

CHAPTER 16:

Women and Children's Services

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

Program Description

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

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 and includes all screenings and services described in the AHCCCS EPSDT section of this chapter, as well as referenced EPSDT Periodicity Schedule (AHCCCS Medical Policy Manual (AMPM) Policy 430, Attachment A) and AHCCCS Dental Periodicity Schedule (AMPM Policy 431, Attachment A).

Refer to AMPM Policy 430, Attachment E for the AHCCCS EPSDT Tracking Forms, which are to be used by providers to document all age-specific, required information related to EPSDT screenings and visits. Providers must use the EPSDT Tracking forms provided by AHCCCS Contractors (or electronic equivalent that includes all components found in the hard copy form) at every EPSDT visit.

Amount, Duration and Scope

The Medicaid Act defines EPSDT services to include screening services, vision services, dental services, hearing services, and *“such other necessary health care, diagnostic services, treatment and other measures described in Federal Law Subsection 42 USC 1396d (a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening*

services, whether or not such services are covered under the (AHCCCS) State Plan.” This means that EPSDT covered services include services that correct or ameliorate physical and behavioral defects, conditions, and illnesses discovered by the screening process when those services fall within one of the optional and mandatory categories of “Medical Assistance” as defined in the Medicaid Act. Services covered under EPSDT include all 29 categories of services in the Federal Law even when they are not listed as covered services in the AHCCCS State Plan, AHCCCS statutes, rules, or policies as long as the services are medically necessary and cost effective.

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

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

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

EPSDT screening services are provided in compliance with the periodicity requirements of Title 42 of the Code of Federal Regulations (42 CFR 441.58). Providers must ensure members receive required health screenings in compliance with the AHCCCS EPSDT Periodicity Schedule and the AHCCCS Dental Periodicity Schedule. The AHCCCS Periodicity Schedules for EPSDT are intended to meet reasonable and prevailing standards of medical and dental practice and specify screening services at each stage of the child's life (Policy 430, Attachment A, AHCCCS EPSDT Periodicity Schedule and Policy 431, Attachment A, AHCCCS Dental Periodicity Schedule).

The service intervals represent minimum requirements, and any services determined by a primary care provider to be medically necessary shall be provided, regardless of the interval. EPSDT focuses on the continuum of care by assessing health needs, providing preventive screening, initiating needed referrals, and completing recommended medical treatment and appropriate follow-up.

EPSDT Definitions

- Early means in the case of a child already enrolled with Health Choice Arizona as early as possible in the child's life, or in other cases, as soon after the member's eligibility for AHCCCS services has been established.
- Periodic means at intervals established by AHCCCS for screening to assure that a

condition, illness, or injury is not incipient or present.

- **Screening** means regularly scheduled examinations and evaluations of the general physical and behavioral health, growth, development, and nutritional status of infants, children and adolescents, and the identification of those in need of more definitive evaluation. For the purpose of the AHCCCS EPSDT program, screening and diagnosis are not synonymous.
- **Diagnostic** means the determination of the nature or cause of a condition, illness, or injury through the combined use of health history, physical, developmental and psychological examination, laboratory tests, and X-rays, when appropriate.
- **Treatment** means any of the 29 mandatory or optional services described in Federal Law 42 USC 1396d (a), even if the service is not covered under the AHCCCS State Plan, when necessary to correct or ameliorate defects and physical and mental illnesses and conditions detected by screening or diagnostic procedures.

Screening Requirements

Comprehensive periodic screenings must be performed by a provider according to the time frames identified in the AHCCCS EPSDT Periodicity Schedule, the AHCCCS Dental Periodicity Schedule. Inter-periodic screenings should be performed as appropriate for each member. Providers must ensure providers utilize AHCCCS approved standard developmental screening tools and complete training in the use of these tools, as indicated by the American Academy of Pediatrics. The Contractor must monitor providers and implement interventions for non-compliance. Contractors must ensure that the Bloodspot Newborn Screening Panel and hearing tests are conducted, including initial and secondary screenings, in accordance with 9 A.A.C. 13, Article 2.

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

EPSDT visits are all-inclusive visits. The payment for the EPSDT visit is intended to cover all elements outlined in the AHCCCS EPSDT Periodicity Schedule (AMPM Policy 430, Attachment A). Exceptions to payments are noted in each of the paragraphs listed below. Only those services specifically identified below as a separately billable service may be billed separately or in addition to the EPSDT visit.

EPSDT screenings must include the following:

1. A comprehensive health and developmental history, including growth and development screening (42 C.F.R. 441.56(B) (1) which includes physical, nutritional and behavioral health assessments. Refer to the Centers for Disease Control and Prevention Website at <http://www.cdc.gov/growthcharts/> for Body Mass Index (BMI) and growth chart resources.) or contact your Provider Relations Representative for copies of the charts.
2. Nutritional Screening provided by a PCP.

3. Nutritional Assessment provided by PCP - Nutritional assessments are conducted to assist EPSDT members whose health status may improve with nutritional intervention. Payment for the assessment of nutritional status provided by the member's PCP is part of the EPSDT screening specified in the AHCCCS EPSDT Periodicity Schedule (AMPM Chapter 430, Attachment A), and on an inter-periodic basis as determined necessary by the member's PCP. Payment for nutritional assessments are included in the EPSDT visit and are a separately billable service.
4. Behavioral Health Screening and Services provided by a PCP - AHCCCS covers behavioral health services for members eligible for EPSDT. EPSDT behavioral health services include the services listed in Federal Law 42 USC 1396d (a) necessary to correct or ameliorate mental illnesses and conditions discovered by the screening services, whether or not the services are covered under the (AHCCCS) State Plan. PCPs may treat Attention Deficit Hyperactivity Disorder (ADHD), depression and anxiety. All other behavioral health conditions must be referred to a contracted behavioral health specialist. American Indian members may receive their behavioral health services through Indian Health Services or tribally operated 638 facility, regardless of health plan enrollment or behavioral health assignment. PCPs that elect to prescribe medications to treat ADHD, depression, or anxiety disorders must complete an annual assessment of the member's behavioral health condition and treatment plan. Payment for behavioral health screenings and assessments are included as part of the EPSDT visit and are not separately billable services. Developmental surveillance shall be performed with the PCP at each EPSDT visit.

NOTE: CPT code 96101 - PSYCHOLOGICAL TESTING (includes psycho-diagnostic assessment of emotionality, intellectual abilities, personality and psychopathology) is not a separately billable service. The code may be billed on the claim to indicate the service was performed, but payment will be included in the fee paid for the EPSDT visit.

5. Developmental Screening Tools used by a PCP - AHCCCS approved developmental screening tools should be utilized for developmental screening by all participating PCPs who care for EPSDT-age members. PCPs must be trained in the use and scoring of the developmental screening tools, as indicated by the American Academy of Pediatrics (A list of available training resources may be found in the Arizona Department of Health Services website at www.azdhs.gov/clinicians/training-opportunities/developmental/index.php). The developmental screening should be completed for EPSDT members from birth through three years of age during the 9th month, 18th month and 24th month EPSDT visits. A copy of the screening tool must be kept in the medical record. Use of AHCCCS approved developmental screening tools may be billed separately using CPT-4 code 96110 (Developmental screening, with interpretation and report, per standardized instrumentation) for the 9th month, 18th month and 24th month visit when the developmental screening tool is used. A developmental screening CPT code (with EP modifier) must be listed in addition to the preventive medicine CPT codes. Other CPT-4 codes, such as 96111 – Developmental Testing (includes assessment of motor, language, social, adaptive) are not considered screening tools and are not separately billable. To receive the developmental screening tool payment, the modifier EP

must be added to the 96110. For claims to be eligible for payment of code 96110; the provider must have satisfied the training requirements, the claim must be a 9, 18, or 24-month EPSDT visit, and an AHCCCS approved developmental screening tool must have been completed.

- a. AHCCCS approved developmental screening tools include:
 - a. The Parent's Evaluation of Developmental Status (PEDS) tool which may be obtained from www.pedstest.com or www.forepath.org (Age range: Birth to 8 years of age)
 - b. Ages and Stages Questionnaire (ASQ) tool which may be obtained from www.agesandstages.com/ (Age range: Birth to 5 years of age)
 - c. The Modified Checklist for Autism in Toddlers (MCHAT) may be used only as a screening tool by a primary care provider, for members 15-30 months of age, to screen for autism when medically indicated. Copies of the completed tools must be retained in the medical record.(Age range: 15 to 30 months)
6. A comprehensive unclothed physical examination.
7. Appropriate immunizations according to age and health history (administration of the immunizations may be billed in addition to the EPSDT visit using the CPT-4 code appropriate for the immunization with an SL modifier). Combination vaccines are paid as one vaccine. Providers must be registered as Vaccines for Children (VFC) providers and VFC vaccines must be used.
8. Laboratory tests including blood lead screening assessment and blood lead testing appropriate to age and risk, anemia testing and diagnostic testing for sickle cell trait (if a child has not been previously tested with sickle cell preparation or a hemoglobin solubility test). EPSDT covers blood lead screening. Blood lead screening is required for children under the age of six based on the child's risk as determined by either the member's place of residence zip code or the presence of other known high risk factors, as specified in the Arizona Department of Health Services Targeted Lead Screening Plan.

NOTE: Payment for laboratory services that are not separately billable and considered part of the payment made for the EPSDT visit include but are not limited to: 99000, 36415, 36416, 36400, 36406 and 36410. In addition, payment for all laboratory services must be in accordance with limitations or exclusions specified in the health plan contract with the providers.
9. Health education, counseling, and chronic disease self-management are not separately billable services and are considered part of the EPSDT visit payment.
10. Appropriate oral health screening, intended to identify oral pathology, including tooth decay and/or oral lesions, and the application of fluoride varnish conducted by a physician, physician's assistant or nurse practitioner. Application of fluoride varnish may be billed separately from the EPSDT visit using CPT code 99188. Fluoride varnish is limited in a primary care provider's office to once every six months, during an EPSDT visit for children who have

reached six months of age with at least one tooth erupted, with recurrent applications up to two years of age.

11. Appropriate vision, hearing, and speech screenings are covered during an EPSDT visit. EPSDT covers eye examinations as appropriate to age according to the AHCCCS EPSDT Periodicity Schedule (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 and hearing requirements provided in a PCP's office during an EPSDT visit, are considered part of the EPSDT visit and are not a separately billable services.

Ocular photo screening with interpretation and report, bilateral (CPT code 99177) is covered for children age's three to six as part of the EPSDT visit due to challenges with a child's ability to cooperate with traditional chart based vision screening techniques. Ocular photo screening is limited to a lifetime coverage limit of one. This procedure, although completed during the EPSDT visit, is a separately billable service and is eligible for a one-time only enhanced reimbursement (use 99177-EP on claim form).

Note: Automated visual screening, described by CPT code 99177, is not recommended for or covered by AHCCCS when used to determine visual acuity for purposes of prescribing glasses or other corrective devices.

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.

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

- Each hospital or birthing center screens all newborns using a physiological hearing screening method prior to initial hospital discharge.
- Each hospital or birthing center provides outpatient re-screening for babies who were missed or are referred from the initial screening. Outpatient re-screening must be scheduled at the time of the initial discharge and completed between two and six weeks of age.
- When there is an indication that a newborn or infant may have a hearing loss or congenital disorder, the family must be referred to the PCP for appropriate assessment, care coordination and referral(s), and
- All infants with confirmed hearing loss receive services before turning six months of age.

12. 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
- Traveling/emigrating from, or having significant contact with persons indigenous to, endemic countries

16.1 EPSDT SERVICE STANDARDS

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

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

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

- **Immunizations** - EPSDT covers all child and adolescent immunizations as specified in the Centers for Disease Control and Prevention (CDC) recommended childhood immunization schedules. All appropriate immunizations must be provided to establish, and maintain, up-to-date immunization status for each EPSDT age member. (Refer to the CDC website at <http://www.cdc.gov/vaccines/schedules/index.html> for current immunization schedules.) The vaccine schedule shall also reflect current state statutes governing school immunization requirements as listed on www.AZADHS.gov. If appropriate, document in the member's medical record the member/guardian/designated representative's decision not to utilize EPSDT services or receive immunizations. AHCCCS will cover the human papilloma virus (HPV) vaccine for female and male EPSDT members' age 11 to 21 years of age. AHCCCS will cover members nine and ten years of age, if the member is deemed to be in a high-risk situation. For adult immunizations, refer to AMPM Policy 310-M, Immunizations.

Providers must coordinate with the Arizona Department of Health Services (ADHS) Vaccines for Children (VFC) program in the delivery of immunization services. Immunizations must be provided according to the Advisory Committee on Immunization Practices Recommended Schedule. (Refer to the CDC website <http://www.cdc.gov/vaccines/schedules/index.html> where this information is included).

Providers must enroll and re-enroll annually with the VFC program, in accordance with AHCCCS Contract requirements. The Contractor shall not utilize AHCCCS funding to purchase vaccines covered through the VFC program for members younger than 19 years of age. Providers must document each EPSDT age member's immunizations in the Arizona State Immunization Information System (ASIIS) registry. In addition, Contractors must ensure providers maintain the ASIIS immunization records of each EPSDT member in ASIIS, in accordance with A.R.S. Title 36, Section 135. Health Choice Arizona is required

to monitor provider's compliance with immunization registry reporting requirements and take action to improve reporting when issues are identified.

- **Eye Examinations and Prescriptive Lenses** - EPSDT covers eye examinations as appropriate to age, according to the AHCCCS EPSDT Periodicity Schedule, and as medically necessary using standardized visual tools. Vision exams provided in a PCP's office during an EPSDT visit are not a separately billable service. Prescriptive lenses and frames are provided to correct or ameliorate defects, physical illness and conditions discovered by EPSDT screenings, subject to medical necessity. Frames for eyeglasses are also covered.

Blood Lead Screening - EPSDT covers blood lead screening for all members at 12 months and 24 months of age and for those members between the ages of 24 and 72 months who have not been previously tested or who missed either the 12th 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 I response to parental concerns. Additional Screening for children under six years of age is based on the child's risk as determined by either the member's residential zip code or presence of other known risk factors.

Blood lead test levels that are equal to or greater than 10 micrograms of lead per deciliter of whole blood which is obtained through a capillary specimen or finger stick, must be confirmed using a venous blood sample.

A verbal blood lead screening risk assessment must be completed at each EPSDT visit for children six through 72 months of age (six years of age) to assist in determining risk.

Providers must report all blood lead levels equal to or greater than 10 micrograms to Arizona Department of Health Services per A.A.C. R9-4-302.

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

- **Organ and Tissue Transplantation Services** – Note: Please refer to the AHCCCS Medical Policy Manual, Chapter 300, Policy 310-DD with Attachment A for further discussion of AHCCCS-covered transplantations.
- **Tuberculosis Screening** - EPSDT covers TB screening. Providers must ensure timely reading of the TB skin test for members who received TB testing and treatment if medically necessary.
- **Nutritional Assessment and Nutritional Therapy**- Nutritional assessments are conducted to assist EPSDT members whose health status may improve with nutrition intervention. Health Choice Arizona covers the assessment of nutritional status provided by the member's primary care provider (PCP) as a part of the EPSDT screenings specified in the AHCCCS EPSDT Periodicity Schedule, and on an inter-periodic basis as determined necessary by the member's PCP. Health Choice Arizona also covers nutritional assessments provided by a registered dietitian when ordered by the member's PCP. This includes EPSDT eligible members who are under or overweight.

To initiate the referral for a nutritional assessment, the PCP must use the Health Choice Arizona prior authorization form.

If a member qualifies for nutritional therapy due to a medical condition as outlined below, Health Choice Arizona is the primary payer for:

- Infant formulas above the amount provided through the WIC program or formula types deemed medically necessary that are not provided through the WIC program. **NOTE:** This does not include formulas outside of those offered through the WIC program that are not medically necessary, such as formula types selected based on brand preference.
 - i. For AHCCCS members, infants and children under the age of five, requiring formula types deemed medically necessary that are not provided through the WIC program, an AHCCCS Certificate of Medical Necessity for Commercial Oral Nutritional Supplements (Chapter 430, Attachment B) is to be submitted directly to Health Choice Arizona, as WIC is considered a secondary payer of specialty exempt formulas.
 - ii. For AHCCCS members, infants (0-1 year), requiring infant formulas above the amount provided through the WIC program, an AHCCCS Certificate of Medical Necessity for Commercial Oral Nutritional Supplements (Chapter 430, Attachment B) is to be submitted directly to Health Choice Arizona for the amount of formula that exceeds that provided through the WIC program.

NOTE: WIC is considered a secondary payer of infant formulas above the amount provided through the WIC program.

- Medical foods
- Parenteral feedings
- Enteral feedings

If an AHCCCS covered member has a congenital metabolic disorder identified through the Bloodspot Newborn Screening Panel (such as Phenylketonuria, Homocystinuria, Maple Syrup Urine Disease or Galactosemia), refer to AMPM Policy 310-GG Nutritional Therapy, Metabolic Goods, and Total Parenteral Nutrition

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

- Enteral nutritional therapy: Provides liquid nourishment directly to the digestive tract of a member who cannot ingest an appropriate amount of calories to maintain a healthy nutritional status.
- Parenteral nutritional therapy: Provides nourishment through the venous system to members with severe pathology of the alimentary tract, which does not allow for absorption of sufficient nutrients to maintain weight and strength appropriate for the

individual's general condition.

- 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.
 - Prior Authorization is required for commercial oral nutritional supplements unless the member is also currently receiving nutrition through enteral or parenteral feedings.
 - Medical necessity for commercial oral nutritional supplements must be determined on an individual basis by the member's PCP or specialty physician, using at least the criteria specified in this policy. The PCP or specialty physician must use the AHCCCS approved form, "Certificate of Medical Necessity for Commercial Oral Nutritional Supplements" (Policy 430, Attachment B) to obtain PA.
 - The Certificate of Medical Necessity for Commercial Oral Nutritional Supplements must document that the PCP or attending physician has provided nutritional counseling as a part of the EPSDT services provided to the member. The documentation must specify alternatives that were tried in an effort to boost caloric intake and/or change food consistencies before considering commercially available nutritional supplements for oral feedings, or to supplement feedings.

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

(a) The member has been diagnosed with a chronic disease or condition, is below the recommended BMI percentile (or weight-for-length percentile for members less than two years of age) for the diagnosis per evidence based guidance as issued by the American Academy of Pediatrics, and there are no alternatives for adequate nutrition.

Or

At least two of the following criteria have been met:

- The member is at or below the 10th percentile for weight-for-length or BMI on the appropriate growth chart for age and gender, as recommended by the CDC, for three months or more.
- The member has reached a plateau in growth and/or nutritional status for more than six months (prepubescent) or more than three months if the member is an infant less than one year of age
- The member has already demonstrated a medically significant decline in weight within the past three months (prior to the assessment)

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

Additionally, each of the following requirements must be met:

- The member has been evaluated and treated for medical conditions which may cause problems with growth
- The member has had a trial of higher caloric foods, blenderized foods or commonly available products that may be used as a dietary supplement for a period no less than 30 days in duration.
- Supporting documentation must accompany the Certificate of Medical Necessity for Commercial Oral Nutritional Supplements (Members 21 Years of Age or Greater- Initial or Ingoing Requests). This documentation must demonstrate that the member meets all of the required criteria and includes:
 - Initial Requests
 - a. Documentation demonstrating that nutritional counseling has been provided as a part of the health risk assessment and screening services provided to the member by the PCP or specialty provider, or through consultation with a registered dietitian.
 - b. Clinical notes or other supporting documentation dated within three months of the request, providing a detailed history and thorough physical assessment demonstrating evidence of member meeting all of the required criteria, as indicated on the Certificate of Medical Necessity. The physical assessment must include the member's current/past weight-for-length and BMI percentiles (if member is two years of age or older).
 - c. Documentation detailing alternatives that were tried in an effort to boost caloric intake and/or change food consistencies that have proven unsuccessful in resolving the nutritional concern identified, as well as member adherence to the prescribed dietary plan/alternatives attempted.
 - Ongoing Requests
 - a. Subsequent submissions must include a clinical note or other supporting documentation dated within three months of the request, that includes the members overall response to supplemental therapy and justification for continued supplement use. This must include the member's tolerance to formula, recent hospitalizations, current weight-for-length or BMI percentile (if member is two year of age or older).

NOTE: Members receiving nutritional therapy must be physically assessed by the member's PCP, specialty provider, or registered dietitian at least annually.

- b. Additionally, documentation demonstrating encouragement and assistance provided to the caregiver in weaning the member from supplemental nutritional feedings should be included, when appropriate.

PROVIDER REQUIREMENTS

When requesting initial or ongoing Prior Authorization (PA) for commercial oral nutritional supplements, providers must ensure the following:

- a. Documents are submitted with the completed Certificate of Medical Necessity to support all of the necessary requirements for Commercial Oral Nutritional Supplements as detailed above.
- b. If the member's parent or guardian elects to prepare the member's food, education and training regarding proper sanitation and temperatures to avoid contamination of foods that are blended or specially prepared for the member is provided.
- c. Ongoing monitoring is conducted to assess member adherence/tolerance to the prescribed nutritional supplement regimen and determine necessary adjustments to the prescribed amount of supplement are appropriate based on the member's weight loss/gain.
- d. Documentation demonstrating encouragement and assistance provided to the caregiver in weaning the member from the necessity for supplemental nutritional feedings, when appropriate.

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

- **Oral Health Services** - As part of the physical examination, the physician, physician's assistant or nurse practitioner must perform an oral health screening. A screening is intended to identify gross dental or oral lesions but is not a thorough clinical examination and does not involve making a clinical diagnosis resulting in a treatment plan. An oral health screening must be part of an EPSDT screening conducted by a PCP, however, it does not substitute for examination through direct referral to a dentist. PCPs are expected to refer EPSDT members for appropriate services based on needs identified through the screening process and for routine dental care based on the AHCCCS Dental Periodicity Schedule (see Chapter 430, Attachment A). Evidence of this referral must be documented on the EPSDT form.

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

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

cochlear implantation in instances where individuals have one functioning cochlear implant.

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

- A diagnosis of bilateral profound sensorineural deafness (using age-appropriate standard testing), with little or no benefit from a hearing (or vibrotactile) aid, as established by audiologic and medical evaluation
- Presence of an accessible cochlear lumen structurally suited to implantation, with no lesions in the auditory nerve and acoustic areas of the central nervous system, as demonstrated by CT scan or other appropriate radiologic evaluation
- No known contraindications to surgery
- Demonstrated age appropriate cognitive ability to use auditory clues, and
- The device must be used in accordance with the FDA approved labeling

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

- Complete auditory testing and evaluation by an otolaryngologist, speech language pathologist or audiologist
- Pre-surgery inpatient/outpatient evaluation by a board certified otolaryngologist
- Diagnostic procedures and studies, including CT scan or other appropriate radiologic evaluation, for determining candidacy suitability
- Pre-operative psychosocial assessment/evaluation by psychologist or licensed counselor
- Prosthetic device for implantation (must be non-experimental/non-investigational and be FDA approved and used according to labeling instructions)
- Surgical implantation and related services
- Post-surgical rehabilitation, education, counseling and training
- Equipment maintenance, repair and replacement of the internal/external components or both if not operating effectively and is cost effective

Examples include but are not limited to: the device is no longer functional or the used component compromises the member's safety. Documentation which establishes the need to replace components not operating effectively must be provided at the time prior authorization is sought. Cochlear implantation requires PA from the Health Choice Arizona Medical Director.

- **Osseointegrated implants (bone anchored hearing aid [BAHA])** – Health Choice Arizona coverage of medically necessary services for osseointegrated implantation is limited to EPSDT members. Osseointegrated implants are devices implanted in the skull that replace the function of the middle ear and provide mechanical energy to the cochlea via a mechanical transducer. These devices are indicated only when hearing aids are medically inappropriate or cannot be utilized due to congenital malformation, chronic disease, severe sensorineural hearing loss or surgery. Osseointegrated implantation requires PA from the Health Choice Arizona Medical Director.
- **Conscious Sedation** – Health Choice Arizona covers conscious sedation for members receiving EPSDT services. Conscious sedation provides a state of consciousness that

allows the member to tolerate an unpleasant procedure while continuously maintaining adequate cardiovascular and respiratory function, as well as the ability to respond purposely to verbal command and/or tactile stimulation.

Coverage is limited to the following procedures:

- Bone marrow biopsy with needle or trocar
- Bone marrow aspiration
- Intravenous chemotherapy administration, push technique
- Chemotherapy administration into central nervous system by spinal puncture
- Diagnostic lumbar spinal puncture
- Therapeutic spinal puncture for drainage of cerebrospinal fluid

Health Choice Arizona will consider conscious sedation for other procedures on a case-by-case basis.

- **Behavioral Health Services** – Health Choice Arizona covers behavioral health services for members eligible for EPSDT services described in AMPM Chapter 300, Policy 310-B, also see Chapter 18 Behavioral Health Services of this provider manual. EPSDT behavioral health services include the services listed in Federal Law 42 USC 1396d (a) necessary to correct or ameliorate mental illnesses and conditions discovered by the screening services whether or not the services are covered under the AHCCCS State Plan. Please refer to the AHCCCS clinical guidelines (Appendix E of the AMPM) for the diagnosis of attention deficit disorder/attention deficit hyperactivity disorder, depression and/or anxiety disorders. The AHCCCS clinical guidelines include assessment tools and algorithms. The clinical guidelines are to be used by the PCPs as an aid in treatment decisions.

As adopted by AHCCCS, Health Choice Arizona has integrated the 12 Guiding Principles to maintain the integrity of the best practices and approaches to providing behavioral health services for children (EPSDT age members). Health Choice Arizona conducts bi-annual provider audits for those providers who are prescribing psychotropic medications to ensure members are receiving the appropriate treatment and being monitored according to contractual requirements.

12 Guiding Principles:

1. Collaboration with the child and family: Respect for and active collaboration with the child and parents is the cornerstone to achieving positive behavioral health outcomes. Parent and children are treated as partners in the assessment process, and the planning, delivery, and evaluation of behavioral health services, and their preferences are taken seriously.
2. Functional Outcomes: Behavioral health services are designed and implemented to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Implementation of the behavioral health services plan stabilizes the child's condition and minimizes safety risks.

3. Collaboration with Others: When children have multi-agency, multi-system involvement, a joint assessment is developed and a jointly established behavioral health services plan is collaboratively implemented. Client centered teams plan and deliver services. Each child's team includes the child, parents, any foster parent, and any individual important in the child's life who is invited to participate by the child or parents. The team also includes all other persons needed to develop an effective plan, including as appropriate, the child's teacher, the child's Child Protective Service and/or Division of Developmental Disabilities case worker, and the child's probation officer. The team develops a common assessment of the child's and family's strengths and needs, develops an Individualized Service Plan and monitors the implementation of the plan and makes adjustments in the plan if it is not succeeding.
4. Accessible Services: Children have access to a comprehensive array of behavioral health services, sufficient to ensure that they receive the treatment they need. Case management is provided as needed. Behavioral health services plans identify transportation the parents and the child need to access behavioral health services, and how transportation assistance will be provided. Behavioral health services are adapted or created when they are needed but not available.
5. Best Practices: Behavioral health services are provided by competent individuals who are adequately trained and supervised. Behavioral health service plans identify and appropriately address behavioral symptoms that are reactions to death of a family member, abuse or neglect, learning disorders, and other similar traumatic or frightening circumstances, substance abuse problems, the specialized behavioral health needs of children are developmentally disabled, maladaptive sexual behavior, including abusive conduct and risky behavior, the need for stability and the need to promote permanency in the class members' lives, especially class members in foster care. Behavioral health services are continuously evaluated and modified if ineffective in achieving desired outcomes.
6. Most appropriate setting: Children are provided behavioral health services in their home and community to the extent possible. Behavioral health services are provided in the most integrated setting appropriate to meet the child's needs. When provided in a residential setting, the setting is the most integrated and most home-like setting that is appropriate to the child's needs.
7. Timeliness: Children identified as needing behavioral health services are assessed and served promptly.
8. Services tailored to the child and family: The unique strengths and needs of children and their families dictate the type, mix, and intensity of behavioral health services provided. Parents and children are encouraged and assisted to articulate their own strengths and needs, the goals they are seeking, and what services they think are required to meet these goals.
9. Stability: Behavioral health service places strive to minimize multiple placements. Service plans identify whether a class member is at risk of experiencing a placement disruption and, if so, identify the steps to be taken to minimize or eliminate the risk. Behavioral health service plans anticipate crisis that might develop and include specific strategies and services that will be employed if a crisis develops. In responding to crises, the behavioral health system uses all appropriate behavioral health services to help the child remain at home,

minimize placement disruptions, and avoid the inappropriate use of the police and the criminal justice system. Behavioral health service plans anticipate and appropriately plan for transition in children's lives, including transitions to new schools and new placements, and transitions to adult services.

10. Respect for the child and family's unique cultural heritage: Behavioral health services are provided in a manner that respects the cultural tradition and heritage of the child and family. Services are provided in Spanish to children and parents whose primary language is Spanish.
11. Independence: Behavioral health services include support and training for parents in meeting their child's behavioral health needs, and support and training for children in self-management. Behavioral health service plans identify parents' and children's needs for training and support to participate as partners in the assessment process, and in the planning and delivery, and evaluation of services, and provide that such training and support, including transportation assistance, advance discussions, and help with the understanding of written materials, will be made available.
12. Connection to natural supports: The behavioral health system identifies and appropriately utilizes natural supports available from the child and parents' own network of associates, including friends and neighbors, and from community organizations, including service and religious organizations.

NOTE: PCPs are encouraged to implement postpartum depression screenings to identify and refer mothers who would benefit from additional treatment due to concerns related to postpartum depression during EPSDT visits for infants up to one year of age.

- **Religious Non-Medical Health Care Institution Services** – Health Choice Arizona covers religious non-medical health care institution services for members eligible for EPSDT services as described in AMPM Chapter 1200, Policy 1210.
- **Case Management Services** – Health Choice Arizona covers care management services for both physical and behavioral health care, as appropriate for members eligible for EPSDT services. In EPSDT, care management involves identifying the health needs of a child, ensuring necessary referrals are made, maintaining health history, and initiating further evaluation/diagnosis and treatment when necessary.
- **Chiropractic Services** – Health Choice Arizona covers chiropractic services to members eligible for EPSDT services when ordered by the member's PCP and approved by Health Choice Arizona in order to ameliorate the member's medical condition.
- **Personal Care Services** – Health Choice Arizona covers personal care services, as appropriate, for members eligible for EPSDT services.
- **Incontinence Briefs** – Incontinence briefs, including pull-ups and incontinence pads, are covered in order to prevent skin breakdown and to enable participation in social, community, therapeutic and educational activities under the following circumstances:
 - The member is over three years and under twenty-one years old
 - The member is incontinent due to a documented disability that causes incontinence of bowel and/or bladder

- The PCP or attending physician has issued a prescription ordering the incontinence briefs
- Incontinence briefs do not exceed 240 briefs per month unless the prescribing physician presents evidence of medical necessity for more than 240 briefs per month for a member diagnosed with chronic diarrhea or spastic bladder
- Prior authorization must be obtained from Health Choice Arizona
- **Medically Necessary Therapies** – Health Choice Arizona covers medically necessary therapies including physical therapy, occupational therapy and speech therapy necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services. Therapies are covered under both an inpatient and outpatient basis when medically necessary.

SICK VISIT PERFORMED IN ADDITION TO AN EPSDT VISIT-

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

- 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.
- The “sick visit” is documented on a separate note.
- 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).
- The current status (not history) of the abnormality or preexisting condition is the basis of determining medical necessity.

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

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

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

Vaccine for Children (VFC) Program: Health Choice Arizona, in accordance with AHCCCS and federal requirements, provides immunization services for EPSDT eligible children and young adults under the age of 19. All PCPs treating members under the age of 19 must enroll every year with the Vaccine for Children (VFC) Program through Arizona Department of Health Services (ADHS) in order to deliver EPSDT immunizations. Through the VFC Program, the federal government purchases and makes available to the states, free of charge, vaccines for children

under age nineteen (19) who are eligible. Health Choice Arizona provides an administration fee for each VFC antigen administered to a Health Choice Arizona member. Health Choice Arizona cannot utilize AHCCCS funding to reimburse VFC vaccines for members younger than 19 years of age.

The PCP will need to contact Arizona Department of Health Services at (Arizona Immunization Program-VFC): <http://azdhs.gov/index.php> for enrollment information. Once the enrollment package is received the PCP:

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

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

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

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

EPSDT Notification: The Member Handbook, which is found on our website or can be requested to be mailed, includes a section that explains the benefits of the EPSDT program. Health Choice Arizona mails a notice to the parent/guardian of each EPSDT eligible member, informing them when an EPSDT exam is due with instructions to contact their PCP to schedule an appointment. The PCP is responsible for the following:

Informing EPSDT eligible members who fail to make or keep EPSDT visits by faxing or emailing this information to the EPSDT Department at: Fax (480) 760-4716 or HCH.EPSDTCHEC@steward.org

- Completing standard EPSDT Tracking Forms, during every EPSDT visit
- Placing copies of the EPSDT Tracking Forms and developmental screening tool, as appropriate, signed by the provider, in the member's medical record
- Fax or email a copy of the completed EPSDT Tracking Form and developmental screening tool, as appropriate, to the Health Choice EPSDT Coordinator Fax (480) 760-4716 or email HCH.EPSDTCHEC@steward.org

- The tracking forms should be forwarded on a daily or weekly basis to ensure timely processing.

Please do not submit EPSDT Tracking Forms or developmental screening tool copies to AHCCCS

Administration

EPSDT Tracking Forms are available from your Provider Performance Representative, fax the EPSDT Tracking Form Order to Health Choice Arizona to (480) 784-2933, or by downloading them from the AHCCCS web site at <http://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/AppendixB.pdf>

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

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

- PCPs are encouraged to use their monthly member roster to identify and outreach to assigned members who are due for an EPSDT visit
- Refer to the EPSDT Periodicity Schedule (Exhibit 430-1) for the required age appropriate services for children under the age of 21
- Refer members to WIC and Head Start as appropriate
- Refer members to AzEIP services as appropriate
- Initiate and coordinate referrals to behavioral health providers as necessary

16.2 CHILDREN WITH SPECIAL HEALTH CARE NEEDS

Early referral of children identified with special health care needs is encouraged to assure the most successful results. Health Choice Arizona will provide care management services for referred children to ensure appropriate care coordination support services can be implemented.

General Eligibility

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

Medical Eligibility

Special health care conditions include, but are not limited to the following examples:

- Deformities present at birth or acquired, such as club feet, dislocated hip, cleft palate, mal-united fractures, scoliosis, spina bifida, and congenital GU and GI anomalies
- Many muscle and nerve disorders
- Epilepsy (only when not well managed or controlled in spite of medication within therapeutic range)
- Heart conditions due to congenital malformation

- Certain eye and ear conditions may be eligible
- Cystic fibrosis
- Burn scars which are causing functional limitations
- PKU and other related metabolic disorders
- Sickle cell anemia
- Neurofibromatosis
- Hydrocephalus
- Rheumatoid Arthritis
- Rehabilitative Care three months after traumatic injury

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

16.3 ARIZONA EARLY INTERVENTION PROGRAM (AZEIP)

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

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

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

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

To ensure coordination of care is taking place and provision of EPSDT and early intervention services are being provided the following steps will be followed:

1. AZEIP will screen and, if needed, conduct evaluation to determine the child's eligibility.

2. If the child is determined to be AzEIP eligible, AzEIP will develop an Individualized Family Service Plan (IFSP) that will identify:
 - a) The child's present level of development
 - b) Child outcomes
 - c) The services that are needed to support the family and child in reaching the IFSP outcomes
 - d) Planned start date for each early intervention service(s) identified on the IFSP
3. The AzEIP Service Coordinator will send via fax or email the "AzEIP Member Service Request form" and copies of the evaluation/developmental summaries completed during the IFSP process to Health Choice Arizona within 2 business days of completing the IFSP.
4. Health Choice Arizona will enter the AzEIP Member Service request into the prior authorization system within 1 business day of receipt of the request.
5. Health Choice Arizona will forward the documentation to the PCP within 2 business days.
6. PCP is required to review all AzEIP documentation and determine which services are medically necessary based on review of the documentation. If the PCP needs to see the child before determining the child's need for services, the appointment will be scheduled as a routine appointment.
7. Within 10 business days from the date Health Choice Arizona forwards the documentation to the PCP, PCP will determine which services are medically necessary by indicating on the AzEIP Referral Form and sign the form. The PCP will send the form back to Health Choice Arizona along with a script (s), and medical records that support the medical necessity for services.
8. Within 2 business days Health Choice Arizona will notify the PCP, service provider and AzEIP Service Coordinator of the authorization determination
9. The AHCCCS Health Plan must send a Notice of Action letter to the PCP, the AzEIP service coordinator, the member's guardian/ parent, and the AHCCCS designee denying the service pending examination by the PCP.
10. AzEIP AHCCCS Member Service Request form (AMPM Chapter 430, Attachment D) must also be returned to the AzEIP service coordinator indicating the PCP wishes to examine the member and services are denied pending examination by the PCP.
11. AHCCCS EPSDT Coordinators must assist the member's guardian/ parent in making an appointment with the PCP and follow up with the PCP to ensure all medically necessary services identified on the AzEIP AHCCCS Member Service Request form are considered for medical necessity.
12. After the member is examined by the PCP and a determination is made, steps 1 through 8 should be followed.

Health Choice Arizona encourages providers to refer children 0-3 years of age with developmental disabilities to AzEIP. AzEIP will recommend medically necessary services through Health Choice Arizona. Health Choice Arizona will act as the liaison between the provider, AzEIP and the servicing agency to coordinate medically necessary services for the member. Health Choice Arizona will have Pediatric care management services available to assist with care coordination needs.

To initiate the referral process contact AzEIP directly at (602) 532-9960 or via the AzEIP website at <https://des.az.gov/services/disabilities/developmentalinfant>

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

For assistance with issues related to child health, the EPSDT program, and developmental screening, you may call Health Choice Arizona Member Services at (800) 322-8670 and ask to speak to the EPSDT Department.

16.4 TRANSPORTATION

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

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

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

16.5 FAMILY PLANNING SERVICES

Health Choice Arizona members who voluntarily choose to delay or prevent pregnancy are eligible for family planning services. These services are at no cost to members. Primary Care Obstetricians (PCO) are required to inform the member of family planning options during the member's last trimester and postpartum visits. PCOs are required to submit a claim for all family planning services.

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

Covered family planning services include:

- Pregnancy screening
- Contraceptive counseling
- Pharmaceuticals
 - Oral and injectable contraceptives
 - Subdermal implantable contraceptives

- Intrauterine Devices
- Diaphragms
- Condoms
- Foams
- Suppositories
- Long Acting Reversible Contraceptive (LARC)
- Post-coital emergency oral contraceptive within 72 hours after unprotected sexual intercourse
- Screening and Treatment for Sexually Transmitted Infections for female and males
- Treatment of complications resulting from contraceptive use
- Sterilization (for both male and female members)
- Pregnancy Termination and Hysterectomy (refer to exhibit 16.5 Hysterectomy Consent Form)
- Natural Family Planning Education
- Medical and laboratory examinations related to family planning
- Radiological procedures related to family planning

16.6 FAMILY PLANNING SERVICE FOR LONG ACTING REVERSIBLE CONTRACEPTION (LARC)

Health Choice Arizona will reimburse LARC services through regular claims process submitted on a 1500 claim form. Health Choice Arizona will no longer accept billing with an invoice. The family planning provider must provide proper counseling to the eligible member to minimize the likelihood of a request for early removal. Counseling information is to include a statement to the member indicating if the implant is removed within two years of insertion, the member may not be an appropriate candidate for reinsertion for at least one year after removal.

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

Non-covered family planning services:

- Pregnancy termination except as specified in AMPM Policy 410 and/or pregnancy termination counseling
- Hysterectomies for the purpose of sterilization
- Infertility services
- Reversal of voluntary sterilization

There is no cost for family planning services and supplies.

16.7 FAMILY PLANNING SERVICES FOR MEMBERS WHO LOSE AHCCCS ELIGIBILITY

In the event members lose AHCCCS eligibility, PCPs/PCOs are encouraged to help inform and direct such members to available community resources where they may receive low or no-cost

service. Resources are available on our Health Choice Arizona website, AHCCCS website and through Arizona 211.

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

16.8 WELL WOMAN PREVENTIVE SERVICES

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

- A physical (well exam) that assess the member's overall health
- Family Planning Counseling
- Mammogram
- Preconception Counseling-This does not include genetic testing
- Clinical breast exam
- Pelvic Exam (as necessary, according to current recommendations and best practice standards)
- Review and administration of immunizations, screenings and testing as appropriate for age and risk factors
- Necessary referrals when the need for further evaluation, diagnosis and/or treatment is identified

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

- Hypertension screening
- Cholesterol screening
- Routine mammography annually after age 40 and at any age if considered medically necessary
- Pap smears
- Colon cancer screening
- Sexually transmitted infection screenings
- Tobacco/substance use, abuse and/or dependency
- Tuberculosis screening
- Human Immunodeficiency Virus (HIV) screening
- Immunizations
- Physical examinations
- Depression screening
- Interpersonal and domestic violence screening
- Family planning counseling

Preconception counseling that includes discussion regarding a healthy lifestyle before and between pregnancies that includes:

- a. Reproductive history and sexual practices
- b. Healthy weight, including diet and nutrition, as well as the use of nutritional supplements and folic acid intake
- c. Physical activity or exercise
- d. Oral health care
- e. Chronic disease management
- f. Emotional wellness
- g. Tobacco and substance use (caffeine, alcohol, marijuana and other drugs), including prescription drug use
- h. Recommended intervals between pregnancies

NOTE: Preconception counseling does not include genetic testing.

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

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

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

AHCCCS covers the Human Papilloma Virus (HPV) vaccine for female's members 11 to 26 years of age. AHCCCS also covers other immunizations for adults refer to AMPM Policy 310-M.

Health Choice Arizona monitors provider compliance with providing well-woman preventive care services through a medical record audit conducted by a delegated vendor. The vendor audits random provider charts to ensure well-woman preventive care services are being performed according to Health Choice Arizona policy and AHCCCS regulations.

All audit results are provided to the Quality Management Department and presented at Quality Committee at a minimum annually. Providers who fail to pass the audit will receive a corrective action plan, which will be monitored by the Quality Management Committee. All audit results are part of Health Choice Arizona's provider case file.

16.9 STERILIZATION

Members can request to have a sterilization procedure if the following criteria are met:

- Member must be 21 years or older
- Member must have completed a Federal Consent Form (see Exhibit 16.3) 30 days prior to the procedure. The member must be 21 years or older when the consent is signed
- Member has not been declared mentally incompetent
- Voluntary consent was obtained without coercion and 30 days, but not more than 180 days, have passed between the date of informed consent and the date of the sterilization, except in the case of a premature delivery or emergency abdominal surgery.
- Mental competency of the member has been determined
- Sterilization's only require PA if the member is under the age of 21 years. Provider will need to show medical necessity for the sterilization prior to age 21 years.
- Members may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since they gave informed consent for sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery

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

- Consent form requirements See 42CFR 441.25)
- Answers to questions asked regarding the specific procedure to be performed
- Notification that withdrawal of consent can occur at any time prior to surgery without affecting future care and/or loss of federally funded program benefits
- Explanation of available alternative methods
- Advice that the sterilization procedure is considered to be irreversible
- A thorough explanation of the specific sterilization procedure to be performed
- Descriptions of the discomforts and risks that may accompany or follow the procedure. This should include an explanation of the possible effects of the anesthetic to be used
- Advantages and disadvantages that may be expected as a result of the sterilization
- Notification that sterilization cannot be performed for at least 30 days once the consent

is signed

- All information should be presented to the member in a manner that is suitable to ensure that the information in the consent form is effectively communicated. Consideration of the member's English proficiency, reading skills, cultural or ethnic background, as well as the member's visual or auditory abilities must be taken into account when obtaining consent for sterilization

Bilateral Tubal Ligation (at time of delivery)

- Member must be 21 years or older
- Member must complete a Federal Consent Form (see Exhibit 16.3) and meet sterilization guidelines. The member must be 21 years or older when the consent is signed
- The procedure will be done immediately after delivery
- The performance of the BTL with delivery should not extend the normal hospitalization for vaginal (24-48 hours) or C Section (78 – 96 hours) deliveries

Sterilization consents cannot be obtained when a member:

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

16.10 OBSTETRICAL SERVICES

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

Member's Choice of PCO

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

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

- Referral by the Member's PCP (must be to a contracted OB) no authorization is required
- Geographic location of the member and provider

- Availability/limitation of the PCO
- Assessment of medical risk

Primary Care Obstetrician Responsibility (PCO)

The PCO must notify Health Choice Arizona of each pregnant woman at the beginning of her prenatal care (initial visit) by faxing a completed Maternal Health Risk Assessment for Total OB Authorization form. This Risk Assessment form is a critical component of coordinating care between Health Choice Arizona and the obstetrician or Maternal Fetal Medicine provider and MUST be completed and submitted promptly after the member's first visit. A copy of the member's ACOG notes may be submitted in lieu of the clinical documentation requested on the Maternal Risk Assessment form as long as all of the requested information is included in the notes. The Maternal Risk Assessment should be faxed to Health Choice Arizona at (480) 760-4762. Upon receipt of the Maternal Risk Assessment, the Maternal Child Health Department will issue a Total OB Notification number to the PCO. The PCO will use this number for all professional services related to the pregnancy. See Exhibit 16.10 for a copy of the Maternal Health Request for Total OB Authorization form.

Health Choice Arizona as a Secondary Insurance Plan

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

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

Education for Pregnant Women

During your patients' pregnancy, be sure to document any and all education done by you and your staff. Important topics to discuss with your patients include proper nutrition, screening for sexual transmitted infections, breast feeding, dangers of lead exposure, smoking cessation, physiology of pregnancy, labor and delivery process, warning signs, drug and alcohol avoidance, depression and postpartum depression as well as family planning options. PCOs are required to review the CSPMP once a trimester and for 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

OB ultrasound:

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

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

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

eviCore contact information:

Phone number (888) 693-3211

Fax number: (888) 693-3210

Provider Portal: <https://www.evicore.com/pages/providerlogin.aspx>

eviCore Clinical Guidelines are available at:

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

Prior Authorization and Referrals

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

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

Please refer to Chapter 6: Authorizations and Notifications for detailed information.

Women, Infants and Children

PCOs are required to educate all Health Choice Arizona pregnant members on the WIC Program as well as other appropriate community-based resources geared toward healthy pregnancy outcomes. For information regarding available services in your area related to WIC and nutrition, please contact your local WIC office.

Transfer of Care

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

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

Prenatal Appointments

PCOs must make it possible for Health Choice Arizona members to obtain initial prenatal care based on the standards listed in *Chapter 3: Provider Responsibility*. Providers are encouraged to use an appointment system that monitors missed appointments. Health Choice Arizona monitors appointment availability through various means.

Providers who do not meet the AHCCCS standard may have a Corrective Action Plan (CAP) placed on their membership or a reduction in assigned members.

Health Choice Arizona members must be able to schedule an appointment within the following time frames.

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

Perinatal and Postpartum Depression Screening

PCOs must conduct a perinatal depression screening at a minimum once during the member's pregnancy and also during a postpartum visit. If a positive screening is obtained appropriate counseling and referrals must be made. The PCO can initiate a behavioral health referral, the member can self-refer and/or the PCO can contact Health Choice Arizona member services for assistance. Please refer to Chapter 18 Behavioral Health Services for further guidance on the referral process. PCOs at any time during the pregnancy can make a referral to the Maternal Child Health Case Management Department for outreach and support services.

If a member has a significant behavioral health concern impacting the pregnancy the OB Case Management will work collaboratively with a behavioral health case manager to ensure the member receives all needed services to have a healthy pregnancy and baby.

EPSDT Services for OB Members

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

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

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

Laboratory Services for OB Members

Laboratory services for pregnant members must be referred to a Health Choice Arizona contracted laboratory unless otherwise noted on the Physician Office Lab Testing (POLT) List found on our website www.HealthChoiceAZ.com under 'Provider Education'. Please refer to the Provider Directory for the contracted laboratory in your area.

HIV Testing for OB Members

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

Reporting Non-Compliant OB High Risk Members

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

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

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

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

- Previous pre-term delivery at or before 37 weeks gestation and/or delivery of an infant weighing less than 2500 grams.
- Multiple gestation pregnancy (twins or more).
- Placenta Previa, Placental Abruption
- Seizure disorder
- Heart disease
- Renal disease
- Teen pregnancies (17 years of age or younger)
- Women with complex psychological, emotional, education or physical support needs

- Non-adherent behaviors
- Current preterm labor, PIH or diabetes requiring insulin and/or nutritional education
- Premature or preterm rupture of membranes
- Homeless
- Reoccurring sexually transmitted infections
- Substance abuse
- Domestic violence

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

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

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

Storkline

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

Reporting Births

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

Genetic Consult and Testing

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

Genetic testing is not covered to determine the likelihood of associated medical conditions occurring in the future. Genetic testing is not a covered service for purposes of determining current or future family planning.

Infertility

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

Pregnancy Terminations (Including Mifepristone)

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

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

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

The attending physician must acknowledge that a pregnancy termination has been determined medically necessary by submitting the AHCCCS Certificate of Necessity for Pregnancy Termination in addition to the Prior Authorization request form and clinical information that supports the medical necessity for the procedure.

The Certificate of Necessity for Pregnancy Termination form is available by calling the Health Choice Arizona Maternal and Child Health Department at (800) 828-7514. The Health Choice Arizona Chief Medical Officer will review all requests for pregnancy terminations.

Cases of Incest, Rape or Incapacitated Adult

If the pregnancy is a result of rape or incest, the following additional documentation must be included with the Certificate of Necessity for Pregnancy Termination form and part of the member's medical record:

- Documentation that the incident was reported to the proper authorities, including the name of the agency to which it was reported, the report number if available, and the date the report was filed. This documentation requirement must be waived if the treating

physician certifies that, in his or her professional opinion, the member was unable, for physical or psychological reasons, to comply with the requirement

- A copy of the complete police report
- A written consent must be obtained from the member for all pregnancy terminations. If the member is under 18 years of age, or is 18 years of age or older and considered an incapacitated adult, a dated signature of the member's parent or legal guardian is required

Medical Emergencies

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

Additional Considerations Related to Use of Mifepristone

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

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

After Administration of Mifepristone the Following Documentation is Required:

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

Billing and Reimbursement

Claims should not be submitted until after the delivery of the newborn or the care is transferred to another provider. Each provider should submit all prenatal services, ancillary services, and delivery of the newborn on a CMS 1500 form using the OB authorization number. Health Choice Arizona will reimburse the physician via the contractual agreement. Review your Health Choice Arizona Subcontractor Agreement for the required minimum number of prenatal visits in order to receive the Total Global OB Package fee if applicable. The global fee reimbursement is paid to members assigned PCO for all professional services listed in the "The Total OB Reimbursement".

Reimbursements for carve-out services are listed separately on the CMS 1500. The authorization number should be listed on all claims submitted for reimbursement.

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

Medical Record Review

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