HEALTH

Home health care is a covered service when members require part-time or intermittent care but do not require hospital care under the daily direction of a physician. Twenty-four (24) hour care is not a covered service.

HEARING

Hearing evaluation and treatment (hearing aids) are covered for members under age 21. Hearing evaluations are covered for member age 21 and older.

SECTION VI: Covered Services

LABORATORY

Sonora Quest is contracted for all outpatient laboratory work for all lines of business, lab draws in the office must be sent to Sonora Quest for processing. Service locations are available at www.sonoraquest.com by clicking the patient service center locator tab. Web-based patient service center appointment scheduling is also available and offers members the ability to schedule an appointment for a convenient day and time, resulting in reduced wait time upon arrival at a patient service center. The web based scheduling system is available 24-hr a day. Walk-in appointments are still available during scheduled hours of operation as well, although appointments are encouraged.

MATERNITY CARE

SERVICES INCLUDED IN THE TOTAL OB PACKAGE

• OB Physical Exams • Initial and subsequent history • Weight and blood pressure • Breast stimulation studies • Genetic counseling (*excludes testing) • Artificial rupture of membrane • Follow up visits • Fetal scalp monitoring • Induction of labor • Delivery (includes multiple births) • 5+ prenatal visits & 1 post partum (pap smear included) Family planning	• Laboratory services and handling fees by TOB provider Maternity counseling • Nutritional Evaluation • Inpatient & Observation services • Wet preps and wet mounts • External cephalic versions • Risk Screening per ACOG Standards • All Prenatal Visits • WIC Referrals for Medically Eligible Members • Prostaglandin Gel Insertion

SERVICES EXCLUDED FROM THE TOTAL OB PACKAGE & REIMBURSED SEPARATELY - Prior authorization may be required

• Amniocentesis • Amnioinfusion (requires prior authorization) • Colposcopy (CPT codes 56820-56821, 57420-57421, 57452, 57454-57456 and 57460-57461) • OB Ultrasound (3 or more 2D ultrasounds require prior authorization) • Non-Maternity related visits	• Post Delivery D&C (59160) • Post-partum Tubal Ligation (requires prior authorization) • RhoGAM Injection • Surgical Assist • Non-stress test • Lab Services not billed by TOB provider

SECTION VI: Covered Services

HIGH RISK PRENATAL HOME CARE INFUSION
Please contact our Case Management Team at 602.778.1800 x8301 for assistance with high risk members.

MATERNITY CARE APPOINTMENT SCHEDULING

Trimester	Timeframe
• First trimester	• Within 14 calendar days of request
• Second trimester	• Within 7 calendar days of request
• Third trimester	• Within 3 business days of request
• High risk pregnancies	• Within 3 business days of identification of high risk by the health plan or maternity care provider, or immediately if an emergency exists

Return appointments are scheduled per the ACOG standards indicated below:
- Monthly through 28 weeks
- Bi-weekly between 29 and 36 weeks
- Weekly after the 36th week

Post-partum services are to be provided per ACOG standards.

WELL WOMAN CARE
A well woman exam includes (as appropriate for age): pap smear, Chlamydia screening and referral for a mammogram. Bill with the appropriate preventive care codes. Women may self-refer to any contracted OB/GYN or be directly referred by their PCP.

OPTOMETRY/VISION

Covered services are available for members under age 21. Members may self refer to *Nationwide Vision*. Covered services per contract year (i.e. October 1st through September 30th) include:
- 1 exam
- 1 pair of prescription lenses or additional frames and glasses if medically necessary
- 1 repair of prescription lenses

ORTHOTICS AND PROSTHETICS

Orthotic and Prosthetic services are covered when medically indicated, costs less than other treatments that are as helpful for the condition and prescribed by a contracted provider for members under the age of 21.

Orthotic devices will be covered for adults, i.e. members over the age of 21, when the following apply:

a. The use of the orthotic is medically necessary as the preferred treatment option consistent with Medicare Guidelines.
b. The orthotic is less expensive than all other treatment options or surgical procedures to treat the same diagnosed condition.
c. The orthotic is ordered by a Physician or Primary Care Practitioner.

Medical equipment may be rented or purchased only if other sources, which provide the items at no cost, are not available. When prior authorization for an adult member is requested, plans are being required to obtain a completed Certificate of Medical Necessity to document medical necessity and that the criteria defined above is met.

Prosthetic services, except for microprocessor controlled lower limbs and microprocessor controlled joints for lower limbs, for adult member 21 years and older are a covered benefit.

PHARMACY

FORMULARY

The Care1st formulary, including quarterly updates, is made available on our website www.care1staz.com. Updated Drug Lists can be viewed on our website www.care1staz.com on the first day of the month following the previous quarter (ie. Quarter 2 updates are available on July1st. Providers may also contact Network Management for a copy. Please ensure that your office is prescribing medications listed on the current formularies. Before submitting the Pharmacy Prior Authorization Request Form for a non-formulary medication, consider all formulary alternatives. Prior authorization requests and supporting documentation are faxed to 602.778.8387.

Care1st utilizes the AHCCCS Drug List as mandated by Policy 310-V. Our website contains a link to the AHCCCS Drug List on the AHCCCS website

1. AHCCCS developed the AHCCCS Drug List of the medications that are available to all members when medically necessary.
2. AHCCCS' goal is to use the AHCCCS Drug List to assist providers when selecting clinically appropriate medications for AHCCCS members.
3. The AHCCCS Drug List is not an all-inclusive list of medications.
4. The AHCCCS Drug List specifies medications available without prior authorization as well as medications that have specific quantity limits, or require step therapy and/or prior authorization prior to dispensing to AHCCCS members.
5. Health plans are required to cover all medically necessary, clinically appropriate, cost effective medications that are federally and state reimbursable.
6. Care1st's formulary is more expansive – it includes the medications listed on the AHCCCS Drug List and additional drugs necessary to meet the needs of our specific patient population. The drugs fall into the following categories:

- Preferred
- Non Preferred
- Step Therapy
- Non Formulary
- Excluded
- Prior Authorization

The Prescription Benefit Manager manages all prescription drug transactions and pharmacy networks for all lines of business.

SPECIALTY MEDICATIONS PURCHASING PROGRAM

Specialty oral and injectable drugs may be obtained through our contracted vendor. Please use the following procedure to procure specialty drugs:

Prior Authorization Process

- Complete the Pharmacy Prior Authorization Request and fax to us at 602.778.8387.

- Once approved, the Pharmacy Department will fax back the approval to the practice and the specialty pharmacy.

The specialty pharmacy will process the order, reaching out to the provider if necessary, and ship the medication.
Prior authorization requests must first come to the health plan before an order is placed. If prior authorization is not obtained before the order is placed, the plan decision and patient care may be delayed.

*This program does not include vaccines. Please review the Prior Authorization Guidelines for J and Q codes that require prior authorization. In addition, all unclassified drugs (i.e. J3490, J9999) require prior authorization and are evaluated on a case by case basis for approval and reimbursement.

Contact Pharmacy Prior Authorization at 602.778.1800 (Options 5, 5) if you have any questions.

PODIATRY

The following medically necessary podiatric services are covered for members:

- Casting for the purpose of construction or accommodating orthotics
- Orthopedic shoes that are an integral part of a brace
- Foot care for patients with severe systemic disease which prohibits care by a nonprofessional person
- Bunions with underlying neuroma

Non-covered services include:

- Treatment of fungal (mycotic) infections without underlying systemic disease
- Painful bunions without laceration

SECTION VI: Covered Services

RADIOLOGY

Radiology services required in the course of diagnosis, prevention, treatment and assessment are covered services.

REHABILITATION

OCCUPATIONAL THERAPY

Occupational therapy services are medically prescribed treatments to improve or restore functions which have been impaired by illness or injury, or which have been permanently lost or reduced by illness or injury. Occupational therapy is intended to improve the member's ability to perform those tasks required for independent functioning.

Amount, Duration and Scope: Care1st covers medically necessary inpatient and outpatient occupational therapy services for all members. Outpatient occupational therapy visits are limited to 15 rehabilitation visits and 15 habilitation visits for a total of 30 OT visits per contract year (October 1 – September 30) for adult members 21 years and older. Append modifier GO to the billing code for OT services.

Inpatient occupational therapy consists of evaluation and therapy. Therapy services may include:

a. Cognitive training
b. Exercise modalities
c. Hand dexterity
d. Hydrotherapy
e. Joint protection
f. Manual exercise
g. Measuring, fabrication or training in use of prosthesis, arthrosis, assistive device, or splint
h. Perceptual motor testing and training
i. Reality orientation
j. Restoration of activities of daily living
k. Sensory re-education, and
l. Work simplification and/or energy conservation

PHYSICAL THERAPY

Physical therapy is a covered service when provided by, or under the supervision of, a registered physical therapist to restore, maintain or improve muscle tone, joint mobility or physical function.

Amount, Duration and Scope: Care1st covers medically necessary physical therapy services for all members. Physical therapy is covered on an inpatient and outpatient basis. Outpatient physical therapy visits are limited to 15 visits for the purpose of rehabilitation to restore a level of function and 15 visits for the purpose of keeping or getting to a level of function per contract year (10/1-9/30) for adult members 21 years and older.

SPEECH THERAPY

Speech therapy is the medically prescribed provision of diagnostic and treatment services provided by, or under, the direct supervision of a qualified speech pathologist.

Amount, Duration and Scope: Care1st covers medically necessary speech therapy services provided to all members who are receiving inpatient care at a hospital (or a nursing facility) when services are ordered by the member's PCP. Speech therapy provided on an outpatient basis is covered only for members under the age of 21 receiving EPSDT services, KidsCare and ALTCS members.

Inpatient speech therapy consists of evaluation and therapy. Therapy services may include:

a. Articulation training
b. Auditory training
c. Cognitive training
d. Esophageal speech training
e. Fluency training
f. Language treatment
g. Lip reading
h. Non-oral language training
i. Oral-motor development, and
j. Swallowing training

TRANSPORTATION

Medically necessary transportation to and from contracted providers is a covered services for members who are not able to arrange or pay for transportation. Members are responsible for contacting Customer Service to arrange transportation 3 days prior to a routine appointment.

NON-COVERED SERVICES

In response to significant fiscal challenges facing the State and continuing growth in the Medicaid population, AHCCCS implemented several changes to the adult benefit package. The changes to the benefit package impact ***all*** adults 21 years of age and older, unless otherwise specified.

Complete information regarding benefit changes can be found on the AHCCCS website: https://www.azahcccs.gov/Resources/Legislation/sessions/BenefitChanges.html

AHCCCS EXCLUDED BENEFITS TABLE FOR ADULTS 21 YEARS AND OLDER

Bone-Anchored Hearing Aids	AHCCCS will eliminate coverage of Bone-Anchored Hearing AID (BAHA). Supplies, equipment maintenance and repair of component parts will remain a covered benefit. Documentation that establishes the need to replace a component not operating effectively must be provided at the time prior authorization is sought.	L8690, L8692
Cochlear Implants	AHCCCS will eliminate coverage of cochlear implants. Supplies, equipment maintenance and repair of component parts will remain a covered benefit. Documentation that establishes the need to replace a component not operating effectively must be provided at the time prior authorization is sought.	L8614
Prosthetics	AHCCCS is limiting this benefit change to apply only to the elimination of microprocessor controlled lower limbs and microprocessor controlled joints for lower limbs.	L5856, L5857, L5858 and L5973