# 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 SERVICES

The Health Plan has a comprehensive dental network for members. To serve the needs of its members, the health plan partners with Envolve Dental who administers the health plan's dental benefits. Dental Providers must submit claims and prior authorizations to Envolve Dental, or by phone at 844-876-2028.

The Health Plan offers dental services for:

- Oral Health Care for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) aged members
- EPSDT and Oral Health services through the RBHA are covered only for members 18 to 21 years of age. All other members receive Oral Health and EPSDT services up to 21 years of age.
- Preventive dental services for EPSDT Members under the age of 21 years
- Therapeutic Dental Services for members under 21
- Emergency Dental Coverage for members under 21
- PCP Fluoride Varnish Application for children up to 5 years of age

Eligible EPSDT Members up to the age of 21 years old have comprehensive dental service benefits which include preventive, therapeutic and emergency dental services. All members age out of the Oral Health & EPSDT program and services at age 21.

If a member does not qualify under their dental eligibility and a medical condition is present, medical necessity is determined by the health plan. Medical documentation is required and must be submitted directly to the health plan for review and prior authorization determination.

Dental Providers should include parent/guardian or caregivers in all consultations and counseling of members regarding preventive oral health care and the clinical findings.

The Health Plan adheres to the Dental Uniform Prior Authorization List and the Uniforms Warranty List as outlined in AHCCCS AMPM Policy 431.

## Oral Health Care for Early and Periodic Screening, Diagnosis and Treatment aged members

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 Contract:

- URGENT - As expeditiously as the member's health condition requires but no later than three business days from the request
- ROUTINE - Within 45 days of request·

PCPs must refer EPSDT members for appropriate services based on needs identified through the screening process and for routine dental care based on the AHCCCS EPSDT Periodicity Schedule (AMPM Chapter 430). Evidence of this referral must be documented on the AHCCCS Clinical Visit Sample Template and in the member's medical record.

EPSDT Members may select a dentist within the health plans contracted network and receive preventive dental services without a referral.

## PCP Application of Fluoride Varnish

Physicians who have completed the AHCCCS required training may be reimbursed for fluoride varnish applications completed at the EPSDT Well Child Visit for members as often as every three months up to 5 years of age, after the eruption of the first tooth.

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. Upon completion of the required training, providers should upload a copy of their certificate to the Council for Affordable Quality Healthcare (CAQH) site. Providers should also submit a copy of their certification to the Health Planvia fax at (855) 872-1858 or email to HEDIS_Operations@azcompletehealth.com. This certificate is used in the credentialing process to verify completion of training necessary for reimbursement. 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 must 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 (AMPM Chapter 431, Attachment A). Evidence of this referral must be documented on the AHCCCS Clinical Visit Sample Template and in the member's medical record.

## Preventive Dental Services

Preventive dental services provided as specified in the AHCCCS Dental Periodicity Schedule AHCCCS AMPM 431, Attachment A, https://www.azahcccs.gov/shared/MedicalPolicyManual/, including but not limited to:

- Diagnostic services include comprehensive and periodic examinations. The Health Plan allows two oral examinations and two oral prophylaxes per member per year for all members up to 21 years of age. For members up to five (5) years of age, fluoride varnish may be applied four times a year (i.e., one every three months). Additional examinations or treatments shall be deemed medically necessary;
- Radiology services screening for diagnosis of dental abnormalities and/or pathology, including panoramic or full-mouth x-rays, supplemental bitewing x-rays, and occlusal or periapical films, as medically necessary and following the recommendations by the American Academy of Pediatric Dentistry (AAPD); and
- Panorex films are covered as recommended by AAPD, up to three times maximum per provider for members between ages three (3) to twenty (20). Additional panorex films needed above this limit must be deemed medically necessary through the health plan prior authorization process. Preventive services, including:

Preventive services, including:

- Oral prophylaxis performed by a dentist or dental hygienist which includes self-care oral hygiene instructions to member, if able, or to the parent/ legal guardian;
- Application of topical fluoride varnish. The use of a prophylaxis paste containing fluoride or fluoride mouth rinses do not meet the AHCCCS standard for fluoride treatment;
- Dental sealants for first and second molars are covered every three years up to age 15, with a two- time maximum benefit. Additional applications must be deemed medically necessary and require prior authorization through The Health Plan;
- Space maintainers when posterior primary teeth are lost and when deemed medically necessary through The Health Plan prior authorization process.

## Therapeutic Dental Services

All therapeutic dental services will be covered when they are considered medically necessary and cost effective but may be subject to PA by the health plan.

These services include, but are not limited to:

- Periodontal procedures, scaling/root planing, curettage, gingivectomy, and osseous surgery;
- Crowns:
    - When appropriate, stainless-steel crowns may be used for both primary and permanent posterior teeth; composite, prefabricated stainless steel crowns with a resin window or crowns with esthetic coatings should be used for anterior primary teeth; or
    - Precious or cast semi-precious crowns may be used on functional permanent endodontically treated teeth, except third molars, for members who are 18 to 21 years of age.
- Endodontic services including pulp therapy for permanent and primary teeth, except third molars (unless a third molar is functioning in place of a missing molar);
- Restoration of carious permanent and primary teeth with accepted dental materials other than cast or porcelain restorations unless the member is 18 to 21 years of age and has had endodontic treatment;
- Restorations of anterior teeth for children under the age of five, when medically necessary. Children, five years and over with primary anterior tooth decay should be considered for extraction, if presenting with pain or severely broken-down tooth structure, or be considered for observation until the point of exfoliation as determined by the dental provider;
- Removable dental prosthetics, including complete dentures and removable partial dentures; and
- Orthodontic services and orthognathic surgery are covered only when these services are necessary to treat a handicapping malocclusion. Services must be medically necessary and determined to be the primary treatment of choice or an essential part of an overall treatment plan developed by both the PCP and the dentist in consultation with each other. Orthodontic services are not covered when the primary purpose is cosmetic.

Examples of conditions that may require orthodontic treatment include the following:

1. Congenital craniofacial or dentofacial malformations requiring reconstructive surgical correction in addition to orthodontic services;
2. Trauma requiring surgical treatment in addition to orthodontic services; or
3. Skeletal discrepancy involving maxillary and/or mandibular structures.

## Emergency Dental Coverage for Members under 21 Years of Age

EPSDT covers the following dental services:

Emergency dental services including:

1. Treatment for pain, infection, swelling and/or injury;
2. Extraction of symptomatic (including pain), infected and non-restorable primary and permanent teeth, as well as retained primary teeth (extractions are limited to teeth which are symptomatic); and
3. General anesthesia, conscious sedation or anxiolysis (minimal sedation, members respond normally to verbal commands) when local anesthesia is contraindicated or when management of the member requires it. (See AHCCCS AMPM Policy 430, Section E, Item No. 8 regarding conscious sedation.)

## Dental Services Not Covered For EPSDT Age Members

Orthodontic services are not covered when the primary purpose is cosmetic. Extraction of asymptomatic teeth are generally not covered services; this includes third molars. Services or items furnished solely for cosmetic purposes are not covered.

## Emergency Dental Coverage For Members 21 Years of Age and Older

Medically necessary emergency dental care and extractions are covered for persons age 21 years and older who meet the criteria for a dental emergency. A dental emergency is an acute disorder of oral health resulting in severe pain and/or infection as a result of pathology or trauma.

AHCCCS covers the following dental services provided by a licensed dentist for members who are 21 years of age or older:

1. Emergency dental services up to $1000 per member per contract year (October 1st to September 30th) as a result of A.R.S. §36-2907. The emergency dental services are described in subsection A;
2. Medical and surgical services furnished by a dentist only to the extent such services may be performed under state law either by a physician or by a dentist when such services would be considered a physician service if furnished by a physician (A.A.C. R9-22-207);
3. These services must be related to the treatment of a medical condition such as acute pain (excluding Temporomandibular Joint Dysfunction [TMJ] pain), infection, or fracture of the jaw. Covered services include a limited problem focused

examination of the oral cavity, required radiographs, complex oral surgical procedures such as treatment of maxillofacial fractures, administration of an appropriate anesthesia and the prescription of pain medication and antibiotics. Diagnosis and treatment of TMJ is not covered except for reduction of trauma. Services described in this paragraph are not subject to the $1000 adult emergency dental limit.

The following services and procedures are covered as emergency dental services:

1. Emergency oral diagnostic examination (limited oral examination – problem focused);
2. Radiographs and laboratory services, limited to the symptomatic teeth;
3. Composite resin due to recent tooth fracture for anterior teeth;
4. Prefabricated crowns, to eliminate pain due to recent tooth fracture only;
5. Recementation of clinically sound inlays, onlays, crowns, and fixed bridges;
6. Pulp cap, direct or indirect plus filling;
7. Root canals and vital pulpotomies when indicated for the treatment of acute infection or to eliminate pain;
8. Apicoectomy performed as a separate procedure, for treatment of acute infection or to eliminate pain, with favorable prognosis;
9. Immediate and palliative procedures, including extractions if medically necessary, for relief of pain associated with an oral or maxillofacial condition,
10. Tooth reimplantation of accidentally avulsed or displaced anterior tooth, with favorable prognosis;
11. Temporary restoration which provides palliative/sedative care (limited to the tooth receiving emergency treatment);
12. Initial treatment for acute infection, including, but not limited to, periapical and periodontal infections and abscesses by appropriate methods;
13. Preoperative procedures and anesthesia appropriate for optimal patient management; and
14. Cast crowns limited to the restoration of root canal treated teeth only.

***Follow up procedures necessary to stabilize teeth as a result of the emergency service are covered and subject to the $1000 limit.***

## Limitations

Adult Emergency Dental Services Limitations for Persons age 21 Years and Older.

Maxillofacial dental services provided by a dentist are not covered except to the extent prescribed for the reduction of trauma, including reconstruction of regions of the maxilla and mandible.

Diagnosis and treatment of temporomandibular joint dysfunction (TMD or TMJ) is not covered except for the reduction of trauma.

Routine restorative procedures and routine root canal therapy are not emergency dental services and are not covered.

Treatment for the prevention of pulpal death and imminent tooth loss is limited to non-cast fillings, crowns constructed from pre-formed stainless steel, pulp caps, and pulpotomies only for the tooth causing pain or in the presences of active infection.

Fixed bridgework to replace missing teeth is not covered.

Dentures are not covered.

## Exceptions for Transplants and Members with Cancer

I. Transplant Cases

- For members who require medically necessary dental services as a pre-requisite to AHCCCS covered organ or tissue transplantation, covered dental services are limited to the elimination of oral infections and the treatment of oral disease. Covered dental services are limited to the following:
- Dental cleaning (Prophylaxis);
- Treatment of periodontal disease;
- Medically necessary extractions;
- Simple restorations. A simple restoration means silver amalgam and/or composite resin fillings, stainless steel crowns or preformed crowns.

The health plan covers these services only after a transplant evaluation determines that the member is an appropriate candidate for organ or tissue transplantation. These services are not subject to the $1000 adult emergency dental limit.

II. Members with Cancer

Covered dental services are limited to the following:

- Prophylactic extraction of teeth in preparation for radiation treatment of cancer of the jaw, neck or head is also covered. These services are not subject to the $1000 adult emergency dental limit.

III. Members on Ventilators

- Cleanings for members who are in an inpatient hospital setting and are placed on a ventilator or are physically unable to perform oral hygiene are covered for dental

cleanings performed by a hygienist working under the supervision of a physician. These services are not subject to the $1,000 adult emergency dental limit. If services are billed under the physician, then medical codes will be submitted and are not subject to the $1000 adult emergency dental limit.

## Charging of Members

Emergency dental services of $1000 per contract year are covered for AHCCCS member's age 21 years and older. Billing of AHCCCS members for emergency dental services in excess of the $1000 annual limit is permitted only when the provider meets the requirements of A.A.C R9-22-702 and A.A.C. R9-28-701.10.

In order to bill the member for emergency dental services exceeding the $1000 limit, the provider must first inform the member in a way s/he understands, that the requested dental service exceeds the $1000 limit and is not covered by AHCCCS. Before providing the dental services that will be billed to the member, the provider must furnish the member with a document to be signed in advance of the service, stating that the member understands that the dental service will not be fully paid by AHCCCS and that the member agrees to pay for the amount exceeding the $1000 emergency dental services limit, as well as services not covered by AHCCCS.

The member must sign the document before receiving the service in order for the provider to bill the member. It is expected that the document contains information describing the type of service to be provided and the charge for the service.

## Informed Consent

Informed consent is a process by which the provider advises the member, member's guardian, and/or designated representative 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.

1. Informed consent for oral health treatment:
    1. A written consent for examination and/or any 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, and
    2. A separate written consent for any irreversible, invasive procedure, including but not limited to dental fillings, pulpotomies, etc. In addition, a written treatment plan shall be reviewed and signed by both parties, as described below, with the member/ guardian/designated representative receiving a copy of the complete treatment plan.
2. All providers shall 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 the member, member's guardian, and/or designated representative. This requirement extends to all Contractor mobile unit providers. Consents and treatment plans shall be in writing, signed and dated by both the provider and the patient or patient's representative, if the patient is a) under 18 years of age or b) is 18 years of age or older and considered an incapacitated adult (as specified in A.R.S. §14-5101). Completed consents and treatment plans shall be maintained in the members' chart and are subject to audit.

## Facility and Anesthesia Charges

Adult members requiring general anesthesia in an ambulatory service center or outpatient hospital the general anesthesia are subject to the $1000 emergency dental limit.

Dentist performing general anesthesia on adult emergency members must bill dental codes that count towards the $1000 adult emergency benefit.

Physicians performing general anesthesia on adult emergency members for a dental procedure must bill medical codes and it will count towards the $1000 emergency dental limit.

## Dental Referrals

Dental services may be initiated by a Primary Care Provider (PCP) through referral to a participating dental provider, the member or member's legal guardian. No referral is required for an eligible member to make a dental appointment or receive dental care from one of the contracted health plan dental providers. Prior authorizations may be required for therapeutic services.

The AHCCCS EPSDT Periodicity Schedule gives providers necessary information regarding timeframes in which age-related required screenings and services must be provided. Depending on the results of the oral health screening, a referral to a dentist must be made.

PCP Providers must:

- Encourage Members who call for a dental referral to obtain any routine or follow up care and document all referrals in the Member's medical record.
- Identify appropriate dental services based on needs
- Document evidence of referrals on the AHCCCS Clinical Visit Sample Template or in the member's electronic medical records;
- Refer members for a dental assessment if their oral health screening reveals potential carious lesions or other conditions requiring assessment and/or treatment

by a dental professional according to the AHCCCS EPSDT Dental Periodicity Schedule (AMPM Chapter 431, Attachment A)..
- Encourage eligible Members to see a dentist regularly;
- Obtain appropriate prior authorization before rendering non-emergency dental services.

Although the AHCCCS Dental Periodicity Schedule (AMPM Chapter 431, Attachment A) identifies when routine referrals begin, PCP's 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 dentists who are in the health plan provider network.

## Dental Home Assignment for EPSDT age Members under the age of 21

The American Academy of Pediatric Dentistry (AAPD) defines the dental home as the ongoing relationship between dentist and the member, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. The dental home must include:

1. Comprehensive oral health care, including acute care and preventive services in accordance with the Arizona Health Care Cost Containment System (AHCCCS) Dental Periodicity Schedule;
2. Comprehensive assessment for oral diseases and conditions;
3. Individualized preventive dental health program based upon a caries-risk assessment and a periodontal disease risk assessment;
4. Anticipatory guidance about growth and development issues (such as teething, digit or pacifier habits);
5. Plan for acute dental trauma;
6. Information about proper care of the child's teeth and gingivae. This would include the prevention, diagnosis, and treatment of disease of the supporting and surrounding tissues and the maintenance of health, function and esthetics of those structures and tissues;
7. Dietary counseling; and
8. Referrals to dental specialists when care cannot directly be provided within the dental home.

Members must be assigned to a dental home by age one and seen by a dentist for routine preventive care according to the AHCCCS Dental Periodicity Schedule (AHCCCS AMPM Chapter 400, Exhibit 431- Members must also be referred for additional oral health care concerns requiring additional evaluation and/or treatment.

A member may change their assigned dental home by calling Care1st Member Services at 1-866-560-4042.

## Provider Request for Dental Home Re-assignment of an EPSDT Age Member

Dental home providers can request that a covered member be removed from their panel by issuing the person a written notice and allowing up to 60 days for assignment to a new dental home provider.

# 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*

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is a comprehensive child health program of prevention, treatment, correction, and improvement (amelioration) of physical and behavioral/mental health conditions for AHCCCS members up to 21 years of age. The purpose of EPSDT is to ensure the availability and accessibility of health care resources, as well as to assist Medicaid 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 conditions for AHCCCS members up to 21 years of age. EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary, mandatory, and optional services listed in Federal Law 42 USC 1396d (a) to correct or ameliorate defects and physical and behavioral/mental illnesses and conditions identified in an EPSDT screening, whether or not the services are covered under the AHCCCS State Plan. Members receiving EPSDT and Oral Health services through the RBHA are only covered for members 18 up to 21 years of age. All members age out of Oral Health & EPSDT services at age 21. 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. EPSDT services include all screenings and services described below, as well as the referenced AHCCCS EPSDT Periodicity Schedule, (AMPM Chapter 430, Attachment A [Insert link: https://www.azahcccs.gov/shared/MedicalPolicyManual/]) and the AHCCCS Dental Periodicity Schedule, (AMPM Chapter 431, Attachment A [Insert link: https://www.azahcccs.gov/shared/MedicalPolicyManual/]).

# SECTION VI: Covered Services

## EPSDT Coverage

EPSDT coverage includes the following:

1. Immunizations;
2. Blood Lead Screening;
3. Covered Services (refer to AHCCCS AMPM, Chapter 310 [Insert link: https://www.azahcccs.gov/shared/MedicalPolicyManual/] for detailed coverage);
4. Metabolic Medical Foods;
5. Nutritional Therapy;
6. Oral Health Services;
7. Cochlear and Osseointegarted Implantation;
8. Conscious Sedation;
9. Behavioral Health Services;
10. Religious Non-Medical health care Institution Services;
11. Care Management Services;
12. Chiropractic Services;
13. Personal care;
14. Incontinence Briefs;
15. Medically Necessary therapies.

In addition, federal and State law govern the provision of EPSDT services for Members under the age of 21 years. The provider is responsible for providing these services to pregnant Members under the age of 21 unless the Member has selected an Obstetrics (OB) provider to serve as both the OB and Primary Care Provider. In that instance, the OB provider must provide EPSDT services to the pregnant Member.

EPSDT includes, but is not limited to, coverage of: inpatient and outpatient hospital services, laboratory and x-ray services, physician services, naturopathic services; nurse practitioner services, medications, dental services, therapy services, behavioral health services, medical equipment; medical appliances; and medical supplies, orthotics, prosthetic devices, eyeglasses, transportation, and family planning services. EPSDT also including a comprehensive history, developmental and behavioral health screenings, comprehensive unclothed physical examination, appropriate vision testing, hearing testing, laboratory tests, dental screenings and immunizations. 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.

## PCP EPSDT Regulatory Requirements

# SECTION VI: Covered Services

PCPs are required to comply with EPSDT regulatory requirements, including the following:

1. Provide EPSDT services in accordance with Section 42 USC 1396d (a) and (r), 1396a (a) (43), 42 C.F.R. 441.50 et seq. and AHCCCS rules and policies;
2. Providers must complete a Developmental screening (using an AHCCCS-approved developmental screening tool) for members ages 9, 18 and 30 months;
3. Providers must complete the Autism Spectrum Disorder (ASD) Specific Developmental Screening at the 18 month and 24 month visits;
4. Document immunizations within 30 days of administration of an immunization into the Arizona State Immunization Information System (ASIIS);
5. Enroll every year in the Vaccines for Children (VFC) program;
6. Providers must use and complete all applicable elements of the AHCCCS EPSDT Clinical Sample Templates as required by the AHCCCS AMPM, Chapter 430, Section A [insert link: https://www.azahcccs.gov/shared/MedicalPolicyManual/], (or an electronic equivalent that includes all components from the hard-copy form);
    - AHCCCS EPSDT Clinical Sample Template located within the AHCCCS AMPM Chapter 430, Attachment E.
7. Provide and document EPSDT screening services in accordance with the AHCCCS EPSDT and Dental Periodicity Schedules AHCCCS EPSDT Periodicity Schedule (AHCCCS AMPM, Chapter 430, Attachment A [insert link: https://www.azahcccs.gov/shared/MedicalPolicyManual/]) and the Dental Periodicity Schedule (AHCCCS AMPM Chapter 431, Attachment A [insert link: https://www.azahcccs.gov/shared/MedicalPolicyManual/], ),
8. Refer members for follow up, diagnosis and treatment, ensuring that treatment is initiated within 60 days of screening services;
9. If appropriate, document in the medical record the member's or legal guardian's decision not to utilize EPSDT services or receive immunizations;
10. Document a health database assessment on each EPSDT participant. The database must be interpreted by a physician or licensed health professional who is under the supervision of a physician, and provide health counseling/education at initial and follow up visits;
11. Ensure all infants receive both the first and second newborn screening tests;
12. Ensure all infants with confirmed hearing loss receive services prior to turning six months of age;
13. Implement protocols for care and coordination of members who received Tuberculosis (TB) testing to ensure timely reading of the TB skin test and treatment, if medically necessary;
14. Send copies of the completed EPSDT Clinical Sample Templates to the health plan's Quality Management Department by secure fax at (844)266-5339;
15. Providers must verify that Members receive EPSDT services in compliance with the AHCCCS EPSDT Periodicity Schedule (AHCCCS AMPM, Chapter 430,

Attachment A) and the Dental Periodicity Schedule (AHCCCS AMPM Chapter 431, Attachment A), https://www.azahcccs.gov/shared/MedicalPolicyManual/;

16. Schedule the next appointment at the time of the current office visit for children ages 24 months and younger;
17. Claims for EPSDT services must be submitted on a CMS (formerly HCFA) 1500 form. Providers must bill for preventative EPSDT services using the preventative service, office or other outpatient services and preventive medicine CPT codes (99381 – 99385, 99391 – 99395) with an EP modifier;
18. Refer members to Children's Rehabilitative Services (CRS) when they have conditions covered by the CRS program;
19. Initiate and coordinate referrals to ALTCS, Audiology, DDD, Dental, Occupational Therapy, Physical Therapy, Speech, Developmental, behavioral health, Women, Infants and Children (WIC), the Arizona Early Intervention Program (AzEIP) and Head Start as necessary.

Hospital or birthing center shall screen all newborns using a physiological hearing screening method prior to initial hospital discharge, including outpatient re-screening for babies who were missed or are referred from the initial screening. Outpatient re-screening shall be scheduled at the time of the initial discharge and completed between two and six weeks of age. Additionally, when there is an indication that a newborn or infant may have a hearing loss or congenital disorder, the family shall be referred to the PCP for appropriate assessment, care coordination and referral(s).

## An EPSDT Well-Child Basic Elements

A Well-Child exam includes the following elements:

1. Comprehensive health and developmental history, including growth and development screening 42 CFR 441.56(b)(1) which includes physical, nutritional, and behavioral health assessments;
2. Developmental screening. Providers are required to complete a developmental screening (using an AHCCCS-approved developmental screening tool) for members during visits at ages 9, 18 and 30 months. However, any time there is a potential developmental concern, it is appropriate for providers to screen the member. Developmental survey items are part of each EPSDT visit so that if concerns are noted, a screening can be done;
3. Autism Spectrum Disorder (ASD) Specific Developmental Screening at the 18 month and 24 month visits;
4. A comprehensive unclothed physical examination;
5. Provide appropriate immunizations according to age and health history;
6. Laboratory tests appropriate to age and risk for blood lead, tuberculosis skin testing, anemia testing and sickle cell trait;

7. Health education, counseling, chronic disease self-management, counseling about child development, healthy lifestyles and accident and disease prevention;
8. An oral health screening must be part of an EPSDT screening conducted by a Primary Care Provider; however, it does not replace the need for examination through direct referral to a Dentist;
9. Fluoride varnish application as often as every three months between the ages of 6 months and 2 years of age, after the eruption of the first tooth (by providers who have completed training);
10. Provide appropriate vision and hearing/speech testing;
11. Nutritional Screening by a PCP;
12. Nutritional Assessment by a PCP;
13. Obesity screening using the body mass index (BMI) percentile for children (or weight-for-length percentile for members less than two years of age);
14. Behavioral health screening, referrals, and services;
15. Tuberculin skin testing as appropriate to age and risk. Children at increased risk of Tuberculosis (TB) include those who have contact with persons;
    - Confirmed or suspected as having TB,
    - In jail or prison during the last five years,
    - Living in a household with an HIV-infected person or the child is infected with HIV, and
    - Traveling/emigrating from, or having significant contact with persons indigenous to, endemic countries.
16. Provide Anticipatory Guidance;
17. Vision exam appropriate to age, according to the AHCCCS EPSDT Periodicity Schedule; and
18. Documentation of the member's AHCCCS Identification number on the AHCCCS EPSDT Clinical Sample Templates or electronic medical record.

## Vision Coverage for EPSDT Aged Members

The Health Plan covers eye and optometric services provided by qualified eye/optometry professionals within certain limits based on Member age and eligibility. All vision services related to medical issues should be verified with the Health Plan. Emergency eye care, which meets the definition of an emergency medical condition, is covered for all Members. For Members who are 21 years of age or older, treatment of medical conditions of the eye, excluding eye examinations for prescriptive lenses and the provision of prescriptive lenses, are covered through the Health Plan. Vision examinations and the provision of prescriptive lenses are covered for Members under the EPSDT program and for adults when medically necessary following cataract removal. Cataract removal is a covered medical service for all eligible Members with certain conditions. For more information, visit the AHCCCS website under Medical Policy for AHCCCS Covered Services.

Appropriate vision screenings are covered during an EPSDT visit. EPSDT benefits cover eye examinations as appropriate to age according to the AHCCCS EPSDT Periodicity

Schedule (AHCCCS AMPM, Chapter 430, Attachment A) and as medically necessary using standardized visual tools. Payment for vision and hearing exams, (including, but not limited to CPT codes 92015, 92081, 92285, 92551, 92552, 92553, 92567, 92568, 92285, 92286, 92587, 92588, 95930, and 99173) or any other procedure that may be interpreted as fulfilling the vision requirements provided in a PCP's office during an EPSDT visit, are considered part of the EPSDT visit and are not a separately billable service.

Ocular photoscreening with interpretation and report, bilateral (CPT code 99177) is covered for children aged three to five as part of the EPSDT visit due to challenges with a child's ability to cooperate with traditional vision screening techniques. Ocular photoscreening is limited to a lifetime coverage limit of one. This procedure, although completed during the EPSDT visit, is a separately billable service through the Health Plan. Automated visual screening, described by CPT code 99177, is for vision screening only, and not recommended for or covered by AHCCCS when used to determine visual acuity for purposes of prescribing glasses or other corrective devices. All vision services related to medical issues should be verified with the Health Plan. Coverage for EPSDT members includes:

- Medically necessary emergency eye care, vision examinations, prescriptive lenses, frames for eyeglasses and treatments for conditions of the eye;
- PCPs are required to provide initial vision screening in their office as part of the EPSDT program. Vision exams provided in a PCP's office during an EPSDT visit are not a separately billable service;
- Replacement of lost or broken glasses, or due to a change in prescription is a covered benefit.

Vision CPT codes with the EP modifier must be listed on the claim form in addition to the preventive medicine CPT codes for visit screening assessment. With the exception of CPT code 99177, no additional reimbursement is allowed for these codes.

Medical condition-related and preventive vision services including hardware should be billed through the Health Plan. Providers can verify all non-emergency services with the appropriate entity in advance of care, as needed.

## Sick Visit Performed in Addition to an EPSDT Visit

Billing of a "sick visit" at the same time as an EPSDT if a separately billable service if:

https://www.azahcccs.gov/PlansProviders/Downloads/MedicalCodingResources/AMPM430EPSDT_PolicyCodingResource.pdf

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). 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.
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.

## Developmental Screening Tools

Primary care providers (PCPs) must be trained in the use and scoring of developmental screening tools. Training resources may be found at Arizona Department of Health Services website at www.azdhs.gov/

The following developmental screening tools are available for members at their 9, 18 and 30 month EPSDT visit:

- Ages and Stages Questionnaires™ Third Edition (ASQ) is a tool used to identify developmental delays in the first five years of a child's life. The sooner a delay or disability is identified, the sooner a child can be connected with services and support that make a real difference. The tool is available online at www.agesandstages.com.
- The Modified Checklist for Autism in Toddlers Revised (M-CHAT-R) used only as a screening tool by a PCP, for members ages 18 and 24 months, to screen for autism when medically indicated. The tool is available online at www.m-chat.org.
- The Parents' Evaluation of Developmental Status (PEDS) used for developmental screening of EPSDT members from birth to 8 years of age. The tool is available online at www.pedstest.com or https://www.pedstestonline.com/.

An additional payment for use of screening tools is covered when the following criteria are met:

- The member's EPSDT visit is at 9, 18, or 30 months;
- Prior to providing the service, the provider must complete the required training for the developmental screening tool being utilized and submit a copy of the training certificate to the Council for Affordable Quality Healthcare (CAQH). Providers must also submit to the Health Plan via fax to (855) 872-1858 or email to HEDIS_Operations@azcompletehealth.com.
- The code is appropriately billed using CPT-4 code 96110 and the "EP" modifier. Providers must retain copies of the completed tools in the member's medical record and submit it to the health plan with the completed AHCCCS EPSDT Clinical Sample Templates.
    - Only for the 9, 18, or 30 month screening may the "EP" modifier be added to the CPT-4 code 96110.

## PCP Application of Fluoride Varnish

Physicians who have completed the AHCCCS required training may be reimbursed for fluoride varnish applications completed at the EPSDT visit.

Application of fluoride varnish may be billed separately from the EPSDT visit using CPT Code 99188. Fluoride varnish can be applied as often as every three months between the ages of 6 months and 5 years of age, after the eruption of the first tooth.

## Blood Lead Screening

EPSDT requires 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 either the 12-month or 24-month test.

- Lead levels may be measured at 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 six year of age is based on the child's risk as determined by either the member's residential zip code or presence of other known risk-factors.
- The ADHS Parent Questionnaire may be utilized to help determine if a lead test should be performed outside of the required testing ages.
- Providers must report blood lead levels equal to or greater than 3.5 micrograms of lead per deciliter of whole blood or as determined by CDC recommendations to ADHS (A.A.C. R9-4-302).
- In-office capillary blood draws utilizing validated CLIA waived testing equipment will be covered for in-network point of care EPSDT visits.

## Missed/No-Show EPSDT Appointments

Providers are expected to follow up with members who miss or no-show their EPSDT appointments and notify the health plan when a member has missed or cancelled three or more visits. Providers may utilize the health plan's Missed/No-Show Log. Providers are encouraged to use the recall system in order to reduce the number of missed or cancelled appointments.

## Arizona Early Intervention

AHCCCS and AzEIP jointly developed procedures for the coordination of services under Early Periodic Screening, Diagnostic and Treatment (EPSDT) and AzEIP to ensure the coordination and provision of EPSDT and AzEIP services.

**PCP-Initiated Services**

When concerns about a child's development are initially identified by the child's primary care physician (PCP), the PCP requests an evaluation and, if medically necessary, approval of services from the health plan.

Evaluation/Services: The Health Plan may pend approval for services until the evaluation has been completed by the provider and may deny services if the PCP determines there is no medical need for services based on the results of the evaluation.

- Requests for services from PCPs, licensed providers or the AzEIP service coordinator based on the Individual Family Service Plan (IFSP) must be reviewed for medical necessity prior to authorization and reimbursement.
- If services are approved, The Health Plan authorizes the services with The Health Plan
- participating provider, whenever possible, and notifies the PCP (requesting provider if other than the PCP) that (a) the services are approved, and (b) identifies the provider that has been authorized, the frequency, duration, and the service begin and end dates.
- The Health Plan follows the Code of Federal Regulation 42 438.210 for completion of prior authorization requests.

The Health Plan provides a decision as expeditiously as the member's health condition requires, but not later than 48 hours following the receipt of a standard authorization request, with a possible extension of up to 48 hours if the member or provider requests an extension or if The Health Plan justifies a need for additional information and the delay is in the member's best interest.

Referral to AzEIP: After completing the evaluation, the provider who conducted the evaluation submits an evaluation report to the PCP (requesting provider if other than the PCP) and the Health Plan's Prior Authorization Department for authorization of medically necessary services.

If the evaluation indicates that the child scored two standard deviations below the mean, which generally translates to AzEIP's eligibility criteria of 50 percent developmental delay, the child continues to receive all medically necessary EPSDT covered services through the health plan. The health plan's EPSDT Coordinator refers the child to AzEIP for non-medically necessary services that are not covered by Medicaid, but are covered under IDEA Part C. If the evaluation report indicates that the child does not have a 50 percent developmental delay, the EPSDT Specialist continues to coordinate medically necessary care and services for the child.

The Health Plan and AzEIP continue to coordinate services for Medicaid children who are eligible for and enrolled in both AzEIP and Medicaid. The EPSDT Coordinator assists the parent or caregiver in scheduling the EPSDT covered services, as necessary or as requested. The EPSDT services are provided by the health plan's participating provider (or AzEIP service provider reimbursed by the health plan) until the services are determined by the PCP and provider to no longer be medically necessary.

**AzEIP-Initiated Service Requests**

When concerns about a Medicaid enrolled child's development are initially identified by AzEIP:

- If an EPSDT-eligible child is referred to AzEIP, AzEIP screens and, if needed, conducts an evaluation to determine the child's eligibility for AzEIP. AzEIP obtains parental consent to request and release records to and from the health plan and the child's PCP;
- The PCP reviews all AzEIP documentation and determines which services are medically necessary based on review of the documentation;
- The PCP takes no longer than 10 business days from the date the EPSDT Specialist faxes the documentation to the PCP to determine which services are medically necessary and returns the signed AzEIP AHCCCS Member Service Request form (AHCCCS AMPM Chapter 430, Attachment D [insert link: https://www.azahcccs.gov/shared/MedicalPolicyManual/]) to the EPSDT Coordinator.

The PCP will determine the requested services are medically necessary:

1. Within two business days, the EPSDT Coordinator sends the completed AzEIP AHCCCS Member Service Request form located at (AHCCCS AMPM, Chapter 430, Attachment D [insert link: https://www.azahcccs.gov/shared/MedicalPolicyManual/]) to the AzEIP service coordinator and PCP advising them that: (a) the services are approved, and (b) identifying the provider that has been authorized, the frequency, duration, and the service begin and end dates;
2. The Health Plan authorizes services with a participating provider whenever possible;
3. AzEIP providers may only be reimbursed (a) if they are AHCCCS registered and (b) for the categories of services for which they are registered and that were provided. Billing must be completed in accordance with AHCCCS guidelines;
4. When services are determined by the PCP and service provider to be no longer medically necessary, the AzEIP service coordinator implements the process for amending the IFSP, which may include (a) non medically necessary services covered by AzEIP, and (b) changes made to IFSP outcomes and IFSP services, including payer, setting, etc;
5. The AzEIP service coordinator, family and other IFSP team members review the IFSP at least every six months or sooner if requested by any team member. If services are changed (deleted or added) during an annual IFSP or IFSP review, the AzEIP service coordinator notifies the EPSDT Coordinator and PCP within two business days of the IFSP review. If a service is added, the AzEIP service coordinator's notification to the EPSDT coordinator initiates the process for determining medical necessity and authorizing the service as outlined above.

If the requested services do not show a 50% developmental delay:

- If the evaluation report received by a PCP, licensed provider or AzEIP, indicates that the child does not have a 50% developmental delay, medically needed services and therapies will be provided as needed.
- The health plan EPSDT Coordinator will coordinate medically necessary care and services for the child, including anticipatory guidance for the member's parent/HCDM or Physician.
- The EPSDT services are provided by the health plan until the services are determined to no longer be medically necessary.

## Body Mass Index or Weight-for-Length

Primary care providers (PCPs) should calculate each child's body mass index (BMI) starting at age 2 until the member is age 21 (or weight-for-length percentile for members

less than two years of age). BMI is used to assess underweight, overweight and those at risk for overweight. BMI for children is sex and age specific. PCPs are required to calculate the child's BMI percentile utilizing the Centers for Disease Control and Prevention website [Insert link: https://www.cdc.gov/growthcharts/] for Body Mass Index (BMI) and growth chart resources or for children under age two, refer to the Centers of Disease Control and Prevention website for weight-for-length chart.

The following established percentile cutoff points are used to identify underweight and overweight in children:

| PERCENTILE | WEIGHT |
|---|---|
| ≥ 95th percentile | Obese |
| 85th to < 95th percentile | Overweight |
| 5th to < 85th percentile | Healthy Weight |
| < 5th percentile | Underweight |

Primary care providers (PCPs) should calculate the growth of children under 2 years of age by using the World Health Organization (WHO) growth standards to monitor growth for infants and children ages 0 to 2 years of age in the U.S., as the Centers for Disease Control and Prevention recommends the use of the WHO standards for children under age 2 to avoid incorrectly labeling a child as failure to thrive despite following the optimal growth

pattern for children in this age group. Refer to the Centers for Disease Control and Prevention website for WHO growth chart resources.

## Medical Food

The Health Plan covers medical foods when medically necessary for members diagnosed with one of the following inherited metabolic conditions:

1. phenylketonuria
2. homocystinuria
3. maple syrup urine disease
4. galactosemia (requires soy formula)
5. beta keto-thiolase deficiency
6. citrullinemia
7. glutaric acidemia type I
8. 3 methylcrotonyl CoA carboxylase deficiency
9. isovaleric acidemia
10. methylmalonic acidemia
11. propionic acidemia
12. arginosuccinic acidemia
13. tyrosinemia type I
14. HMG CoA lyase deficiency
15. Very long chain acyl-CoA Dehydrogenase deficiency (VLCAD)
16. Long Chain acyl-CoA Dehydrogenase deficiency (LCHAD)
17. cobalamin A, B, C deficiencies

Medical foods are metabolic formula or modified low- protein foods produced or manufactured specifically for persons with a qualifying metabolic disorder and are not generally used by persons in the absence of a qualifying metabolic disorder. Soy formula is covered for members receiving Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services and KidsCare members diagnosed with galactosemia and only until they are able to eat solid lactose-free foods.

Upon completion of the member's initial consultation with a genetics physician and metabolic nutritionist, and the determination that metabolic formula and/or low-protein foods are necessary to meet the member's nutritional needs, providers forward the request for metabolic nutrition to the Health Plan's Prior Authorization unit for review and processing. All approvals and payments for medical foods are the responsibility of The Health Plan.

## Nutritional Assessment and Nutritional Therapy

Nutritional assessments are part of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program for the health plan's members under age 21, whose health status may improve with nutrition intervention. Nutritional therapy is covered for EPSDT-eligible health plan members for the below enteral, Total Parenteral Nutritional (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.

- Enteral nutritional therapy–Provides liquid nourishment directly to the digestive tract of a member who cannot ingest an appropriate amount of calories to maintain an acceptable nutritional status. Enteral nutrition is commonly provided by jejunostomy tube (J-tube), gastrostomy tube (G-tube) or nasogastric (N/G) tube Parenteral nutritional therapy - Provides nourishment through the venous system to members with severe pathology of the alimentary tract, which does not allow absorption of sufficient nutrients to maintain weight and strength.
- 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

The Health Plan covers the following for members with a medical condition described in the section above:

- Special Supplemental Program for Women, Infants and Children (WIC)-eligible infant formulas, including specialty infant formulas;
- Medical foods;
- Parenteral feedings; and
- Enteral feedings.

Refer to the Medical Foods section for the health plan's members with a congenital metabolic disorder, such as phenylketonuria, homocystinuria, maple syrup urine disease, or galasctosemia.

## Nutritional Assessment and Nutritional Therapy – Members Ages 21 and Older

Nutritional assessments and nutritional therapy are provided for members whose health status may improve with nutrition intervention. Arizona Health Care Cost Containment System (AHCCCS) covers nutritional therapy on an enteral, parenteral, and oral basis when determined medically necessary to provide either complete daily dietary requirements, or to supplement a member's daily nutritional and caloric intake.

Nutritional assessments and nutritional therapy are covered benefits for members ages 21 and older when all of the following apply:

- The member is currently underweight with a BMI of less than 18.5 presenting serious health consequences for the member, or the member has demonstrated a medically significant decline in weight within the past three months (prior to the assessment).
- The member is able to consume no more than 25 percent of their nutritional requirements from typical food sources.
- The member has been evaluated and treated for medical conditions that may cause problems with weight gain (such as feeding problems, behavioral conditions, or psychosocial problems, or endocrine or gastrointestinal problems).
- The member has had a trial 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. After this trial, there is clinical documentation and other supporting evidence indicating that higher caloric foods would be detrimental to the member's overall health.

## Referrals for Nutritional Assessment

Nutritional assessments are conducted to assist members whose health status may improve with nutritional intervention. The health plan covers the assessment of nutritional status, as determined necessary and as a part of health risk assessment and screening services provided by the member's primary care provider (PCP).

Nutritional assessment services provided by a registered dietitian are covered when ordered by the member's PCP.

To initiate a referral for a nutritional assessment, complete the health plan's referral form and fax it to the health plan's Prior Authorization Department.

The assessment of a member's nutritional status is covered as part of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program specified in the Arizona Health Care Cost Containment System (AHCCCS) EPSDT Periodicity Schedule (AMPM Chapter 430, Attachment A), and on an inter-periodic basis as determined necessary by the member's primary care physician (PCP). This includes members who are under or overweight. A PCP may perform the nutritional assessment or may refer the member to a registered dietician.

Providers are required to provide education, support and training, if the member, parent or guardian elects to prepare the member's food, regarding proper sanitation and temperatures to avoid contamination of foods that are blended or specially prepared for the member, and

provide encouragement and assistance to the parent/guardian/HCDM,DR in weaning the member from the necessity for supplemental nutritional feedings.

## Prior Authorization for Nutritional Therapy

Prior authorization is always required for nutritional therapy. Providers must submit all clinically relevant information for medical necessity review and prior authorization requests. To obtain prior authorization for enteral or parenteral nutritional therapy, providers must complete and submit a Request for Prior Authorization form to the health plan‘s Prior Authorization Department.

Prior authorization is required for commercial oral supplemental nutritional feedings, including specialty infant formulas, unless the member is also currently receiving nutrition through enteral or parenteral feedings. Prior authorization 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. An example of a nutritional supplement is an amino acid-based formula used by a member for eosinophilic gastrointestinal disorder.

The primary care physician (PCP) or attending physician must determine medical necessity on an individual basis for commercial oral nutritional supplements.

For prior authorization on commercial oral supplemental nutritional feedings, the member’s PCP or attending physician must complete and submit the Arizona Health Care Cost Containment System (AHCCCS)-approved Certificate of Medical Necessity for Commercial Oral Nutritional Supplements form to the health plan’s Prior Authorization Department.

The PCP or attending physician must have documentation that nutritional counseling was provided as part of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program and specify alternatives that were tried in an effort to boost caloric intake and change food consistencies before considering commercially available nutritional supplements for oral feedings, or to supplement feedings.

The PCP or attending physician must complete the Certificate of Medical Necessity for Commercial Oral Nutritional Supplements form and indicate on the form which criteria were met when assessing medical necessity of providing commercial oral nutritional supplements.

## Behavioral Health Screening and Services provided by a PCP

Behavioral health services are covered for members eligible for EPSDT. PCP’s may provide behavioral health services within their scope of practice. Refer to (AHCCCS

AMPM, Chapter 510), https://www.azahcccs.gov/shared/MedicalPolicyManual/ [Insert Link: https://www.azahcccs.gov/shared/MedicalPolicyManual/] .

American Indian/Alaska Native members may receive behavioral health services through an Indian Health Service or tribally operated 638 facility, regardless of health plan enrollment or behavioral health assignment,

Screenings including:

i. Postpartum consisting of a standard norm-criterion referenced screening tool to be performed for screening the birthing parent for signs and symptoms of postpartum depression during the one-, two-, four- and six-month EPSDT visits. Positive screening results require referral to appropriate case managers and services at the respective maternal health plan, and

ii. Adolescent Suicide consisting of a standardized, norm-referenced screening tool specific for suicide and depression shall be performed at annual EPSDT visits beginning at age 10 years of age. Positive screening results require appropriate and timely referral for further evaluation and service provision.

A Developmental Surveillance must be performed by the PCP at each EPSDT visit.

## FAMILY PLANNING SERVICES

The Health Plan covers family planning services in accordance with the AHCCCS AMPM Policy 420 (Family Planning) https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/400/420.pdf for all Members, regardless of gender, who choose to delay or prevent pregnancy.

1. Covered family planning services and supplies for members include the following medical, surgical, pharmacological, and laboratory services as well as contraceptive devices (including Intrauterine Devices (IUDs) and subdermal implantable contraceptives):
    a. Contraceptive counseling, and/or medication and supplies, including, but not limited to oral and injectable contraceptives, LARC (Long-Acting Reversible Contraceptive)(including placement of Immediate Postpartum Long-Acting Reversible Contraceptives [IPLARC]), , diaphragms, condoms, foams and suppositories,
    b. Associated medical and laboratory examinations and radiological procedures, including ultrasound studies related to family planning,
    c. Treatment of complications resulting from contraceptive use, including emergency treatment,
    d. Natural family planning education or referral to qualified health professionals,

e. Post-coital emergency oral contraception within 72 hours after unprotected sexual intercourse (mifepristone, also known as Mifeprex or RU-486, is not a post-coital emergency oral contraception).
f. Sterilization:
    1. Clarification related to hysteroscopic tubal sterilization:
        1. Hysteroscopic tubal sterilization is not immediately effective upon insertion of the sterilization device. It is expected that the procedure will be an effective sterilization procedure three months following insertion. Therefore, during the first three months the member must continue using another form of birth control to prevent pregnancy, and
        2. At the end of the three months, it is expected that a hysterosalpingogram will be performed confirming that the member is sterile. After the confirmatory test, the member is considered sterile.

2. Coverage for the following family planning services are as follows:
    a. Pregnancy screening is a covered service,
    b. Pharmaceuticals are covered when associated with medical conditions related to family planning or other medical conditions,
    c. Screening and treatment for Sexually Transmitted Infections (STI) are covered services for members, regardless of gender,
    d. Sterilization services are covered regardless of member's gender when the requirements specified in AHCCCS Policy for sterilization services are met (including hysteroscopic tubal sterilizations, if available), and

    Pregnancy termination is covered only as specified in AMPM Policy 410.
3. Limitations - The following are not covered for the purpose of family planning services and supplies:
    a. Infertility services including diagnostic testing, treatment services and reversal of surgically induced infertility,
    b. Pregnancy termination counseling,
    c. Pregnancy terminations except as specified in AMPM Policy 410, and
    d. Hysterectomies for the purpose of sterilization. Refer to AMPM Policy 310-L for hysterectomy coverage requirements.

## Requirements for Providing Family Planning Services and Supplies

Providers are required to collaborate with the Health Plan to implement effective family planning services which includes:

1. Notifying Members of reproductive age of the specific covered family planning services and supplies available and how to request them. Notification must be in accordance with ARS § 36.2904(L). The information provided to Members should include, but is not limited to:
    a. A complete description of covered family planning services and supplies available, including counseling regarding availability and benefits of LARC and IPLARC;

   b. Information advising how to request/obtain these services;
   c. Information that assistance with scheduling is available; and
   d. A statement that there is no copayment or other charge for family planning services and supplies.
   e. A statement that medically necessary transportation services are available.
2. Provide family planning services that are:
   a. Provided in a manner free from coercion or behavioral/mental pressure;
   b. Available and easily accessible to Members;
   c. Provided in a manner which assures continuity and confidentiality;
   d. Provided by, or under the direction of, a qualified physician or practitioner; and
   e. Documented in the medical record. In addition, documentation must be recorded that each Member of reproductive age (12-55 years) was notified verbally or in writing of the availability of family planning services and supplies.
3. Provide translation/interpretation of information related to family planning in accordance with the requirements of the cultural competency policy.
4. Have a process for ensuring prior to insertion of intrauterine and subdermal implantable contraceptives, the family planning provider has provided proper counseling to the eligible Member to minimize the likelihood of a request for early removal.
5. Establish procedures for referral of those Members who may lose AHCCCS eligibility to low-cost/no-cost agencies for family planning services.

In addition, providers are responsible for the following:

- Informing pregnant members by the end of the second trimester of family planning services and supplies and how to request them, including information on LARC/IPLARC.
- Making appropriate referrals to health professionals who provide family planning services.
- Keeping complete medical records regarding referrals.
- Verifying and documenting a member's willingness to receive family planning services.
- Providing medically necessary management of Members with family planning complications.
- Notify Members of reproductive age either directly or to the appropriate Health Care Decision Maker (HCDM), whichever is most appropriate, of the specific covered family planning services and supplies available to them, and a plan to deliver those services to members who request them.
  - Members of any age whose sexual behavior exposes them to possible conception or Sexually Transmitted Infections (STIs) should have access to the most effective methods of contraception.
  - Every effort should be made to include partners in such services.

- Providing counseling and education to Members of all genders that is age appropriate and includes information on prevention of unplanned pregnancies. Counseling should include the following:
    - The member's short- and long-term goals;
    - Spacing of births to promote better outcomes for future pregnancies; and
    - Preconception counseling to assist Members in deciding on the advisability and timing of pregnancy, to assess risks and to reinforce habits that promote a healthy pregnancy.
    - Sexually transmitted infections, to include methods of prevention, abstinence, and changes in sexual behavior and lifestyle that promote the development of good health habits.

Contraceptives should be recommended and prescribed for sexually active Members. Providers are required to discuss the availability of family planning services annually. Information should include all of the family planning services and supplies covered through AHCCCS as well as instructions to members regarding how to access these services and supplies. If a member's sexual activity presents a risk or potential risk, the provider should initiate an in-depth discussion on the variety of contraceptives available and their use and effectiveness in preventing sexually transmitted infections (including HIV/AIDS). Such discussions must be documented in the Member's medical record.

## Sterilization

The Health Plan requires all participating providers to comply with the informed consent forms and procedures for sterilization as specified in the AHCCCS Specifications Manual (42 CFR Part 441, Sub-part B). The following criteria must be met for the sterilization of a member to occur:

- The Member is at least 21 years of age at the time the consent is signed.
    - For Members under the age of 21, the provider must be able to demonstrate medical necessity for the procedure with supporting documentation including Prior Authorization. The medical necessity prior authorization and supporting documentation must be submitted to The Health Plan.
- Mental competency is determined; member has not been declared mentally incompetent.
- Voluntary consent was obtained without coercion; and
- Thirty (30) days, but not more than 180 days, have passed between the date of informed consent and the date of sterilization, except in the case of a premature delivery or emergency abdominal surgery.
- Members may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since they gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

Any Member requesting sterilization must sign an AHCCCS AMPM, Chapter 400, Exhibit 420 Attachment A, (AHCCCS Consent to Sterilization Form Attachment A), with a witness present when the consent is obtained. Suitable arrangements must be made to ensure that the information in the consent form is effectively communicated to Members with limited English proficiency or reading skills and those with diverse cultural and ethnic backgrounds, as well as Members with visual and/or auditory limitations. Prior to signing the consent form, a member shall have been given a copy of the consent form and offered factual information that includes all of the following:

1. Consent form requirements (specified in 42 CFR 441.250 et seq.),
2. Answers to questions asked regarding the specific procedure to be performed;
3. Notification that withdrawal of consent can occur at any time prior to surgery without affecting future care and/or loss of federally funded program benefits;
4. A description of available alternative methods;
5. Advice that the sterilization procedure is considered to be irreversible,
6. A thorough explanation of the specific sterilization procedure to be performed,
7. A description of available alternative methods
8. A full description of the discomforts and risks that may accompany or follow the performing of the procedure, including an explanation of the type and possible effects of any anesthetic to be used;
9. A full description of the advantages or disadvantages that may be expected as a result of the sterilization; and
10. Notification that sterilization cannot be performed for at least 30 days post consent.
11. Sterilization consents may NOT be obtained when a member:
12. Is in labor or childbirth;
13. Is seeking to obtain, or is obtaining, a pregnancy termination; or
14. Is under the influence of alcohol or other substances that affect the Member's state of awareness.

The Health Plan submits a Monthly Sterilization Report to AHCCCS which documents the number of sterilizations performed for all Members under the age of 21 years of age during the month. If no sterilizations were performed for Members under the age of 21 years of age during the month, the monthly report must still be submitted to attest to that information.

Hysteroscopic tubal sterilization is not immediately effective upon insertion of the sterilization device. It is expected that the procedure will be an effective sterilization procedure three months following insertion. Therefore, during the first three months the member must continue using another form of birth control to prevent pregnancy. At the end of the three months, it is expected that a hysterosalpingogram will be performed confirming that the Member is sterile. After the confirmatory test, the member is considered sterile.

## Medically Necessary Pregnancy Termination for Title XIX/XXI Adults With SMI

Prior authorization is required for pregnancy termination except in emergency situations where the life of the mother is threatened. In these situations, authorization may be sought post procedure. Prior authorization must be obtained before the services are rendered or the services will not be eligible for reimbursement. Pregnancy termination services are covered when one of the following occurs:

- 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 a result of incest.
- The pregnancy is a result of rape; or
- 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; or
  - Preventing the pregnant Member from obtaining treatment for a health problem.

For medical necessary pregnancy terminations, providers must submit AHCCCS AMPM Chapter 410 Attachment D (AHCCCS Verification of Diagnosis by Contractor for a Pregnancy Termination Request) to the Health Plan Medical Director including a written explanation describing why the procedure is medically necessary, a copy of the Member's medical record and written informed consent from the Member. The provider is required to obtain the written informed consent and retain it in the Member's medical record for all pregnancy terminations. For pregnant Members younger than 18 years of age, or those 18 or older and considered incapacitated, providers must secure a dated signature of the pregnant Member's parent/Health care Decision Maker (HCDM) indicating approval of the pregnancy termination procedure is required.

In addition, if the pregnancy termination is requested as a result of incest or rape, providers must include identification of the proper authority to which the incident was reported. This must include the name of the agency to which it was reported, the report number (if available), and the date that the report was filed. This documentation requirement shall be

waived if the treating provider certifies that, in his/her/their professional opinion, the member was unable, for physical or psychological reasons, to comply with the requirement.

Follow Food and Drug Administration (FDA) medication guidance for the use of medications to end a pregnancy. Current standards of care per ACOG shall be utilized when the duration of pregnancy is unknown or if ectopic pregnancy is suspected.

Pregnancy termination by surgery is recommended in cases when medications are used and fail to induce termination of the pregnancy. When medications are administered, the following documentation is also required:

- Name of medication(s) used,
- Duration of pregnancy in days,
- The date medication was given,
- The date any additional medications were given (unless a complete abortion was already confirmed), and
- Documentation that pregnancy termination occurred.

## Prior Authorization Requirements for Sterilization and Pregnancy Termination

Prior authorization is required for sterilization of Members under the age of 21 or pregnancy termination. Prior authorization must be obtained before the services are rendered or the services will not be eligible for reimbursement. The Health Plan monitors all claims and encounters with a primary diagnosis of pregnancy termination.

To obtain authorization for sterilization, complete the applicable forms:

- For sterilization: AHCCCS AMPM, Chapter 400, Exhibit 420 (Consent for Sterilization Form) and AHCCCS AMPM, Chapter 800, Exhibit 820-1 (Hysterectomy Consent and Acknowledgement Form)

To obtain authorization for pregnancy termination, except in cases of medical emergencies, the provider shall obtain a Prior Authorization from the Health Plan Medical Director. A completed AHCCCS AMPM Section 410 Attachment C (Certificate of Necessity for Pregnancy Termination) and the AHCCCS AMPM Section 410 Attachment D (Verification of Diagnosis by Contractor for Pregnancy Termination Request) forms shall be submitted with the request for Prior Authorization, along with the lab, radiology, consultation or other testing results that support the justification/necessity for pregnancy termination. The Health Plan Medical Director or designee will review the Prior Authorization request and supporting documentation and expeditiously authorize the procedure if the documentation meets the criteria for justification of pregnancy termination.

In cases of medical emergency, the provider must submit all documentation of medical necessity to the Health Plan within two working days of the date on which the pregnancy termination procedure was performed.

For pregnancy termination: A completed AHCCCS AMPM Section 410 Attachment C (Certificate of Necessity for Pregnancy Termination) is required.

## 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.

## 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

Maternity care services include, but are not limited to, pregnancy identification through the submission of **Provider Manual Form Notification of Pregnancy** form (can be obtained by calling the Customer Services at 1-866-560-4042), prenatal services, treatment of pregnancy related conditions, labor and delivery services, postpartum depression screening, and postpartum care. In addition, related services such as outreach and family planning services are provided (AHCCCS AMPM Policy 420 – Maternity Care Services), whenever appropriate, based on the member's current eligibility and enrollment.

### Maternity Care Provider Standards

# SECTION VI: Covered Services

Providers must provide quality maternity care services with the goal of achieving optimal birth outcomes. Upon identification of Member pregnancy, all Maternity Care Providers are required to submit the **Provider Manual Form Notification of Pregnancy Form (NOP)** (can be obtained by calling the Customer Service at 866-560-4042). For members who are identified as being medically or socially at-risk/high-risk should be referred to the Health Plan to coordinate care with the Member's physical/behavioral health providers throughout the pregnancy, delivery, and postpartum treatment. This includes identified difficulties with navigating the health care system, evidenced by missed visits, transportation difficulties, or other perceived barriers. Particular attention should be given to the screening, assessment, and treatment of perinatal mood disorders, to include post-partum depression, and substance use disorders.

Members who transition to a new Health Plan or become enrolled during their third trimester must be allowed to complete maternity care with their current AHCCCS-registered provider, regardless of contractual status, to ensure continuity of care.

The Health Plan confirms that members who are receiving physical health care services and who are pregnant have a designated maternity care provider for the duration of the Member's pregnancy and postpartum care.

AHCCCS AMPM Policy 410 (Maternity Care Services) provides detailed descriptions of maternity care requirements and expectations. Members have a choice to be assigned a Primary Care Provider that provides obstetrical care consistent with the freedom of choice requirements for selecting health care professionals so as not to compromise the Member's continuity of care.

For anticipated low-risk deliveries, Members may elect to receive labor and delivery services in their home from their maternity provider and may also elect to receive prenatal care, labor and delivery, and postpartum care by licensed midwives.

According to the American College of Obstetricians and Gynecologists (ACOG) guidelines, all cesarean section deliveries must be medically necessary and include medical documentation to attest to medical necessity. Inductions and cesarean section deliveries prior to 39 weeks must be medically necessary. Any inductions performed prior to 39 weeks or cesarean sections performed at any time that are found to not be medically necessary based on nationally established criteria are not eligible for payment.

## General Obstetrical Standards of Care

All providers must follow standard guidelines such as those established by the American College of Obstetrics and Gynecology (ACOG) standards of care, which include, but are not limited to the following:

- Use of a standardized prenatal medical record and risk assessment tool, such as the ACOG Form, documenting all aspects of maternity care.
- Completion of history including medical and personal health (including infections and exposures), menstrual cycles, past pregnancies and outcomes, and family and genetic history.
- Clinical expected date of confinement.
- Performance of physical exam (including determination and documentation of pelvic adequacy).
- Performance of laboratory tests at recommended time intervals.
- Comprehensive risk assessment incorporating psychosocial, nutritional, medical, and educational factors.

Routine prenatal visits with blood pressure, weight, fundal height (tape measurement), fetal heart tones, urine dipstick for protein and glucose, ongoing risk assessment with any change in pregnancy risk recorded and an appropriate management plan. Providers are required to screen all pregnant members through the Controlled Substances Prescription Monitoring Program (CSPMP) once a trimester, and for those members receiving opioids, appropriate intervention and counseling must be provided, including referral of members for behavioral health services as indicated for Substance Use Disorder (SUD) assessment and treatment.

Providers need to identify perinatal mood and anxiety disorders during and after pregnancy for referral of members to the appropriate health care providers. Perinatal and Postpartum depression screenings, using any norm-criterion referenced screening tool, should be conducted at least once during the pregnancy and then repeated at the postpartum visit with appropriate counseling and referral made if a positive screening is obtained.

Maternity care providers need to be aware of and encouraged to use the Arizona Perinatal Psychiatry Access Line (A-PAL) when questions surrounding mental health or substance use treatment, including medication management, arise,

Providers must educate Members about healthy behaviors during the perinatal period, including the importance proper nutrition, dangers of lead exposure to people who are pregnant and their developing babies, tobacco cessation, avoidance of alcohol and other harmful substances, including illegal drugs, screening for sexually transmitted infections, the physiology of pregnancy, the process of labor and delivery, breast feeding, other infant care information, prescription opioid use, interconception health and spacing, family planning options, including IPLARC options; warning signs of complications of pregnancy and postpartum, including when to contact the provider and postpartum follow-up.

Providers need to refer members to support resources such as WIC, as well as other community-based resources to support healthy pregnancy outcomes, including information about, and referrals to, home visiting programs for pregnant individuals and their children,

ADHS Breastfeeding Hotline, and other infant care resources., In the event where a member loses eligibility, the member shall be notified where they may obtain low-cost or no-cost maternity services.

Providers are also required to educate Members about the risks associated with elective deliveries prior to 39 weeks and/or Cesarean-sections (C-Sections) unless medically necessary; signs and symptoms of preterm labor; effects of smoking, diabetes, hypertension on pregnancy and/or fetus/infant; prenatal and postpartum visits. Providers are required to inform members of voluntary prenatal HIV/AIDS testing and the availability of medical counseling and treatment, as well as the benefits of treatment for birthing parent and baby, if the test is positive. In the event where a member loses eligibility, the member must be notified where they may obtain low-cost or no-cost maternity services. In preparation for delivery, it is important for providers to discuss pain management/pain treatment plan options with the member and offer Immediate Postpartum Long-Acting Reversible Contraception (IPLARC). For members with barriers to care, providers can contact the Health Plan Care Management Team to assist the member with a plan of safe care prior to discharge including behavioral health services, alternative infant care, and alternative nutritional supplementation plans if the member is breastfeeding.

Health Plan Care Management Staff are available to assist providers with managing pregnant members with substance use disorders. The Care1st Maternal Child Health Care Management Team can be reached by calling Customer Service at 1-866-560-4042 (TTY/TDD: 711).The staff includes nurses with OB clinical expertise and social workers. They are available to assist providers with coordination of care and collaboration between the OBGYN and other providers. This can be done through the provision of education, providing support and resources to the member including behavioral health services, and alternative nutritional supplementation plans if the member is breastfeeding. Because many do not view prescription medications as a “substance,” it is important to engage in a face-to-face discussion about all types of substance use with a pregnant member and with all members of reproductive age even when the member does not report or denies use. **An individualized plan of care should be developed using American College of Obstetrics and Gynecologists (ACOG) guidelines for each member identified with a history of Substance Use Disorder (SUD), including medication adjustment needs, evidenced-based breastfeeding recommendation and precautions, and Narcan prescription.** It is also important that screening be done for additional health issued related to SUD, including Hepatitis C, as well as inquiring about any barriers to care. All pregnant members must be screened for STI’s, including syphilis at the first prenatal visit, third trimester, and time of delivery. In preparation for delivery, it is important for providers to discuss pain management/pain treatment plan options with the member and offering Immediate Postpartum Long-Acting Reversible Contraception (IPLARC). For members with barriers to care, providers can contact the Health Plan Care Management staff to assist the member with a plan of safe care prior to discharge including behavioral health services, alternative infant care, and alternative nutritional supplementation plans if the member is breastfeeding.

## *HIGH RISK PRENATAL HOME CARE INFUSION*

Please contact our Case Management Team at 1-866-560-4042 for assistance with high risk members.

## High Risk Maternity and Perinatal Care Management

The Health Plan Integrated Care Managers, together with providers, identify pregnant members who are at risk for adverse pregnancy outcomes. The Health Plan assists providers in managing the care of at-risk pregnant Members due to medical conditions, social determinants, severe mental illness, or non-compliant behaviors. The Health Plan evaluates At Risk Members for ongoing follow up during their pregnancy. The Care1st Maternal Child Health Care Management Team can be reached by calling Customer Service at 1-866-560-4042 (TTY/TDD: 711).

The Health Plan's Maternal Child Health Team provides comprehensive care management services to high-risk pregnant Members, for the purpose of improving maternal and fetal birth outcomes. The perinatal care management team consists of a social worker, care management associates, and professional registered nurses skilled in working with the unique needs of high-risk pregnant members. The Maternal Child Health Team take a collaborative approach in working with outpatient behavioral health providers, PCPs and OB/GYNs to engage high risk pregnant Members throughout their pregnancy and postpartum period. Members who present with high-risk perinatal conditions should be referred to the Health Plan care management team. These conditions include:

- A history of preterm labor before 37 weeks of gestation;
- Bleeding and blood clotting disorders;
- Chronic medical conditions;
- Polyhydramnios or oligohydramnios;
- Placenta previa, abruption or accreta;
- Cervical changes;
- Multiple gestation;
- Teenage mothers;
- Hyperemesis;
- Poor weight gain;
- Advanced maternal age;
- Substance abuse;
- Prescribed psychotropic drugs;
- Domestic violence; and
- Non-adherence with Obstetrics appointments.

## Reporting High Risk and Non-Adherent Behaviors in Pregnant Members

Behavioral Health providers, obstetrical physicians and practitioners must refer all "at risk" pregnant Members to The Health Plan. The following types of situations must be reported to The Health Plan for Members that:

- Are diabetic and display consistent complacency regarding dietary control and/or use of insulin.
- Fail to follow prescribed bed rest.
- Fail to take tocolytics as prescribed or do not follow home uterine monitoring schedules.
- Admit to or demonstrate continued alcohol and/or other substance abuse disorder.
- Show a lack of resources that could influence well-being (e.g. food, shelter, and clothing).
- Frequently visit the emergency department/urgent care setting with complaints of acute pain and request prescriptions for controlled analgesics and/or mood altering drugs.
- Fail to appear for two or more prenatal visits without rescheduling and fail to keep rescheduled appointment. Providers are expected to make two attempts to bring the member in for care prior to contacting The Health Plan.

### *MATERNITY CARE APPOINTMENT SCHEDULING*

| | |
|---|---|
| • First trimester<br>• Second trimester<br>• Third trimester<br>• High risk pregnancies | • Within fourteen (14) calendar days of request<br>• Within seven (7) calendar days of request<br>• Within three (3) business days of request<br>• as expeditiously as the member's health condition requires and no later than three (3) business days of identification of high risk by the contractor or maternity care provider, or immediately if an emergency exists. |

## Outreach, Education and Community Resources for Pregnant Members

The Health Plan is committed to maternity care outreach. Maternity care outreach is an effort to identify currently enrolled pregnant individuals and to enter them into prenatal care as soon as possible, but no later than within the first trimester or 42 days after enrollment. Behavioral provider Care Coordinators, PCPs, OB/GYNs and other treating providers are expected to ask about pregnancy status when Members call for appointments,

to report positive pregnancy tests to The Health Plan through submission of **Provider Manual Form Notification of Pregnancy form (NOP),** (can be obtained by calling the Customer Service at 1-866-560-4042 (TTY/TDD: 711)) and to provide general education and information about prenatal care, when appropriate, during Member office visits.

The Health Plan is involved in many community efforts to increase the awareness of the need for prenatal care. PCPs are strongly encouraged to actively participate in these outreach and education activities, including the Women, Infants and Children (WIC) Nutritional Program. Please encourage Members to enroll in this program in order to support healthy pregnancy outcomes. Various other services are available in the community to help pregnant individuals and their families. Please call The Health Plan for information about how to help your patients use these services.

Questions regarding the availability of community resources may also be directed to the Arizona Health Care Cost Containment System (AHCCCS) Hot Line at 800-833-4642.

## Loss of AHCCCS Coverage During Pregnancy

Members may lose AHCCCS eligibility during pregnancy. Although Members are responsible for maintaining their own eligibility, providers are encouraged to notify The Health Plan if they are aware that a pregnant Member is about to lose or has lost eligibility. The Health Plan Member Services can assist in coordinating or resolving eligibility and enrollment issues so that pregnancy care may continue without a lapse in coverage. Please call Member Services at 888-560-4042 to report eligibility changes for pregnant Members.

## Newborns

AHCCCS covers no less than 48 hours of inpatient hospital care after a routine vaginal delivery and no less than 96 hours of inpatient care after a cesarean delivery.

The newborn may be covered under the Health Plan. Prior to the birth of the baby, the mother will be asked to select a PCP for the newborn. The newborn is assigned to the pre-selected PCP after delivery. The mother may elect to change the assigned PCP at any time.

## Special Policies

Covered related services with special policy and procedural guidelines include, but are not limited to:

- Circumcision (for males) is only covered when it is determined to be medically necessary. The procedure requires prior authorization by the Health Plan Medical Director or designee for enrolled members;
- Extended stays for newborns related to status of birthing parent's stay:
    - Members will receive up to 48 hours of inpatient hospital care after a routine vaginal delivery and up to 96 hours of inpatient care after a cesarean

delivery. The attending health care provider, in consultation with an agreement by the member, may discharge the member or newborn prior to the minimum length of stay. A newborn may be granted an extended stay in the hospital of birth when the member's continued stay in the hospital is beyond the minimum 48- or 96-hour stay, whichever is applicable. In addition, if the member's stay is to extend beyond 48/96 hours, an extended stay for the newborn shall be granted if the member's condition allows for member-infant interaction and the child is not a ward of the State or is not to be adopted.

- Home uterine monitoring technology:
  - AHCCCS covers medically necessary home uterine monitoring technology for members with premature labor contractions before 35 weeks gestation, as an alternative to hospitalization.
  - If the member has one or more of the following conditions, home uterine monitoring may be considered:
    - Multiple gestation, particularly triplets or quadruplets,
    - Previous obstetrical history of one or more births before 35 weeks gestation, or
    - Hospitalization for premature labor before 35 weeks gestation with a documented change in the cervix, controlled by Tocolysis and ready to be discharged for bed rest at home.

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

- Labor and delivery services provided in freestanding birthing centers
  - Services rendered in a freestanding birthing center must be provided by a physician by a Certified Nurses midwife (CNM) who has hospital admitting privileges for labor and delivery services, or a Licensed Midwife [AP1] (LM) who is following licensing and practice requirements as specified in A.A.C. R9-16-111-113;
  - Only members for whom an uncomplicated prenatal course and a low-risk labor and delivery can be anticipated may be scheduled to deliver at a freestanding birthing center. Risk status shall be determined by the attending physician or CNM using standardized assessment tools for high-risk pregnancies. The age of the member shall also be a consideration in the risk status evaluation, members younger than 18 years of age are generally considered high risk.
- Labor and delivery services provided in a home setting:
  - For members who meet specified medical criteria, labor and delivery services provided in the home by the member's maternity provider, physicians, CNMs, or LMs would be covered.
  - Only members with an anticipated uncomplicated prenatal course and a low-risk labor and delivery should deliver in member's home.

- Risk status shall initially be determined at the time of the first visit, and each trimester thereafter, by the member's maternity care provider, using current standardized assessments for high-risk pregnancies.
- A risk assessment shall be conducted when a new presenting complication or concern arises to ensure appropriate care and referral to a qualified provider, if necessary.
- Physicians and practitioners who render home labor and delivery services must have admitting privileges at an acute care hospital in close proximity to the site where the services are provided in the event of complications during labor and/or delivery.
- For anticipated home labor and delivery, LMs shall have a plan of action, including the name and address of an AHCCCS registered physician who can be contacted immediately and an acute care hospital in close proximity to the planned location of labor and delivery for referral in the event that complications should arise. This plan of action shall be submitted to the Health Plan Medical Director or designee for enrolled members.
- Upon delivery of the newborn, the physician, CNM or LM is responsible for conducting newborn examination procedures, including a mandatory Bloodspot Newborn Screening Panel and referral of the infant to an appropriate health care provider for a mandatory hearing screening, as well as a second mandatory Bloodspot Newborn Screening Panel and a second newborn hearing screening (if infant's first hearing screening indicates further assessment is needed). Refer the infant and/or member to an appropriate health care provider for follow-up care of any assessed problematic conditions.
- In addition, the maternity care provider shall notify the birthing parent's Health Plan, of the birth no later than one day from the date of birth, in order to enroll the newborn with AHCCCS.

## Neonate Transfers Between Acute Care Facilities

Acutely ill neonates may be transferred from one acute care center to another, given certain conditions. The chart that follows provides the levels of care, conditions appropriate for transfer, and criteria for transfer.

Refer to the below table for neonatal care:

| Level of Care | | Transfer Criteria |
|---|---|---|
| From | To | |
| Primary | Secondary | 1. The nursing and medical staff of the sending hospital cannot provide:<br>• The level of care needed to manage the infant beyond stabilization to transport<br>• The required diagnostic evaluation and consultation services needed<br>2. Transportation orders specify the type of transport, the training level of the transport crew and the level of life support |
| | Tertiary | Same as above |
| Secondary | Tertiary | Same as above |
| | Primary | Same as above |
| Tertiary | Tertiary (rare) | 1. The sending and receiving neonatalogists (and surgeons, if involved) have spoken and agreed that the transfer is safe.<br>2. The infant is expected to remain stable, considering the period of time required for the distance to be traveled.<br>3. Transport orders specify the type of transport and training level of the transport crew. |
| | Secondary | Same as above |
| | Primary | Same as above |

## *WELL WOMAN CARE/ANNUAL PREVENTIVE CARE*

An annual preventive care visit is intended for the identification of risk factors for disease, identification of existing medical/mental health problems, and promotion of healthy lifestyle habits essential to reducing or preventing risk factors for various disease processes. An annual well-person preventative care visit is a covered benefit for members to obtain the recommended preventive services, including preconception counseling. Providers are responsible for having a process to inform members about preventative health services annually and within 30 days of enrollment for newly enrolled members.

The information must include:

- The benefits of preventive care,
- A complete description of services available,
- Assistance in obtaining information on how to obtain medically necessary transportation,
- A statement that there is no copayment or other charges for the preventive care.

The information must also be provided in a second language, in addition to English, in accordance with the requirements of the AHCCCS Division of Health Care Management (DHCM) "Cultural Competency" policy.

As such, the annual preventative care visit is inclusive of a minimum of the following:

1. A physical exam (well exam) that assesses overall health;
2. Clinical breast exam (if/as necessary);
3. Pelvic exam (if/as necessary, according to current recommendations and best standards of practice);
4. Review and administration of immunizations, screenings and testing as appropriate for age and risk factors. NOTE: Genetic screening and testing is not covered;
5. Screening and counseling focused on maintaining a healthy lifestyle and minimizing health risks. Screening and counseling addresses at a minimum the following:
    a. Proper nutrition;
    b. Physical activity;
    c. Elevated BMI indicative of obesity;
    d. Tobacco/substance use, abuse, and/or dependency;
    e. Depression screening;
    f. Interpersonal and domestic violence screening that includes counseling involving elicitation of information from members of all ages about current/past violence and abuse, in a culturally sensitive and supportive manner to address current health concerns about safety and other current or future health problems;
    g. Sexually transmitted infections;
    h. Human Immunodeficiency Virus (HIV);
    i. Family planning counseling and supplies;
    j. Preconception counseling that includes discussion regarding a healthy lifestyle before and between pregnancies that includes: (**NOTE: Preconception counseling does not include genetic testing.)**
        i. Reproductive history and sexual practices
        ii. Healthy weight, including diet and nutrition, as well as the use of nutritional supplements and folic acid intake
        iii. Physical activity or exercise
        iv. Oral health care
        v. Chronic disease management
        vi. Emotional wellness
        vii. Tobacco and substance use (caffeine, alcohol, marijuana, and other drugs), including prescription drug use
        viii. Recommended intervals between pregnancies
6. Initiation of necessary referrals when the need for further evaluation, diagnosis, and/or treatment is identified.

Immunizations:

- The Health Plan will cover the Human Papilloma Virus (HPV) vaccine for members.
- Providers must coordinate with the Arizona Department of Health Services (ADHS) Vaccines for Children (VFC) Program in the delivery of immunization services if providing vaccinations to Early and Periodic Screening, Diagnostic and Treatment (EPSDT) aged members less than 19 years of age.
- Immunizations must be provided according to the Advisory Committee on Immunization Practices Recommended Schedule.
- Refer to the CDC website where this information is included.

Providers must enroll and re-enroll annually with the VFC program, in accordance with AHCCCS contract requirements in providing immunizations for EPSDT aged members less than 19 years of age and must document each EPSDT age member's immunizations in the Arizona State Immunization Information System (ASIIS) registry. The VFC program must be used for members under 19 years of age. Providers not enrolled in the VFC program will not be assigned members aged 19 years and under.

## 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

***Preferred Drug List*** The Care1st Preferred Drug List (PDL) and Behavioral Health Drug List are available on our website at www.care1staz.com. The Drug Lists are updated quarterly and as needed following the AHCCCS P&T committee meeting. Updated Drug Lists can be viewed on our website at www.care1staz.com and formulary update notifications are sent to all in network providers via Blast Fax at least 30 days prior to changes. Providers may also contact Network Management for a copy. Please ensure that your office is prescribing medications listed on the current Drug List(s). Before submitting a Prior Authorization Request for a non-formulary medication, consider all formulary alternatives. Prior authorization requests and supporting documentation must be submitted to Care1st for review for all medications that are not on the Care1st Drug Lists or are listed on the Drug Lists but required prior authorization.

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

The Care1st Preferred Drug Lists:

1. Are determined by the AHCCCS Pharmacy and Therapeutics Committee and provides a list of safe, cost-effective and efficacious medications that are available to members.
2. AHCCCS' goal is to use the Drug List to assist providers when selecting clinically appropriate medications for members.
3. The Care1st Drug List is not an all-inclusive list of medications.
4. The Care1st 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 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 Drug Lists are more expansive – they include 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 Care1st.

## *SPECIALTY MEDICATIONS AND LIMITED SPECIALTY NETWORK:*

Care1st has a Limited Specialty Network primarily for chronic conditions that require Specialty Medications dispensed through the pharmacy benefit. The Limited Specialty Network was developed with 3 key areas of focus:

- Specialty Pharmacy Certification
- Documented and proactive adherence management to minimize gaps and identify barriers to care AND
- Drug therapy management programs to promote cost effective drug management

AcariaHealth is the Care1st Preferred Specialty Pharmacy:

| | | |
|---|---|---|
| AcariaHealth | Multiple Locations Nationwide | 1-800-511-5144 |

**Prior Authorization Process**

- Submit an Electronic Prior Authorization (ePA) request: through COVER MY MEDS. The landing page is located at
- https://www.covermymeds.com/main/prior-authorization-forms/ OR
- Complete the Pharmacy Prior Authorization Request Form available on the Care1st website (www.care1staz.com) and fax it to us at 602.778.8387

**Prior Authorization Process for Medical Benefit Drugs**

Please review the Prior Authorization Guidelines for J and Q codes that require prior authorization using the online Pre-Auth Check Tool located on our website (www.care1staz.com). In addition, all unclassified drugs (i.e. J3490, J9999) require prior authorization. Requests for provider-administered drugs through the Medical benefit may be submitted:

- Via our Secure Provider Portal
- Via fax using the Outpatient Prior Authorization request form and faxing requests to the Biopharmacy/Medpharmacy department

Contact the Pharmacy Prior Authorization department at 866-560-4042 (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

# 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 service 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.

# TELEHEALTH

Care1st covers medically necessary, non-experimental, and cost effective Telehealth services provided by AHCCCS register providers. Telehealth is healthcare services delivered via asynchronous (store and forward), remote patient monitoring, Teledentistry, or telemedicine (interactive audio and video).

There are no geographic restrictions for Telehealth, as these services can be provided within rural or urban regions. Care1st promotes the use of Telehealth to support an adequate provider network.

### *ASYNCHRONOUS (Store and forward)*

Asynchronous is defined as transmission of recorded health history (e.g. pre-recorded videos, digital data, or digital images, such as x-rays and photos) through a secure electronic communications system between a practitioner, usually a specialist, and a member or other practitioner, in order to evaluate the case or to render consultative and/or therapeutic services outside of a synchronous (real-time) interaction.

Asynchronous care allows practitioners to assess, evaluate, consult, or treat conditions using secure digital transmission services, data storage services and software solutions.

Asynchronous does not require real-time interaction with the member. Reimbursement for this type of consultation is limited to:

- Allergy/Immunology
- Cardiology;
- Dermatology;
- Infectious diseases;
- Neurology;
- Ophthalmology;
- Pathology;
- Radiology;
- Behavioral Health

### *SYNCHRONOUS TELEMEDICINE AND REMOTE PATIENT MONITORING*

The practice of synchronous (real-time) health care delivery, diagnosis, consultations, and treatment and the transfer of medical data through interactive audio and video communications that occur in the physical presence of the patient.

Synchronous (real-time) Telemedicine and Remove Patient Monitoring:

- Shall not replace provider choice for healthcare delivery modality
- Shall not replace member choice for healthcare delivery modality
- Shall not be AHCCCS-covered services that are medically necessary and cost effective

***TELEDENTISTRY***

Teledentistry is defined as the acquisition and transmission of all necessary subjective and objective diagnostic data through interactive audio, video or data communications by AHCCCS registered dental provider to a dentist at a distant site for triage, dental treatment planning, and referral.

Care1st covers Teledentistry for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) aged members when provided by an AHCCCS registered dental provider. Refer to AMPM Policy 431 for more information on Oral Health Care for EPSDT aged members including covered dental services.

Teledentistry includes the provision of preventative and other approved therapeutic services by the AHCCCS registered Affiliated Practice Dental Hygienist, who provides dental hygiene services under an affiliated practice relationship with a dentist. Refer to AMPM Policy 431 for information on Affiliated Practice Dental Hygienist.

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

***CONDITIONS, LIMITATIONS, EXCLUSIONS, AND OTHER INFORMATION***

1. All Telehealth reimbursable services shall be provided by an AHCCCS registered provider.
2. Non-emergency transportation (NEMT) is a covered benefit for member transport to and from the Originating Site where applicable.
    a. An Originating Site is defined as a Location of the AHCCCS member at the time the service is being furnished via telehealth or where the asynchronous service originates.
3. Informed consent standards for Telehealth services should adhere to all applicable statutes and policies governing Telehealth, including A.R.S. §36-3602.
4. Confidentiality standards for Telehealth services should adhere to all applicable statutes and policies governing Telehealth.
5. There are no Place of Service (POS) restrictions for Distant Site.
    a. A Distant Site is defined as the site at which the provider is located at the time of the service is provided via telehealth.
6. The POS on the service claim is the Originating Site.

Refer to the AHCCCS coding webpage for coding requirements for Telehealth services, including applicable modifiers and Place of Service (POS).

***TELEHEALTH COVID 19 TEMPORARY WAIVERS***

Telehealth codes have been temporarily expanded to include telephonic codes. Please refer to the AHCCCS Frequently Asked Questions for expanded updated COVID 19 Telehealth and Delivery guidance.

# 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 |